AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Thursday, January 12, 2017

SUBJECT	DESCRIPTION	PRESENTER
Docket No.	Rules Review - Idaho State Board of Pharmacy	Alex J. Adams, Executive Director
27-0101-1601	Legislative Conformance	
27-0101-1602	Telepharmacy	
27-0101-1603	Technician Modernization	
27-0101-1604	Pharmacy Practice	
27-0101-1606	Partial Fills of Schedule II Drugs	
Docket No.	Rules Review - Idaho Board of Nursing	Sandra Evans, Executive Director
23-0101-1601	Fees for Emeritus Status Nurses	
23-0101-1602	Clinical Opportunities for APRN Students	
RS24911	Relating to Compensation for Board of Nursing Members	Sandra Evans
RS24913	Relating to Renewal of Nursing Licenses on Emeritus Status	Sandra Evans

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
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MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Thursday, January 12, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	Senators Anthon
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Health and Welfare Committee (Committee) to order at 3:00 p.m. Chairman Heider welcomed everyone to the first meeting of the Committee.
PAGE WELCOME:	**Chairman Heider** introduced Page Tia Youts from Richfield as the Committee page for the first half of the 2017 Legislative Session.
PASSED THE GAVEL:	Chairman Heider passed the gavel to Vice Chairman Souza to conduct the rules review.
DOCKET NO. 27-0101-1601	**Rules of the Idaho Board of Pharmacy Relating to Legislative Conformance. Alex Adams**, Executive Director of the Idaho Board of Pharmacy, introduced himself and described how the Board obtained feedback on improving the rules and allowed additional time for public comment on the proposed rule changes. **Mr. Adams** explained several bills in the 2016 Idaho Legislature were passed that necessitate conforming changes in the Board rules. The rule updates will exempt investigational drugs from certain registration requirements; allow prescription medications such as epinephrine injectors to be labeled in the name of an authorized entity; enable delegate access to the Prescription Monitoring Program and update the reporting requirements to conform to current practice; allow regional behavioral health clinics to donate and receive donated medications to dispense to medically indigent patients; and expand the venues at which emergency medication kits can be housed to include specialty infusion clinics. **Vice Chairman Souza** asked Committee members if they had any questions, and there were none.
TESTIMONY:	**Vice Chairman Souza** invited testimony. **Mark Johnston** introduced himself as the former Executive Director of the Idaho Board of Pharmacy and now representing CVS Health and others. **Mr. Johnston** stated he was appreciative of the work done by the Board and Mr. Adams to be a national leader in pharmacy. He is in support of the five rule dockets before the Committee. **Pam Eaton** introduced herself on behalf of Idaho Retailers Association and Idaho State Pharmacy Association. **Ms. Eaton** said she also supports all five rule dockets and commended the Board of Pharmacy for working with stakeholders to develop the rules.
MOTION:	There being no more testimony or questions, **Senator Harris** moved to approve **Docket No. 27-0101-1601. Senator Lee** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 27-0101-1602 **Rules of the Idaho Board of Pharmacy Relating to Telepharmacy. Mr. Adams** explained telepharmacy involves a remote dispensing site that looks like a retail pharmacy, but there is no pharmacist physically on premises. Instead, the pharmacy is staffed by a pharmacy technician, and pharmacist oversight is provided by a pharmacist via live video feed so the pharmacist can verify orders, screen prescriptions, verify final products, and counsel the patient. The pending rule would: allow streamlined registration of remote dispensing sites to applicants who meet certain criteria; broaden the technology that may be used at a remote dispensing site beyond just an automated dispensing system; remove the requirement that a remote dispensing site be co-located with a medical care facility; remove the requirement that business contracts be filed with the Board; update limits on the oversight of multiple remote dispensing sites; and remove duplicative language from the telepharmacy rules that are already specified in other existing Board rules. Benefits of telepharmacy include expanded access to citizens in rural communities and enhanced ability to obtain prescriptions 24 hours a day, as well as more opportunities for business expansion.

Senator Lee commended Mr. Adams for his work. She knows the rule docket was a compromise and her previous concerns have been addressed. The change will allow for expanded access in a cost-effective manner. **Mr. Adams** responded the Board has grown increasingly comfortable with the concept of telepharmacy. In many ways, they perform better than the industry average.

Chairman Heider asked how long it takes to obtain a prescription when ordered through a telepharmacy, and how the prescription is delivered. **Mr. Adams** replied there is a pharmacy technician on site and it looks just like a regular pharmacy. The technician scans the prescription and the off-site pharmacy reviews it in real time. The prescription would be delivered in ten to 15 minutes just as in a retail pharmacy. **Chairman Heider** asked how the pharmacy knows what drugs will be needed. **Mr. Adams** answered that inventory management is handled like any retail pharmacy, and it involves trial and error for the products and volume. If a patient has a prescription not on the shelf, it can be ordered and received the next business day.

MOTION: There being no more questions, **Senator Foreman** moved approval of **Docket No. 27-0101-1602. Chairman Heider** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 27-0101-1603 **Rules of the Idaho Board of Pharmacy Relating to Technician Modernization. Mr. Adams** explained pharmacy technicians are support personnel who work under the supervision of a licensed pharmacist. Competency exams and criminal background checks are required. The pending rule updates and modernizes the Board's pharmacy technician rules given advancements in the education and training of technicians as well as advancements in the technology environment. Delegated activities have not been updated since the 1970s, and nearly one-half of a pharmacist's time in Idaho is now spent doing things that can be delegated to technicians in other states.

Mr. Adams explained after conducting research on practices in other states, the Board developed this docket, which would allow pharmacy technicians to conduct activities that don't require professional discretion. Pharmacists could delegate certain non-judgmental tasks to properly-trained, registered, and certified pharmacy technicians under their supervision. Such tasks include the ability to clarify missing elements on prescriptions, transfer prescriptions, administer medications, and take verbal prescriptions in certain circumstances. The docket also expands verification technician programs beyond acute care hospitals and enables remote data entry by certain pharmacy technicians. The State of Arizona took a similar approach and 500 new jobs were created for technicians, including people with disabilities or small children. Pharmacist supervision is defined as the pharmacist being physically present on the premises and immediately available to the technician to

respond to emergencies and questions. The docket is supported by the Idaho Society of Hospital Pharmacies and many others.

Vice Chairman Souza called for questions from the committee, and there were none. **Vice Chairman Souza** thanked Mr. Adams for promptly and thoroughly answering her questions when she contacted him about the docket.

MOTION: There being no more questions, **Senator Lee** moved approval of **Docket No. 0101-1603. Senator Harris** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 27-0101-1604 **Rules of the Idaho Board of Pharmacy Relating to Pharmacy Practice. Mr. Adams** informed the Committee the Board of Pharmacy needs to update several rule sections given advancements in technology and changes in pharmacy practice. In addition, the board intends to clarify several rules based on recent inspections and Board administrative hearings. The pending updates would limit the number of times an applicant can take the law or competency exam to a maximum of five times. Additionally, the docket would allow pharmacists to synchronize prescriptions for chronic conditions so they are all due at the same time to simplify monitoring for the physician and make it easier for the patient to obtain refills. The docket also adds language specifically authorizing institutional pharmacies to collected unwanted medications for destruction; updates requirements for pharmacy building security; enables broader emergency room dispensing in conformance with a U.S. Supreme Court decision; clarifies prepackaged product labeling requirements; updates the list of required pharmacy references; and allows for controlled substances to be delivered directly to a provider if the product is intended for direct administration.

Vice Chairman Souza invited questions from the Committee.

MOTION: There being no questions, **Senator Agenbroad** moved approval of **Docket No. 27-0101-1604. Senator Jordan** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 27-0101-1606 **Rules of the Idaho Board of Pharmacy Relating to Partial Fills of Schedule II Drugs. Mr. Adams** informed the Committee this docket did not go through negotiated rulemaking, as it relates to federal law changes signed late in 2016 and there was no time to go through the process. However, the Board provided time for public comment and e-mailed the docket to interested parties. The docket would allow a patient to receive fewer Schedule II controlled substance pills than written by a prescriber, while not forfeiting the balance if picked up within a certain time frame. The federal law change is intended to reduce the amount of Schedule II controlled substances dispensed, including opiods.

Vice Chairman Souza commented the change makes sense and she is glad to see it. **Vice Chairman Souza** invited questions from the Committee.

MOTION: There being no questions, **Senator Harris** moved approval of **Docket No. 27-0101-1606. Senator Lee** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 23-0101-1601 **Rules of the Idaho Board of Nursing Relating to Fees for Emeritus Status Nurses. Sandra Evans** introduced herself as the Executive Director of the Board of Nursing. **Ms. Evans** informed the Committee that this docket accomplishes four objectives. Section 008 allows nurses to provide an electronic address in addition to a street address for purposes of receiving notifications and communications from the Board of Nursing and permits the Board to use e-mail communication in appropriate circumstances, including for service of process in contested cases. Section 060.04 and Section 900.04 deletes the requirement to biennially review an emeritus nursing license and the related fee. An emeritus license is issued to nurses choosing to retire from practice. It does not allow active nursing practice but allows the holder to continue to use the protected title Licensed Practical Nurse, Registered Nurse, or Advanced Practice Registered Nurse. This confers a benefit on the retired nurse who has maintained a license in good standing.

Ms. Evans explained Sections 132 and 133 contain updated language referencing substance use and mental health disorders and the current preferred language for these primary illnesses. Finally, Section 315 and Section 901 would delete the application fee for prescribing and dispensing authority for advanced practice registered nurses. Recent changes in course content requirements for accredited APRN programs have reduced the complexity of processing of prescribing and dispensing authority applications sufficiently to warrant elimination of the related application fee. **Ms. Evans** stated notice of the intent to promulgate rules and negotiated rulemaking was published on July 6, 2016. Comments received were limited in number and supportive, noting specifically that as proposed, the rules are in alignment with current trends and national standards. There is an estimated negative fiscal impact of less than $10,000 annually to the Board's dedicated fund resulting from implementation of these rules. These is no fiscal impact to the State General Fund. The anticipated loss of revenue is supported by the Board's current fund balance and will not require an increase in license fees.

Vice Chairman Souza remarked she likes a fee reduction and invited questions from the Committee.

MOTION: There being no questions, **Senator Jordan** moved approval of **Docket No. 23-0101-1601. Chairman Heider** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 23-0101-1602 **Rules of the Idaho Board of Nursing Relating to Clinical Opportunities for APRN Students. Ms. Evans** informed the Committee that this rule amends Section 640.05 of Board Rules to allow licensed physicians and physician assistants, in addition to licensed Advanced Practice Registered Nurses (APRNs), to serve as clinical preceptors for APRN students. **Ms. Evans** explained clinical preceptors, which are critical to the education of APRN students prior to their transition to independent practice. However, clinical preceptors are limited in number and location under the current rules. This docket would allow licensed physicians and physician assistants, in addition to licensed APRNs, to serve as clinical preceptors, thus expanding their availability. **Ms. Evans** reported notice of the intent to promulgate rules and negotiated rulemaking was published on July 6, 2016. Comments received were limited in number and supportive, noting specifically that as proposed, the rules are in alignment with national standards for APRN educational programs. The change may serve to retain graduates of these programs who will choose to continue to practice in communities where their clinical preceptorship occurred. There is no fiscal impact resulting from implementation of the rules.

Vice Chairman Souza commented she was a clinical nursing instructor and knows the importance of this role.

Senator Heider asked for the definition of a clinical preceptor, and the required training level. **Ms. Evans** answered a preceptor provides direct oversight for patient care activities with an APRN student to get clinical experience. APRNs are nurses with a second advanced license. Preceptors serve in a voluntary capacity.

MOTION: There being no more questions, **Senator Foreman** moved approval of **Docket No. 23-0101-1602. Senator Lee** seconded the motion. The motion carried by **voice vote.**

PASSED THE GAVEL: Vice Chairman Souza passed the gavel back to Chairman Heider.

RS 24911 **Relating to Compensation for Board of Nursing Members. Ms. Evans** informed the Committee that the RS would amend Idaho Code to make technical corrections and revise the compensation to members of the Board of Nursing for their service on the Board. The current honorarium is $50 and the legislation provides for an upward adjustment to $75 per day as provided in Idaho Code § 59-509(i). There is a negative fiscal impact of less than $5,000 on the Board's dedicated fund and none to the General Fund. The Board's current fund balance supports this impact without having to raise license fees.

Senator Martin inquired if the amount of the honorarium was identified in the RS. **Ms. Evans** answered the reference in the Board of Nursing statutes does not specify a dollar amount but instead references the compensation schedule located in a separate section of Idaho Code.

Senator Lee commented she would prefer to see the schedule of honorarium fees with the RS, since the Statement of Purpose (SOP) does not reflect the specific dollar amount of the new honorarium. **Senator Lee** asked if the Statement of Purpose could be revised. **Chairman Heider** said any revision would require a new RS with a new Statement of Purpose.

Senator Harris asked how long the honorarium has been $50. **Ms. Evans** responded it was in place since 1998.

Chairman Heider asked if the concern was great enough to justify referring the RS back to the sponsor for amendment. **Senator Foreman** remarked that the SOP would have been a little clearer if the $75 figure was included, but he is satisfied with it as written because the amount is incorporated in Idaho Code, and it can be explained by the floor sponsor.

MOTION: There being no more questions, **Senator Foreman** moved to send **RS 24911** to print. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**

RS 24913 **Relating to Renewal of Nursing Licenses on Emeritus Status. Ms. Evans** informed the Committee the legislation would eliminate the requirement in Idaho Code for a nurse on emeritus status to renew the nursing license and pay the renewal fee. There is an estimated negative fiscal impact of less than $10,000 annually to the Board's dedicated fund resulting from the change, and there is no fiscal impact to the General Fund. The anticipated loss of revenue is supported by the Board's current fund balance and will not require an increase in license fees.

MOTION: There being no questions, **Senator Martin** moved to send **RS 24913** to print. **Senator Lee** seconded the motion. The motion carried by **voice vote.**

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 3:56 p.m.

Senator Heider
Chair

Jeanne Jackson-Heim
Secretary

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Monday, January 16, 2017

SUBJECT	DESCRIPTION	PRESENTER
Docket No. 16-0210-1710	Idaho Reportable Diseases	Dr. Leslie Tengelsen Division of Public Health
Docket No. 16-0219-1601	Food Safety and Sanitation Standards for Food Establishments	Patrick Guzzle Division of Public Health
Docket No. 16-0601-1601	Chafee Program Funding Age	Gracie O'Brien Family & Children's Services
Docket No. 16-0719-1601	Certification of Peer Support Specialists and Family Support Partners	Jennifer Barnett Division of Behavioral Health
Docket No. 16-0737-1601	Children's Mental Health Services	Stephanie Hoffman Division of Behavioral Health
RS24846	Relating to Child Protection	Miren Unsworth Division of Family and Community Services

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

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MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Monday, January 16, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Health and Welfare Committee (Committee) to order at 3:00 p.m. and welcomed Department of Health and Welfare (Department) staff to the meeting. **Chairman Heider** remarked that he appreciated the Department's support of the Committee and, on behalf of the Committee, expressed his support of the Department.
PASSED THE GAVEL:	Chairman Heider passed the gavel to Vice Chairman Souza to conduct the rules review.
DOCKET NO. 16-0210-1701	**Idaho Reportable Diseases. Dr. Leslie Tengelsen** introduced herself to the Committee as a Senior Epidemiologist with the Bureau of Communicable Disease Prevention, Division of Public Health. She informed the Committee her title is State Public Health Veterinarian, and she is concerned with protecting Idaho residents from diseases acquired from animals and insects. The temporary rule, adopted by the Board of Health and Welfare on November 17, 2016, requires all suspected or confirmed cases of insect-borne viral disease, known as arboviral disease, be reported within three working days of identification to public health officials in the Department or local public health districts.

Dr. Tengelsen explained there are approximately 130 arboviral diseases that cause death or disease in people, and the reportable disease rules already mandate the reporting of West Nile virus. Until this rule was adopted, other arboviruses were only reported to public health agencies voluntarily and are likely under-reported because of this practice. Zika virus is a serious arbovirus, and four imported cases have been voluntarily reported in Idaho. To protect the public's health, arboviral diseases must be tracked to reduce the spread and likelihood of local insect-borne transmission.

Dr. Tengelsen described specific changes to the rule. Rule 16.02.10.125, entitled Arboviral Diseases, is a new section devoted to arboviral disease reporting requirements and case investigation. This addition will allow the Department to capture all arboviral infections under one category. Arboviral diseases, as a category, was added to the table in Section 050 where the reporting requirements are listed. Because the new section includes West Nile virus, West Nile virus was removed from the tables in Sections 050 and 800. Several documents incorporated by reference were updated: 1.) the "National Notifiable Diseases Surveillance System Case Definitions" URL was added and unnecessary language was removed; 2.) the 2005 "U.S. Public Health Service Guidelines for the Management of Occupational Exposure to Human Immunodeficiency Virus (HIV) and Recommendations for Post-Exposure Prophylaxis" was replaced with the updated 2013 version of the same document; 3.) the 2011 "Compendium of Animal Rabies Prevention and Control" was replaced with the updated 2016 version of the

same document; and 4.) a new Subsection 004.07 was added to incorporate the document entitled "Use of Reduced (4-Dose) Vaccine Schedule for Post-Exposure Prophylaxis to Prevent Human Rabies: Recommendations of the Advisory Committee on Immunization Practices, 2010" as a companion document to the "Human Rabies Prevention, 2008" document currently incorporated by reference in Section 004.03. A few minor changes were made in the definitions section to match the updated incorporated references, and parts of Section 610 were updated to align with new guidance incorporated by reference.

Dr. Tengelsen informed the Committee the Department anticipates no fiscal impact to the General Fund or any other funds except the costs associated with rule promulgation, printing, and publication. Negotiated rulemaking was not conducted, although public health district stakeholders were consulted and support the temporary rule.

Vice Chairman Souza invited questions from the Committee. **Senator Martin** asked why no public hearings were held on the docket. **Dr. Tengelsen** responded the temporary rule was put in place rather urgently with the emergence of the Zika virus. The Department consulted with public health districts, the primary stakeholders, and they were supportive. **Senator Martin** inquired whether stakeholders will be informed about the new reporting requirements. **Dr. Tengelsen** answered that health care providers and laboratorians are being advised of the change through newsletters to various groups.

MOTION: There being no more questions or testimony, **Senator Martin** moved to approve **Docket No. 16-0210-1701**, noting the agenda reference to the docket number contained a typographical error. **Senator Anthon** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 16-0219-1601 **Food Safety and Sanitation Standards for Food Establishments. Patrick Guzzle**, introduced himself as the Food Protection Program Manager with the Department's Division of Public Health. **Mr. Guzzle** informed the Committee the Food Protection Program (Program) works closely with Idaho's public health districts to inspect and license food establishments, investigate complaints, and ensure the safety of food being purchased and consumed in Idaho. The Program provides direct support and technical guidance to the public health districts as well as consumers, industry representatives, and all other food safety stakeholders.

Mr. Guzzle explained there was some confusion in terminology in the food safety rules approved by the 2016 Legislature because the term "critical" was used to describe two different things: 1.) the severity of a food safety infraction and how soon it must be resolved; and 2.) the actual score of the inspection, reflecting the number of food safety violations observed. To resolve the confusion, the docket replaces the term "critical" with the term "risk factor" and the term "non-critical" with the term "good retail practice" for the purposes of scoring an inspection. This change will match the food inspection report that is separated into two sections: risk factors and good retail practices. It is consistent with how many other states use these terms and results in no change to the health districts or food establishments.

Mr. Guzzle clarified the terms "critical" and "non-critical" will still be used but only to describe the nature of a food safety violation and how soon it must be resolved. Some examples of "critical" violations include staff members working while ill with a condition that can be easily transmitted to others through the food, improper handwashing practices, improper temperature control of foods, or contamination of foods. A much shorter time frame is allowed to correct critical violations, and they are usually required to be corrected while the inspector is still on-site. Some examples of "non-critical" violations include broken floor tiles, soiled surfaces that do not result in food contamination, or inadequate ventilation or lighting. Such situations warrant a longer correction time frame because they normally do not present an immediate risk to food safety.

Vice Chairman Souza invited questions from the Committee. **Chairman Heider** asked how often inspections are conducted. **Mr. Guzzle** responded they are usually conducted annually. **Chairman Heider** inquired if a violation such as a broken pipe or food not warm enough to kill bacteria was found whether it could be an entire year until the facility was reinspected for compliance. **Mr. Guzzle** answered it would be another year until an inspection. However, during the initial inspection where a violation is found, documentation is left with the food establishment. Follow-up is conducted within ten calendar days, either by conducting a follow-up inspection or allowing the establishment to submit a correction report back to the local health district, depending on the history of the establishment and the nature of the violation. **Senator Martin** asked how many attended the September 15, 2016 public hearing, how many called in, and what was the response from participants. **Mr. Guzzle** replied no one called into the hearing although the phone line was left open for one-half hour. **Senator Martin** further inquired whether people could attend the hearing in person. **Mr. Guzzle** confirmed the option to attend in person was provided, but no one participated either in person or by telephone.

TESTIMONY: **Pam Eaton** introduced herself as the President and CEO of the Idaho Lodging and Restaurant Association and informed the Committee her members are the primary stakeholders impacted by this rule. Her group is fine with the rule and they applaud the Department and Mr. Guzzle for how closely they work with industry and stakeholders when creating the rules.

MOTION: There being no more questions or testimony, **Senator Harris** moved to approve **Docket No. 16-0219-1601. Senator Lee** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 16-0601-1601 **Chafee Program Funding Age. Gracie O'Brien** introduced herself to the Committee as the Independent Living Program Specialist, Child Welfare Policy Unit, Division of Family and Community Services. **Ms. O'Brien** informed the Committee her team oversees the development of policy and practice standards for the safety, well being, and permanency for children and families served in the child welfare system.

Ms. O'Brien provided background on the John H. Chafee Foster Care Independence Program Act (Chafee Program), passed by the U.S. Congress in 1999 to promote a more successful transition to adulthood for youth leaving foster care. The Chafee Program also provides federal funding to accomplish this goal. The Idaho Foster Care Independence Program uses this federal funding to provide services to eligible youth in foster care between the ages of 15 to 21 who have been in State custody for at least 90 days after their 15th birthday. Independent living services focus on culture and personal identity formation, supportive services and community connections, physical and mental health, life skills, education, employment, and housing.

Ms. O'Brien informed the Committee that 2016 changes to Idaho Code §§ 16-1621 and 16-1622 and Public Law 113-183 require the Department to begin assessing and providing independent living services to young people in foster care beginning at age 14 instead of age 15. To align with changes in these laws, the pending rule docket lowers the age at which foster youth are eligible to receive independent living services funded by the Chafee Program from 90 days after their 15th birthday to 90 days after their 14th birthday. Negotiated rulemaking was deemed not feasible because the rule changes increase services and align the rules with State and Federal law. One public hearing was held with no attendees or further comments received by the Department. The program is federally funded, and the increased access to services afforded by the rule change could reduce demand on General Fund monies and other federal funding.

Senator Lee asked whether the entire $500,000 in federal funds currently received for the program is expended, and if so, will the rule change place additional demand on these resources. **Ms. O'Brien** replied all money allocated each year is expended, but how it is used depends on need. If the population is lower than anticipated, the Department can add additional services and be more creative in how funds are used.

Senator Lee inquired what services might become unavailable if the age is lowered and where the tension on these dollars might be going forward. **Ms. O'Brien** gave an example of regions running independent living groups. If there are extra dollars, the Department can provide incentives to increase participation. These processes will not change if the rule is approved. **Senator Foreman** asked how many additional persons will be covered by lowering the age to 14. **Ms. O'Brien** answered an analysis was conducted for fiscal years 2013 to 2016, and there would be an additional 20 youth per year. **Vice Chairman Souza** asked for clarification about the number and whether it meant there are 20 year per year in the entire program or 20 additional youth. **Ms. O'Brien** stated it would be 20 youth per year statewide. **Senator Martin** asked why the age is changing from 15 to 14. **Ms. O'Brien** explained research shows youth in foster care typically have a hard time exiting foster care. The longer the Department is able to engage with these young people, the more successful the transition to be a member of society. Most are in high school by age 14.5 so it would enable them to start doing career planning. Because of what they know about trauma and foster care, it gives more time to make a positive impact.

MOTION: There being no more questions, **Senator Foreman** moved to approve **Docket No. 16-0601-1601. Senator Martin** seconded the motion. The motion carried by **voice vote.**

Vice Chairman Souza recognized Ms. O'Brien, who asked to clarify for the Committee that it is 20 additional youth who would be added to the program, not a total of 20 youth statewide who would be involved in the program. **Vice Chairman Souza** asked if any Committee member wished to change his or her vote based on the additional information, and no changes were requested.

DOCKET NO. 16-0719-1601

Certification of Peer Support Specialists and Family Support Partners.

Jennifer Eason-Barnett, Quality Assurance Specialist with the Department of Health and Welfare Division of Behavioral Health, introduced herself to the Committee to present the pending rule docket. **Ms. Eason-Barnett** explained the Division of Behavioral Health seeks to expand provider types in the behavioral health service system by training and certifying Peer and Family Specialists, who are unregulated by the Idaho Bureau of Occupational Licensing. The rule will protect the public health, safety, and welfare of vulnerable individuals with behavioral health issues by ensuring these providers are qualified and meet certain standards. Peer Support Specialist Training began in 2007. In 2014, the Division of Behavioral Health developed behavioral health standards for Peer Support Specialists and for an additional provider category of Family Support Partner. The standards were developed in collaboration with stakeholders, including peers and families, and underwent a public comment process prior to adoption into the behavioral health standards handbook.

Ms. Eason-Barnett informed the Committee that over the last nine years, peer and family support services have grown significantly. The pending rule would legitimize and support this provider type as a para-professional occupation with adherence to standards and a code of ethics. The provision of support services by a peer or family provider is nationally a best practice to assist individuals with behavioral health issues towards recovery. These providers are unique to the behavioral health system due to the "lived-experience" support they can provide to an individual currently in services. People serving as Peer Support Specialists have expressed the program helps give them a purpose in life and allows them to use their own challenges in recovery to provide a unique perspective. Peer Support Specialists and Family Support Partners are found in settings such as behavioral health clinics, on ACT teams, in recovery centers, and hospitals.

Ms. Eason-Barnett stated the rule provides the qualifications and requirements needed to become certified by the Division of Behavioral Health and addresses the administration of certification, including enforcement and actions for denial, revocation, or suspension. For certification, as outlined in the pending rules, these para-professionals would be required to obtain supervised work experience and on-going continuing education or training following certification to ensure the safety, health, and welfare of those receiving behavioral health services. There is no anticipated impact to the General Fund or any other funds for this rule change. Negotiated rulemaking was conducted in 2016. Comments from the public hearing were positive, and recommendations for changes were incorporated into the pending rule.

Vice Chairman Souza requested that Ms. Eason-Barnett walk the Committee through the changes in the rule. **Ms. Eason-Barnett** responded this is a brand new chapter of rules. Peer Support Specialists began appearing in 2007 to help individuals receiving behavior health services. The rule docket outlines guidelines for training and certification.

Ms. Eason-Barnett reviewed the definition of Family Support Partner in Section 010.05 as someone who has had the experience of raising a child with a behavioral health disorder diagnosis, mental illness, or substance use disorder. Section 010.07 defines "lived experience" as personal experience with the behavioral health services system. Section 200.02 identifies the minimum training topics to demonstrate competency in accordance with national best practices. This section also adds a training topic of motivation and empowerment to ensure the provider has the skills to assist the individual in care.

Beverly Barr introduced herself as the Rules Specialist for the Department of Health and Welfare and stated the rule is a brand new chapter. The Division conducted negotiated rulemaking, and the docket was published as a proposed rule in October 2016. The proposed rule has never been codified. In January, the rule was republished as a temporary rule. **Vice Chairman Souza** asked if there was different language in the rule that was deleted during negotiated rulemaking and if there was new language inserted. **Ms. Barr** replied that the words were inserted after the rule was first published to incorporate comments received during the 21-day public comment period. **Senator Lee** asked for clarification whether the red additions came from negotiated rulemaking and were not added independently by the Department. **Ms. Barr** answered the changes were based on public comments received by the Department through the public hearings.

Mr. Edmunds, Administrator for the Division of Behavioral Health, informed the Committee this is the process of the Department of Administration. The original set of rules are submitted, and then they were improved based on public comment. The changes came from negotiated rulemaking and the public hearing, and this is the Department's best effort at a finished rule. **Mr. Edmunds** apologized for the confusion; however, this is the rule that was intended to be published. The Department is very comfortable with the rules and wants the Committee to be comfortable with them as well.

Senator Martin asked how many people called in or attended the public hearing on October 21. **Stephanie Hoffman**, Program Specialist with the Department's Division of Behavioral Health, was recognized and introduced herself to the Committee. **Senator Martin** repeated his question of how many providers this rule affects and how many gave input to the process. **Ms. Hoffman** advised she was present at the public hearing, and there were two providers who participated by telephone and one provider who attended in person who gave input on the rules. **Ms. Hoffman** referred Senator Martin's question about the number of providers affected by the rule to Ms. Eason-Barnett. **Ms. Eason-Barnett** returned to the podium and stated this is a new provider type and an addition to the behavioral health network so the program has the potential to grow.

Senator Harris asked whether the text in red print was added after the public comment period. **Ms. Eason-Barnett** answered that is correct. **Senator Harris** inquired if any public comment was obtained after the text in red print was added. **Ms. Eason-Barnett** replied no additional public comment was taken. **Senator Foreman** asked whether he understands the process correctly: public hearings were held, a proposed document was developed, the proposed document was published in a bulletin but not codified, and it became the pending document. The changes in red are the differences between the proposed and the pending rule. The Committee is not seeing the entire flow because members do not have the bulletin, but if the bulletin was included, the Committee could see the changes. **Ms. Eason-Barnett** confirmed Senator Foreman's understanding and added there was negotiated rulemaking conducted prior to the public hearing with no input, and the only input was received after the public hearing.

Senator Jordan inquired how many peer reviewers and counselors the program has had. **Ms. Eason-Barnett** answered there were approximately 200 providers in the first group of training. From that initial training, the Department identified a need for quality assurance of the providers to protect those receiving behavioral health services, and this rule is the result. **Senator Jordan** stated she has spoken with a number of providers and those who have availed themselves of the services. She knows the services are valuable but has some concerns about people who place themselves in a peer support role because their own emotional experiences can color a lot of things. **Senator Jordan** asked what type of monitoring the Division of Behavioral Health has in place to either visit or observe or otherwise ensure that people providing these services are performing appropriately. **Ms. Eason-Barnett** responded the rule requires providers to adhere to a code of ethics. If a provider was to be hired as an employee of a community behavioral health organization, the provider would also be required to undergo a background check. An applicant undergoes further review of qualifications to ensure eligibility for certification. The Division of Behavioral Health maintains a list of those who have passed the minimum 40 hours of training and obtained certification. There are written standards to follow for peer support or family services providers, including standards to prevent overbilling, requirements for supervision, support for the provider, consistent enforcement and discipline of ethical violations, and a mechanism to respond to concerns.

Senator Jordan asked about the "family dynamics" training requirement in Section 200.02 as it relates to the Section 300.q reference to the "child and family team" and "how to be a team player." **Senator Jordan** expressed concern as to why these two sections are different. **Ms. Eason-Barnett** explained the training requirements are based on recommended best practices. The "team player" reference relates to the Family Support Provider understanding their role on a child-family team and interacting with other members of that team versus understanding family dynamics in general.

Chairman Heider judged the topics are good things and sees the rule as a productive step. These are not professionals but peers and they are appropriate ideas for a list of topics to be discussed and a collection of ideas to help people communicate better. **Chairman Heider** expressed his support for the rule as written. **Ms. Eason-Barnett** asserted her agreement with Chairman Heider and stated this is about helping someone be more successful in behavioral health treatment. People progress through treatment when they have this kind of support versus working with a professional with a degree.

Senator Foreman asked if consideration was given to whether the certification requirements would discourage young people from going through the process. **Ms. Eason-Barnett** replied the Division's experience was to the contrary; the program has given many people an avenue to help others if they only have a high school diploma or GED and they have few other options except for the story of their own mental health journey. Individuals are very excited about the possibility of giving back to others. The family support piece is also beneficial because it is difficult for families with children with severe emotional disturbances to navigate the system.

Senator Jordan asked if the family support component relates to adults working with adults, or might it involve an adult working with a child or young person. **Ms. Eason-Barnett** responded that the Family Support Partner is an adult working with a parent or caregiver who has a child currently in the behavioral health system. There may also be a peer on the child-family team, and a family member that is struggling may have his or her own peer support provider. **Senator Jordan** further inquired if an adult family support partner works with their own peers and not with the young person unless another person is brought in for that younger person. **Ms. Eason-Barnett** answered that is correct. **Senator Lee** asked whether there is a cost to the person undertaking the training and certification, and if there is a cost to the Department to implement the rules. **Ms. Eason-Barnett** replied there is no cost for the certification, but there is a cost for the training. They are not anticipating any additional costs to the Division of Behavioral Health's budget. **Senator Lee** inquired whether the cost for training is for the Department or for the participant. **Ms. Eason-Barnett** answered there is a cost to the participant for the training; however, most of the community behavioral health providers adding peer supports to their array of services find enough value in it that they are paying for the training. **Vice Chairman Souza** asked what the cost is to the individual. **Ms. Eason-Barnett** stated it is approximately $300 for the training but sometimes there are scholarships for individuals.

MOTION: There being no more questions, **Senator Martin** moved to approve **Docket No. 16-0719-1601**. **Chairman Heider** seconded the motion.

Senator Lee concurred the program is a great idea; however, it is a substantive addition to the rules. Her preference would be to have the Legislature pass a policy followed by the agency adopting a rule to implement the policy. **Senator Lee** stated she will support the motion but cautioned the agency about bringing new programs without having a conversation first as she does not want to approve policy in a rule.

The motion carried by **voice vote.**

DOCKET NO. 16-0737-1601 **Children's Mental Health Services. Stephanie Hoffman,** Ph.D., Human Services Program Specialist, Division of Behavioral Health, introduced herself to the Committee. The rule docket makes changes to the Children's Mental Health Services chapter to: 1.) adhere to best practices regarding alternate care placement; 2.) add definitions that clarify procedures; and 3.) add some minor clarifications regarding the initial implementation phase of the Jeff D settlement agreement approved by the federal court. **Dr. Hoffman** explained the Jeff D lawsuit is a 36-year-old federal class action lawsuit against the State of Idaho regarding children's mental health services. The settlement agreement required the Department to utilize a specific tool to assess the child's and the family's strengths and needs to assist in the development of an individual treatment plan. An individual treatment plan describes the strengths, needs and goals that are unique to the individual child and his or her family. With input from the family, the plan guides the individualized services and supports that will assist the child in meeting the desired outcomes. This rule adopts a new assessment tool to comply with the settlement agreement, and language in the eligibility section of this chapter is being revised to allow for implementation of the new tool.

Dr. Hoffman informed the Committee the Division of Behavioral Health is removing language from the rule that speaks of federal child welfare requirements which no longer apply to children's mental health practices because the Division no longer accesses federal child welfare funding for children's mental health services. Alternate care placement practices have been adjusted in response to the change in funding. Alternate care is a temporary living arrangement outside the family home which may include licensed therapeutic foster care or residential treatment that provides 24-hour care for children. Finally, throughout the chapter, the docket includes technical or clerical corrections or minor clarifications of existing language. This rule has no fiscal impact to the General Fund or any funds. Negotiated rulemaking was not conducted for this docket; however, the changes were vetted with Department staff from the affected divisions, and the new assessment tool was negotiated with representative stakeholders through the Jeff D mediation and implementation planning process. A public hearing with teleconference option was held. No members of the public participated, and there was no opposition or support from the public.

Vice Chairman Souza asked Dr. Hoffman to describe significant changes in the language. **Dr. Hoffman** responded the most significant changes involve the definitions; specifically, the definitions of "behavioral health," "crisis plan," "face-to-face contact," "placement agreement," and "treatment plan." As a result of the Jeff D lawsuit, the definition of "treatment plan" was expanded to add components. Some sections were moved to other locations in the rule to improve the flow. Page 171 includes a most significant section under "Eligibility Determination." Section 107.02.d. adds the Department's approved tool and removed the tool they were using. Also, language is added to clarify parents and guardians retain custody of the child when the child is receiving services from the Division of Behavioral Health. On page 172, language was added to bring clarity to development of a treatment plan. Again, language was moved from other sections. On page 176, the Department will be responsible for explaining financial arrangements to the parent. Page 179 includes updates to the rates for family alternate care payments. Finally, on page 181, a clarification was made in Section 800 to ensure treatment plans focus on goals, safety, and effectiveness of treatment, and to add the Department may request the Court hold a review hearing for the child in accordance with Idaho Code.

Vice Chairman Souza invited questions from the Committee. **Senator Anthon** asked about the difference between substance abuse and substance use disorder in Section 013.02. **Dr. Hoffman** explained nationally, the terminology has changed because the term substance abuse has a negative connotation. Best practice and research shows it's a disorder because of the chemistry of the brain and the body, and it's not a person's fault they have a substance use disorder.

Senator Agenbroad asked for clarification on Dr. Hoffman's statement that the rule was fiscally neutral when page 179 contains a table of increased amounts for alternate care payments, and how those increases will be covered. **Dr. Hoffman** replied the rates fall under the Division of Family and Community Services and they are adjusted due to inflation. **Senator Agenbroad** reiterated the rule does not appear to be fiscally neutral if the rates are going up, regardless of the reason. **Dr. Hoffman** deferred to Mr. Edmunds to answer the question. **Mr. Edmunds** returned to the podium and informed the Committee the cost of the individual services will go up but there is no difference in the Department's appropriation to pay for those services, so there is no fiscal impact to the Department or General Fund.

Senator Harris inquired about the various plans referenced in the rule and whether the plans are tracked by the Department. **Dr. Hoffman** explained when a child comes under services of the Department, there is a treatment plan. The treatment plan includes a crisis plan and, if the child goes to alternate care placement, an alternate care placement plan. Not every child will have an alternate care placement plan because not every child is outside the home for a while. Each plan covers specific goals for the child's safety. A crisis plan sets forth to everyone in the child's life what needs to happen in a time of crisis. The plans are kept in one electronic file.

Senator Lee asked who has the final say in the event parents disagree with the Department. **Dr. Hoffman** replied the parents are very much involved and are part of the team. They help make up the treatment plan. If they disagree, they are able to say that at the table at the time. If they disagree later, the plan can be changed. Just because the parents say they don't like something, it doesn't automatically change the plan, however. All players on the team have a say in the best interest of the child, and in the case of a court-ordered placement, the court decides. **Senator Lee** further inquired if the parents have access to judicial review or if the appeal process is strictly handled within the Department. In addition, if the placement is not court ordered, **Senator Lee** asked who makes the final decision. **Dr. Hoffman** answered there are periodic reviews to make sure the child is getting what he or she needs and to ensure the plan is working. If the parent disagrees with the plan but the rest of the team feels it is in the best interest of the child, it would depend on the situation. **Mr. Edmunds** returned to the podium and explained parents have the decision making power. If parents don't want to put their kids in services, then they don't. If the court orders it, then compliance is necessary, but ultimately the parent makes the decision. There are times when parents request things of the system that the system can't provide. For example, if they ask the child be placed in residential care and it's not clinically indicated, then the request would be denied. Ultimately, unless it's a court-ordered case, the parent is 100 percent in control and makes the decisions for their child.

MOTION: There being no more questions, **Senator Agenbroad** moved to approve **Docket No. 16-0737-1601. Senator Lee** seconded the motion. The motion carried by **voice vote.**

PASSED THE GAVEL: Vice Chairman Souza passed the gavel back to Chairman Heider.

RS 24846 **Relating to Child Protection. Miren Unsworth** introduced herself to the Committee as Deputy Administrator, Division of Family and Community Services. **Ms. Unsworth** informed the Committee this legislation modifies the definitions in the Idaho Child Protective Act (Act) to include human trafficking under the definitions of "abused" and "sexual conduct." Since 2007, the National Human Trafficking Hotline has received 366 referrals from Idaho, including both adult and minor victims. The Act does not currently include human trafficking in its definitions of abuse or neglect, potentially leaving child victims vulnerable to further abuse. The Justice for Victims of Sex Trafficking Act of 2015 (Public Law 114-22) amends the Child Abuse Prevention and Treatment Act (CAPTA) state grant program requirements and specifically requires states to consider any child who is identified by a state as a victim of sex trafficking or severe forms of trafficking as a victim of "child abuse and neglect" and "sexual abuse." The law utilizes the definitions of sex trafficking or severe forms of trafficking as defined in the Trafficking Victims Protection Act of 2000 (TVPA).

Ms. Unsworth explained the proposed legislation will increase the State's ability to protect minor victims of sex trafficking by including human trafficking in the definitions of abuse and sexual conduct and the aggravated circumstances definitions of the Act. Federal partners have affirmed the Idaho Code definitions of human trafficking meet the definitions under the TVPA and the requirements of the Justice for Victims of Sex Trafficking Act of 2015. The Division has worked closely with the Administrative Office of the Courts on this proposed legislation and has shared the legislation with the Governor's Task Force on Children at Risk, the Idaho Children's Trust Fund, the Idaho Coalition Against Sexual and Domestic Violence, the Idaho Department of Juvenile Corrections, and attorneys for each of the Idaho tribes. This legislation is intended to clearly define sex trafficking in the Act, utilizing the current definition found in the State's criminal code. It will also allow for a civil action under the Act to be opened when the State's involvement is necessary.

MOTION: **Senator Martin** moved to send **RS 24846** to print. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:42 p.m.

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Senator Heider
Chair

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Jeanne Jackson-Heim
Secretary

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Tuesday, January 17, 2017

SUBJECT	DESCRIPTION	PRESENTER
Docket No. 58-0105-1601	Rules and Standards for Hazardous Waste	Matt Alvarado Waste Management and Remediation Division
Docket No. 58-0101-1602	Rules for the Control of Air Pollution in Idaho	Tiffany Floyd Air Quality Division Administrator
Docket No. 58-0101-1603	Rules for the Control of Air Pollution in Idaho	Tiffany Floyd
RS24817	Relating to Crop Residue Burning	Tiffany Floyd

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Tuesday, January 17, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	Senator Lee
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the Committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.
PASSED THE GAVEL:	Chairman Heider passed the gavel to Vice Chairman Souza to conduct the rules review.
DOCKET NO. 58-0105-1601	**Rules and Standards for Hazardous Waste. Matt Alvarado**, Hazardous Waste Regulation and Policy Coordinator for the Waste and Mediation Division at Department of Environmental Quality (DEQ) presented this docket. He described the adoption by reference of final federal hazardous waste regulations promulgated with effective dates from July 1, 2015 through June 30, 2016. Adoption by reference of federal hazardous waste regulations was a routine procedure that DEQ performed annually to: 1.) satisfy the consistency and stringency requirements of the Hazardous Waste Management Act; 2.) meet the legislative intent to avoid the existence of duplicative, overlapping or conflicting state and federal regulatory systems; and 3.) provide for DEQ to maintain primacy and authorization to operate the federal Resource Conservation and Recovery Act (RCRA) program in lieu of Environmental Protection Agency (EPA). The public notice for the rulemaking appeared in the August 2016 edition of the Idaho Administrative Bulletin. No public hearing was requested or held, and no objections and no written comments were received from the public. This proposed rule was neither broader in scope nor more stringent than federal regulations and did not regulate an activity that was not regulated by the federal government. This docket included four new rules that have been promulgated since the last incorporation, a new incorporation by reference, a new definition of solid waste rule covering the disposal of Coal Combustion Residuals (CCR) from electric utilities, technical corrections to the effective date of the CCR rule and a rule covering transboundary hazardous waste shipments. **Mr. Alvarado** briefly described the contents of these new rules. The Definition of Solid Waste (DSW) changed as, EPA revised several recycling related provisions associated with the DSW, which are used to determine the hazardous waste regulations under Subtitle C of the RCRA. Specifically, the new DSW rule withdraws the transfer based exclusion that was in the existing regulation and replaced it with the verified recycler exclusion. The new requirements also created a new definition of legitimate recycling of Hazardous Secondary Material (HSM). The new requirements apply to both generators of HSM and recycling of such material, whether on-site by the generator or by an off-site third party recycler. This rule included a new "remanufacturing exclusion" for 18 higher-value spent solvents that included revisions to the process for existing variances and "non-waste determinations." The new DSW rule included a requirement for the National

Response Center to be notified in certain emergency situations. The Idaho rules have been revised to ensure the state communication center is also notified in these situations. These requirements were identical to current Idaho Rules for Hazardous Waste Generators and for treatments towards in-disposal facilities in certain emergency situations. The new DSW rule is more stringent than the State's current DSW rule and, therefore, adoption is required by the federal government in order to meet the stringent requirements for state programs. Currently, only one facility in Idaho is using an HSM recycling exclusion and a generator controlled exclusion for recycling solvents on site. Therefore, there should be no impact on the regulatory community from this new rule in Idaho.

Mr. Alvarado next explained the Coal Combustion Waste (CCR) rule definition by stating EPA had regulated disposal of residuals from coal combustion at electric utilities under solid waste regulations authorized by Subtitle D of RCRA. The rules contained a revision to RCRA Subtitle C, hazardous waste regulation, which identified solid waste was not hazardous and therefore excluded from regulations under Subtitle C. Impacts from this rule in Idaho should be minimal because currently there are no coal-fired electric plants located in Idaho. He further explained the technical corrections to the CCR rule stating this docket simply corrected typographical errors in the original final rule which resulted in two different effective dates being published.

Mr. Alvarado explained the Transboundary Shipment rule, stating EPA was amending certain existing regulations that applied to transboundary movement of hazardous waste among the Organization for Economic Cooperation and Development (OECD) member countries. This revised the list of OECD member countries to include Estonia, Israel and Slovenia. EPA did not authorize states to administer federal import/export functions in any section of the RCRA hazardous waste regulations and must be notified of all imports/exports of RCRA hazardous waste. The non authorized state programs were required to adopt import/export provisions to maintain consistency with federal requirements. The addition of these three countries to the OECD member list should have no impact on Idaho facilities.

Senator Martin emphasized how important the word "primacy" was in the testimony. He further stated primacy was one of the most important things which could be discussed in the State of Idaho and he appreciated the efforts of DEQ and the efforts of former Senator John Tippets, now Director of DEQ who was in the audience.

Mr. Alvarado thanked everyone and pointed out it is important DEQ has adopted and brought on the program they are enforcing in the State, so DEQ is a voice for Idaho in this process rather than the federal government being in charge of the regulations.

MOTION: There being no more questions, **Senator Martin** moved to approve **Docket No. 58-0105-1601. Senator Harris** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 58-0101-1602 **Rules for the Control of Air Pollution in Idaho. Tiffany Floyd**, Air Quality Division Administrator at Department of Environmental Quality (DEQ), introduced herself and explained rulemaking has been initiated to delete Idaho Administrative Procedures Act (IDAPA) Section 582. In reviewing the rules, DEQ discovered Section 582 was outdated and no longer applicable. **Ms. Floyd** informed the Committee northern Ada County was designated non-attainment (not meeting NAAQS) for Particulate Matter 10 in 1990. In the late 1990s, EPA attempted to assist states with non-attainment planning processes and transportation requirements, but was sued in 2001 and lost. As part of the court settlement, an interim measure was adopted to ensure transportation projects could legally still go forward until DEQ developed a maintenance plan for the non-attainment area.

DEQ submitted the maintenance plan, and it was approved by EPA in 2003. DEQ did not conduct negotiated rulemaking, as DEQ felt it was not feasible because of the nature of this matter. However, DEQ held a public comment period and a public hearing.

Senator Jordan questioned if this section was specific to the non-attainment in 1990, if there was another non-attainment, would new rules applicable to that specific situation be implemented at the time. **Ms. Floyd** replied that if a new non-attainment area came about and DEQ is designated for another pollutant in that same process, then DEQ will have transportation planning requirements not specific to Ada County.

MOTION: There being no more questions, **Senator Agenbroad** moved to approve **Docket No. 58-0101-1602**. **Senator Anthon** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 58-0101-1603 **Rules for the Control of Air Pollution in Idaho. Tiffany Floyd**, Air Quality Division Administrator at DEQ, presented this docket. She explained the purpose of this rulemaking was to ensure Idaho's rules remain consistent with federal regulations. The rules for control of air pollution are updated annually to maintain consistency with federal regulations implementing the Clean Air Act. This proposed rule incorporated by reference federal regulations revised in July 1, 2016. Adoption of federal regulations was necessary for EPA approval of Idaho's Title V operating permit program and state primacy of the Clean Air Act programs. This rule allows DEQ to keep its rules up to date with federal changes and simplified compliance for the regulated community. As required by Idaho Code, DEQ prepared a brief overview detailing the latest revisions being proposed for incorporation. **Ms. Floyd** stated if upon review the Committee required any detail on a specific rule or update, she could schedule a time with the appropriate staff to discuss further. **Ms. Floyd** further highlighted some of the changes which most impact Idaho. The NAAQS for ozone was reduced from 75 to 70 parts per billion. The Treasure Valley had been affected by ozone but is currently in compliance with the new standard. The new ozone standard will have an impact on how the crop residue burn program is implemented.

Ms. Floyd explained there were also a number of updates associated with DEQ's permit program that will have an impact on Idaho facilities. Three types of facilities in particular are power plants, phosphate fertilizer plants, and the oil/gas industry. **Ms. Floyd** stated EPA promulgated two rules to control carbon dioxide emissions from power plants, one for new facilities and the other for existing facilities, both of which are currently being litigated. The existing facilities in Idaho which are impacted are Rathdrum Power and Idaho Power's Langley Gulch natural gas plant. **Ms. Floyd** mentioned the phosphate fertilizer plants update added new requirements for monitoring and record-keeping and updated emission requirements for certain processes within those facilities. The new monitoring and record-keeping requirements would affect Idaho facilities such as Simplot in Pocatello and Agrium in Soda Springs. **Ms. Floyd** explained methane was added as a regulated pollutant for oil and natural gas wells, and the update added requirements for additional equipment in their production chains. This rule affects Alta Mesa and any new facility built in Idaho. DEQ did not conduct negotiated rulemaking because it was not feasible due to the nature of this rule and because DEQ has no discretion with respect to adopting federal regulations. DEQ held a public comment period and a public hearing and did not receive any comments.

Senator Harris asked how companies such as Agrium and Simplot are monitoring the new regulations. **Ms. Floyd** explained mercury and fluoride are monitored by Continuous Emissions Monitoring (CEM) to ensure they meet the requirements. The companies maintain the records when taking samples of the tests for those pollutants and provide them to DEQ. **Senator Harris** asked if this change will help with any future litigation. **Ms. Floyd** replied if DEQ was asked about the mercury emissions and the accuracy, DEQ would have the information and documentation that DEQ conducted the proper testing as outlined in the federal regulations.

MOTION: There being no more questions, **Senator Harris** moved to approve **Docket No. 58-0101-1602**. **Chairman Heider** seconded the motion. The motion carried by **voice vote**.

RS 24817 **Relating to Crop Residue Burning. Tiffany Floyd**, Air Quality Division Administrator at DEQ, explained **RS 24817.** The proposed amendment is to Idaho Code § 39-114, which relates to Crop Residue Burning (CRB). In 2008, the Legislature enacted Idaho Code § 39-114, which required DEQ to assess air quality conditions before approving the burning of crop residue. DEQ implemented these requirements at IDAPA 58.01.01.618 through 58.01.01.624. Section 621 requires that before approving a burn in the program, DEQ must evaluate a number of criteria such as: proximity to sensitive groups; other burning activity; weather conditions; and pollutant concentrations.

Ms. Floyd informed the Committee DEQ requires that pollutant concentrations not exceed 75 percent of any NAAQS, essentially creating a backstop or threshold to ensure that DEQ was not approving burns that caused a violation of NAAQS. Next year the implementation of the current program will become more problematic due to the ozone standard for two reasons: 1.) EPA reduced the standard for ozone from 75 to 70 parts per billion (ppb) making it difficult to approve burn days; and 2.) there will be days when ozone concentrations could be high enough to limit crop residue burns on what would otherwise be a "good" burn day, meaning a day when burning is not predicted to cause a violation of any NAAQS. That conflict was a significant issue for many in the agricultural sector and an issue for the grass seed growers in the northern part of the state because ozone is one of the drivers that determined whether a crop residue burn can or cannot occur on a specific day.

Ms. Floyd stated to address these limitations, DEQ engaged in negotiated rulemaking. Based on those meetings, DEQ proposed to increase the 75 percent threshold to 90 percent for ozone. DEQ is confident there will be enough buffer to ensure the ozone standard is not exceeded from a crop residue burn. The goal of the CRB program was to protect public health and allow crop residue burning as an agricultural practice. DEQ believes the new threshold of 90 percent will meet these goals.

Ms. Floyd said this program change will require EPA approval. Therefore, to account for the time needed to obtain EPA approval, the change will be implemented in two stages. For the 2017 burn season, the ozone threshold will remain at the current level or 75 percent of the 2008 ozone standard. On February 28, 2018, which is the expected date of EPA approval, the 90 percent threshold of the 2015 ozone standard will become effective. Lastly, this change will not have any direct fiscal impact on the state and the change will not alter resources used by DEQ to implement the CRB program, nor will the current crop residue burn fee structure outlined in Idaho Code § 39-114 be changed.

Senator Jordan asked if approval is anticipated in February 2018. **Ms. Floyd** explained EPA made the change to the ozone standard reduction in late October 2015, when the evaluation occurred. As far as the February 2018 deadline, DEQ can work closely with EPA to demonstrate the change is still protective as DEQ's current program is within the 75 percent.

Senator Jordan asked if there was an emergency clause and why was this bill not addressed in the earlier session. **Ms. Floyd** explained if this legislation is approved, DEQ will conduct rulemaking to conform the rules to the new statute. It is important to change the statute first, and in 2018, DEQ will present the rule change to mirror the statute. **Senator Jordan** asked what happens if this bill is not approved. **Ms. Floyd** explained if the bill is not approved, the existing program with 75 percent of the NAAQS would remain in effect.

Senator Martin asked if a farmer who wanted to burn his ditch banks needed to get pre-approval from DEQ. **Ms. Floyd** explained pre-approval was specific to crop residue burning and would not apply to ditch bank burning.

Senator Martin referring to the last page of this docket asked about an emergency existing and who declares the emergency. **John Tippets,** Director of DEQ, was recognized to explain the legislation has a specified default effective date. There is an emergency clause to make the legislation effective immediately rather than waiting until July 1 because DEQ expects EPA to approve the new rule prior to February 28, 2018, and it will allow Sections 2 and 3 to be in full force and effect on and after February 28, 2018.

Chairman Heider asked if burning depended on the amount of crop residue or the amount of burning that took place in a day and how DEQ would delegate the days for burning. **Ms. Floyd** answered that DEQ prepares a list of farmers who apply for those burns and based on the number of acres, farm location, pollution levels, DEQ works with the farmers to address the number of burns and then decides on the burn days.

Senator Foreman asked if DEQ is unable to go to the 90 percent standard, assuming it is going to have a negative impact on the ability to burn, how severe an impact would occur. **Ms. Floyd** explained if not approved at 90 percent, then DEQ would implement at 75 percent, but the additional average number of days could be affected depending on the location. For instance, if the farm is located in South Idaho, then roughly 60 days and in North Idaho roughly 30 days would be affected. It is difficult for DEQ to burn under these circumstances, and a potential increase of "no burn days" is important to DEQ.

Senator Foreman asked when the burn season occurs and the length of the total burn season. **Mary Anderson,** Air Quality Program Manager who oversees DEQ's CRB program, explained a specific spring burn season occurs from March through May and the fall burning season starts mid July through mid October.

MOTION: There being no more questions, **Senator Anthon** moved to send **RS 24817** to print. **Senator Harris** seconded the motion. The motion carried by **voice vote**.

PASSED THE GAVEL: Vice Chairman Souza passed the gavel back to Chairman Heider.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 3:35 p.m.

Senator Heider	Jeanne Jackson-Heim
Chair	Secretary

Arti Clark

Assistant Secretary

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Wednesday, January 18, 2017

SUBJECT	DESCRIPTION	PRESENTER
Presentation	Immunization Waivers	Richard Armstrong, Director, Department of Health & Welfare Dr. Christine Hahn, State Epidemiologist and Public Health Medical Director Elke Shaw-Tulloch, Administrator, Division of Public Health
Rules Review		
Docket No. 16-0309-1601	Medicaid Basic Plan Benefits	Tiffany Kinzler Division of Medicaid
Docket No. 16-0309-1602	Medicaid Basic Plan Benefits	Tiffany Kinzler
Docket No. 16-0310-1601	Medicaid Enhanced Plan Benefits	Sheila Pugatch Division of Medicaid
Docket No. 16-0318-1601	Medicaid Cost Sharing	Elizabeth Kriete Division of Medicaid

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
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MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, January 18, 2017

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies, and other related materials will be retained with the minutes in the Committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting to order at 3:00 p.m.

PRESENTATION: **Chairman Heider** introduced Richard Armstrong, Director of the Idaho Department of Health and Welfare (Department), to present a public health update (see Attachment 1). **Director Armstrong** introduced Dr. Christine Hahn, State Epidemiologist and Public Health Director, and Elke Shaw-Tulloch, Administrator of the Division of Public Health, as co-presenters. **Director Armstrong** informed the Committee public health impacts everyone, from restaurant food safety, to vital statistics records of births, marriages, and deaths. The Division of Public Health coordinates medical services throughout Idaho, maintains a universal vaccination program, and operates a radio communication system to contact any emergency vehicle wherever it might be. Public health measures have added 25 years to life expectancy. In 1900, a woman had a life expectancy of 48 years and 48 years for a man. In 2000, life expectancy has increased to 79 years for a woman and 74 years for a man. The U.S. experienced a slight decline in life expectancy last year for the first time, and this is somewhat concerning. Overall mortality rates have declined primarily because of the control of infectious diseases.

Dr. Hahn stated this year's flu season has already resulted in ten deaths and possibly seven more in the last week and a half. Hospitals, emergency rooms, and long-term care centers report people are presenting with flu symptoms. Idaho flu vaccination rates are among the lowest in the United States. Only 39 percent of Idaho residents receive a flu shot. Challenges arise because of a number of myths about the flu vaccine. For example, some believe the flu vaccine can give someone the flu, but it's not possible because there are no live viruses in the vaccine.

Dr. Hahn explained the flu is different from a cold, and even if the vaccine is not 100 percent effective, a person can be less sick and return to work more quickly. She did her infectious disease training at Duke University and started getting a flu shot then because it decreased the chance of her infecting patients with compromised immune systems. It takes two weeks to develop immunity so it is possible to get the flu even after receiving the vaccine. However, the vaccine helps prevent people from spreading the flu. If everyone around is immunized, it won't spread to the unimmunized. This is called "herd immunity." However, if not enough are immunized, then it will continue to spread in the population.

Dr. Hahn informed the Committee another concern about vaccines is a belief they cause autism. The medical journal article published in 1997 making that correlation was since retracted by the journal. The physician author of the article lost his medical license, and all other coauthors withdrew their names. Other studies have been done and found no correlation. Autism Speaks has issued a statement that vaccines do not cause autism and resources should be expended looking for other causes. In addition, some people believe natural immunity is better than vaccinated immunity. While that is sometimes true, a disease can cause death or other complications, and vaccines help protect children and adults from those complications.

Dr. Hahn provided information about the Idaho Immunization Program which distributes vaccines to doctors and nurses and maintains the registry to track the different immunizations. Parents have a right to exempt children from immunizations for medical, religious, and philosophical reasons. A parent can request a conditional admission to school, allowing the child to attend until immunizations are received. A doctor must complete the Department's exemption form in the case of a medical exemption. Religious and philosophical exemptions can be made by the parent. The form (see Attachment 2) helps school administrators track the exemptions and provide statistical information to the Department. If there is an outbreak, some exempted children may need to be pulled out of school so they don't contract the disease. For example, there are presently 179 unimmunized students out of school in Spokane, Washington due an outbreak of mumps.

Dr. Hahn advised the Committee some counties have very high immunization rates and some have higher exemption rates. The most common vaccine parents request exemption from is varicella (chicken pox). This information is important because outbreaks continue. Idaho has had a case of tetanus and cases of mumps. Sometimes the public is not aware this is happening because information does not always get out in the news due to privacy concerns. The "Disneyland measles outbreak" in California is another example, and Utah had several cases of measles. There was a meningitis outbreak in Oregon and one case in Idaho in the last year. California also had a terrible whooping cough outbreak. As a result, California recently eliminated all immunization exemptions except those for medical reasons. Oregon requires a parent to watch a series of educational videos in order to get an exemption.

Vice Chairman Souza stated she has heard there have been a few cases of polio and tuberculosis in the U.S. and wondered whether Idaho will see an increase in communicable diseases with people now entering the country from war-torn areas where services are not available. **Dr. Hahn** answered the refugee health screen clinic is under the Division's purview, and she personally works at the tuberculosis clinic twice a month. Refugees are intensely screened and rescreened again within 30 days. She finds they want to receive immunizations and medication and has no concerns about them. However, with undocumented immigrants, there are no guarantees, and better systems are needed to monitor that population.

Director Armstrong said Idaho Code § 56-1003 mandates the Department to supervise the promotion and protection of the life, health, and mental health of Idaho citizens. It is important to find a reasonable balance between an individual's freedom and public safety. There is now a shift away from loose exemptions to absolute exclusion of an exemption. He wants to keep a level eye and not swing to the more restrictive side, and he willing to engage with anyone on the best way to strike that balance.

Chairman Heider thanked Director Armstrong for explaining the issues and mentioned some members of the Committee have been approached by constituents about them. **Senator Martin** asked if Idaho is statistically within the "herd rate" for disease. **Dr. Hahn** said the immunization rate for polio is 90 percent but other diseases such as pertussis are not at a herd protective rate. Some of the vaccinations now are right at the protective rate and are in danger of falling below. **Senator Martin** sits on the Immunization Assessment Board and has heard that dosages may be a problem. He asked Dr. Hahn to speak to that issue. **Dr. Hahn** replied she has heard this, too. People are used to the idea that it's important to take the lowest dosage possible to have an effect and the immunization dosages are too high. However, the dosages are based on research, and if the dosages for immunizations are reduced, it is unknown whether they will be strong enough to provide immunity. **Senator Foreman** complimented the Department on its enlightened approach to letting people opt out of immunizations and account for competing interests in a professional and workable way. This approach distinguishes Idaho from other states.

PASSED THE GAVEL: Chairman Heider passed the gavel to Vice Chairman Souza to conduct the rules review.

DOCKET NO. 16-0309-1601 **Medicaid Basic Plan Benefits. Tiffany Kinzler** introduced herself as the Bureau Chief for Medical Care at the Division of Medicaid. The pending rule docket clarifies requirements for ordering and prescribing home health services and durable medical equipment (DME) and ensures compliance with federal regulations. The rule changes clarify these services can be provided in any setting in which normal life activities take place, other than a hospital, intermediate care facility for the intellectually disabled, or nursing facility. The pending rule aligns IDAPA Medicaid rules with federal regulations. The changes have already been implemented by Medicare. **Ms. Kinzler** explained home health services include nursing and aide services, physical and occupational therapy, speech-language pathology services, and audiology services. Home health services are generally provided in the Medicaid participant's home. Durable medical equipment includes items such as crutches and walkers, manual and electric wheelchairs, ventilators, monitors, pressure mattresses, shower chairs, and nebulizers. This equipment is designed for repeated use by individuals with disabilities, injuries, or illnesses. A simple item such as a walker can make the difference between a participant being bedridden and being able to move freely around the home or community.

Ms. Kinzler informed the Committee for services to be covered by Medicaid using federal matching dollars, the service or item must be: 1.) medically necessary to meet the needs of the participant as provided in IDAPA; 2.) ordered based on a face-to-face assessment completed by the participant's primary care provider; 3.) provided under an individualized plan of care developed by the licensed, qualified professional who established the plan; and 4.) signed by the participant's physician. The pending rule: 1.) expands the types of practitioners allowed to complete and document the face-to-face encounter with the participant; 2.) clarifies who can order home health and DME services and supplies; 3.) clarifies the interval at which the plan of care is reviewed; 4.) updates and clarifies references, requirements, and definitions in response to provider concerns and questions about rule requirements; 5.) allows for coverage of services delivered by telehealth methods when appropriate; and 6.) shifts prior authorization requirements from rule to the provider handbook to ensure a more timely and effective response to changes.

Ms. Kinzler advised the Department has worked closely with the Idaho physician assistant, nurse practitioner, primary care, and medical associations as well as therapy and DME providers to develop the rule. The Department held hearings across the state, received several comments, and revised the rules to meet those concerns to the extent possible under the statutes and federal regulations. The Department has standing meetings with the various associations and provider groups and will continue to work with them to address implementation of the rules. **Ms. Kinzler** requested the Committee approve the docket with an effective date of July 1, 2017.

Vice Chairman Souza asked Ms. Kinzler to review the significant changes to the rule. **Ms. Kinzler** explained Section 004.04 updates an incorporation by reference to add a live link to the CMS/Medicare DME Coverage Manual. This change is very important because the manual is developed and updated quarterly, and it would be very quickly out of date otherwise. The manual describes the services most likely to improve the medical condition of an individual. It is available online, but the entire document is not printed in the rule. The second significant change is on pages 80 and 81 of the pending rule book pertaining to home health services. These sections have been updated to align with federal regulations. Everyone is working hard to make sure people have the choice to live in the least restrictive environment while keeping them safe. Currently, a physician must sign the home health and DME order. Due to a lack of medical providers in some parts of Idaho, the rule would add physician assistants, nurse practitioners, and midwives to the list of practitioners who could conduct the face-to-face encounter. The rule would also allow the encounter to take place via telehealth.

Vice Chairman Souza asked for clarification whether nurse practitioners and physician assistants work under the direction of a physician. **Ms. Kinzler** replied nurse practitioners can work alone without physician oversight in Idaho. In reality, many physician assistants also work that way because Idaho is a shortage area and there are not enough primary care providers.

Senator Martin thanked Ms. Kinzler for including the date of the manual in Section 004.04.

Senator Martin asked whether the telehealth approach is working and how that is accommodated. **Ms. Kinzler** answered the Division of Medicaid has not exactly defined how telehealth works because the various medical boards have defined those rules. Medicaid is willing to reimburse for telehealth services. If a nurse practitioner is providing the face-to-face encounter, the telehealth process would include the participant, the primary care provider, and the physician providing the signature. **Senator Martin** further inquired whether telehealth is working. **Ms. Kinzler** responded the Division of Medicaid does not have any data on the use of telehealth. She would be happy to research and provide information to the Committee. **Vice Chairman Souza** thanked Ms. Kinzler and stated the Committee would appreciate having that information.

Senator Lee asked why the rule changes include two definitions of home health services in two sections and whether there are any implications in how payments would be made by changing the definitions. **Ms. Kinzler** reported the changes in both sections are almost word for word out of the federal regulations. The definitions have changed dramatically because the goal is for a participant to be able to receive care in any place where normal life functions.

MOTION: There being no more questions, **Senator Martin** moved to approve **Docket 16-0309-1601. Senator Harris** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 16-0309-1602

Medicaid Basic Plan Benefits. Ms. Kinzler explained the purpose of this docket is to align IDAPA rule language and definitions with new federal regulations at 42 CFR 447 which represent the Center for Medicare and Medicaid Services (CMS) adoption of the actual acquisition cost pricing methodology. These rules clarify reimbursements to pharmacies and 340B-covered entities for physician-administered drugs. To determine the Actual Acquisition Cost (AAC) for each drug, the Department conducts an annual state cost survey called a rebase. All Idaho Medicaid pharmacies are required to participant in the cost survey. Each pharmacy must disclose the actual acquisition cost of all drugs. The result of the AAC survey is used to establish the pharmacy reimbursement fee schedule.

Ms. Kinzler informed the Committee there are two types of pharmacies for Idaho Medicaid. Most pharmacies are retail pharmacies. When a retail pharmacy submits a claim to Idaho Medicaid for dispensed prescriptions, Idaho Medicaid is allowed to collect a rebate from the drug manufacturer to offset the retail cost of the pharmaceutical supply. These rebates significantly reduce the actual cost of drugs dispensed to Idaho Medicaid participants. The second type of pharmacy is called a 340B entity. These pharmacies purchase drugs at a discounted rate which is roughly equivalent to the average manufacturer's price minus the Medicaid rebate amount; this results in a significant savings to the 340B entity. Ultimately, this discounted price is passed on to Idaho Medicaid when the 340B covered entity submits claims at no more than their 340B actual acquisition cost. Entities such as hospitals and community clinics can participate in the 340B program which is administered by the Health Resources and Services Administration, also known as "HRSA." The 340B Program is designed to help covered entities stretch scarce Federal dollars as far as possible so they can serve more patients and provide more comprehensive services. The 340B entity can choose to serve Medicaid patients or only non-Medicaid patients with their 340B drug stock. The entity's decision determines how they must enroll with Idaho Medicaid and how they price and bill their drug claims.

Ms. Kinzler stated the rule changes specific to 340B entities clarify: 1.) the provider's enrollment requirements, including the disclosure of their 340B status; 2.) the provider must disclose if Idaho Medicaid participants will be given 340B-acquired drugs; and 3.) claim pricing must not exceed actual acquisition cost plus the pharmacy's professional dispensing fee. Additionally, the proposed rules clarify how physician-administered drugs are priced and reimbursed and ensure Idaho Medicaid IDAPA rules are in alignment with federal regulations. The Department has worked closely with the Idaho Pharmacy, Primary Care, Hospital, and Medical Associations to develop these rules and provided opportunity for input by conducting hearings across the state. They received several comments and revised the rules to meet any concerns to the extent possible under the statutes and federal regulations. The Department meets regularly with each of these associations and the providers they represent and will continue to work with them to address implementation of the rules. The effective date of the docket would be July 1, 2017.

Senator Martin noted the effective dates are the same for both this docket and the previous docket and asked how many people attended the public hearings or called in about the docket. **Ms. Kinzler** replied it was a handful, no more than four people at any of the hearing sites. The Department received written comments from the groups before and after the docket was published. In total, there were eight to ten comments on each docket. **Vice Chairman Souza** inquired whether non-340B pharmacies also have the discretion whether or not to take Medicaid orders in the same manner as 340B pharmacies. **Ms. Kinzler** explained 340B pharmacies specify upon enrollment in HRSA whether or not they will use their drug supply for Medicaid participants. Retail pharmacies have the choice not to serve a Medicaid participant, but don't have to track whether or not the drugs are 340B. **Vice Chairman Souza** asked whether retail pharmacies would take a loss if they buy drugs at a different rate and sell to Medicaid patients. **Ms. Kinzler** replied she did not know how to answer the question. Retail pharmacies bill their actual acquisition cost, the Division pays according to statute, and the payment is based on the actual acquisition cost for the drug in the market. The pharmacies receive a dispensing fee in addition to the cost reimbursement.

Senator Harris referred to the last sentence of Section 665 that states, "Reimbursement is restricted to those drugs supplied from labelers that are participating in the CMS Medicaid Drug Rebate Program." **Senator Harris** inquired whether it is difficult for labelers not participating in the CMS drug rebate program to sign up to participate and whether there are a lot of labelers not participating. **Ms. Kinzler** answered she does not know how many do not participate in the Medicaid drug rebate program, but they have multiple manufacturers in every drug class that participate. It is the same rule as with Medicare. **Ms. Kinzler** offered to get more information for the Committee. **Senator Lee** stated there are a lot of definitions in the DME section and asked whether the 2016 rule changes increased any flexibility for the Division or improved services for rural Medicaid patients. **Senator Lee** said in her district there are some rural areas where Medicaid patients appear to be better served by purchasing through the State DME. **Ms. Kinzler** answered she does not have any specific information but they have also heard stories that services are easier to access since the 2016 rule changes.

MOTION: There being no more questions, **Senator Foreman** moved to approve **Docket No. 16-0309-1602. Senator Lee** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 16-0310-1601 **Medicaid Enhanced Plan Benefits. Sheila Pugatch** introduced herself as Bureau Chief for the Bureau of Financial Operations in the Division of Medicaid, Department of Health and Welfare. The pending rule aligns Idaho rules with recently-modified federal law regarding hospice reimbursement. Because Idaho Medicaid must follow the federal law regarding hospice reimbursement, the Division did not go through negotiated rulemaking. There was a public comment period and a public hearing was held on June 13, 2016, but they did not receive any comments on the rules. The effective date of this rule was January 01, 2016.

Ms. Pugatch explained hospice is a service when a participant needs supportive care in the final phase of a terminal illness. It focuses on comfort and quality of life, rather than a cure. The goal is to enable patients to be comfortable and free of pain, so that they live each day as fully as possible. This rule implements two different payment rates for routine home care resulting in a higher base payment rate for the first 60 days of hospice care and a reduced base payment rate for the 61st and higher days of hospice care. These differing payment rates more accurately align per-diem payments to appropriately pay for the cost of providing care based on visit intensity. In addition, the rule implements a service intensity add-on payment for hospice care provided in the last seven days of life of a Medicaid participant if certain criteria are met. This add-on payment is in addition to the per-diem rate for routine home care and encourages increased patient visits by the hospice provider when more resource-intensive patient needs typically occur.

Senator Martin noted the rule references payments made as of January 1, 2016 and asked, if the rule was effective January 1, 2016, why the Committee is seeing the rule now instead of one year ago. **Ms. Pugatch** answered the Department's claims processing system had to be updated, and it took some time to make the changes. The rule promulgation process also was lengthy. **Senator Martin** asked for clarification that the Committee was being asked to approve a rule that has been in effect since January 2016. **Matt Wimmer,** Administrator for the Division of Medicaid, was recognized to respond to the question. **Mr. Wimmer** replied the changes were part of MACRA, the Medicaid Access and CHIP Reauthorization Act, passed late last year. The changes came in fairly late. At the same time, because it was a change to federal statute, they were required to comply quickly. The docket was adopted as a temporary rule with an effective date of January 1st for that reason. **Senator Agenbroad** asked Ms. Pugatch if the retroactive rule would have any financial impact and whether there would be billings going back to that date. **Ms. Pugatch** replied there is a small fiscal impact of approximately $213,000 per year. **Senator Agenbroad** inquired how much of that amount is the result of going back to 2016 as opposed to having an effective date of 2017. **Ms. Pugatch** answered it is an annual fiscal impact so it goes back to January 1, 2016. For the full year, it would be $213,000.

Senator Lee inquired about the impact of the 60-day gap provision on recipients who were home, then went into a hospital and returned home. She noted it could be a significant change in the expected reimbursement, and it might have an effect on decisions made had participants understood this rule. **Senator Lee** asked whether the Division anticipates a number of folks will be affected, particularly with the 2016 effective date. **Ms. Pugatch** responded she does not. The reimbursement rate for the first 60 days in Ada County is $182 and for 61 plus days the rate is $143.09 per day. The average time a Medicaid participant stays in hospice care is about 60 days. **Senator Lee** asked if the reimbursement rates are different by county. **Ms. Pugatch** replied the rates are broken out between Franklin, Kootenai, Nez Perce, Bannock, Bonneville, Butte, Jefferson, Ada, Boise, Canyon, Gem, and Owyhee Counties. There is a different rate for the other counties that are all rural. **Vice Chairman Souza** inquired why there is a difference county to county. **Ms. Pugatch** responded the Division of Medicaid is following Medicare reimbursement methodology, and Medicare has dictated the reimbursement rates are different based on county divisions. **Senator Foreman** asked whether the term "rate for which the participant is qualified" could be changed to "reduced rate." **Ms. Pugatch** answered it may not be a reduced rate; it depends on the county where the participant is being served.

MOTION: There being no more questions, **Senator Harris** moved to approve **Docket No. 16-0310-1601. Chairman Heider** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 16-0318-1601

Medicaid Cost Sharing. Elizabeth Kriete introduced herself to the Committee as Bureau Chief for the Bureau of Long Term Care for the Division of Medicaid. **Ms. Kriete** informed the Committee the Department elected to move this rule change forward as temporary, in order to secure an appropriation for the change during the 2016 session. The temporary rule has been in effect since July 1, 2016. **Ms. Kriete** explained a Medicaid waiver is a mechanism that allows states flexibility to administer health insurance for specific populations with specific eligibility criteria, which includes applying different methods for income counting and cost-sharing. Idaho waivers provide long term services and support to maintain individuals with special health needs in their home or community, rather than in an institution, such as a nursing facility. Benefits of Idaho waivers include increasing participants' quality of life, enhancing community integration and decreasing costs to the state.

Ms. Kriete reported advocates for Idaho residents with disabilities, including representatives from DisAbility Rights Idaho, requested the Department review the personal needs allowance amounts used in the financial eligibility calculation for Medicaid waiver participants who are responsible for their own rent or mortgage expenses. The purpose of the personal needs allowance is to ensure that waiver participants living in the community have sufficient funds remaining for basic housing expenses after contributing their share of cost for Medicaid waiver services. The personal needs allowance amount is based on a participant's marital status and legal obligation to pay rent or mortgage and is deducted from their countable income. The federal Supplemental Security Income amount, also known as "SSI", is adjusted annually by the Social Security Administration to account for cost of living increases. The Department has determined that the adjustment has not kept pace with the increase of housing and utility expenses in Idaho. These rules increase the personal needs allowance from 150% of SSI, equivalent to $1,100 per month, to 180% of SSI, or $1,319 per month, for eligible waiver participants who incur a rent or mortgage expense.

Ms. Kriete advised the impact to the state general fund is projected to be a total of $443,377 per year for the approximately 2,700 Medicaid waiver participants who live in their own homes. The funds necessary to cover this increase were appropriated during the 2016 Legislative session and on an ongoing basis starting in Fiscal Year 2017. The Department held a negotiated rulemaking session on July 21, 2015, as well as public hearings on June 10, 2016 in Boise and Lewiston and on June 22, 2016 in Idaho Falls. The Department received a total of 14 comments, all in favor. Despite carrying a fiscal impact, Medicaid waiver participants who reside in their community will be better able to afford living expenses and remain out of high cost institutions, saving taxpayer money and improving quality of life.

Vice Chairman Souza invited questions from the Committee. **Senator Lee** thanked Ms. Kriete for the Department's work to be inclusive with changing the rules. She asked to be reminded of the actual amounts resulting from the changes. **Ms. Kriete** replied the estimated amount of the allowance increase will be about $219 per month. **Senator Lee** inquired when the rates were last increased. **Ms. Kriete** answered the last time the rate was changed was 1999.

TESTIMONY: **Vice Chairman Souza** invited testimony from attendees. **Randall Nilson** introduced himself to the Committee to speak in support of the docket (see Attachment 3). He has been a Medicaid participant since 2007 and worked for the State Tax Commission for 26 years. **Mr. Nilson** explained he has been in a wheelchair since 1991 and continued to work for 20 years. He was under a workers with disabilities program for five to six years and he paid a low premium for his Medicaid services. He must have assistance at home with bathing, eating, and other situations. The highest premium he paid was $153 per month, and he deemed that was fairly reasonable. Subsequently, he retired and in 2013 he had to move onto the Aged & Disabled waiver program where he has to pay a share of the costs. At that time, his share went from $153 a month to $2,258 a month. That is partially because he worked in administration at the Tax Commission and was making $60,000 a year. He has a fairly decent retirement and fairly high Social Security. He has no issues with increasing the personal needs allowance but he doesn't think it's enough. He should not have to pay $2,200 a month of his retirement income for services that he only paid $153 a month for when he was working. He owns a three bedroom home in West Boise and pays mortgage, property taxes, and other expenses. He is not allowed to keep enough of his own retirement money to actually enjoy life. His money is going all to Medicaid whereas a lot of other states have higher allowances.

Mr. Nilson began working with Health and Welfare in 2013 to increase the personal needs allowance. Most states allow a participant to keep more money, either an unlimited amount of income or 300 percent of SSI rate. That would be equivalent to approximately $2,200 per month. If someone owns a house, there are other expenses a renter doesn't have. Medicaid sets a budget for him to live on and all the rest of his money goes to Medicaid for his share of costs, so there's no money to buy a washer. Under Medicaid he can only have $2,000 in his checking account. It's not viable for a person to stay in their house by keeping the allowance so low. AARP did a survey in 2010 showing 25 states had an allowance of $2,200 on up, and Idaho at that time only had $1,100. A lot of states like New Mexico don't make a participant pay anything for share of costs, and Medicare and CMS allow for that. He doesn't mind paying some of his income for Medicaid services, but he worked and paid into the system for 26 years. There has to be some recognition of that, and he should be able to keep a little of his retirement money to enjoy retirement.

Senator Martin asked Mr. Nilson if the rule docket affects him. **Mr. Nilson** said it does not. He filed an ADA reasonable request to get a higher personal needs allowance and his allowance is currently higher than $1,300. He is not the only person in the State of Idaho who could be in that situation. For example, an electrician who becomes injured after 30 or 40 years with a high retirement income might only be allowed to live on a limited amount of money, even though they earned much more. It doesn't seem fair to him. It's not a CMS issue, it's a State of Idaho issue. Health and Welfare is setting the budget for Randy Nilson, saying, "You have to live on this amount of money and we are going to take all the rest." **Senator Martin** thanked Mr. Nilson for making the effort to attend the meeting and testify, and for his service to the State of Idaho. **Vice Chairman Souza** also thanked Mr. Nilson for sharing his experiences with the Committee. Mr. Nilson provided a letter to be included in the record of Committee proceedings.

Alec Pechota introduced himself as a representative of DisAbility Rights Idaho. He informed the Committee the Idaho "Share of Cost" rules were set many years ago. There is no evidence they were based on actual costs. In the intervening years, the cost of housing in most Idaho communities has gone up disproportionately to other essential costs. People with disabilities serious enough to qualify for skilled nursing care can qualify for Medicaid with a household income exceeding the typical income limits. However, they are required to pay most of this income to the State as their share of cost. The share of cost is not a fixed amount or percentage of the cost of care. Instead, a participant is required to pay all income except for a fixed personal needs allowance. In most cases, the only income these people have is from disability payments, Social Security, or veterans or employer benefits.

Mr. Pechota commented the personal needs allowance was originally set for people in nursing homes where room and board are provided. Since the late 1980s, Idaho residents have had the opportunity to receive care at home instead of an institutional setting through Home and Community Based Services waivers, as long as the in-home services cost Medicaid less than the cost of nursing home care. A different personal needs allowance was set for these participants. People receiving the waivers have to pay for their own housing, food, utilities, transportation, etc. The participant can only keep the personal needs allowance and must pay the rest of their income to the State as share of cost. The current personal needs allowance is $1,102 per month or the current SSI benefit level times one point five. This is grossly inadequate for most housing markets in Idaho, especially if the person requires wheelchair accessible housing. It is especially inadequate for people who bought a home before they became disabled and now carry a mortgage. Increasing the personal needs allowance is not an increase in benefits. It only allows a person to keep more of their own money. When the allowance is too low, people try to get by on fewer services than they need, sometimes leading to health problems and institutionalization, or they lose their home and are forced into nursing care. This docket increases the personal needs allowance to about $1,323 per month. It will not be enough for everyone, but it will allow more people to stay in their homes and neighborhoods and get the home-based services they need.

Senator Martin asked Mr. Peculate for clarification that he supports the docket but would like it to be more. **Mr. Pechota** replied Senator Martin's characterization was correct and his testimony was more in the nature of an impact statement. **Vice Chairman Souza** advised Mr. Peculate that having his statement on the record was very helpful. She asked whether he thought it was a step in the right direction but not a big enough step. **Mr. Pechota** answered yes.

MOTION: There being no more testimony or questions, **Senator Foreman** moved to approve **Docket No. 16-0318-1601. Senator Jordan** seconded the motion. The motion carried by **voice vote.**

PASSED THE GAVEL: Vice Chairman Souza passed the gavel back to Chairman Heider.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:30 p.m.

Senator Heider Chair	Jeanne Jackson-Heim Secretary

PUBLIC HEALTH UPDATE

Division of Public Health

Idaho Department of Health and Welfare

The “U” in Public Health

- Have you…

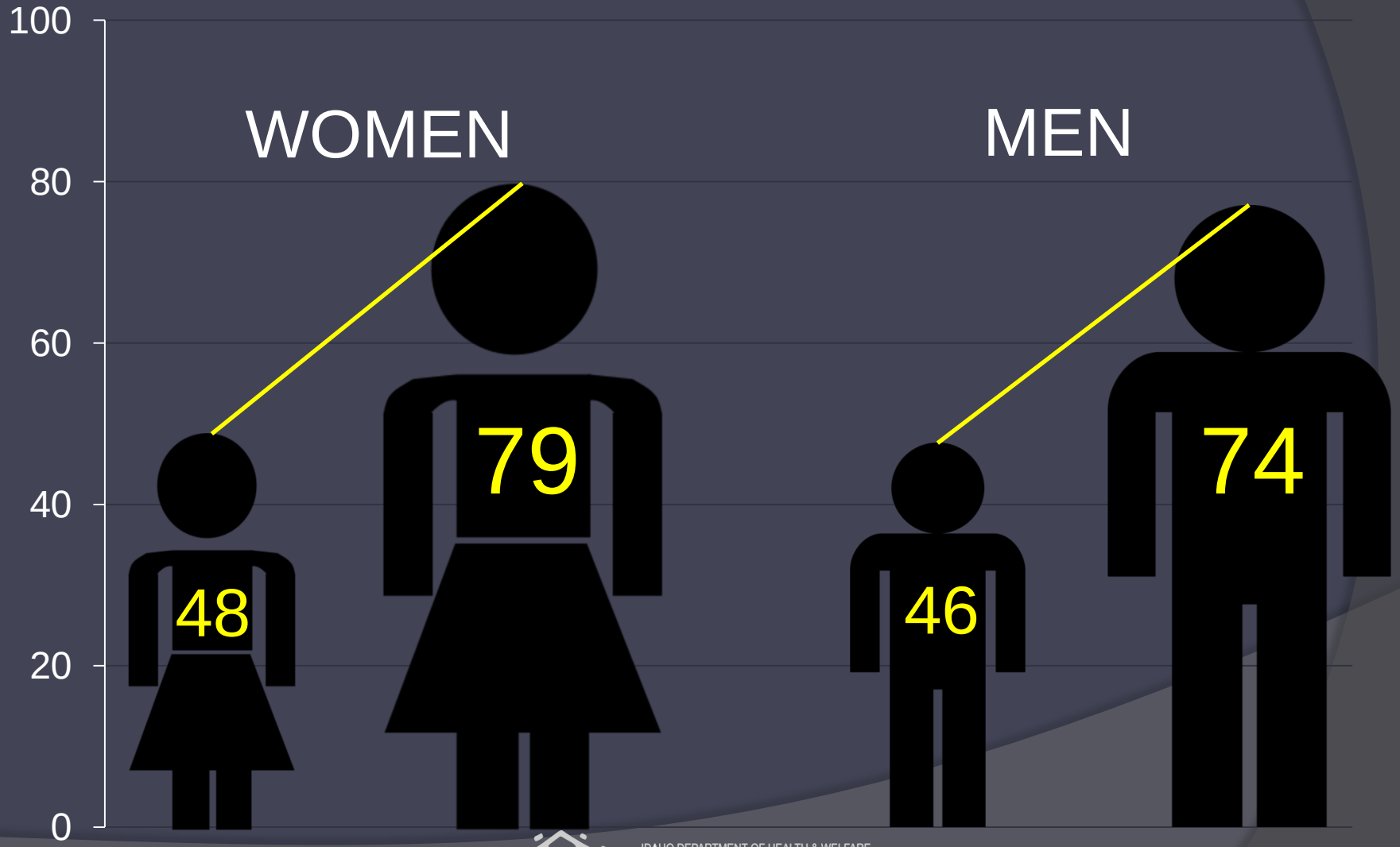
YOU have been impacted by Public Health in Idaho!

Strong Public Health = Long Life

- Public health measures have added 25 years to the life expectancy of people living in the U.S. during the 20th century.

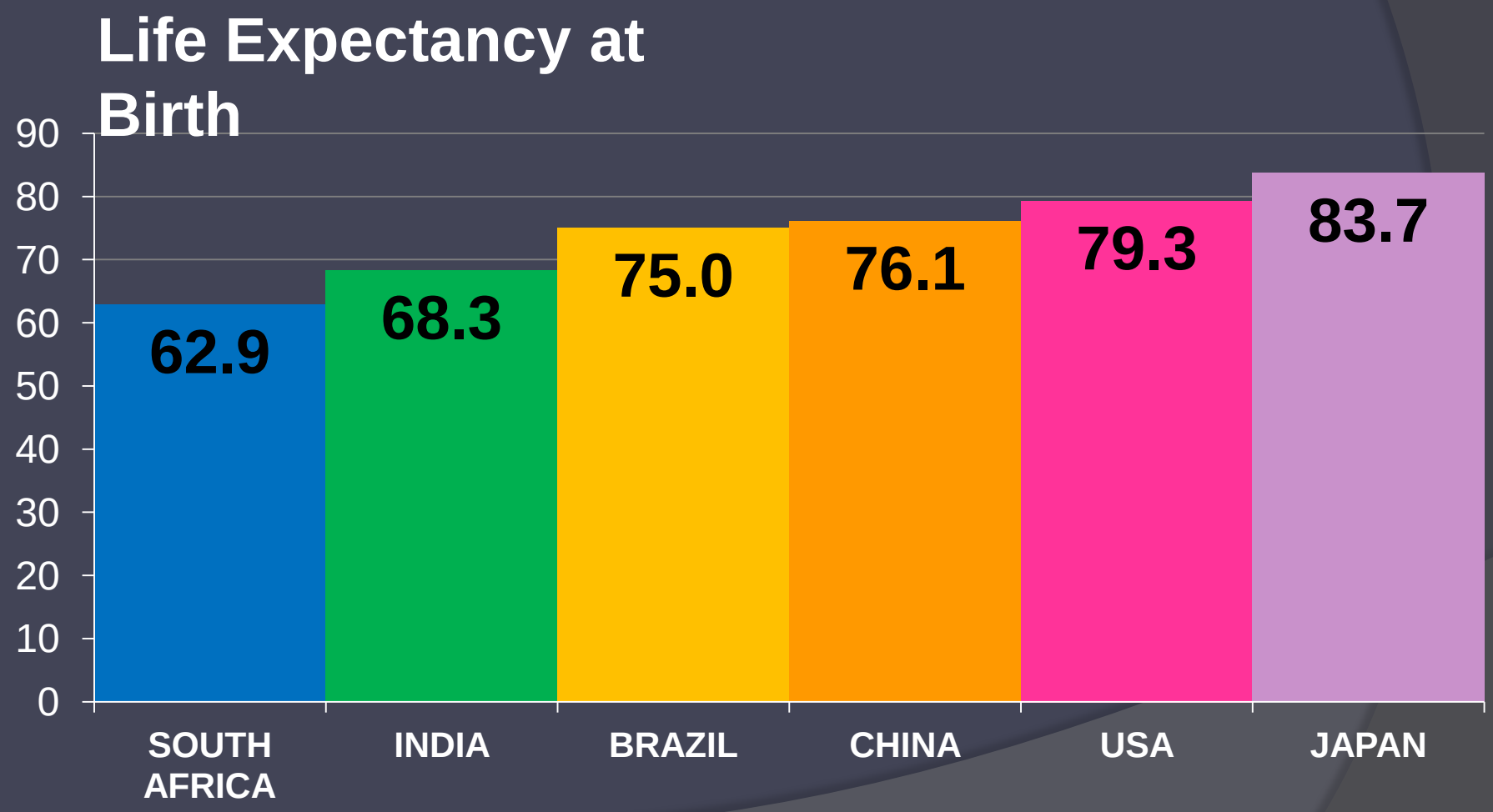
- Reduced tobacco use
- Improved motor-vehicle safety
- Improved workplace safety
- Control of infectious diseases
- Decline in cardiovascular deaths
- Improved food safety
- Improved maternal and child health
- Family planning
- Fluoridation of drinking water
- Reduced vaccine-preventable diseases

Life Expectancy 1900 vs. 2000



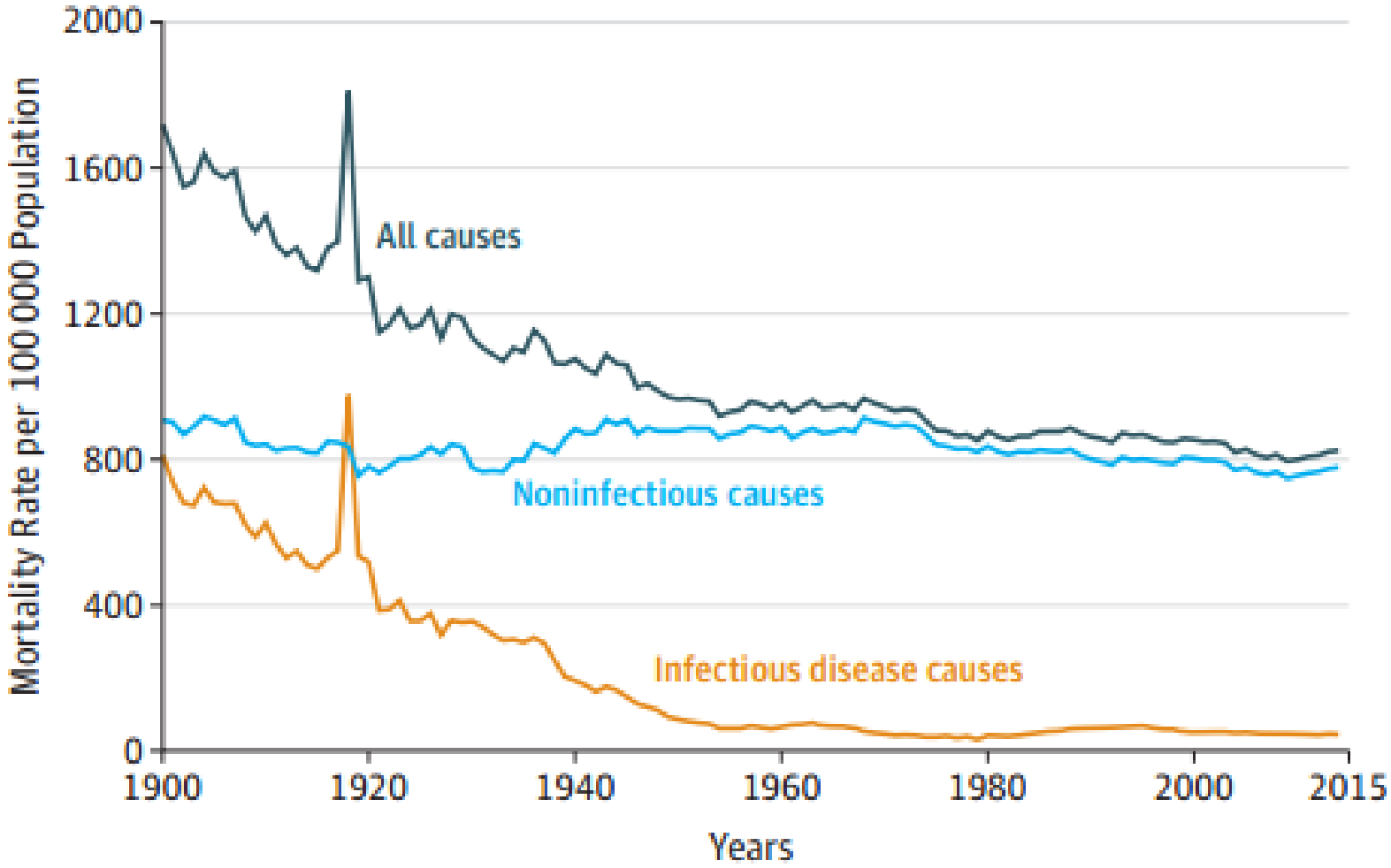
IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Life Expectancy Globally: 2015



Overall Mortality Rates/100,000 Pop.

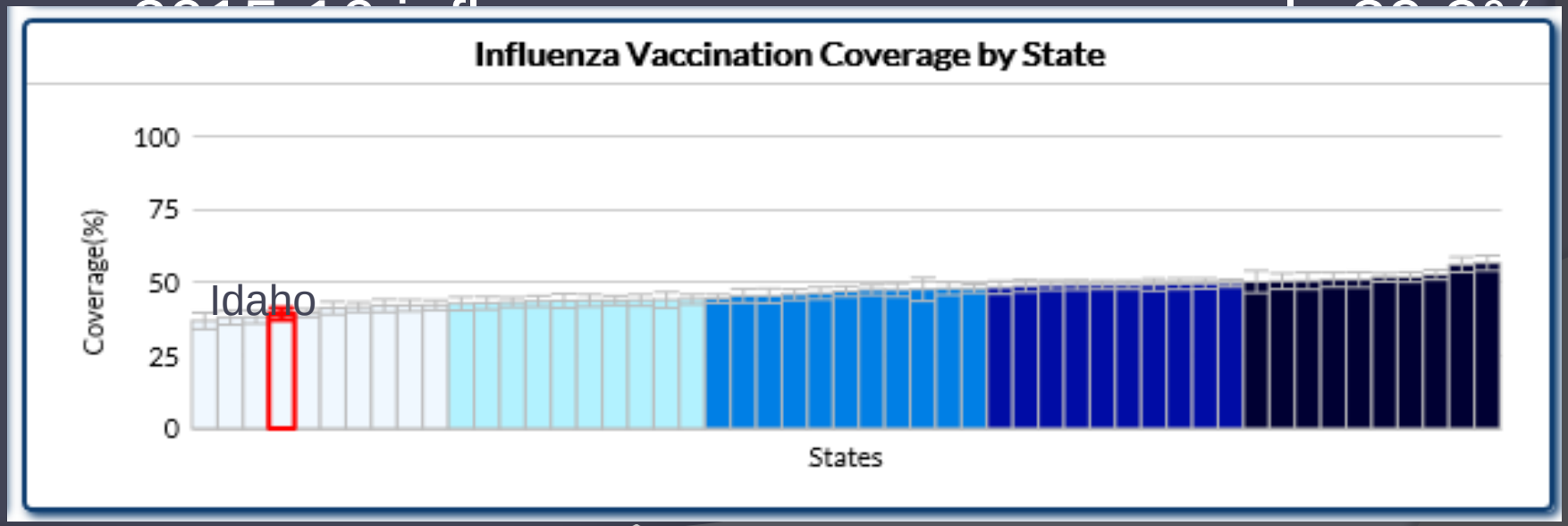
United States, 1900 - 2015



IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Influenza season 2016-17

- >10 deaths among Idaho residents reported due to influenza so far this season
- Flu vaccination rates lower than in most other states



Flu Vaccine Myths vs. Facts

MYTH

FACT
USED IN FLU SHOTS ARE NOT LIVE AND CAN'T CAUSE INFECTION

FACT
THE BEST WAY TO PROTECT THE PEOPLE AROUND YOU FROM GETTING SICK

MYTH

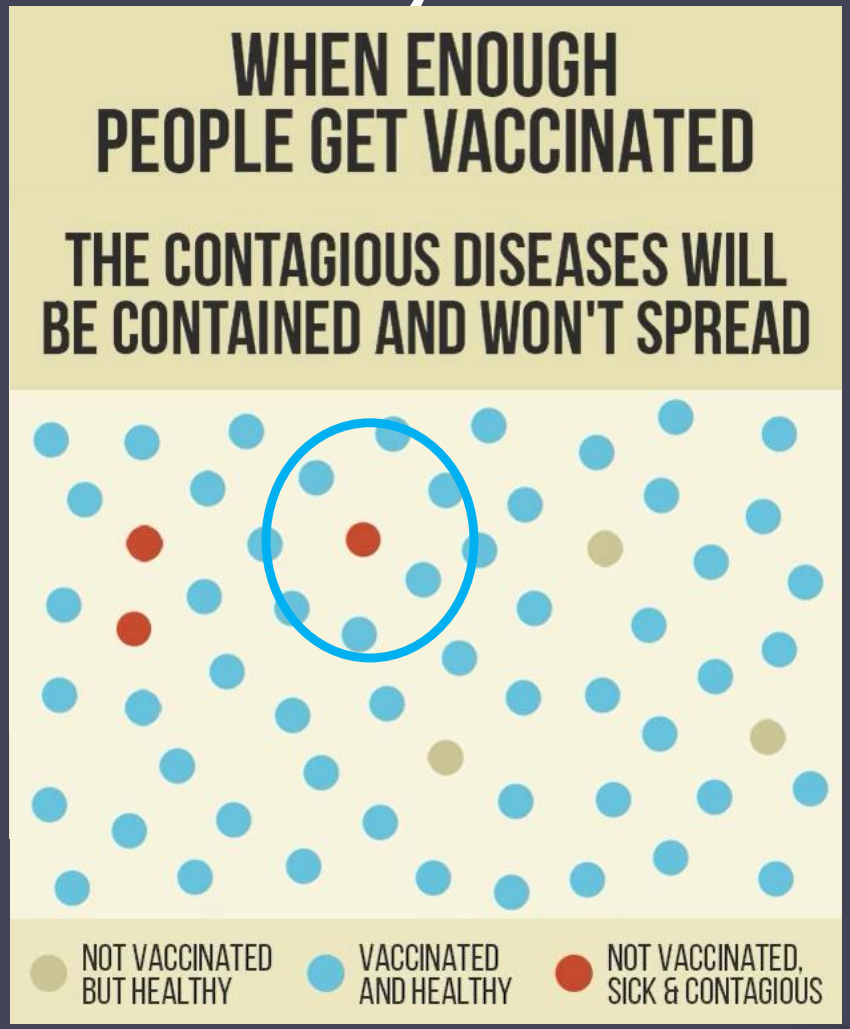
MYTH

FACT
VACCINE AND CATCH THE FLU, YOU WON'T BE AS SICK

FACT
DEVELOP, SO PEOPLE SHOULD GET A FLU SHOT AS SOON AS THEY ARE AVAILABLE

MYTH

Keeping Loved Ones Healthy



You may have heard….

- Originated with a single paper published in 1997
- Discredited due to serious procedural errors, undisclosed financial conflicts of interest, ethical violations
  - Author lost his medical license
  - paper retracted by the journal
- Hundreds of studies since 1997 have found no association
- **Autism Speaks statement on vaccinations:** "Over the last two decades, extensive research has asked whether there is any link between childhood vaccinations and autism. The results of this research are clear: Vaccines do not cause autism."

"Vaccines cause autism"

You may have heard….

- Dangers of this approach outweigh the relative benefits
  - For measles, you face a 1 in 500 chance of death from natural disease
  - Compare with a 1 in 1,000,000 chance of severe allergic reactions to the MMR vaccine

"Natural immunity is better than vaccine-acquired immunity"

Idaho Immunization Program: Keeping Idaho kids healthy

- Distributes vaccines to all Idaho healthcare providers immunizing children
- Maintains Idaho's Immunization Registry
- Works with Idaho child care centers, daycares, and schools to help them comply with Idaho laws

School Immunization Laws Basics

- Section 39-4801, Idaho Code
- IDAPA 16.02.15
- All children in preschool and grades K-12 must be immunized before attendance
- Our laws respect a parent's right to choose: a parent/guardian may claim an exemption from immunization requirements for medical, religious, or personal reasons

School Immunization Records

- A record kept by the school, showing child has received immunizations
- If a child is not up to date, parents may complete a form showing schedule of planned immunizations

Child's Name: _____

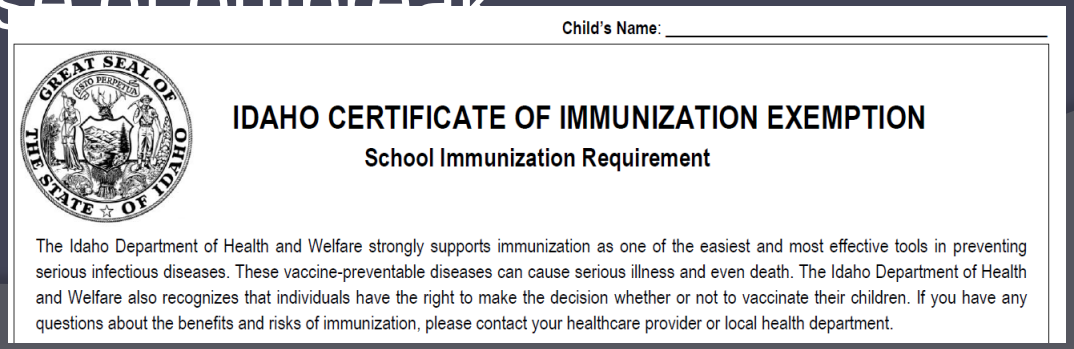
IDAHO CONDITIONAL ADMISSION TO SCHOOL

Schedule of Intended Immunizations Form

The Schedule of Intended Immunizations Form is required by IDAPA 16.02.15 to document the intended immunization schedule of a child who has not received all required immunizations for school admission. To be eligible for conditional attendance, a child must have received at least one dose of each required vaccine and currently be on schedule for subsequent immunizations following the intervals listed below.

School Immunization Exemptions

- Form provided by the Department
- Standardized way for school administrators to:
  - Determine school compliance with Idaho law
  - Rapidly respond to disease outbreaks in schools
- Ensures parents are informed about risks, including disease and exclusion from school in case of outbreak



Child's Name: _____

IDAHO CERTIFICATE OF IMMUNIZATION EXEMPTION

School Immunization Requirement

The Idaho Department of Health and Welfare strongly supports immunization as one of the easiest and most effective tools in preventing serious infectious diseases. These vaccine-preventable diseases can cause serious illness and even death. The Idaho Department of Health and Welfare also recognizes that individuals have the right to make the decision whether or not to vaccinate their children. If you have any questions about the benefits and risks of immunization, please contact your healthcare provider or local health department.

Medical Exemption

SECTION 1: ***Please read the following statements, check the box(es), and date each statement regarding vaccine-preventable diseases for which an exemption is claimed. Sections 1 and 2 must be completed for this exemption to be valid.***

SECTION 2: ***Please select ONE of the following exemption types (medical, religious, philosophical) for vaccines checked in Section 1.***

☐ **MEDICAL EXEMPTION (This exemption requires the signature of a licensed physician)**

As the child's physician, I certify that the physical condition of this child is such that the immunization(s) checked in Section 1 would endanger the health of the child.

- ☐ This medical exemption is permanent.
- ☐ This medical exemption is temporary. Duration of temporary exemption: _____/_____/_____

I hereby request that this child be exempted from the Immunization Requirements for Idaho School Children (IDAPA 16.02.15) due to a medical condition for which immunizations are contraindicated.

_____	_____	_____	_____
Name of Physician (PRINT)	Signature of Physician	Medical License #	Date

As the child's parent/guardian, I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak, both for his/her own protection and for the protection of others. I acknowledge that I have read this document in its entirety.

_____	_____	_____
Name of Parent/Guardian (PRINT)	Signature of Parent/Guardian	Date

_____	_____
Full Name of Exempted Child (PRINT)	Child's Date of Birth (Month, Day, Year)

Religious or Philosophical Exemptions

☐ **RELIGIOUS EXEMPTION**

As the child's parent/guardian, I certify that I am a member of a recognized religious organization which has doctrine that opposes immunizations for the following reason(s):

☐ **PHILOSOPHICAL EXEMPTION**

As the child's parent/guardian, I am opposed to having my child receive the immunization(s) checked in Section 1 of this form for the following reason(s):

_____

_____

_____

_____

_____

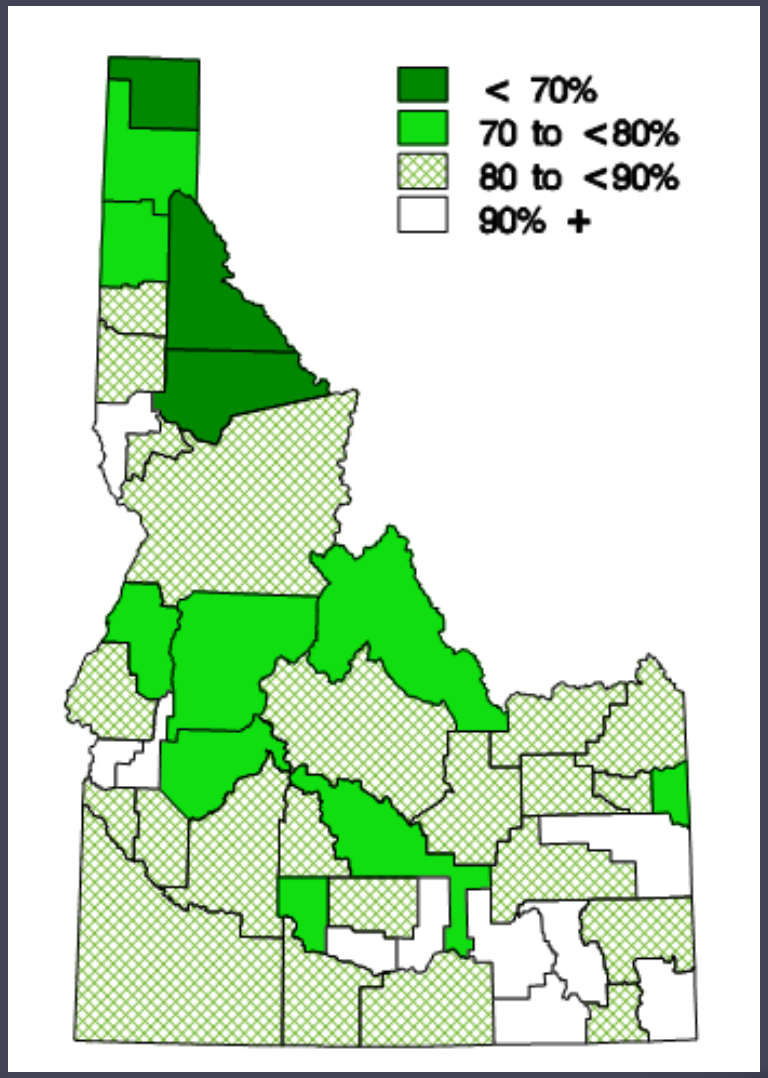
_____

I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak, both for his/her own protection and for the protection of others. I acknowledge that I have read this document in its entirety.

Name of Parent/Guardian (PRINT)	Signature of Parent/Guardian	Date
Full Name of Exempted Child (PRINT)	Child's Date of Birth (Month, Day, Year)	

School Report

Percent of students adequately immunized



Highest Reported Percent of Adequately Immunized Students

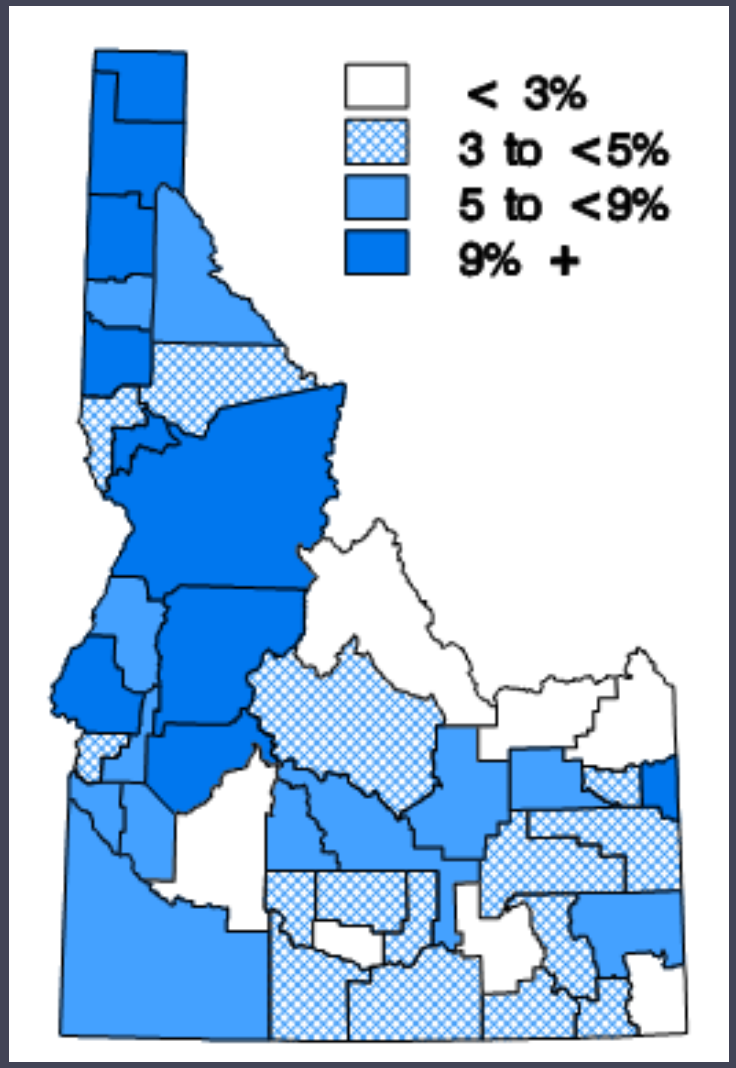
- Bear Lake (96%)
- Oneida (95%)
- Payette (94%)

Lowest Reported Percent of Adequately Immunized Students

- Boundary (50%)
- Clearwater (64%)
- Shoshone (67%)

School Report

Percent of records with at least one exemption



Lowest Reported Percent of Records with Exemption(s)

- Fremont (1%)
- Power (1%)
- Bear Lake (2%)

Highest Reported Percent of Records with Exemption(s)

- Valley (20%)
- Bonner (17%)

Outbreaks of Vaccine-Preventable Diseases

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Mumps outbreak in Idaho spreads to Washington state

KTVB-TV, Boise, Idaho 1:01 a.m. ET Feb. 8, 2015

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News

As va
Okla

By JONATHAN BA

KOIN 6
Watching out for you

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Mumps making a comeback in Oregon, SW Washington

Cases of the infamous illness known as the mumps are on the rise

Lisa Balick and KOIN 6 News Staff
Published: January 10, 2017, 4:14 pm | Updated: January 10, 2017, 5:33 pm

Outbreaks of Vaccine-Preventable Diseases

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News

Two more people die in southeast Idaho because of flu

By: Staff Writer |

Posted: Jan 03, 2017 04:23 PM MST
Updated: Jan 03, 2017 04:23 PM MST

Disneyland Measles Outbreak Spreads To 27 States | NBC Nightly News

Public policy should be designed to protect all….

"The director, under the rules, codes or standards adopted by him, shall have the general supervision of the promotion and protection of the life, health and mental health of the people of this state."
56-56-1003

Child's Name: _____

IDAHO CERTIFICATE OF IMMUNIZATION EXEMPTION

School Immunization Requirement

The Idaho Department of Health and Welfare strongly supports immunization as one of the easiest and most effective tools in preventing serious infectious diseases. These vaccine-preventable diseases can cause serious illness and even death. The Idaho Department of Health and Welfare also recognizes that individuals have the right to make the decision whether or not to vaccinate their children. If you have any questions about the benefits and risks of immunization, please contact your healthcare provider or local health department.

SECTION 1: ***Please read the following statements, check the box(es), and date each statement regarding vaccine-preventable diseases for which an exemption is claimed. Sections 1 and 2 must be completed for this exemption to be valid.***

☐ **Diphtheria (DTaP, DT, Tdap, Td):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing diphtheria if exposed to this disease. Serious symptoms and effects of this disease include: heart failure, paralysis (can't move parts of the body), breathing problems, coma, and death. _____ Date

☐ **Tetanus (DTaP, DT, Tdap, Td):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing tetanus if exposed to this disease. Serious symptoms and effects of this disease include: "locking" of the jaw, difficulty in swallowing and breathing, seizures (jerking and staring), painful tightening of muscles in the head and neck, and death. _____ Date

☐ **Pertussis (Whooping Cough) (DTaP, Tdap):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing pertussis (whooping cough) if exposed to this disease. Serious symptoms and effects of this disease include: severe coughing fits that can cause vomiting and exhaustion, pneumonia, seizures (jerking and staring), brain damage, and death. _____ Date

☐ **Polio:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing polio if exposed to this disease. Serious symptoms and effects of this disease include: paralysis (can't move parts of the body), meningitis (infection of the brain and spinal cord covering), permanent disability, and death. _____ Date

☐ **Measles, Mumps, Rubella (MMR):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing measles, mumps, and/or rubella if exposed to these diseases. Serious symptoms and effects of measles include: pneumonia, seizures (jerking and staring), brain damage, and death. Serious symptoms and effects of mumps include: meningitis (infection of the brain and spinal cord covering), painful swelling of the testicles or ovaries, sterility, deafness, and death. Serious symptoms and effects of rubella include: rash, arthritis, and muscle or joint pain. If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects such as deafness, heart problems, and mental retardation. _____ Date

☐ **Hepatitis B:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing hepatitis B if exposed to this disease. Serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), life-long liver problems, such as scarring and liver cancer, and death. _____ Date

☐ **Varicella (Chickenpox):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing varicella (chickenpox) if exposed to this disease. Serious symptoms and effects of this disease include: severe skin infections, pneumonia, brain damage, and death. A person who has had chickenpox can get a painful rash called shingles years later. _____ Date

☐ **Varicella Disease History:** I believe that my child has had chickenpox, but was not diagnosed by a licensed health care professional. _____ Date

☐ **Hepatitis A:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing hepatitis A if exposed to this disease. Serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), "flu-like" illness, hospitalization, and death. _____ Date

☐ **Meningococcal:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing meningococcal disease if exposed to this disease. Serious symptoms and effects of this disease include: meningitis (infection of the covering of the brain and spinal cord), blood infections, loss of arms or legs, problems with nervous system, deafness, mental retardation, seizures (jerking and staring), strokes, and death. _____ Date

Please continue to complete Section 2

SECTION 2: ***Please select ONE of the following exemption types (medical, religious, philosophical) for vaccines checked in Section 1.***

☐ MEDICAL EXEMPTION (This exemption requires the signature of a licensed physician)

As the child's physician, I certify that the physical condition of this child is such that the immunization(s) checked in Section 1 would endanger the health of the child.

- ☐ This medical exemption is permanent.
- ☐ This medical exemption is temporary. Duration of temporary exemption: _____/_____/_____

I hereby request that this child be exempted from the Immunization Requirements for Idaho School Children (IDAPA 16.02.15) due to a medical condition for which immunizations are contraindicated.

Name of Physician (PRINT) | Signature of Physician | Medical License # | Date

As the child's parent/guardian, I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak, both for his/her own protection and for the protection of others. I acknowledge that I have read this document in its entirety.

Name of Parent/Guardian (PRINT) | Signature of Parent/Guardian | Date

Full Name of Exempted Child (PRINT) | Child's Date of Birth (Month, Day, Year)

☐ RELIGIOUS EXEMPTION

As the child's parent/guardian, I certify that I am a member of a recognized religious organization which has doctrine that opposes immunizations for the following reason(s):

_____

_____

_____

_____

_____

_____

I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak, both for his/her own protection and for the protection of others. I acknowledge that I have read this document in its entirety.

Name of Parent/Guardian (PRINT) | Signature of Parent/Guardian | Date

Full Name of Exempted Child (PRINT) | Child's Date of Birth (Month, Day, Year)

☐ PHILOSOPHICAL EXEMPTION

As the child's parent/guardian, I am opposed to having my child receive the immunization(s) checked in Section 1 of this form for the following reason(s):

_____

_____

_____

_____

_____

_____

I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak, both for his/her own protection and for the protection of others. I acknowledge that I have read this document in its entirety.

Name of Parent/Guardian (PRINT) | Signature of Parent/Guardian | Date

Full Name of Exempted Child (PRINT) | Child's Date of Birth (Month, Day, Year)

Dear legislators:

Re: Increase in Personal Needs Allowance for participants on the A & D waiver.

I am requesting a reasonable modification of the policies and practices utilized in calculating a participant's contribution for Medicaid under Idaho's A & D waiver program.

Currently, I am eligible for community-based services under Idaho's Aged and Disabled Services (A&D) Waiver. Previously, I was eligible for Medicaid waiver services under the Medicaid for Workers Program. I am currently eligible for Medicaid and Medicare. While eligible for the Medicaid for Workers Program, I was assessed a Reasonable Premium for my services. After I was determined eligible under the A&D waiver, I was informed that my client participation amount was $2,258.72 per month - an increase in over $2,000.00 per month.

It is recognized that federal law requires states to set policies and procedures for recipients of home and community-based waiver services that could potentially result in a recipient's participation in the cost of the Medicaid services. Federal rules require a consideration of the income of the recipient, but they also require that certain items be deducted from this income before the share of cost is determined. One of these items is a deduction for maintenance needs allowance. This maintenance needs allowance must be based upon a reasonable assessment of the individual's needs. States are allowed to set a maximum amount for the deduction and this amount must be included in the states' waiver applications.

Idaho has set a maintenance allowance for A&D waiver recipients who are responsible for a rent or mortgage payment at 180% of the federal benefit rate, or $1,323.00 as of July 1, 2016. It is this amount that I requested be modified as necessary to allow me to remain in the community in the most integrated setting. Idaho's maintenance needs allowance and other policies make it virtually impossible for me to maintain my residence. With this allowance, I must fund my most right mortgage, utilities, property taxes, home owner's association dues, over-the-counter medications, home maintenance and repairs, yard care, water and irrigation costs, trash removal, food, clothing, transportation in an accessible van, supportive home care not covered by Medicaid, and many other daily living expenses.

The Medicaid and Welfare programs do not do an individualized assessment of need, and therefore do not make adjustments for the amount of an individual's mortgage and other housing costs. For some recipients such as myself, many of these costs are higher than average because the individual's disability must be accommodated. Additionally, the Department's own cost sharing rules for other eligibility criteria point out the discrimination that occurs for an individual in my situation. For example, a single recipient who does not pay rent or a mortgage is allowed $735.00 as a maintenance allowance, but this person has no mortgage or other costs associated with a home. Thus this individual has that amount to pay for food, clothing, and over-the-counter medications. Although the Department has apparently determined this amount is necessary to purchase these items in the community, I would've had nothing left to purchase these items after I paid for all the expenses associated with my home. Even if this $735 was deducted from the $1,323.00 allowance, I would only have $588.00 left for my housing costs.

Likewise, individuals who pay rent are allowed the same $1,323.00, but do not have similar home maintenance costs. These individuals can also lower their rent and/or their maintenance costs by having a roommate. If I receive rental income, this money does not go to my mortgage; it is rather counted as income to me and increases my share of cost. An individual eligible under the Department's other 1915(c) waiver, the Developmentally Disabled Services Waiver, is allowed three times the federal benefit rate, or $2,205.00 for a maintenance allowance. Community spouses were allowed a minimum of $1,891.25 and a maximum of $2,898.00 for monthly home maintenance costs in 2013, in addition to being allowed resources of over $100,000.00. Although, individuals eligible under the Medicaid for Workers with Disabilities program pay monthly premiums, these premiums are far less than my share of cost even though these recipients can earn and retain more money than A&D waiver recipients.

I am an individual with a serious medical condition that has resulted in significant medical needs. Because I have limited upper and lower extremity mobility, I cannot reside in the community home care. I could also not afford to retain and maintain my residence under the current maintenance allowance set by Idaho. I am a relatively young individual with a son who needs a father and a home to live in. My most integrated setting is unquestionably the community.

I believe the state of Idaho should increase its personal needs allowance for an individual on the A & D waiver to 300% of the federal SSI benefit rate to allow individuals to remain in their homes.

- Medicaid Participant, Randall Nilson

- (208)-409-8798 (cell), (208)-375-9760 (home)

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Thursday, January 19, 2017

SUBJECT	DESCRIPTION	PRESENTER
Docket No. 19-0101-1601	Rules of the Idaho State Board of Dentistry	Susan Miller Idaho Board of Dentistry
Docket No. 22-0103-1601	Rules for the Licensure of Physician Assistants	Angela Wickham Idaho Board of Medicine
Docket No. 24-1601-1601	Rules of the State Board of Denturitry	Mitch Toryanski Idaho Bureau of Occupational Licensing
Docket No. 24-1701-1601	Rules of the State Board of Acupuncture	Mitch Toryanski
Docket No. 24-1901-1601	Rules of the Board of Examiners of Residential Care Facility Administrators	Mitch Toryanski
Docket No. 24-2701-1601	Rules of the Idaho State Board of Massage Therapy	Mitch Toryanski

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Thursday, January 19, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the Committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.
PASSED THE GAVEL:	Chairman Heider passed the gavel to Vice Chairman Souza to conduct the rules review.
DOCKET NO. 19-0101-1601	**Rules of the Idaho State Board of Dentistry. Susan Miller** introduced herself as the Executive Director of the Board of Dentistry. **Ms. Miller** explained all changes in the pending rule. The docket deleted a reference to a document in Section 004 and added relevant portions of that document to Section 041. Section 010 clarifies the five-year time limit for accepting exams only applies to applications for licensure by examination. There is no time limit on acceptance of examinations for candidates applying by credential. Section 014.02 specifies examinations for dentist licensure must be board approved and include a periodontal examination section. Section 15.02 requires dental hygiene license examinations to be board approved and include a clinical local anesthesia examination. Not all testing agencies currently include these specific exams, and the Board of Dentistry wants to maintain them as components of the clinical exams for licensure. Section 018 clarifies the cardiopulmonary resuscitation (CPR) rule applies to applicants for initial licensure as well as licensees who currently practice. Sections 030.01.1 and 030.2.a would allow dental hygienists to administer nitrous oxide under general supervision rather than the more stringent indirect supervision. There is a high safety record, and it is reasonable for hygienists to be able to administer nitrous oxide for patient comfort when the dentist is out of the office. **Ms. Miller** advised Section 035.03 is a technical correction to update the reference to a previous section that was renumbered. Section 035.04 removed a reference to expanded functions, allowing the Board of Dentistry to approve curriculum in both the fundamentals and expanded functions of dental assisting. In Section 40.05, the rule expanded the unprofessional conduct section to include any prescription drug, rather than only controlled substances, in an effort to address the issue of dentists prescribing outside their scope of practice. One strikeout of "controlled substances" was missed, and a correction will be made in future rulemaking for consistency. Section 040.28 added a new subsection to include false, misleading, or deceptive advertising to the list of unprofessional conduct. Advertising is referenced in Idaho Code § 54-924, which provides grounds for refusal, revocation, or suspension of a dentist license, and the rule also provides grounds for discipline under Idaho Code § 54-924(7).

Ms. Miller explained Section 041 is a new section regarding minimum requirements for patient records. This section added language taken from the document formerly incorporated by reference in Section 004 and are not new requirements. Section 042 is a new rule regarding minimum infection control and sterilization requirements. The rule partially eliminates reliance on the CDC Infection Control Guidelines that are currently incorporated by reference. Section 046 deleted the general advertising provisions due to concerns about defensibility and antitrust issues. However, the rule maintains the requirements for specialty advertising to ensure the public knows whether they are seeing a general practitioner or a specialist.

Ms. Miller said Sections 050 and 051 deleted a reference to CPR under the continuing education requirements. The CPR requirement is separate from the education requirement, and the change clarifies for practitioners they cannot claim CPR hours for license renewal. Section 050.01 added a continuing education requirement for dentists of one credit hour on the use of the Idaho Prescription Monitoring Program to increase awareness and usage of that program. The first sentence of Section 055 was moved to the end of the paragraph for clarity. Section 058 is a new rule requiring every dental office to maintain minimum emergency drugs where anesthetic agents are administered, as recommended by the American Dental Association Council of Scientific Affairs.

Ms. Miller stated Sections 060 and 061 added pediatric advanced life support to the life support certification requirements, as suggested by former Senator Schmidt during a previous rule review. Section 060.03 added a piece of equipment as an option for certain sedation permit holders and includes an additional technical correction. Sections 060 and 061 added clarifications for the non-renewal and reinstatement process for sedation permits. Finally, Section 61.01.c removed the requirement for general anesthesia and deep sedation permit holders, who are typically oral surgeons or dental anesthesiologists, to be admitted to a recognized hospital. The Board of Dentistry's Anesthesia Committee reviewed the rule and recommended removing the admission requirement.

Senator Martin inquired whether there was a public hearing or opportunity for people to comment on the rule changes. **Ms. Miller** responded no public hearings were held because none were requested. The docket has been in process for well over one year and the Board of Dentistry invited participation by the Idaho Dental Association and the Idaho Dental Hygiene Association, and it also notified licensees of the proposed rule changes through newsletters. The Board of Dentistry received good feedback from the Idaho Dental Association and made some revisions based on that input. **Senator Martin** asked whether there was opposition to the final draft. **Ms. Miller** answered there was none.

Senator Lee asked whether the drugs mentioned in Section 058 are typically something most dentists keep in the office, and if not, what is the anticipated cost to the provider to implement the rule. **Ms. Miller** said most dental offices have a basic emergency kit. A pre-packaged emergency kit can cost a few hundred dollars, but there are less expensive ways to obtain the drugs through pharmacies. The Board of Dentistry inspects about 75 offices per year and part of the inspection process is to look at the emergency drug kits, which often contain expired drugs. **Senator Lee** asked whether the kit is an annual cost and what costs a provider should anticipate for budgeting purposes if the rule is implemented. **Ms. Miller** replied she did not know how long most of the drugs last but it likely one year or more. Most offices do carry a basic emergency kit as a good practice standard. While this would place an additional requirement on the permit holders, a very high percentage of offices are already maintaining the kit.

There being no more questions, **Senator Martin** moved to approve **Docket No. 19-0101-1601. Chairman Heider** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 22-0103-1601

Rules for the Licensure of Physician Assistants. Angela Wickham introduced herself to the Committee as the Associate Director of the Idaho State Board of Medicine. **Ms. Wickham** provided background information about the Idaho State Board of Medicine, established in 1892 as a self-governing agency operating with dedicated funds from licensing fees. The Board of Medicine has primary responsibility for licensure and regulation of physicians, physician assistants, athletic trainers, dietitians, and respiratory therapists. It regulates physicians who supervise physician assistants, residents, interns and externs, and athletic trainers. The Board of Medicine also has primary responsibility for the coordination and implementation of malpractice pre-litigation hearings. Its mission is to protect and enhance the public's health, safety, and welfare by establishing and maintaining standards of excellence used in regulating the practice of medicine through licensure, discipline, and education.

Ms. Wickham informed the Committee the pending rule: 1.) updates the titles of the accrediting boards; 2.) clarifies the educational and certification requirements for licensure and renewal of licensure; 3.) adds the ability of a physician assistant to order controlled substances for office use; 4.) streamlines the process for physician assistants to volunteer; and 5.) includes other small housekeeping changes.

Ms. Wickham said the Board of Medicine sought input from the Idaho Academy of Physician Assistants, the Idaho Medical Association, professionals from the Idaho State University Physician Assistant Program, licensed physician assistants, and other interested parties. Negotiations continued throughout the comment period. Several meetings were conducted informally with these stakeholders, and the draft rule was available on the Board of Medicine's website for review and comment. The Board of Medicine conducted a formal public hearing on the rules on November 2, 2016. There was no testimony given at that time, and the rules were approved in December 2016. The pending rule clarifies previously vague or non-existent language, removes redundant language, and provides guidance to needed physician assistants and their supervising physicians who often practice in under-served rural areas of Idaho.

Senator Lee asked for an explanation of the reference to "the committee" in Section 010.02. **Ms. Wickham** answered it is the Physician Assistant Advisory Committee that reports directly to the Board of Medicine. **Senator Lee** further inquired where that explanation appears in the rules. **Ms. Wickham** replied it is not included in the pending rule docket because the docket does not include the entire text of the physician assistant rules. **Senator Lee** commented the reference might be vague and confusing for people and suggested clarifying it in future rulemaking.

Senator Harris moved to approve **Docket No. 22-0103-1601. Senator Lee** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 24-1601-1601

Rules of the State Board of Denturitry. Mitch Toryanski introduced himself to the Committee as legal counsel for the Idaho Bureau of Occupational Licenses, representing the State Board of Denturitry. The mission of the Board of Denturitry is to protect the health, safety, and welfare of the public through licensing and regulation of those who provide prosthetic dental appliances, or dentures. The pending rule: 1.) allows the Board of Denturitry more flexibility on meeting dates and time of year they can administer the denturitry exam; 2.) requires the Board of Denturitry to notify exam applicants about their eligibility to take the exam and, if approved, the date and location the exam will be administered; and 3.) adds supervisor requirements for the internship program.

Mr. Toryanski explained to become a denturist, a person must pass an exam established by the Board of Denturitry; attend two years of formal training at an accredited educational institution; and serve a two-year internship under the supervision of a licensed denturist or dentist. The rules do not currently specify any qualifications for a supervisor, and it could be a newly-minted denturist who just finished his or her internship the day before with no actual experience. The Board of Denturitry feels having no actual days of experience is insufficient to protect the public. The pending rule proposes that: 1.) supervisors be approved by the Board of Denturitry before becoming a supervisor; 2.) they not have been the subject of discipline for the five years preceding their service as a supervisor; and 3.) whether a denturist or dentist, they must have actively practiced three of the five years immediately preceding their employment as a supervisor. The docket also includes general guidelines for how patient records should be kept and specifies minimal information to maintain, as well as a seven-year record retention requirement.

Mr. Toryanski advised the Board of Denturitry approved the rule changes in an open meeting noticed to the public and sent a postcard to all licensees informing them of the changes and inviting their comments. Five comments were received. One was from the Board of Dentistry, saying they had no concern or comment. There were three comments that took exception to having any experience requirements to be a supervisor. One comment said five years experience was too long and instead suggested three years experience with at least one year active experience immediately preceding appointment as a supervisor. The Board of Denturitry considered all of these comments, and agreed that three years experience to be a supervisor was in fact sufficient. Thus, the rule was amended to require only three years experience in the five preceding years.

Senator Lee inquired about the meaning of the term "jurisdiction" in Section 300.07.a.ii regarding the internship supervisor requirements. **Mr. Toryanski** answered that discipline refers to whether a license has been suspended or revoked or some action taken against it. The term "jurisdiction" means places other than Idaho. For example, if a denturist from Minnesota had been disciplined in Minnesota within five years of appointment as a supervisor, that would be disqualifying. **Senator Lee** asked whether this section relates to any criminal convictions or civil issues. **Mr. Toryanski** confirmed the section applies only to discipline against a license in Idaho or any other state or territory.

Senator Martin asked whether there were objections to the rule changes. **Mr. Toryanski** replied there were three objections to having any experience requirement as a precondition of being appointed a supervisor.

There being no more questions, **Chairman Heider** moved to approve **Docket No. 24-1601-1601. Senator Harris** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 24-1701-1601

Rules of the State Board of Acupuncture. Mr. Toryanski presented the docket to the Committee on behalf of the State Board of Acupuncture. The pending rule strikes Section 500 of the rules, eliminating the requirement that practitioners register any business or trade name they may use with the Board of Acupuncture. There is no statute that requires the Board of Acupuncture to collect this information, and there is no compelling reason to do it because the Board of Acupuncture regulates individuals, not businesses. Further, the Secretary of State collects business and trade name information, and it is available to the public.

Mr. Toryanski stated the Board of Acupuncture approved the rule changes in an open meeting noticed to the public and sent a postcard to all 184 licensees informing of the changes and inviting their comments. No comments were received.

There being no more questions, **Senator Martin** moved to approve **Docket No. 24-1701-1601. Senator Lee** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 24-1901-1601

Rules of the Board of Examiners of Residential Care Facility Administrators. Mr. Toryanski introduced himself on behalf of the State Board of Examiners of Residential Care Facility Administrators (RCFA). **Mr. Toryanski** informed the Committee the docket is a pending fee rule to align the rules of the Board of Examiners of RCFA with changes to Idaho Code § 67-2614 made by H 332 (2016). The changes result in: 1.) a reinstatement fee of $35 rather than $25; 2.) no impact to the General Fund since the Board of Examiners of RCFA operates only on dedicated funds; and 3.) an increase to the Board's dedicated fund of about $330 for the estimated 33 out of 477 licensees who will fail to renew their licenses and must reinstate.

There being no questions, **Senator Foreman** moved to approve **Docket No. 24-1901-1601. Senator Harris** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 24-2701-1601

Rules of the Idaho State Board of Massage Therapy. Mr. Toryanski informed the Committee he represents the State Board of Massage Therapy. In 2016, the Legislature passed H 519, which allowed massage therapy students to receive compensation while in school so they could work off tuition expense, and authorized the Board of Massage Therapy to establish requirements for temporary licenses and provisional permits.

Mr. Toryanski added the Board of Massage Therapy proposes to lower the initial license fee and the license renewal fee from $75 to $65. The Board of Massage Therapy's fund balance has been steadily increasing over the last five years and it is now more than twice its budget of $112,000 per year. In general, boards are advised to keep 100 to 150 percent of their budget in a balance, but more than that is unnecessary, and the Board of Massage Therapy wants to return its excess balance to the licensees.

Mr. Toryanski explained a temporary license is for applicants who have submitted applications showing they have met all the requirements for the license, but the Board of Massage Therapy has not met to take action on the application. A provisional permit is for applicants who have met all the requirements for licensure except the national exam. Provisional permittees are authorized to work under the supervision of a licensed massage therapist. The purpose of both the temporary license and provisional permit is to enable people to get to work as quickly as possible after they are trained. The rule establishes a $25 processing fee for both. Finally, the rule docket removes one exam as a nationally-recognized licensing exam, which is currently used for certification but not for licensure.

Mr. Toryanski stated the Board of Massage Therapy approved the rule changes in an open meeting noticed to the public and sent a postcard to all 2,195 licensees informing of the changes and requesting comments. No comments were received. However, there were four responses that included only clarifying questions about the definitions of temporary license and provisional permit.

There being no questions, **Senator Agenbroad** moved to approve **Docket No. 24-2701-1601. Senator Jordan** seconded the motion. The motion carried by **voice vote.**

PASSED THE GAVEL:

Vice Chairman Souza passed the gavel back to Chairman Heider.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 3:42 p.m.

Senator Heider Chair	Jeanne Jackson-Heim Secretary

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Monday, January 23, 2017

SUBJECT	DESCRIPTION	PRESENTER
Approval of Minutes	Meeting of January 12, 2017	Senator Agenbroad
Rules Review		
Docket No. 16-0201-1601	Rules of the Idaho Time Sensitive Emergency System Council	Dr. Bill Morgan, Chair Time Sensitive Emergency System Council
Docket No. 16-0102-1601	Emergency Medical Services (EMS) - Rule Definitions	Bruce Cheeseman Idaho Bureau of Emergency Medical Services & Preparedness
Docket No. 16-0103-1602	Emergency Medical Services (EMS) - Agency Licensing Requirements	Bruce Cheeseman
Docket No. 16-0107-1601	Emergency Medical Services (EMS) - Personnel Licensing Requirements	Bruce Cheeseman
Docket No. 16-0103-1601	Emergency Medical Services (EMS) - Agency Licensing Requirements	Bruce Cheeseman
Docket No. 16-0106-1601	Emergency Medical Services (EMS) - Data Collection and Submission Requirements	John Cramer Idaho Bureau of Emergency Medical Services & Preparedness

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Monday, January 23, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.
APPROVAL OF MINUTES:	**Senator Agenbroad** moved to approve the minutes of the January 12, 2017 meeting as presented. **Senator Martin** seconded the motion. The motion carried by **voice vote.**
PASSED THE GAVEL:	Chairman Heider passed the gavel to Vice Chairman Souza to conduct the rules review.
DOCKET NO. 16-0201-1601	**Rules of the Idaho Time Sensitive Emergency System Council. Bill Morgan,** M.D. introduced himself as Chair of the Time Sensitive Emergency Council (TSEC). He is the Trauma Medical Director at Saint Alphonsus Regional Medical Center in Boise and Chair of the State of Idaho American College of Surgeons Committee on Trauma. **Dr. Morgan** explained the TSEC began as an initiative of the Health Quality Planning Commission (HQPC) in 2011. The HQPC wanted the trauma centers and Emergency Medical Services (EMS) Bureau to create and document a system for handling traumas. In 2012, the HQPC asked the work group to include strokes and heart attacks in the new trauma system because they are also time sensitive emergencies. If a certain type of heart attack known as a "STEMI" is treated aggressively, often the patient can be saved and return to full function. **Dr. Morgan** reminded the Committee the Legislature passed HCR 010 (2013) to establish a work group to design the trauma system, identify funding, and implement the system. A work group of individuals from around the State began meeting in May 2013 and held lengthy meetings every month for seven months. The work group developed enabling legislation and a plan to fund and implement the program. In 2014, the Legislature passed legislation to establish the TSEC. The TSEC developed bylaws, regulations, and rules and set up six regional committees around the State. The six regional committee chairs and eleven Gubernatorial appointees comprise the TSEC.

Dr. Morgan said the TSEC designed a standards manual for the State designation of trauma centers for traumas, strokes, and STEMIs. The manual was completed in 2015 and presented to the Legislature in 2016. Next, the TSEC began designating stroke and trauma centers, including hospitals, free-standing emergency rooms, and two free-standing clinics. The two clinics are only open during business hours but they are included in the system because they are located in remote areas, and it is important they also know how to handle time sensitive emergencies. There are 40 different facilities in Idaho that could qualify for a designation. Each facility could receive three separate designations for trauma, stroke, and STEMI centers, making a potential total of 120 designations statewide.

Dr. Morgan advised the TSEC's initial designations were two facilities already designated as American College of Surgeons (ACS) Level II trauma centers: Saint Alphonsus in Boise and Eastern Idaho Regional Medical Center in Idaho Falls. The TSEC considered these two trauma centers to have already met the TSEC standards by virtue of their ACS designations. Twenty-two facilities have since applied for various designations, and eight facilities from around the state have received a total of fourteen designations. The TSEC has received six additional applications for designations. Two site survey visits were recently completed at Boundary Community Hospital and Bonner General Hospital in North Idaho, and these two surveys will be reviewed by the TSEC at its February 2017 meeting. Two facilities have requested additional designations, and these applications will also be considered in February. The regional committees are beginning to effect change because facilities communicate with each other better about improving patient care and lowering mortality.

Dr. Morgan explained the rule docket updates an incorporation by reference for the date of the Time Sensitive Emergency Standards Manual (Manual) from 2016 to 2017. **Dr. Morgan** provided the updates in the Manual, including a revision in the fee for Level II STEMI and Level III stroke surveys to $1,500 per survey and deletions of the word "registry" in two sections. **Dr. Morgan** explained the ACS standard requires facilities with Level II and Level III designations to have a medical doctor anesthesiologist present every time a trauma patient goes to the operating room. In Idaho, nurse anesthetists can operate independently and may never have a medical doctor anesthesiologist present. A phrase "if requested by the Certified Registered Nurse Anesthetist" was added in two sections to align the TSEC standards with Idaho requirements for nurse anesthetists. The only other changes are a few minor technical corrections. (Presentation is attached.)

Senator Jordan asked for a point of personal privilege to thank Dr. Morgan for his service. As a former Boise City Councillor, she is aware two Boise City police officers were recently injured in the line of duty and received remarkable care from the trauma team.

Senator Martin asked for clarification about the number of regional committees. **Dr. Morgan** replied the TSEC was designed for six regional committees, although the idea of seven committees was discussed at the outset of the design process.

MOTION: **Senator Foreman** moved to approve **Docket No. 16-0201-1601. Senator Jordan** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 16-0102-1601 **Emergency Medical Services (EMS) - Rule Definitions. Bruce Cheeseman** introduced himself to the Committee as the Section Manager for the Bureau of Emergency Medical Services (Bureau). **Mr. Cheeseman** informed the Committee this docket is a definitions chapter. It adds a reference to IDAPA § 16.01.06, as well as definitions for air medical support, emergency medical services (EMS) response, National Emergency Medical Services Information System (NEMSIS), seasonal, and the Recognition of EMS Personnel Licensure Interstate Compact (REPLICA).

Vice Chairman Souza inquired whether many people attended the public hearings. **Mr. Cheeseman** answered there were not many. The Bureau conducts several town halls throughout the State each year, and proposed rule changes were presented at those meetings and at an additional telephone town hall meeting. There was no opposition to any of the rules.

MOTION: **Senator Harris** moved to approve **Docket No. 16-0102-1601. Senator Lee** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 16-0103-1601 **Emergency Medical Services (EMS) - Agency Licensing Requirements. Mr. Cheeseman** informed the Committee this docket removes all language pertaining to records, data collection, and submission. This language will be placed in a separate chapter.

Vice Chairman Souza asked for the date of the last update of these rules. **Mr. Cheeseman** answered sections have been gradually removed and placed in their own chapters. **Senator Lee** asked why the new replacement chapter did not come in before the docket to remove the old sections. **Mr. Cheeseman** explained it was the result of his having several dockets to present and the new section will be presented later in the meeting.

MOTION: **Chairman Heider** moved to approve **Docket No. 16-0103-1601. Senator Harris** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 16-0103-1602 **Emergency Medical Services (EMS) - Agency Licensing Requirements. Mr. Cheeseman** advised the rule adds hospitals to the declaration options for EMS agencies. The rule change was proposed because one of the hospitals is no longer providing EMS and turned those services over to the county. The hospital no longer needs to be licensed as an EMS agency, but it still utilizes EMS personnel in their emergency room. Licensed EMS personnel are required to have an affiliation with a licensed EMS agency to maintain licensure. This situation created a hardship for the licensed personnel as they would also have to work at another licensed EMS agency to remain working as an EMS provider in the hospital. The rule change added "hospital" as a declaration option to resolve that issue. "Seasonal" was also added as a license duration to cover agencies that only operate on a seasonal basis, such as wildland fire agencies or ski resorts.

Mr. Cheeseman explained the rules also simplify the air medical declarations. Currently, there are Air Medical 1 and Air Medical 2 license types. The licenses are outdated because a flight now requires a nurse and a paramedic in order to meet Commission on Accreditation of Medical Transport Services standards. Air Medical Support was added as a license type for air resources that provide immediate emergency medical care but do not transport patients. For example, the Idaho National Guard has a medevac unit that is utilized numerous times each year for hoist operations to remove a sick or injured person from a remote area. The airmen have EMS licensure but their personnel did not belong to a licensed EMS agency. Adding air medical support as an option allows these airmen to provide short term care while still complying with personnel licensure rules.

Senator Harris asked for a definition of "seasonal EMS" and what constitutes "seasonal." **Mr. Cheeseman** replied several ski resorts are licensed EMS agencies but are only open a few months and then no one is there to staff the facility. **Vice Chairman Souza** inquired whether the ski resorts would be liable if there was an accident and they were not open and staffed. **Mr. Cheeseman** responded that would be the case, and this rule would ensure that doesn't happen.

TESTIMONY: **Mike McGrane** introduced himself to the Committee on behalf of the Idaho Nurses Association and Nurse Leaders of Idaho. The Nurses Association has reservations about Section 204.07 of the rule docket. Currently, EMS providers, emergency medical technicians (EMTs), and paramedics must be affiliated with a licensed EMS agency or ambulance service. There are already rules to allow for the practice of paramedics and EMTs in a hospital under the supervision of a physician who has to develop a medical supervision plan that dictates the role of the EMT or paramedic. Nurses advocate for this approach because it builds a relationship with the hospital that receives patients from the ambulance service, but it also provides EMTs and paramedics with an opportunity to advance and keep current on their skills. However, this change would eliminate the requirement for affiliation with an ambulance service. The nurses are concerned because EMS has always been in the pre-hospital environment, and this change would allow EMTs and paramedics to practice within the hospital environment. It eliminates the necessity to foster relationships or build competency they get from that practice.

Vice Chairman Souza asked whether the concern is that the paramedics would be working within the hospital rather than in the lead-up to bringing them to the hospital, and if their scope of practice as paramedics would be different than if they were affiliated with an ambulance service. **Mr. McGrane** replied he does not believe the scope of practice would be any different. The rule would allow the hospitals to hire paramedics and EMTs to work in the emergency department without an affiliation with an ambulance service. **Vice Chairman Souza** inquired whether the nurses who work in the emergency room might feel their jobs were not as secure because of the alternative health care providers. **Mr. McGrane** affirmed it is a concern having alternatives to nurses in the emergency department or other locations in the hospital. The licensing standards for hospitals outline who can practice in a hospital so the rule wouldn't eliminate the necessity for nurses, but it could potentially reduce the need for nurses in some departments.

Chairman Heider asked if there is any evidence EMTs are taking the place of nurses in any Idaho hospitals. **Mr. McGrane** responded there is none. A number of hospitals use paramedics in their emergency departments but the paramedics are all affiliated with ambulance services. Because this is a new proposal, there has not been an opportunity for hospitals to hire paramedics independent of ambulance services. **Vice Chairman Souza** asked whether there is something that changes the quality of practice of the EMT or paramedic or is it simply that the ambulance service would require them to only give care up until the doors of the emergency room. **Mr. McGrane** answered the practice of EMS has been traditionally in the pre-hospital environment, responding to emergencies at the scene of an accident and bringing those patients to the hospital and rendering care during that pre-hospital time frame. The concept of EMTs and paramedics working in the hospital was to augment their knowledge, skill, and performance so they could provide better care in the pre-hospital setting. Some nurses have a concern that allowing EMTs and paramedics to be independently hired could eliminate some nursing positions.

DISCUSSION: **Chairman Heider** inquired of Mr. Cheeseman if he had the same concern about ambulance personnel replacing nurses in the emergency room. **Mr. Cheeseman** responded the Bureau did not have that concern. The rule allowing paramedics and EMTs to work in a hospital emergency room has been in place for eight or nine years. The rules are very clear if a provider works within the confines of a hospital, the provider will have the same medical direction than he would out on the street by himself. **Vice Chairman Souza** mentioned there was no negotiated rulemaking, and asked whether there were many respondents at the public hearing. **Mr. Cheeseman** replied the hearing was held by webinar, and no one signed in to attend. **Vice Chairman Souza** asked if Mr. Cheeseman heard from any of the nurses associations or groups regarding their concerns. **Mr. Cheeseman** said the Bureau has not heard these concerns.

MOTION: **Chairman Heider** moved to approve **Docket No. 16-0103-102. Senator Lee** seconded the motion. The motion passed by **voice vote,** with **Senator Martin** and **Senator Jordan** requesting that they be recorded as voting nay.

Chairman Heider commented Mr. McGrane brings a valid point but since there were no complaints when the rules were made, the rule should be approved now and he will follow up later with the Nurses Association. **Senator Lee** said the rule could be revisited next year if there is an attempt to circumvent or displace people. **Vice Chairman Souza** stated she is comfortable with Mr. Cheeseman's clarification that the ability of EMTs and paramedics to work within the hospital setting has been in rule for eight years.

DOCKET NO. 16-0107-1601 **Emergency Medical Services (EMS) - Personnel Licensing Requirements. Mr. Cheeseman** presented the Recognition of EMS Personnel Licensure Interstate Compact Agreement (REPLICA). In 2016, the Legislature passed S 1281 to enact REPLICA, enabling the State of Idaho to enter into the compact agreement with other states that have also enacted REPLICA legislation, including Colorado, Texas, Kansas, Tennessee, Utah, and Virginia. REPLICA will be activated when ten states have passed the enabling legislation and entered into the compact. The Bureau believes REPLICA will be activated in 2017.

Mr. Cheeseman advised REPLICA addresses EMS personnel crossing state lines. This would allow personnel to function under their home state license without violating licensure rules in another REPLICA state. When a licensed provider crosses from one REPLICA state to another REPLICA state, that provider will enjoy the same protection afforded in their home state.

Mr. Cheeseman explained hat REPLICA does not address reciprocity when a licensed provider from a REPLICA state actually moves to Idaho and seeks licensure. Under current law, when a licensed provider from another state wishes to gain Idaho licensure, he must provide proof of licensure, pass a recent national registry exam, and complete a background check. The rule change will allow a licensed provider coming from another REPLICA state to have direct reciprocity with Idaho if the provider holds a current license in the other state. The licensed provider will have 90 days to apply for and obtain an Idaho license, allowing the provider to start working in Idaho immediately. The licensed provider will be given an expiration date that coincides with their original state's license expiration. When the provider applies for an Idaho license, the initial expiration date will be the March or September following the expiration of the original state's license. Idaho licensure will not be required for personnel who maintain primary affiliation in another REPLICA state.

Senator Martin inquired whether this would address a situation where a patient in Payette, Idaho might be transferred to a hospital or clinic in Ontario, Oregon. **Mr. Cheeseman** replied that is correct, but the rule is broader than that because it allows for a provider to move here and do a direct license exchange. **Senator Harris** asked if the rules are the same as the rules in other REPLICA states. **Mr. Cheeseman** responded the REPLICA legislation only addresses a provider entering the state with a patient. The Bureau rule goes farther and provides reciprocity for someone seeking an Idaho license to make the licensing process easier. **Senator Harris** asked how many more states have to join before REPLICA is effective. **Mr. Cheeseman** said three more states are required to join, and currently six states are actively seeking enabling legislation this session. **Vice Chairman Souza** asked if the qualifications for licensure under REPLICA are identical or close to identical between the states where medical personnel might cross state lines. **Mr. Cheeseman** answered yes.

Chairman Heider asked how long people who move into the State of Idaho have until they must obtain an Idaho license. **Mr. Cheeseman** stated the provider can start working immediately under REPLICA and would have 90 days to apply for an Idaho license but would not have to take an exam. Someone licensed in a REPLICA state would have already undergone a background check and obtained a license, and that would satisfy Idaho's requirements for licensure. **Chairman Heider** further inquired whether the provider ever had to obtain or renew an Idaho license. **Mr. Cheeseman** answered if the provider obtains an Idaho license, the license must be renewed every two or three years, depending on the license type.

MOTION: **Senator Martin** moved to approve **Docket No. 16-0107-1601. Senator Harris** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 16-0106-1601 **Emergency Medical Services (EMS) - Data Collection and Submission Requirements. John Cramer** introduced himself as a Program Manager at the Bureau. This docket adds a new chapter relating to data collection and submission. The rules were last updated in 1997 and there have been many profound changes since that time with regard to EMS service delivery and electronic information collection and documentation. The Bureau has been in the process of negotiated rulemaking since the spring of 2014, culminating in a public hearing in September 2016. The current data collection rules were promulgated in a simpler time when the depth of knowledge was limited to 81 defined data points which provide only the most basic operational understanding of EMS responses and care: dates and times of incidents; call and location type; patient gender and age; basic treatment; and call disposition. It was formerly captured on paper using Scantron bubble sheets. Data collection was unreliable because the bubble sheets would often be filled out three or four months after the fact, and the scanner would reject the bubble sheets.

Mr. Cramer advised the Bureau began voluntary electronic data collection in 2007, using the current NEMSIS data standards and data dictionary. The initial pilot was well received and the Bureau was able to secure grant funds to help the rural and frontier agencies obtain computer equipment and software. The Bureau also provided software to assist with transmitting data in other ways than besides over the Internet.

Mr. Cramer explained the Bureau began the negotiated rulemaking process in 2014. As part of this process, the Bureau identified 179 data points suitable for collection by the State. Thirty-seven of those data points are considered mandatory and are reported in every case. The remaining 142 are conditional. For example, in the case of a cardiac arrest where the heart stops, it could mean an additional 15 to 24 data points that are specific to that condition. With the exception of those data points that are confidential, most of the data is used by the Idaho Transportation Department Office of Highway Safety and the Idaho Time Sensitive Emergency Data Registry, to capture the severity of an accident and the locations that generate the most serious types of injuries.

Mr. Cramer reported the new chapter was created as a stand-alone chapter due to the complexity and specificity of the topic and to conform to the current national data standards defined by NEMSIS in its current data dictionary. The Bureau is now also able to share the data with hospitals through their electronic health records systems. The adoption of this new chapter and the associated national data standards will result in improvements to the quality and quantity of information gathered as it relates to the out-of-hospital care provided by Idaho EMS providers and ultimately in the care provided to those patients. The changes will not result in any fiscal impact to the State.

Chairman Heider asked where the data is stored and who has access to it. **Mr. Cramer** answered the data is stored out of state at a very secure data site that is compliant with the Health Insurance Portability and Accountability Act. **Mr. Cramer** has access to all raw data. The EMS providers, agency administrators, and medical directors have access to the respective agency's information. Otherwise, the data is considered confidential like any other medical record.

MOTION: **Senator Anthon** moved to approve **Docket No. 16-0106-1601. Senator Harris** seconded the motion. The motion carried by **voice vote.**

PASSED THE GAVEL: Vice Chairman Souza passed the gavel back to Chairman Heider.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 3:55 p.m.

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Senator Heider
Chair

_____

Jeanne Jackson-Heim
Secretary

2017 LEGISLATIVE UPDATE ON IDAHO TIME SENSITIVE EMERGENCY SYSTEM

BILL MORGAN, MD, FACS

TRAUMA MEDICAL DIRECTOR-SAINT ALPHONSUS REGIONAL MEDICAL CENTER-BOISE

CHAIR OF THE IDAHO AMERICAN COLLEGE OF SURGEONS COMMITTEE ON TRAUMA

CHAIR, IDAHO TIME SENSITIVE EMERGENCY COUNCIL

HISTORY OF THE IDAHO TSE

- HQPC INITIATIVE IN NOVEMBER 2011-TRAUMA CENTERS AND THE STATE EMS BUREAU WERE TO WORK TOGETHER TO DESIGN A TRAUMA SYSTEM FOR IDAHO
- HQPC IN NOVEMBER 2012-ADDED STROKE AND STEMI TO THEIR INITIATIVE
- **HCR 010**-JOINT CONTINUING RESOLUTION IN JANUARY 2013 TO ESTABLISH A "WORKGROUP" TO DESIGN THE SYSTEM, FUNDING AND IMPLEMENTATION
- 45 MEMBER WORKGROUP MET MONTHLY FOR 7 MONTHS TO COMPLETE LEGISLATION DESIGN
- LEGISLATION PRESENTED IN 2014 TO IDAHO LEGISLATURE AND SIGNED INTO LAW IN MARCH 2014
- 11 MEMBER GOVERNOR-APPOINTED COUNCIL BEGAN DESIGNING THE SYSTEM'S BYLAWS, RULES, AND REGULATIONS IN JULY 2014 AND SET UP THE 6 REGIONAL COMMITTEES
- 6 REGIONAL CHAIRS WERE THEN EMPANELED ON THE TSE COUNCIL BY FEBRUARY 2015 TO COMPLETE THE 17 MEMBER COUNCIL AS PRESCRIBED BY THE LEGISLATION

HISTORY OF THE IDAHO TSE

- STANDARDS MANUAL FOR STATE DESIGNATION OF TRAUMA, STROKE AND STEMI CENTERS WAS COMPLETED BY LATE 2015 AND PRESENTED TO THE HOUSE AND SENATE HEALTH AND WELFARE COMMITTEES IN JANUARY 2016
- BEGAN DESIGNATION OF TRAUMA, STROKE AND STEMI CENTERS IN 2016
- 40 HOSPITALS/FREE STANDING ER'S/CLINCS IN THE STATE OF IDAHO THAT COULD QUALIFY FOR A DESIGNATION
- POTENTIALLY, EACH FACILITY COULD RECEIVE 3 DESIGNATIONS-TRAUMA, STROKE, AND STEMI FOR A TOTAL OF 120 DESIGNATIONS IN THE STATE
- INITIAL DESIGNATIONS WERE GIVEN TO ALREADY-DESIGNATED, AMERICAN COLLEGE OF SURGEONS (ACS) LEVEL II TRAUMA CENTERS
  - SAINT ALPHONSUS REGIONAL MEDICAL CENTER-BOISE
  - EASTERN IDAHO REGIONAL MEDICAL CENTER-IDAHO FALLS

HISTORY OF THE IDAHO TSE

- SUBSEQUENTLY, AFTER THE SUBMISSION OF 22 APPLICATIONS FROM IDAHO FACILITIES TO THE TSE COUNCIL REQUESTING DESIGNATION FOR TRAUMA, STROKE, AND STEMI
- THE FOLLOWING HOSPITALS HAVE RECEIVED THESE DESIGNATIONS BY THE STATE TSE COUNCIL

HISTORY OF THE IDAHO TSE

NAME	TRAUMA	STROKE	STEMI
SAINT ALPHONSUS REGIONAL MEDICAL CENTER	LEVEL II	LEVEL II	LEVEL I
EASTERN IDAHO REGIONAL MEDICAL CENTER	LEVEL II	LEVEL II	LEVEL I
ST LUKE'S MEDICAL CENTER-BOISE		LEVEL II	LEVEL I
ST LUKE'S MEDICAL CENTER-MERIDIAN		LEVEL II	LEVEL I
LOST RIVERS MEDICAL CENTER-ARCO	LEVEL IV		
CLEARWATER VALLEY HOSPITAL-OROFINO	LEVEL IV		
TETON VALLEY HOSPITAL-DRIGGS	LEVEL IV		
KOOTENAI HEALTH-COEUR D'ALENE	LEVEL II		

CURRENT STATE OF THE TSE

- THE FOLLOWING APPLICATIONS HAVE BEEN SUBMITTED AND ARE CURRENTLY PENDING SITE SURVEYS
  - LEVEL IV TRAUMA
    - STEELE MEMORIAL HOSPITAL-SALMON, IDAHO
  - LEVEL II STEMI
    - ST LUKE'S FRUITLAND
    - ST LUKE'S NAMPA
    - TETON VALLEY-DRIGGS
  - LEVEL I STROKE
    - SAINT ALPHONSUS REGIONAL MEDICAL CENTER-BOISE
  - LEVEL III STROKE
    - TETON VALLEY HOSPITAL-DRIGGS
- THESE SITE SURVEYS COMPLETED ON JANUARY 12-13, 2017
  - BOUNDARY COMMUNITY HOSPITAL-BONNERS FERRY, IDAHO-**LEVEL IV TRAUMA**
  - BONNER GENERAL HOSPITAL-SANDPOINT, IDAHO-**LEVEL IV TRAUMA**

CONCLUSION

- OF THE 120 DESIGNATIONS AVAILABLE IF ALL HOSPITALS AND CLINCS SUBMITTED FOR AND, RECEIVED ALL 3 DESIGNATIONS IN IDAHO
- CURRENTLY 8 FACILITIES HAVE RECEIVED DESIGNATIONS-2 OF THESE HAVE RECEIVED ALL THREE DESIGNATIONS
- 2 HAVE BEEN SURVEYED AS LEVEL IV TRAUMA CENTERS AND ARE PENDING APPROVAL BY THE TSE COUNCIL
- 6 FACILITES ARE PENDING SURVEYS WITH COMPLETED APPLICATIONS
- REGIONAL TSE COMMITTEES ARE BEGINNING TO EFFECT CHANGE IN THEIR RESPECTIVE REGIONS BY ENGAGING THEIR RESPECTIVE MEMBER FACILITIES TO
  - PROMOTE BETTER COMMUNICATION
  - IMPROVE PATIENT CARE
  - SHORTEN TRANSPORT TIMES TO HIGHER LEVELS OF CARE

IDAHO

IDAHO TIME SENSITIVE EMERGENCY SYSTEM
TRAUMA | STROKE | STEMI

January 15, 2017

Search...

Idaho Time Sensitive Emergency

December 23, Happy holidays from the TSE staff.

November 8, The TSE Council approved and designated Kootenai Health in Coeur d'Alene as a Level II Trauma center.

October11, The TSE Council approved Clearwater Valley Hospital in Orofino as a Level IV Trauma center and Teton Valley Hospital in Driggs, as a Level IV trauma center.

October 6, The TSE Council has updated their TSE Standards Manual which included minor changes. The draft TSE Standards Manual can be found here which will become effective 7/1/2017. Due to being incorporated by reference in the TSE Rules, IDAPA 16.02.01 the proposed rule changes are listed in the October - Idaho Administrative Bulletin and once approved, will go into effect on July 1, 2017.

September 13th- The TSE Council approved and designated Eastern Idaho Regional Medical Center- Idaho Falls as a Level II Stroke Center and a Level I STEMI center.

August 9th- The TSE Council approved and designated St. Luke's Boise, and St Luke's Meridian as Level II Stroke Centers.

July 12th- The TSE Council approved and designated Lost Rivers Medical Center in Arco as a Level IV Trauma Center. The TSE Staff wants to congratulate them for becoming the first Critical Access Hospital in Idaho to become designated.

June 14th - The TSE Council approved and designed St. Luke's Boise Medical Center and St. Luke's Meridian Medical Center as Level I STEMI Centers.

April 12th - The TSE Council approved and designated Saint Alphonsus - Boise, as a Level I STEMI center.

March 8th - The TSE Council approved and designated two Level II trauma centers, Eastern Regional Idaho Medical Center- Idaho Falls, and Saint Alphonsus Regional Medical Center- Boise.

February 9th - The TSE Staff would like to congratulate Saint Alphonsus - Boise in becoming the first

TSE Council Documents

TSE Rules
TSE Standards Manual
TSE Council Bylaws
TSE Statewide Trauma Triage Guidelines
TSE Trauma Elements
TSE Stroke Data Elements
TSE STEMI Data Elements

TSE Data Collection/Reporting Matrix

Statewide Meetings and Minutes

February 14, 2017

Location TBD

9:00 AM - 11:00 AM

Agenda TBD

TSE Council meetings-Second Tuesday of every month

Minutes

December 13, 2016
November 8, 2016
October 11, 2016
September 13, 2016
August 9, 2016

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Tuesday, January 24, 2017

SUBJECT	DESCRIPTION	PRESENTER
Docket No. 16-0303-1601	Child Support Services	Cade Hulbert Program Manager, Child Support
Docket No. 16-0304-1601	Food Stamp Program in Idaho	Kristin Matthews Food Stamp Program Manager
Docket No. 16-0305-1601	Eligibility for Aid to the Aged, Blind, and Disabled (AABD)	Camille Schiller Program Manager, Health Coverage Assistance
Docket No. 16-0319-1601	Rules Governing Certified Family Homes	Steve Millward Manager, Certified Family Home Program
Docket No. 16-0507-1601	Investigation of Enforcement of Fraud, Abuse, and Misconduct	Steve Bellomy Bureau Chief, Audits and Investigations

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Tuesday, January 24, 2017
TIME:	3:00 p.m.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.
PASSED THE GAVEL:	Chairman Heider passed the gavel to Vice Chairman Souza to conduct the rules review.
DOCKET NO. 16-0303-1601	**Child Support Services**. **Cade Hulbert**, Child Support Program Manager with the Department of Health and Welfare (Department), presented this docket. He explained several enforcement actions the Department employs when collecting child support. There are approximately 160,000 open child support cases in Idaho and the Child Support Program currently serves around 400,000 parents and children. The Idaho Child Support Services (ICSS) collected over $215 million in child support last year. The mission of ICSS is to ensure that children receive the necessary financial and medical support from both parents. When a noncustodial parent falls behind on their child support, ICSS seeks to get this parent back in compliance.

Mr. Hulbert said one of the many tools ICSS uses to encourage payment is to report child support arrearages to Consumer Credit Reporting Agencies (CCRA). The current rule requires the program to report noncustodial parents to CCRA when the overdue support or arrearages are in excess of $500. Often by the time ICSS receives a finalized child support order from the courts, the noncustodial parent is already in arrears as the legal process can take up to 90 days or more. Some noncustodial parents were sent to CCRA before the noncustodial parent even had a chance to pay the support amount.

Mr. Hulbert informed the Committee that the Department has received numerous consumer complaints about this rule over the past few years as noncustodial parents receive information from the CCRA about outstanding debts. ICSS believes in giving noncustodial parents an opportunity to pay the support amount first before taking enforcement actions.

Mr. Hulbert explained the proposed rule modifies the amount of arrearages reported to CCRA to $2,000 and three months with no payment. ICSS increased the dollar amount from $500 to $2,000 because monthly support amounts can be greater than $500, especially when there is more than one child involved in the case. This $2,000 amount is also consistent with other enforcement tools that the Department utilizes. ICSS added the three month condition to ensure adequate time for the order to be set up in their system and communicated with the customer after the court order is received.

Mr. Hulbert reported the Department conducted negotiated rulemaking on the docket this past July, but received no comments from the public. ICSS wants to reassure custodial parents are taking every action possible to collect child support while helping noncustodial parents understand the benefits of making consistent payments. There are no anticipated fiscal impacts to the State as the rule is cost-neutral.

Senator Martin asked Mr. Hulbert to elaborate on the word "shall" and "will" regarding the Department's notification of the noncustodial parent when there are arrears in the payment. **Mr. Hulbert** explained the Department will notify the noncustodial parent verbally and in writing. **Senator Anthon** clarified the word "shall" changed to "will" in the rule to make it more readable.

Senator Anthon asked about the remedies taken by the Department so noncustodial parents' credit report is not damaged, especially when the child custody order has not come into effect and reporting has already taken place to the CCRA given that there are 30 days to rectify with the CCRA. **Mr. Hulbert** stated the noncustodial parent are already given a written and verbal notification, and when the case is sent to CCRA, the Department handles the corrections on a case by case basis.

Senator Heider asked the reason for a three-month waiting period for the families until the child support payment is made. **Mr. Hulbert** explained the Department takes other enforcement actions before the end of the three-month period. For instance, the Department automatically sends an income withholding order to receive payments from the noncustodial parent's employer, suspends drivers licenses, intercepts state and federal tax refunds, and a few other enforcement remedies.

Vice Chairman Souza emphasized that $2,000 seems right since the rule has not been updated since July 1998. She also shares Senator Heider's concern about a three-month waiting period to receive child support payment arrearages, and child support payments seem to be more substantial now than in 1998. **Mr. Hulbert** explained child support payments have risen as child support cases have increased and because of the economy.

Senator Anthon spoke in support of the docket and addressed Senator Heider's comments regarding the three-month waiting period when a child support payment is not made. He stated the Department should give the noncustodial parent an opportunity to pay the arrearages before the case is reported to the CCRA because the credit reporting aspect gets very complicated and has a long-term effect when reported inaccurately.

MOTION: There being no more questions, **Senator Anthon** moved to approve **Docket No. 16-0303-1601**. **Senator Agenbroad** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0304-1601 **Food Stamp Program in Idaho**. **Kristin Matthews**, Food Stamp Program Manager, presented the docket. She explained the Idaho Food Stamp Program, also known as the Supplemental Nutrition Assistance Program (SNAP) provides food assistance to Idaho's neediest families. Food stamps are 100 percent funded by the U.S. Department of Agriculture (USDA) and the state processes and approves food stamps under specific state program requirements.

Ms. Matthews explained the docket contains two proposed changes to the Food Stamp Rules which update program regulations and Department processing standards. The first change updates language applicable to the Able Bodied Adults Without Dependents (ABAWD) time limit. ABAWDs are required to either be working or participating in work search activities to receive benefits. If an ABAWD fails to comply with the specific state program requirements, they are restricted from receiving benefits for a three year time period. Based on a recent policy clarification, the Department currently is out of sync with this federally-mandated three-year time period. The only change to this rule is striking the time period that began in December 1996, so it is not in conflict with the counter the Department currently uses to determine compliance with work activities for ABAWDs. No other changes to work requirements for the SNAP program have been made. The second change strikes language requiring the food stamp eligibility notifications to include Idaho Administration Procedures Act (IDAPA) rule citations when informing customers of eligibility decisions. Comments received from legal aid, customers, and federal partners support the proposed rule to allow the Department to make determinations as to when IDAPA rules are needed on the notice. Including rule citations on all notices often leads to confusion making the notices read more like a legal document which can be hard for many people to understand. The Idaho Food Stamp Program continues to provide citations, both State and federal, when requested by participants, attorneys, and other interested parties. There is no fiscal impact to the State as a result of this rule change.

Senator Lee asked why the remedy is to strike the language and not revise the time period of this rule. **Ms. Matthews** explained in order to stay in compliance with the federal regulations, the Department needs to strike the language. The Department started tracking again in January 2016, and the three year period will run from January 2016 through December 2018. As the rule is currently written with the three year counter period starting December 1996, the counter period would end in December 2016, so the Department would only have one year to comply with the new rule by leaving that language in the rule.

Senator Lee was concerned leaving a citation to the rules in the notice and the Departments efforts to make sure people and/or their advocates understand these notifications. **Ms. Matthews** explained if a family was calculated to be over income and cited, they were not given any explanation regarding how their determination was calculated. However, the IDAPA rule now explains to people and/or their advocates the different types of incomes considered for eligibility determination. The Department has now realized by putting more information on the notice, IDAPA rule citation interferes in a fair hearing situation. Especially when there are multiple citations, the notice only trigger the first IDAPA citation that go towards the eligibility determination and often lose hearings.

Chairman Souza asked if the support people, attorney, or case worker for the family who receives the notice can contact the Department for further information about the specific IDAPA rules that apply. **Ms. Matthews** confirmed that is correct.

Senator Lee stated the Department should make sure when the eligibility determinations are made, the notices and citations should be very transparent particularly that the Department added IDAPA rules.

Chairman Heider asked for a brief synopsis of the changed rule from one-day delivery to ten-day delivery of food stamps and food pick up. **Ms. Matthews** explained that prior to implementation, the Department spent a year communicating with external partners, including retailers for smooth functioning of delivery of food stamps and food pick up. The Department arranged to handle a large volume of phone calls during the change from customers inquiring what their issuance date was. The Department has an increased call volume for the first ten days of every month from customers inquiring when benefits are issued. The feedback from the food banks and retailers were good.

Senator Martin asked about the costs associated with the change from one-day delivery to ten-day delivery of food stamps and food pick up. **Ms. Matthews** explained the Department had budgeted for those one time costs. Currently, the Department's budget continues to cover any costs associated with increased call volumes.

MOTION: There being no more questions, **Senator Foreman** moved to approve **Docket No. 16-0304-1601**. **Senator Martin** seconded the motion. The motion carried by **voice vote**. **Senator Lee** and **Senator Jordan** requested to be recorded as voting nay.

DOCKET NO. 16-0305-1601 **Eligibility for Aid to the Aged, Blind, and Disabled (AABD).Camille Schiller**, Program Manager, Health Coverage Assistance presented this docket. **Ms. Schiller** explained this docket addresses three changes to be made to the Medicaid for the Aged, Blind and Disabled (AABD) program. First adding depreciation as an allowable expense to be used in the calculation of self-employment income, which will align the program with other Health Coverage Assistance program as well as federal requirement.

Ms. Schiller explained the second change to clarify eligibility to receive nursing home Medicaid services. The previous rule stated that participants could only be eligible for nursing home services if the participant met the criteria of AABD Medicaid, including a disability determination by the Social Security Standards. Guidance received from the Center for Medicaid and Medicare Services confirmed that individuals meeting nursing home level of care, the appropriate income, and resource limits for the program, were eligible to receive this coverage. A level of care determination was made by a physician at the nursing home to determine if the participant met the criteria needed for services provided by the facility. This determination does not always mean that the participant has met the disability criteria as established by the Social Security Administration. The AABD does not anticipate a fiscal impact as their practice has been in alignment with federal guidance. This rule only changes the language in IDAPA rule to meet federal regulation.

Ms. Schiller stated the final change is based upon a recent interpretation of federal requirements in regard to how annuities are considered when determining asset transfer penalties for eligibility for AABD Medicaid programs. Annuities that are irrevocable are generally counted as an asset transfer penalty unless they meet certain criteria. The guidance does not allow an interest test to be applied when determining if the annuity can be counted as an asset transfer without penalty. This interest test has been used in the past when interest rates were higher, as the interest test ensured the "soundness" of annuity. Interest rates are now significantly lower and therefore it is no longer a reasonable test. The AABD program requests to strike the requirement of the interest test.

Ms. Schiller commented negotiated rulemaking was not conducted for these changes as they were simple in nature and conferred a benefit to the recipients. There were no comments received for any of the changes during the public comment period.

Senator Martin referred to page 58 of the pending rule review book regarding residency. He asked why the rule says the AABD program determines the participants are disabled for the duration of the residency. **Ms. Schiller** explained when participants are in the nursing facility and the physician has determined they should stay there, the participants should be considered disabled for this program.

Senator Anthon asked if AABD program participants' residency determined by the physician was good for five years. **Ms. Schiller** confirmed that was correct.

MOTION: There being no further questions, **Senator Harris** moved to approve **Docket No. 16-0305-1601**. **Senator Lee** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0319-1601

Rules Governing Certified Family Homes. **Steve Millward**, Manager, Certified Family Home Program, Division of Licensing and Certification presented this docket regarding proposed changes to rules governing Certified Family Homes (CFHs) in Idaho. He explained the purpose of a CFH is to provide a home-like, family-styled residential living environment to allow vulnerable adults who are unable to live alone to remain in their own communities, delaying the need to live in a more expensive institutional setting. A CFH provides a home to individuals who are elderly, have mental illness, developmental disabilities, physical disabilities, and whose mental, emotional, and physical condition can be met by the home care provider. CFHs have between one to four residents in the provider's own home, with the average home caring for a single resident. Care by a relative in a home setting accounts for 76 percent of CFHs. Currently, there are approximately 2,400 CFHs located across the State.

Mr. Millward stated negotiated rulemaking sessions were held with stakeholders across the State in May 2016. The first change the CFH Program seeks to make this year regards legislation from two years ago, when the CFH citation program worked with the Veteran's Administration (VA) to exempt VA medical foster homes from additional State CFH certification if the medical foster home cared only for veterans who did not receive Medicaid benefits. VA medical foster homes are similar to CFHs, but the requirements established by the VA are much stricter than the requirements for CFHs. That legislation passed, so the new rule change aligns administrative rules with the change in statute exempting strictly VA medical foster homes from additional certification as CFHs.

Mr. Millward said the remaining changes in this docket relate to resident rights and notice of termination of the admission agreement. As rules were reviewed earlier in the year for potential changes, the CFH Program team discovered the rules relating to termination of the admission agreement between a CFH provider and the residents were inconsistent with Idaho landlord tenant law. The CFH Program proposed to replace the minimum 15 days notice requirement now in effect for termination of the admission agreement with a minimum 30 days notice, unless the termination was for any of the reasons outlined in IDAPA 16.03.19.260.02.b-e. This change aims to align CFH rules with Idaho landlord tenant law, while simultaneously affording vulnerable adults with potentially complex medical and/or behavioral conditions the additional time they need to find a suitable living arrangement.

Senator Lee asked how many homes of both veterans and non veterans does this rule currently apply. **Mr. Millward** replied the numbers are relatively low.

Vice Chairman Souza asked if the number of CFHs in Idaho is 7,500. **Mr. Millward** replied there are 2,400 CFHs in Idaho and 76 percent of those care for their own family members.

MOTION: **Senator Lee** moved to approve **Docket No. 16-0319-1601**. **Senator Jordan** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 16-0507-1601

Investigation of Enforcement of Fraud, Abuse, and Misconduct (IFFAM).

Steve Bellomy, Bureau Chief, Audits and Investigations for the Department of Health and Welfare presented this docket. The Audit and Investigation Team's (Team) role is not about measuring compliance, but targeting questionable billings and recovering improper payments. The Team audits are not representative of the average provider. The providers are selected because someone reported to the Team or because the Team noticed an unusual activity in claims data suggesting improper billing. Last year, the Team completed 557 audits, and identified $4.1 million in overpayments. The Team assessed penalties in 23 percent of those audits. After an audit, the Team can a wide range of actions including, no action, a letter of instruction, recoupment of overpayments and penalties, termination of provider agreement, exclusion from the Medicaid program, and referral to the Attorney General's Office for criminal investigation.

Mr. Bellomy informed the Committee the Team operates under a very broad range of rules in IDAPA 16.05.07. These rules govern how the Team conducts audits, actions taken by the team, and administrative appeals. These pending rules amend Section 235 and added Sections 236 and 237, which were very narrow portions of the rules that focus on civil monetary penalties.

Mr. Bellomy commented this docket does not address all existing rules that give the Team authority to recover overpayments, suspend, terminate, or exclude providers. The three specific rules in Section 205 have been in effect since 1999, and give the Team authority to recover payments made for claims when services were not provided or were provided contrary to the program rules or provider agreement. Section 230 has also been in effect since 1999, stating the Department may impose a penalty if a provider fails repeatedly to comply with Medicaid rules or submits improper claims. Section 235 provides the reason for these penalties is intended to be remedial, at a minimum recovering costs of investigation and administrative review and placing the costs associated with non-compliance on the offending provider. The Team's purpose of S 1295 (2016) is accurately captured in these amended rules.

Mr. Bellomy explained the primary reason for the statute and rule change is to allow the Department to be more fair when assessing penalties. The new statute and proposed rule reduced the minimum penalty from 25 percent of each claim line item to 10 percent when violations were minor. Another important reason for changing the rule was to provide a fair structure to the penalties. The old rule identified one minimum rate of 25 percent did not explain how or why the team assessed a penalty greater than 25 percent. The proposed rules provides an increasing penalty rate for increasingly severe or frequent violations. Finally, the Team needed a fairer way of assessing penalties when employers failed to follow background check rules. In many settings, like residential care, several employees care for one client, so it is difficult to attribute a portion of one claim line for one non-compliant employee. The proposed rule applies a penalty based on each non-compliant employee.

Mr. Bellomy stated the Team worked diligently to engage providers in this rule amendment. Before the Team drafted rules, they created a chart showing how the penalties could be organized in the new rules. The chart and survey was emailed directly to many providers and the links to the materials were posted on the Medicaid Newsletter and website. The survey showed general agreement with the penalty chart. Some of those opposed to the penalties believed the team were being too lenient. In the survey, the Team asked providers to give a feedback about the chart and the changes recommended.

Mr. Bellomy reported the Team held public negotiated rulemaking meetings in Coeur d'Alene, Boise, and Pocatello, and only two people attended each meeting. The team was later invited by the Association of Community Providers to discuss the penalty chart and drafted temporary and proposed rules which were published in July 2016. The Team held public hearings after the rules were published again in the same cities as before, but no one attended. However, the Team received three comment letters from two associations and one hospital. The Team worked with the three commenters individually to make the rules clearer and then republished the pending rules in January. The Team's process was open and collaborative and in the last three weeks, seven school districts submitted comments expressing desire to be exempt from penalties. This request is inconsistent with the Statute and Medicaid rules. In Section 235, the rule was amended to reduce the minimum penalty rate from 25 percent to 10 percent. The Team created a chart (see Attachment 1) which shows organized penalties in a progression from minor violations to severe violations down the left and from minimum to enhanced penalties across the top. Specific examples were added for each category of violation in subsections 01 and 02. Finally, Section 237 described how penalties will be applied when a provider fails to obtain a background clearance for their employees.

Vice Chairman Souza asked for further explanation about the school districts' requests to be exempt. **Mr. Bellomy** explained by giving an example. He stated one of the concerns the Team received was regarding compounding penalties. For each individual claim line that is subject to a penalty, the team assigns the appropriate penalty rate but does not compound the penalties.

Senator Lee asked whether the school districts were subject to penalties and Medicaid reporting prior to this rule. **Mr. Bellomy** answered the school districts have always been subject to penalties and Medicaid reporting.

Senator Martin asked how many penalties were collected from this program. **Mr. Bellomy** replied schools have always been subject to paying penalties; however, because the schools were having trouble maintaining the Medicaid claim records for the audit, the Team agreed to withhold assessing penalties until July of last year. The Team has just begun the audit process and so the dollar amount in the last six months is the relevant period the Team can share with regards to the amount recovered in the overpayment and the penalties.

Ms. Lori Stiles introduced herself to the Committee on behalf of the Medicaid Program Integrity Unit (Unit). She explained that in the last six months, the Unit has completed 11 audits. In two cases, the Unit assessed civil monitoring penalties. The Unit recovered seven overpayments: one for approximately $5,400 and the other for $48.77.

Senator Martin asked to confirm if $5,400 was the exact amount assessed and if that amount was for one or all the districts. **Ms. Stiles** confirmed it was $5,435.90 and the amount collected was for one school district. The Unit had 11 of 15 individual cases from one school district that were reviewed and did not have the eligibility determination.

Senator Martin asked besides that particular district if other districts during this period were fined. **Ms. Stiles** replied not during the six month period. **Senator Martin** asked if the Unit has been imposing these fees previously and what the cost is to the districts. **Ms. Stiles** explained while the Unit may have recovered an overpayment, the Unit still has to look in to the conduct to determine if the school district should be subject to a civil penalty assessment. **Senator Martin** asked if the Unit anticipates collecting a large amount of money from the school districts and if there is a learning curve for the schools to comply with the Department's rules. **Ms. Stiles** replied until the Unit completes the audits, the Unit cannot determine if violations are repeated or substantial to warrant fines.

Vice Chairman Souza asked now that the six-month waiting period has expired to perform these audits in the school districts, how the Unit addresses any concerns with school administration to maintain the claims correctly in the future and what kind of feedback the Unit receives from the school districts. **Ms. Stiles** replied if the Unit finds the schools are incorrectly billing, the Unit educates the schools before the audit is completed and ensures billing is carried out appropriately. The Unit also visits the school to meet and address the concerns. When there is an impasse, the Unit offers an option to the schools to reach out with any concerns or comments to Ms. Stiles or Mr. Bellomy, who ensure the analyst's decisions and findings were appropriate.

Vice Chairman Souza asked if there was any process to explain the concerns to the school district that was fined $5,400, and the reason the penalty became severe. **Ms. Stiles** explained in this particular case the Unit determined substantial rule violations when 11 of the 15 billings were not eligible to receive payments. The Unit did not get the required assessments to determine if those students were eligible for Medicaid services. **Vice Chairman Souza** asked if the school district administration or personnel understood the process and documentation of the claims audit. **Ms. Stiles** replied the analyst who audited the school is very well respected among the school districts and works very closely with the school districts to ensure the schools have an understanding of penalties and refunding overpayments.

Mr. Bellomy continued explaining his presentation on Section 235 of the rules to reduce the minimum penalty rate from 25 percent to 10 percent and a new section to help understand how the Unit organized these penalties in a progressive manner. Finally, Section 237 described how the penalties will be applied when providers fail to obtain background clearances for employees.

Senator Lee asked whether the complete payment is withheld in addition to the penalties, and the withheld funds are returned to federal and/or state funds. **Mr. Bellomy** explained penalties are in addition to recouping overpayments. Accepting return of overpayments is typically done only for minor rule violations. **Senator Lee** asked the consequences if this rule is not approved. **Mr. Bellomy** replied if this rule is not approved then the former standard will apply, which is a flat 25 percent minimum penalty rate.

Vice Chairman Souza asked if there is a process to appeal a fine or a penalty. **Mr. Bellomy** explained there are times when the Unit agrees that something is not clear and that is when the Unit decides not to assess a penalty and simply recoup an overpayment. At the end of the process, the appeal process is to request an administrative appeal, director's appeal, and district court.

MOTION: **Senator Martin** moved to approve **Docket No. 16-0507-1601**. **Senator Heider** seconded the motion. The motion carried by **voice vote**

PASSED THE GAVEL: Vice Chairman Souza passed the gavel back to Chairman Heider.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 3:58 p.m.

_____

Senator Heider

Chair

_____

Jeanne Jackson-Heim

Committee Secretary

_____

Arti Clark

Secretary

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Wednesday, January 25, 2017

SUBJECT	DESCRIPTION	PRESENTER
Gubernatorial Appointment	Reappointment of Wendy Jaquet to the Idaho Board of Health & Welfare	Wendy Jaquet
S 1005	Relating to Child Protection	Miren Unsworth Division of Family and Community Services
S 1009	Relating to Crop Residue Burning	Tiffany Floyd Air Quality Division Administrator

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

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MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Wednesday, January 25, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Senators Martin, Lee, Harris, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	Vice Chairman Souza and Senator Anthon
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.
GUBERNATORIAL APPOINTMENT:	**Consideration of Gubernatorial Appointment of Wendy Jaquet to the Board of the Idaho Department of Health and Welfare (Board). Chairman Heider** introduced Wendy Jaquet and asked her to tell the Committee about herself and why she would like to be reappointed to the Board. **Ms. Jaquet** informed the Committee she was elected to the Legislature in 1994 and served on Governor Batt's Medicaid Reform Committee. At that time, **Ms. Jaquet** was executive director of the Sun Valley Chamber of Commerce. She served in the Legislature until 2012 and enjoyed her time on the House Health and Welfare Committee. After she became Minority Leader, she served on JFAC for four years where she handled the Department of Health and Welfare budget. **Ms. Jaquet** said she currently teaches two 100-level courses and one 500-level course at Boise State University. She is also a Ph.D. candidate but is unsure whether she will complete that degree. **Ms. Jaquet** stated she splits her time between Boise and Ketchum. She enjoys serving on the Board because so much of what the Board does involves things she worked on at the Legislature. **Senator Harris** asked what Ms. Jaquet feels has been her best accomplishment on the Board. **Ms. Jaquet** replied one of the Board's roles is to approve rules, and for a long time, she was involved with the Emergency Medical Services Bureau's old rules. After many meetings, it didn't seem like the rules would ever be updated. **Ms. Jaquet** stated she is pleased that issues with the rules are now straightened out. She feels good about the work done, and the four counties she represents now have rules that will work for their rural communities. **Chairman Heider** mentioned he has attended the Board meetings and Ms. Jaquet is a valuable member. Her experience in the Legislature brings a important quality to the Board.
MOTION:	**Senator Jordan** moved to send the Gubernatorial reappointment of Wendy Jaquet to the Board of Health and Welfare to the floor with recommendation that she be confirmed by the Senate. **Senator Martin** seconded the motion. The motion carried by **voice vote.** Senator Stennett offered to carry the appointment on the floor of the Senate.

S 1005 **Relating to Child Protection.** **Miren Unsworth,** introduced herself to the Committee as the Deputy Administrator in the Department of Health and Welfare's Division of Family and Community Services. **Ms. Unsworth** explained the issue of sex trafficking of minors is an issue of increasing concern at both the state and federal level. While there is no official estimate on the number of human trafficking victims in the United States, in 2015, an estimated one out of five endangered runaways reported to the National Center for Missing and Exploited Children were likely child sex trafficking victims. Since 2007, the National Human Trafficking Hotline has received 366 referrals from Idaho regarding both adult and minor victims.

Ms. Unsworth informed the Committee the Idaho Child Protective Act does not currently include a definition of human trafficking. The Justice for Victims of Sex Trafficking Act of 2015 (JVSTA) amends the Child Abuse Prevention and Treatment Act (CAPTA) state grant program requirements and specifically requires states to consider any child who is identified by a state as a victim of sex trafficking or severe forms of trafficking as a victim of "child abuse and neglect" and "sexual abuse." The law utilizes the definitions of sex trafficking or severe forms of trafficking as defined in the Trafficking Victims Protection Act of 2000 (TVPA). The TVPA defines "sex trafficking" as the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act. The law further defines "severe forms of trafficking in persons" as sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age.

Ms. Unsworth advised "human trafficking" is currently defined in Idaho Code § 18-8602 as: 1.) sex trafficking in which a commercial sex act is induced by force, fraud or coercion, or in which the person induced to perform such act has not attained eighteen (18) years of age; or 2.) the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. The proposed legislation will include this definition of human trafficking in the definitions of abused and sexual conduct in the Idaho Child Protective Act. The current definition of human trafficking meets the definitions under the TVPA and the requirements of the JVSTA.

Ms. Unsworth mentioned the Division of Child and Family Services has worked with the Administrative Office of the Courts on this proposed legislation and has shared the legislation with the Governor's Task Force on Children at Risk; representatives from the Idaho Children's Trust Fund; the Idaho Coalition Against Sexual and Domestic Violence; the Idaho Department of Juvenile Corrections; and attorneys for each of the Idaho tribes.

Senator Lee stated she appreciates conformity and highlighting this issue in Idaho Code and asked if failure to pass this legislation would result in subjecting children to further abuse, or if current Idaho law has left children vulnerable to horrific situations. **Ms. Unsworth** answered the current definitions in the Child Protective Act would allow the Department to act on an instance of sex trafficking and ensure protection of the child. The law change provides clarity and highlights the importance of addressing the issue in Idaho communities. Three children have entered foster care since 2014 who were previous victims of sex trafficking.

MOTION: **Senator Martin** moved to send **S 1005** to the floor with a **do pass** recommendation. **Senator Foreman** seconded the motion. The motion carried by **voice vote.** **Senator Lee** offered to sponsor the bill.

S 1009

Relating to Crop Residue Burning. Tiffany Floyd introduced herself as the Air Quality Division Administrator with the Idaho Department of Environmental Quality (DEQ). **Ms. Floyd** also introduced Mary Anderson, Air Quality Program Manager, and Carl Brown, Rules Coordinator.

Ms. Floyd informed the Committee of the two goals of the Crop Residue Burning (CRB) program: 1.) protect public health by ensuring that crop residue burning does not cause national ambient air quality standards to be exceeded; and 2.) provide flexibility to farmers to burn crop residue as an agricultural practice when it will not jeopardize public health. **Ms. Floyd** explained a 2007 lawsuit resulted in a ban on crop residue burning. Governor Otter convened a group consisting of farmers, environmental groups, and regulators to find a solution. The group reached an agreement, and in 2008 the Legislature enacted those details into Idaho Code. Before approving a burn in the CRB program, DEQ is required to evaluate a number of criteria, including: proximity to hospitals, schools and nursing homes; other burning activity; weather conditions; and pollutant concentrations. Pollutant concentrations cannot exceed 75 percent of any National Ambient Air Quality Standards (NAAQS). This creates a threshold to ensure DEQ is not approving burns that may cause a violation of NAAQS.

Ms. Floyd stated the proposed legislation changes the 75 percent threshold to 90 percent for ozone. EPA reduced the ozone standard and typical ozone levels can limit crop residue burning even when burning is not predicted to cause a violation of any air quality standard. The 2008 ozone standard was 75 parts per billion (ppb). Seventy-five percent of 75 is 56, and that becomes the threshold number. At or above 56 ppb, DEQ is not allowed to approve crop residue burns. The 2015 ozone standard is 70 ppb. Seventy-five percent of 70 equals 52, and that is the new threshold to approve burns (See Attachment 1). Reducing the threshold from 56 ppb to 52 ppb results in a decreased number of burn days for farmers by nearly double or triple in some areas of the State. **Ms. Floyd** mentioned ozone concentrations at Craters of the Moon in rural Southern Idaho, a clean pristine area, can show levels ranging from 30 to 70 ppb.

Ms. Floyd stated it can appear to be counterintuitive that increasing or providing more burn days would better protect public health. By changing the 75 percent to 90 percent using the 2015 ozone standard of 70 ppb, the threshold becomes 63 ppb because 90 percent of 70 equals 63. This provides for greater flexibility in allowing burning to occur when all burn criteria are met. Under the current program, there are days when smoke would disperse well, and the NAAQS would not be exceeded, yet DEQ is prohibited from allowing burning due to ozone levels. Instead, DEQ utilizes days when adequate smoke lift, proper mixing, appropriate air movement and direction, etc. are not as favorable, yet all burn criteria are met. DEQ believes burning on those days could have more of a negative impact on public health than increasing the number of burn days. The proposed change not only strengthens health protections but provides for better opportunities to burn when smoke dispersion is better. Spreading the burns over more days may lead to fewer burns in a day.

Ms. Floyd advised in an effort to address this matter, DEQ engaged in negotiated rulemaking. Based on those discussions, DEQ is proposing to increase the 75 percent threshold for ozone to 90 percent. In the eight years of implementing this program, DEQ has learned a lot and is confident about having enough buffer to ensure the ozone standard will not be exceeded due to a crop reside burn. Some participants believe if the ozone threshold is relaxed, it is only fair to strengthen the particulate matter threshold by the same percent to 60, but this position is not scientifically supported. Instead, the science supports that crop residue burning doesn't add significantly to ozone levels. Therefore, DEQ did not change the 75 percent threshold for particulate matter. The current program is working well for particulate matter and meeting the goals of the program.

Ms. Floyd said if this legislation is passed, it will require Environmental Protection Agency (EPA) approval before it can be implemented. Because of timing issues related to enacting new legislation, adopting new rules, and getting EPA approval, DEQ recommends a temporary measure effective until February 28, 2018, the date of expected EPA approval. The temporary measure will maintain the 56 ppb threshold through 2017 and into early 2018 as outlined in Section 1 of the proposed legislation. The new standard would become effective on and after February 28, 2018 when the temporary measure is replaced with Section 3, which contains the 90 percent language. DEQ is confident that using the threshold of 56 ppb ensures the new ozone standard of 70 ppb will not be exceeded. This change will not have any direct fiscal impact on the state or alter resources used by DEQ to implement the CRB program, nor will the current crop residue burn fee structure be changed. In summary, DEQ is proposing to change the 75 percent threshold to 90 percent for ozone only to address EPA's lowering of the standard as well as meet the needs of the agricultural community.

Senator Foreman asked what percentage of burn days would be lost if the 90 percent rule is not implemented. **Ms. Floyd** answered DEQ has evaluated that question by considering the additional average number of days available for burning. If the change to 90 percent is approved, the average number of days available for possible burn days throughout the year would be 57 days in South Idaho and 31 days in North Idaho. **Senator Foreman** inquired what the impact would be on the growers if the change does not pass. **Ms. Floyd** replied there would be a negative impact because the 75 percent threshold would be used resulting in fewer burn days. **Senator Foreman** further inquired whether it is correct that the growers could lose between one-third and two-thirds of burn days. **Ms. Floyd** responded that would be correct.

Senator Agenbroad asked if tribal lands are included under this restriction. **Ms. Floyd** answered that tribal lands are regulated through the federal government but not through the Idaho program. DEQ works closely with the tribes during burning season to monitor activity, but the tribes follow a separate program which includes a maximum 75 percent of the particulate matter standard.

Senator Lee commented she has received a number of public comments on this issue and many of them come from constituents not in a rural area. **Senator Lee** asked when crops are burned in Idaho and what is the current burn period. **Ms. Floyd** said the typical burn season is March through September, but depending on weather patterns, it can extend beyond that time. **Chairman Heider** asked how long Idaho farmers have been burning crop residue, and whether it is a traditional activity on many fields. **Ms. Floyd** answered it has been an agricultural practice which was overseen prior to 2007 by the Department of Agriculture.

Senator Jordan asked about the Crop Residue Burning Advisory Committee (CRBAC) and its recommendations. **Ms. Floyd** said the rules provide for a crop residue advisory group consisting of environmental groups, health organizations, growers and farmers, DEQ, and EPA to provide direction, recommendations, or changes. Beginning in 2011, the CRBAC considered additional information about ozone and the fact the ozone standard was likely to change which could be problematic for the farmers. The CRBAC agreed to focus on the 75 percent of any NAAQS at negotiated rulemaking and discussed the concept of equal offset in particulate matter if the ozone standard was loosened. **Senator Jordan** asked if the CRBAC recommended an offset and commented the legislation does not include it. **Ms. Floyd** answered the CRBAC discussed the offset and the health risks associated with it. In negotiated rulemaking, DEQ presented an option of 90 percent of ozone with an offsetting 65 percent particulate matter. Questions arose about whether that reduction in particulate matter could be supported, and DEQ did not have supporting science or enough information to change the particulate matter number.

Chairman Heider asked what department is referenced in the provision that a burn may not take place without pre-approval from the Department, and whether the provision is being followed. **Ms. Floyd** responded if growers submit requests to burn, DEQ evaluates the requests based on the established criteria, and DEQ gives approval or non-approval for the burn. **Chairman Heider** asked if all farmers are required to get a permit and prior approval for burning, and if the requirement includes ditch banks. **Ms. Floyd** answered all farmers are required to get prior approval for burning crop residue, which is defined as any vegetative material remaining in the field after harvest or vegetative material produced on designated conservation reserve program lands. The requirement does not include ditch burning.

Senator Foreman asked if there is any scientific tie or link between ozone and particulate matter to justify changing one standard in response to a change in the other. **Ms. Floyd** replied there is not. It would take a number of studies and research to determine that, and none is currently available. **Senator Agenbroad** asked if DEQ can set no standards more strict than EPA, how DEQ can reconcile setting any standard below 75 ppb. **Ms. Floyd** answered DEQ cannot set anything new or more stringent. Instead, DEQ's proposed level was designed to ensure the 70 ppb standard is not violated. **Senator Jordan** asked if the new standard is strictly for the State of Idaho or if it applies to the tribal lands as well. **Ms. Floyd** stated the change would be specific to the State. The tribal areas would continue to evaluate and utilize the program they have.

TESTIMONY: **Jonathan Oppenheimer** and **Austin Hopkins** introduced themselves on behalf of the Idaho Conversation League (ICL), an association that works to protect air, water, and land, to oppose **S 1009**. Mr. Oppenheimer provided the Committee with a written statement (See Attachment 2) from Dr. Patrick Weis, a pulmonologist who conducted research specifically on the effects of ozone on lung function and who serves as the Pulmonary Director of St. Luke's Pulmonary Clinics. The ICL has been involved on this issue for over 10 years, specifically with regard to the rulemaking and the bill. **Mr. Hopkins** stated he has attended the rulemaking sessions, and ICL's major concern is that the proposed action would weaken protections for public health in Idaho. Changing the standard from 75 percent to 90 percent is a change from 56 ppb to 63 ppb. Not only is that a higher number, but it goes against EPA trends. ICL thinks DEQ should keep the current standards to remain protective of public health. It is particularly concerning for impacted populations such as youth, elderly, and those in nursing homes and hospitals. Those suffering from chronic obstructive pulmonary

disease (COPD) and asthma are much more affected by these decisions than normal healthy adults.

Mr. Hopkins informed the Committee the change is contrary to the opinion of Idaho State Toxicologist Dr. Craig Dietrich, who presented at some of the rulemaking about the public health impacts of ozone and particulate matter. Dr. Dietrich's findings illustrate a compounding effect if burning occurs on days with elevated ozone. When EPA requested public comment on changing the NAAQS for ozone from 75 ppb, they offered a range of 60 ppb to 70 ppb. A number of leading health associations, including the American Medical Association, American Lung Association, American Academy of Pediatrics, American Thoracic Society, and American Heart Association, all urged EPA to lower the maximum to a 60 ppb level. The Idaho standard would exceed what leading health professionals recommend.

Mr. Hopkins further commented DEQ has yet to prove this proposal will not exceed the NAAQS as required under the Clean Air Act. Finally, it undermines the consensus building and collaborative efforts of negotiated rulemaking. A number of public health advocates tried to offer a variety of compromises, understanding the ozone threshold might need to be relaxed or given increased flexbility. All proposals were ultimately ignored, even though science was provided to support the proposals.

Senator Martin mentioned DEQ's statement that the air around Craters of the Moon measures 30 to 70 ppb of ozone and inquired why it varies and why the level there is up to 70 if there is no burning going on there. **Mr. Hopkins** responded he is not an expert in atmospheric science, but there are a number of pollutants that form ozone. Ozone is a secondary pollutant and is formed through the interaction of sunlight and pollutants in the atmosphere, most notably nitrogen oxides and volatile organic compounds. Ozone travels through the air laterally. While Craters of the Moon is a pristine area, ozone from populated areas could travel there.

Mr. Oppenheimer stated ICL has significant concerns with the bill and urges it be held in Committee.

TESTIMONY:

Karen Miller introduced herself as a medical doctor at St. Luke's Idaho Pulmonary Associates. She is the Adult Director of the St. Luke's Cystic Fibrosis Center of Idaho. **Ms. Miller** informed the Committee she mainly works in the outpatient setting and her clients have COPD, asthma, and cystic fibrosis as well as interstitial lung disease and others. Patients with COPD are not always responsible for their own disease. Up to 25 percent of Idahoans have COPD for reasons other than smoking. **Dr. Miller** said she is an advocate for her patients and opposes **S 1009**. When pollution levels are high, there is a great increase in visits to the pulmonary clinic that overflow into primary care physician offices as well as urgent care clinics. Patients go to the emergency room and get admitted for COPD, asthma, and cystic fibrosis exacerbations. There is clear evidence in the clinic that visits increase when particulate matter and ozone are high. Increasing the allowable ozone would increase these office and hospital visits and cost the State of Idaho money in taking care of patients who require urgent and emergent care for their temporary exacerbations.

Senator Martin asked if there is a time of year when there is typically an increase with this problem. **Dr. Miller** replied she has been working at St. Luke's for eight years and as Director for five years, and there are increased visits in July, August, and early September when the air quality is lowest. There is also an increase in January and a little bit of February when the inversion is bad because the particulate matter is trapped here. **Senator Harris** inquired if Dr. Miller has seen an increase year to year and not just seasonal. **Dr. Miller** responded there was quite an increase in office visits from the forest fires over the past there years. Some patients come from eastern Oregon, northern Arizona, and eastern Idaho. Patients remark they can't leave their house because of the air quality or get sick if they go outside. **Chairman Heider** asked if Dr. Miller knew the ppb in Boise from a forest fire in Owyhee County. **Dr. Miller** answered she did not. **Senator Jordan** asked if Dr. Miller's patients came from a wide geographical area and not just Ada County. **Dr. Miller** replied she has a large catchment area for cystic fibrosis patients, and her pulmonary patients also come from a large area.

TESTIMONY:

Justin McLeod introduced himself as a Kentucky bluegrass seed producer from Nez Perce, Idaho. He is President of the Nez Perce Prairie Grass Growers Association (NPPGGA). In addition to growing grass, he raises wheat, hay, barley, and legumes and his farm has grown bluegrass for over 50 years. The NPPGGA and the Kentucky bluegrass seed growers support **S 1009**. The NPPGGA was represented at all four negotiated rulemakings. The NPPGGA board of directors met after the May 18th meeting in Boise and discussed the draft proposal, and the board of directors agreed it was vital to continue to support a strong CRB program that addresses the concerns of environmental advocacy groups and also allows farmers to participate in approved agricultural practices to raise their crops. The proposed standard of 90 percent of EPA's revised ozone standard of 70 ppb is adequate in 2018. While the national standard is being tightened, Idaho has consistently fallen well below the ceiling due to a successful agreement and a program that has taken on responsibility of weighing both health concerns and the necessities of agriculture. The grass growing community has taken great pride there have been no adverse health effects while the agreement has been in place. **Mr. McLeod** commented he has a family and a business and he is proud of the farms in his community. The current program is successful, and tightened standards would greatly impact what farmers are able to do.

Senator Foreman asked if there is a way to successfully conduct his business without burning or reduced burning. **Mr. McLeod** said as a bluegrass grower, he could not. Many ways have been tried to raise Kentucky bluegrass. The Inland Northwest produces 60 to 80 percent of all bluegrass in the world. It takes burning to regenerate the plant. Fortunately, there are great health effects from grass at golf courses, parks, and homes, and bluegrass greatly decreases erosion. **Senator Foreman** asked what it would do to Mr. McLeod's operation if he lost one-third to two-thirds of his burn days. **Mr. McLeod** replied if there was no burning those 31 days, there is a great likelihood in his area that the bluegrass could not be burnt. The worst case scenario is he would not have a crop the next year. In a best case scenario, the crop would be 60 to 70 percent.

Senator Harris inquired how many bluegrass farmers there are now compared to 20 years ago. **Mr. McLeod** answered there are probably 70 percent of what there used to be. **Senator Harris** asked whether crop acreage is going up or going down. **Mr. McLeod** said it depends greatly on factors such as the housing market, the number of parks and golf courses constructed, and weather in the East. He believes there are about 25,000 acres of certified grass seed. **Senator Harris** asked if that acreage is less than 20 years ago. **Mr. McLeod** answered it varies drastically.

Senator Jordan asked if there was discussion during negotiated rulemaking of developing a new formula that would maintain the current number of potential burn days without increasing them. Current law allows 56 burn days a year, and with the new 70 ppb standard, there would be 52 burn days, a loss of four days. **Mr. McLeod** explained those four days in his area mean a lot. They could get a lot of rain, or there might be a forest fire on a burn day. Decreasing the number of burn days makes it more unhealthy. Farmers have the opportunity to pick a day to burn, even if DEQ says it's a good day to burn. For example, there might be a wind blowing over a town and the farm might be in that wind, so the farmer would choose not to burn that day to avoid impacting a school or home. Decreasing burn days impacts a farmer's ability to be accountable to his neighbors. It may seem like only four days, but percentage wise it is a big difference. The stakeholders tried diligently to come to consensus but could not.

TESTIMONY:

Eric Olson introduced himself to the Committee as a farmer from Bonners Ferry to testify in support of **S 1009**. He grows wheat, legumes, and canola, and he used to grow bluegrass until it became economically unviable. **Mr. Olson** is a member of the Grain Producers Association and serves on DEQ's Crop Residue Advisory Committee. He has been involved with this issue for the last several years and all last summer. **Mr. Olson** said he participated in negotiated rulemaking meetings and heard from experts and stakeholders on all sides of the issue. DEQ did not have the justification to make changes to any other pollutant because the only pollutant with a change at the federal level that would affect crop residue burning in Idaho is ozone. All parties have agreed the CRB program has worked well with the exception of ozone. Idaho has background ozone that is here due to no fault of Idaho's farmers, present at high enough levels that it has prevented DEQ from approving burn days. The increase will keep DEQ from having its hands tied to approve burn days.

Mr. Olson explained there is a difference between particulate matter and ozone. Burn practices have no impact on ozone. Farmers do not create or destroy it when they burn a field. However, farmers can control particulate matter and that is the pollutant with the biggest impact on population centers. When there is a marginal day and ozone levels are lower, usually the humidity levels are so high that particulate matters are off the charts. In that case, farmers don't want to burn because it will have an impact on a school, hospital, or town, including a town 15 miles north of the border in Canada that must also be considered. During negotiations, the growers offered a compromise of reducing the standard for particulate matter from 75 to 70 percent for particulate matter but there was no further negotiation.

TESTIMONY: **Roger Batt** introduced himself on behalf on the Idaho/Eastern Oregon Seed Association to speak in favor of **S 1009**. The association represents the seed companies and affiliated businesses in Idaho in the seed trade. Association members contract with their grass seed producers and other producers in the State to maintain a viable and productive seed industry and market to 120 countries. The organization has been involved in field burning since before 2008, and this legislation has been a great compromise on behalf of all parties. Growers need the viability of fire as a tool for the bluegrass and seed production in the State of Idaho. On July 20, 2017, during negotiated rulemaking, EPA said it would be willing to accommodate a 90 percent standard as long as it protected human health. No science has been brought forth that has indicated it wouldn't protect human health. Since the 2008 burn program was established, there have been no deaths or incidents attributed solely to field burning in Idaho.

TESTIMONY: **Greg Branson** introduced himself as a farmer from Nez Perce, Idaho who supports **S 1009**. He primarily grows wheat and Kentucky bluegrass, and he also grows garbanzo beans, hot Indian mustard, lentils, peas, and canola. Bluegrass seed production is a vital crop to Lewis County because 70 to 80 percent of the world's Kentucky bluegrass is grown in the Inland Northwest. Bluegrass seed production allows him to employ more local people during the season and the local people rely on the jobs. Bluegrass seed production is a low impact crop that, once established, takes very little field work to maintain, keeping tractors out of the field. It is an environmentally friendly crop because it requires much less pesticide use than other competing crops. The wildlife love it, and it creates beautiful scenery, especially in the spring. In order for bluegrass to be a viable and potentially profitable crop, farmers must be able to burn the residue after harvest is complete. Without the ability to burn, the industry would not survive in Idaho. The process has worked very well for the farmers and the communities.

Senator Harris asked how many gallons of fuel it would take to get rid of the bluegrass stubble if it couldn't be burned. **Mr. Branson** said the bluegrass would have to be windrowed in some manner. If a combine couldn't do it, it would require a swather to make another pass over the field. Then a baler and a tractor would be needed to bale it up. After that, the loader tractor would have to pick up and stack the bales. There is no market for the bales so trucks and trailers would have to be hired to move it, and he is not sure where it could be taken. Even with no residue, the field still wouldn't yield nearly as well the following year. When the grass burns, fire gets down in the crown and shocks the crown of the plant to produce as much seed as possible.

Senator Agenbroad asked about the process for a farmer in the Nez Perce area to burn on tribal land versus non-tribal land. **Mr. Branson** described the process of bluegrass production. Throughout the year, he discs a 20-foot wide burn strip around the field to keep the weeds off and keep it black. After he harvests the crop, he visually inspects the burn strip to make sure there aren't any piles of stubble. Then he calls the tribe, and he provides a lot number that includes the specific location of the field and number of acres. **Mr. Branson** said he submits his permits with the tribe and DEQ, and his name goes on the list. The sooner the field is ready and the sooner the permits get turned in, the higher the spot on the list. He will get a call by 9:30 a.m. to let him know if and when he can burn. Burn times generally run from 1:00 to 4:00 p.m. so it will burn fast and get up in the atmosphere to leave the area. Next, he gets his equipment and fire truck ready. **Mr. Branson** stated he calls extra crew and his neighbors to come over and help. He is ready to burn at 1:00, but he makes the final call. If the wind is blowing the wrong way, he will call off the burn. After he burns the field, he keeps the fire crew around for 60 to 90 minutes to make sure the fire is

out. Without the flexibility of extra burn days, he might choose to burn even if conditions are not ideal because otherwise it might not get done.

Senator Agenbroad asked whether the environmental standards for burning on tribal ground are more or less restrictive than for non-tribal land. **Mr. Branson** responded the standards are nearly the same. The Nez Perce Reservation was using its own burn program before the State implemented its program, and the State used the Nez Perce program as the model for the State's program. The primary difference is he works with the tribe to get burn approval, while others contact the State to get approval.

TESTIMONY: **Russ Hendricks** introduced himself on behalf of the more than 76,000 Idaho families who are members of the Idaho Farm Bureau. The Idaho Farm Bureau supports **S 1009** and appreciates the time and effort DEQ has put into working through this process. In Dr. Miller's testimony about her patients, she referenced forest fires. Forest fires are not regulated in any way so many times there is terrible air quality because of forest fire activity. Many of the calls and complaints received by DEQ about burning come in when there is a wildfire happening, not because of CRB. If the State of Idaho had more management of the forest lands, they could be thinned and reduce that problem. **Mr. Hendricks** explained the DEQ threshold is lower than the EPA standard so the EPA standard will not be exceeded, which is protective of public health. The increase in burn days will increase the availability of burn days but that does not mean there will be burning on all the additional days. More days will be available to choose from so the best days can be selected and have less impact on those around them. To illustrate a "ppb," three seconds out of a century is one ppb. An extra seven ppb equals 21 seconds out of a century. One inch in 16,000 miles is one ppb, or seven inches in 16,000 is seven ppb. This is a strict standard to begin with, and the change is a miniscule change, but it will help give additional flexibility.

TESTIMONY: **Benjamin Kelly** introduced himself on behalf of the Food Producers of Idaho. **Mr. Kelly** stated his members support this legislation.

Chairman Heider asked Tiffany Floyd to return to the podium to close the presentation.

Ms. Floyd explained the difference between the tribal program and the State program. The tribal program addresses particulate matter only and does not consider ozone levels. DEQ interpreted the State Toxicologist's statements at negotiated rulemaking that he did not oppose the program change and supported protecting the NAAQS. EPA sets the NAAQS, and the ozone standard is a "not to exceed" threshold. EPA has defined high ozone as 70 ppb and that is the standard to be complied with. Prior to negotiated rulemaking, DEQ evaluated five years of monitoring data, crop burning, and weather data, and there was no major impact on ozone concentrations from CRB. **Ms. Floyd** commented DEQ takes its obligations under the Clean Air Act very seriously. DEQ respects and appreciates all views heard, and if DEQ thought public health would be jeopardized in any way, DEQ would not be presenting the proposed change.

MOTION: There being no more questions or testimony, **Senator Harris** moved to send **S 1009** to the floor with a **do pass** recommendation. **Senator Agenbroad** seconded the motion.

DISCUSSION: **Senator Martin** admitted he does not fully understand all the scientific information, but his priority is primacy for the State of Idaho. **Senator Martin** supports the bill and DEQ. If there was any evidence this was impacting someone's health, he would be very concerned, but he trusts DEQ is looking at the information and giving correct information.

Senator Foreman commented the DEQ proposal keeps Idaho at or below the EPA standard and that is reassuring. He added DEQ is concerned about protecting public health and the environment, and he thinks this proposal is a safe and intelligent solution to an issue where there are opinions on both sides. It seems the fields must be burned, or the State could lose a very important industry. The proposed legislation allows for burning while still meeting the EPA standards.

Senator Jordan stated she will oppose the motion and said this is not a decision about burning or not burning fields. There is obviously a scientific necessity for it and it has operated for many years under the current standards. **Senator Jordan** said she would have a better comfort level if two things were happening: 1.) if EPA reviewed and approved this change first and then legislation followed; and 2.) if a formula change would accommodate the same number of days currently available and not an increase in days. **Senator Jordan** commented she understands they are only potential burn days but she has some concerns about the advisory committee and some understandings that may or may not have been reached in that group that seem to have fallen by the wayside in the process.

Senator Lee advised there are only so many days that fields can be burned, and in her area, there is pressure to burn on a day that otherwise would not be the best day due to winds or dry conditions. Local growers are also subject to restrictions within counties. **Senator Lee** has talked to growers in her district who are the best stewards of the land, and this bill will give them the same number of burn days but the burning will be spread over more days, allowing them to be better neighbors and partners in the community. This issue can be revisited if it doesn't work. This flexibility will improve community health.

The motion passed by **voice vote. Senator Jordan** requested she be recorded as voting nay. **Senator Harris** offered to sponsor the bill.

ADJOURNED: **Chairman Heider** announced the Committee will meet with the House Health and Welfare Committee for a public hearing on health and welfare issues on Friday, January 27 at 8:00 a.m. There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:34 p.m.

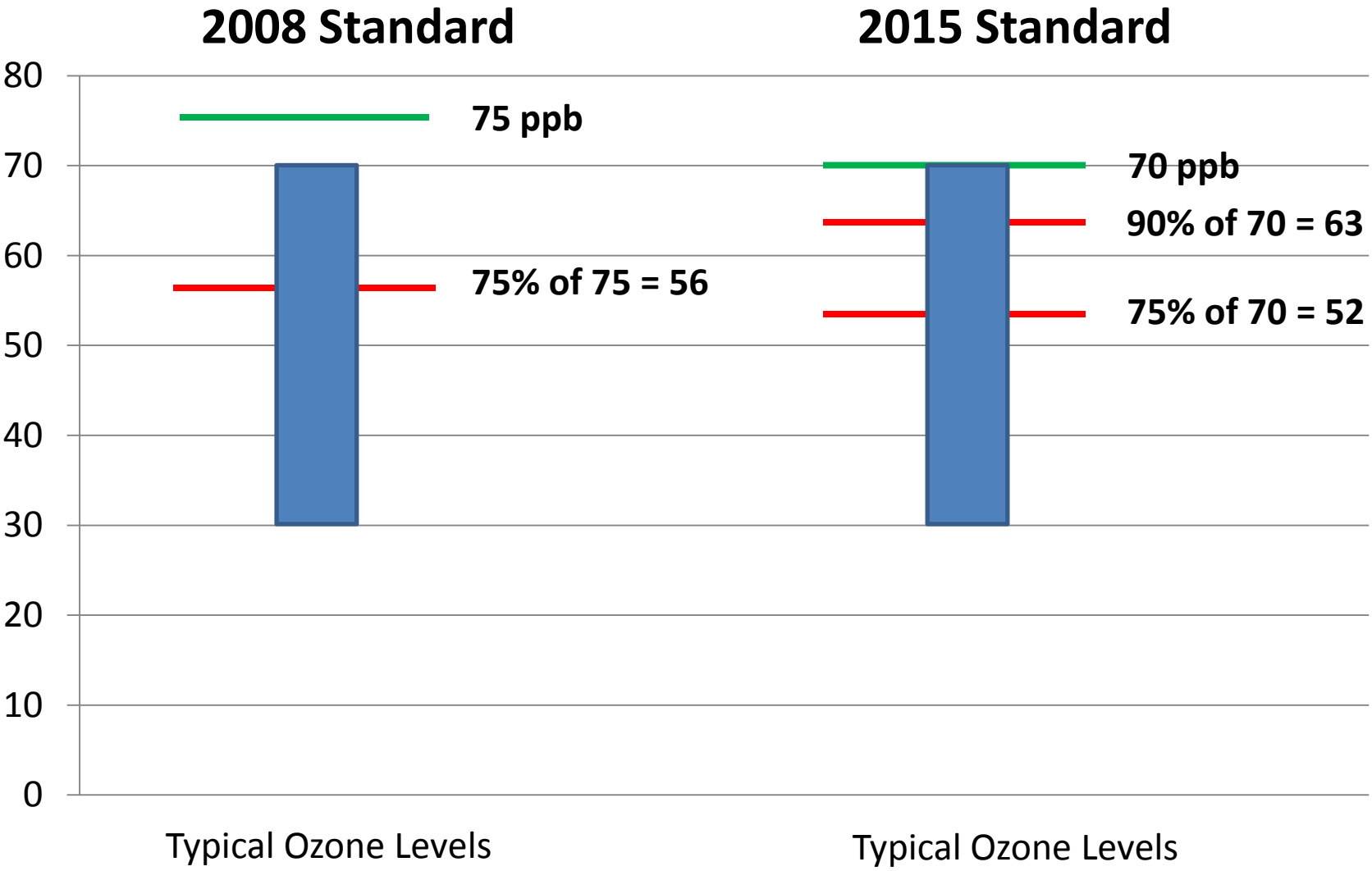
Senator Heider
Chair

Jeanne Jackson-Heim
Secretary

Idaho Department of Environmental Quality

January 2017

Ozone in Rural Idaho



January 25, 2017

To: Idaho Senate Health and Welfare Committee

RE: Senate Bill #1009

Dear Members of the Idaho Senate Health and Welfare Committee:

I am writing in regards to my concerns about air quality in Idaho. Air quality (both PM 2.5 and ozone levels) have clearly been associated with causing lung problems for both healthy patients and patients with medical conditions, particularly chronic lung diseases. I am not writing to debate that well established literature, but rather to discuss the impact of air quality of the patients I help care for.

As a pulmonologist and resident in Idaho, I have various roles in the care of patients with both acute and chronic lung diseases in the state: I am the Medical Director for St Luke's Pulmonary Clinics, a pulmonary representative on the Idaho CMS CAC (Clinical Advisory Committee), the co-chair of the St Luke's "Improve Care for COPD Patients" project, and a member of the Joint Operating Council for Pulmonary and Critical Care at St Luke's Regional Medical Center. I am a member of the American Association of Chest Physicians (ACCP), the American Lung Association, and I carry my board certification in Pulmonary Disease. Finally, during my formal medical training, I conducted research on the effects of ozone on Lung Function. Regardless of my background or expertise, I care for patients in Idaho, and thus feel obligated to stand up for citizens and patients alike regarding air quality issues. I have no conflicts of interest in this matter.

There is well established scientific and medical literature that clearly show direct cause and effect of air quality on both chronic lung disease and precipitating acute respiratory illnesses. We know that patient with such diseases as COPD, Asthma and pulmonary fibrosis suffer when air quality is poor. While we can't control the weather or the forest fires, we can control what we allow in our atmosphere. As pulmonologists, we see a clear uptake in both clinic visits, ER visits and hospitalizations at times of poor air quality. This can result in patients being admitted to the hospital, missing work due to burden of disease, and so this has both medical and societal costs. Of particular concern in Idaho is our COPD population. Of note, COPD is just not "a smoker's disease" anymore, as 25% of

patients over the age of 65 with COPD are never-smokers. This is a particular vulnerable patient population, and is a very common disorder, afflicting a substantial number of Idahoans. Current CDC data suggests that Idaho ranks in the lower quartiles for mortality from COPD, and this is disproportional to the incidence of COPD in Idaho. We need to everything we can to ensure good air quality for our citizens of Idaho and must be stewards of our air quality for our citizens. Just as we wouldn't allow a private company to avoid OHSA standards for its employees, we cannot lower air quality standards at the expense of Idaho residents.

Lastly, I am pro-agriculture. My own immediate family is in the tree farming business, where we had to manage organic debris/crop residue, and I was raised in a farming community, where numerous neighbors and extended family ran large farms. I understand crop residue is an issue that the agriculture industry needs to manage, but that should not be at the expense of the health of our citizens.

I hope the committee strongly considers keeping more stringent air quality standards, to help promote the health and welfare of our communities in Idaho. I am sorry I could not attend in person today, but my clinical obligations prevented me being present to deliver my concerns, and I therefore authorize Mr. Jonathan Oppenheimer to deliver these comments.

Sincerely,

Dr Patrick D Weis, MD

Boise, ID

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Thursday, January 26, 2017

SUBJECT	DESCRIPTION	PRESENTER
Approval of Minutes	Minutes of the January 16, 2017 Meeting Minutes of the January 18, 2017 Meeting	Senator Lee Senator Martin
Docket No. 16-0308-1601	Rules Governing the Temporary Assistance for Families in Idaho (TAFI) Program	Ericka Rupp Program Manager
Docket No. 16-0612-1601	Rules Governing the Idaho Child Care Program (ICCP)	Julie Hammon Deputy Administrator
Docket No. 16-0506-1602	Criminal History and Background Checks	Fernando Castro Program Manager
Docket No. 16-0506-1601	Criminal History and Background Checks	Fernando Castro

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Thursday, January 26, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Senators Martin, Lee, Harris, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	Vice Chairman Souza and Senator Anthon
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.
APPROVAL OF MINUTES:	**Senator Lee** moved to approve the Minutes of January 16, 2017. **Senator Harris** seconded the motion. The motion carried by **voice vote.**
	Senator Martin moved to approve the Minutes of January 18, 2017. **Senator Jordan** seconded the motion. The motion carried by **voice vote.**
DOCKET NO. 16-0308-1601	**Rules Governing the Temporary Assistance for Families in Idaho (TAFI) Program. Ericka Rupp,** introduced herself as Program Manager for the Division of Welfare in the Department of Health and Welfare (Department). The pending rule docket changes two definitions under the Department's program rules for Temporary Assistance for Families in Idaho (TAFI). The first change is the definition of "caretaker relative." The rule clarifies relationships that qualify as caretaker relatives when applying for assistance: grandparents, aunts, uncles, or cousins. Second, the definition of "parent" is changed to include a stepmother or stepfather as a parent when determining a household's eligibility status. These definition changes are reflected in various parts of the rule and must be updated to ensure accuracy across the entire chapter. The Department conducted negotiated rulemaking and did not receive any feedback during the public comment period.
	Senator Lee inquired whether this docket also changes the definitions of the two terms in other parts of IDAPA. **Ms. Rupp** responded the docket only affects the TAFI program.
MOTION:	**Senator Foreman** moved to approve **Docket No. 16-0308-1601. Senator Lee** seconded the motion. The motion carried by **voice vote.**
DOCKET NO. 16-0612-1601	**Rules Governing the Idaho Child Care Program (ICCP). Julie Hammon** introduced herself as the Deputy Administrator in the Department's Division of Welfare. This pending rule became effective October 1, 2016 to coincide with the effective date of reauthorization of the federal Child Care Development Fund. The changes add health and safety requirements for child care providers, streamline eligibility policies, and ensure parents and the general public have transparent information about available child care choices. Current income limit and eligibility requirements will remain the same. To be eligible, families must have a child under the age of 13, meet current income guidelines, and participate in a qualifying activity such as work or attending school. Keeping children in reliable child care is critical to a family's stability in the workplace as well as the child's development and educational success.

Ms. Hammon explained the rule docket contains three major eligibility changes for families:
1.) The new rule establishes a 12-month certification period for eligibility. Once a child is determined eligible under the federal poverty level limit, that child is eligible for 12 months as long as the family remains below 85 percent of the State median income.
2.) At the time of redetermination for eligibility, if the family's income has increased but is still below 85 percent of the State median income, the rule allows the family a three-month phase-out period to transition off assistance.
3.) A family with a temporary job loss or break in education or training can continue to receive assistance for no more than three additional months to search for a job, go back to work, or resume attendance in an education or training program. The family is still required to pay co-pays and additional child care costs, but it ensures stability by allowing the child to stay with the same provider during the break. It is often difficult to get a child placed with a quality child care provider, and losing the child's spot with the provider can be a barrier to returning to the workplace and maintaining consistency for the child.

Ms. Hammon advised the rule also includes changes to health and safety requirements for child care providers. Currently, all ICCP providers are required to undergo an annual health and safety inspection and maintain current pediatric cardiopulmonary resuscitation and first aid certification. The rule specifies the annual health and safety inspections will be unannounced. Also, the rule adds a pre-certification training requirement and requires annual professional development to maintain certification. The IdahoSTARS program offers courses that meet the training requirements at no cost to the provider, or providers can choose alternate courses to meet their own professional development needs.

Ms. Hammon explained all providers are currently required to have a background check at the time of certification. The new rule specifies providers must undergo a background check every five years. Providers have always been required to report child abuse and neglect. Now, providers must also report when a child has been seriously injured or died as a result of participating in the child care program. The Department must make substantiated complaints available to the public and will aggregate and publish data about death and serious injuries in child care. To simplify access to the data, the Department must develop an online web tool for consumers to view this information.

Ms. Hammon pointed out new Section 750.10 regarding "offenses not in the best interest of child care participants." The same provision has been in effect since 2009 as a ground for the Department to refuse to enter into a provider agreement. This docket adds the provision as a reason for the Department to discontinue a provider agreement.

Ms. Hammon informed the Committee there is a fiscal impact. The Department presented a two-year funding plan to the Joint Finance and Appropriations Committee (JFAC) in 2016 that addressed multiple changes to the ICCP program, including the impact of the rule changes. The Administration for Children and Families modified the State's child care allocations to help cover the cost of the changes, and the increase in federal spending was addressed last year during the JFAC hearings. The Department provided a public comment period for providers and citizens in February 2016 and created a web page devoted to this docket to inform providers and citizens of all upcoming changes. The Department conducted negotiated rulemaking in six cities throughout Idaho in June 2016. Providers were invited to attend to learn about the upcoming changes and provide insight to the draft ICCP rules. More than 150 people attended, and 15 provided feedback, all in support of the changes.

Chairman Heider asked whether the 2016 JFAC appropriation was for one or two years. **Ms. Hammon** responded it was a two-year appropriation and continues for 2017. The Department will also present to JFAC regarding additional funding for changes to the program.

Senator Martin inquired what effect Section 104.06 pertaining to citizenship or alien status will have. **Ms. Hammon** answered the Department looks at household size to determine what income limit to apply. When someone in the household is not lawfully in the U.S., that person is not included in the count for family size, but the person's income is counted as part of the total income for the family. **Senator Martin** asked how this would affect the family. **Ms. Hammon** replied it could result in the family being over income. **Chairman Heider** asked for clarification on the term "lawfully." **Ms. Hammon** answered anyone who is in the U.S. lawfully is eligible for the program. It could be a lawful permanent resident or someone on a student visa. An undocumented person who did not have the right to be present in the U.S. would not be eligible.

Senator Lee asked whether the amount of the one-time registration fee in Section 500.02 is the previous fee that was simply placed in rule. **Ms. Hammon** answered there was previously no set fee, and the Department was receiving one-time registration fees in multiple dollar amounts. The Department determined a reasonable one-time registration fee and added it to rule.

Senator Lee inquired where someone could find the local market rate and triennial survey of provider payments referenced in Section 502a. **Ms. Hammon** responded the Department contracts with IdahoSTARS to maintain that information. IdahoSTARS contacts all registered child care providers every quarter to obtain availability for spots and the amount each provider charges. **Senator Lee** asked how a provider or consumer would know to get the information from IdahoSTARS. **Ms. Hammon** replied the providers work directly with IdahoSTARS so they know where to find the information.

Senator Agenbroad asked about the difference between "countable income" and "income" used in various sections and whether the terminology should be consistent throughout the rule. **Ms. Hammon** answered "countable income" is the income used to determine eligibility. Section 072 provides a list of excluded income that is not included in "countable income" for eligibility determination. **Senator Agenbroad** asked for clarification if both countable income and income are used for eligibility. **Ms. Hammon** explained the Department first looks at countable income and that is what is used for income determination. **Senator Agenbroad** pointed out Section 070.01 uses the term "income" and asked if it would be appropriate to state "countable income" in that section. **Ms. Hammon** answered it would be correct. It should say "countable" and will be changed. **Senator Jordan** stated it might be correct as written and explained her understanding that the section referencing "federal poverty guidelines" is not specific to a particular program, while the program rules make decisions about what is counted income. **Ms. Hammon** provided an example of a family of two for which the federal poverty limit is $1,736. For the ICCP, all countable income is used to determine eligibility. If the family's countable income was $1,700, and they had $100 of excluded income such as a travel reimbursement, the family would be eligible for the program.

Senator Lee asked whether the $250 one-time registration fee was a State decision or a federal requirement. **Ms. Hammon** answered the $250 fee was a State decision and was not part of the federal reauthorization. **Senator Lee** inquired which of the proposed changes were discretionary State decisions and which changes were made to conform to federal law.

Ms. Hammon identified the docket sections containing changes related to federal re-authorization: 1.) all changes on page 129; 2.) page 131, Sections 011.11 and 070.02; 3.) page 132, Section 070.03; 4.) page 135, Section 078; 5.) page 137, Sections 105.03.a, 105.03.b,, and 200.02.a; 6.) page 138, Sections 202 and 500.02; 7.) page 139, Section 502.01.a; 8.) page 140, Section 503; 9.) page 141, Sections 600.04.b, 602.01, and 602.02; 10.) page 143, Sections 801, 802, and 802.04; 11.) all changes on page 144; 12.) page 145, Sections 803, 804, and 805; and 13.) all changes on page 146.

Ms. Hammon specified the docket sections containing State discretionary changes: 1.) all changes on page 130; 2.) page 131, Sections 070 and 070.01; 3.) page 132, Section 072.06; 4.) page 133, Sections 072.17 and 073; 5.) page 135, Section 103.03.a; 6.) all changes on page 136; 7.) page 137, Sections 105.103, 200.02.a, 200.02.b, 200.03.b., and 200.03.c; 8.) page 138, Section 401.02; 9.) page 139, all changes in Section 501; 10.) page 140, Section 807; 11.) all changes on page 142; and 12.) page 145, Section 807.

Senator Martin asked how many attended the public hearing. **Ms. Hammon** responded 150 people attended and 15 provided comments, all in favor of the new rules. **Senator Martin** asked if it is common to have such a high number of attendees. **Ms. Hammon** replied it was more than usual. Ericka Rupp did a lot of outreach to ensure all providers knew about the changes and obtain their feedback.

Senator Harris asked about the disaster and emergency planning section and who provides these documented policies and procedures. **Ms. Hammon** answered IdahoSTARS works with all providers and helps them with all aspects of their business. IdahoSTARS provides coaching and mentoring to develop that plan and has example plans for them to use.

MOTION: **Senator Jordan** moved to approve **Docket 16-1612-1601. Senator Foreman** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 16-0506-1602 **Criminal History and Background Checks. Fernando Castro** introduced himself to the Committee as supervisor of the Criminal History Unit (CHU) in the Department's Bureau of Audits and Investigations. The CHU completes nearly 25,000 background checks a year to help the Department protect vulnerable citizens from harm by screening employees of providers and individuals who participate in certain Department programs such as foster care, adoption, and certified family homes (see Attachment 1). Each year about 300 applicants, representing fewer than one percent of applicants, are denied or voluntarily withdraw from background checks because of disqualifying elements. The reauthorization of the Child Care and Development Block Grant of 2014 included some new standards for background checks for child care workers that become effective September 30, 2017. This docket will bring the Department's rules into compliance with federal law.

Mr. Castro informed the Committee the rulemaking process started in February 2015 and concluded in September 2016. CHU identified changes to its processes that would be necessary to meet the federal requirements and determined appropriate rule language. Because the changes were significant, CHU engaged internal and external stakeholders as early as possible. CHU held both negotiated and proposed rulemaking public meetings in Spring and Fall 2016. For those who could not meet in person, CHU disseminated a survey discussing the substance of the changes. This docket is the result of reviewing comments to the rule and the survey results.

Mr. Castro said there are two major changes in the proposed rule affecting background checks for child care staff: 1.) the addition of a separate enhanced set of criteria for passing or failing the background check; and 2.) the ability for the Department to collect from the applicants any additional third party fees that would be paid by the Department to external agencies because of the enhanced background check requirements.

Mr. Castro stated the rule requires an enhanced clearance process for childcare providers and allows an enhanced clearance for others who have agreed to be screened to the higher standard. The enhanced clearance: 1.) requires CHU to disqualify an applicant for the conviction of any crime where a child is a victim; 2.) updates the list of disqualifying crimes; and 3.) requires CHU to obtain additional crime and child protection information from any place where the applicant has lived in the past five years. This is necessary because some criminal offenses and child protection actions are not reported to the Federal Bureau of Investigation, and CHU must learn about unreported events to determine the fitness of the applicant. Some agencies charge a fee for obtaining this additional information. To keep the current cost of the background check as low as possible, the rule authorizes the Department to collect the additional fees required to process the enhanced clearance. CHU expects these costs to be minimal.

Mr. Castro explained with the two types of Department clearances, background check portability will be limited. Applicants cleared to the enhanced standard will still be able to use their background checks without restriction with other employers if allowed by rule. However, applicants not cleared to the enhanced standard will have clearance portability only with employers that do not require the enhanced clearance.

Mr. Castro advised the docket includes additional updates and clarifications. In addition to adding the disqualifying crimes required by the Child Care and Development Block Grant, the rule changes ensure specific disqualifiers match current Idaho Code. Department providers requested that procedures and compliance expectations be clarified, and this docket accomplishes that goal. During the rulemaking process, the Department was pleasantly surprised that some providers voluntarily chose to adopt the enhanced clearance standard. All categories of applicants that will undergo the enhanced clearance process are listed in Section 126 of the docket, including some that are not childcare providers.

Senator Foreman asked about the dollar amount of third-party fees applicants might be required to pay. **Mr. Castro** responded CHU surveyed all states that charge fees, and nine states charge a fee to obtain information from the Child Protection Registry. Idaho charges $20, and the other states' fees range from $8 to $28.

Senator Lee asked why operating a certified family home without certification rises to the same level as other disqualifying offenses. **Mr. Castro** answered the disqualifier was included at the request of the Certified Family Home program because people who were convicted of a violation in that program should not be allowed to participate in other programs. The enhanced background clearance allows people to go more easily from one place of employment to another.

MOTION: **Senator Lee** moved to approve **Docket No. 16-0506-1602. Senator Foreman** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 16-0506-1601

Criminal History and Background Checks. Fernando Castro presented the docket on behalf of the Bureau of Audits and Investigations. The 2016 Legislature approved changes to other Department rules pertaining to requirements for background checks for the Division of Public Health, Emergency Medical Services Bureau, and the Division of Behavioral Health. This docket deletes or rearranges references for conformity with those rules and to ensure CHU has authority to conduct the background checks.

MOTION: **Senator Harris** moved to approve **Docket 16-0506-1601. Senator Jordan** seconded the motion. The motion carried by **voice vote.**

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 3:52 p.m.

_____

Senator Heider
Chair

_____

Jeanne Jackson-Heim
Secretary

What's Next

We want to hear from you.

Do you like this report?
Would you like to see other information?
Please let us know by contacting us using the information below.

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Bureau Chief
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Report Public Assistance Fraud

Health Care Fraud:
Call 208.334.5754
Fax 208.334.2026
Email prvfraud@dhw.idaho.gov

All Other Fraud:
On Line Report Link
Call 866.635.7515
Fax 208.334.5694
Email welfraud@dhw.idaho.gov

Website Continuous Improvement

We will continue to invest in the Department Background Check website to increase its value to our stakeholders. We will keep an eye out for emerging technologies and make changes to the website when possible to ensure that it remains a useful tool to its users. We will listen to them and implement their feedback.

Appointment Availability

We will continue to prudently allocate our resources to satisfy the demand for the Department background check state-wide. Our goal is to maximize access to us for the applicant as soon as they submit their application for the background check online.

Reduce Background Check Costs

We will continue to look for ideas to help us improve our work processes to find savings that will reduce the cost of our background checks. We will continue to partner with the Idaho State Police to deploy and use electronic criminal history information exchange systems to render the process completely paperless.

Accelerate Completion of Background Checks

We will continue to explore ways to leverage electronic data in our systems to ensure that we allocate our resources to resolve background checks that take longer to resolve. Examples of why completion of a Department background check may be delayed are:

- A person may have low quality fingerprints requiring submission of a second set of fingerprints to be compared with federal/state criminal files
- Resolution of research of criminal dispositions in jurisdictions outside of Idaho and, their conversion to an Idaho equivalent depends on the speed of those states' responses affecting the timely completion of our background check
- Reliability of the fingerprint transmission infrastructure and systems is occasionally interrupted for technical reasons which delay the processing of the background check

Bureau of Audits and Investigations

Criminal History Unit (CHU)

IDAHO DEPARTMENT OF HEALTH & WELFARE

A Report to Our Citizens Fiscal Year 2016

The Department and the Bureau

The Department oversees $2.5 Billion in spending for Idaho Citizen's Health and Welfare. The Bureau of Audits and Investigations, part of Support Services, provides critical integrity efforts to ensure public safety and to fight waste, abuse, and fraud. The Bureau of Audits and Investigations has four units which provide very different services.

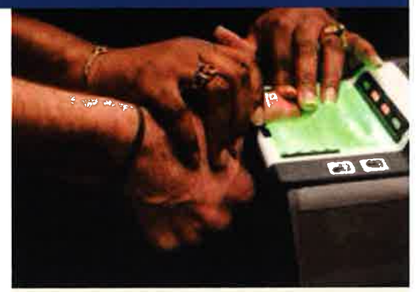
- Internal Audit provides Management with independent feedback on critical controls.
- Criminal History processes background checks to protect vulnerable adults and children.
- Medicaid Program Integrity audits Medicaid providers.
- Welfare Fraud Investigation audits and investigates recipients of public assistance and Non-Medicaid providers.

The Criminal History Unit

The Criminal History Unit is staffed by 12 dedicated professionals that cover the entire state of Idaho needs for the Department background check. The unit is self-funded and completes over 25,000 background checks per year. These background checks help the Department protect those who are vulnerable from harm by screening employees of providers and individuals that participate in certain Department programs such as foster care, adoption and certified family homes. Each year, about 300 applicants are either denied or voluntarily withdraw from their background checks because of disqualifying elements in their background checks. The current average turnaround time for the background check is 14 days.

Providers that were Background Checked

Provider Types	SFY2013	SFY2014	SFY2015	SFY2016
Medicaid Providers	10,654	10,538	10,560	12,319
Long Term Care Providers	8,419	8,316	8,716	8,880
Foster Care and Adoption Candidates	3,131	3,287	3,415	3,460
Day Care/Child Care Providers	2,459	2,618	3,023	2,994
EMS Employees and Volunteers	852	751	848	904
Behavioral Health Providers	413	408	852	1,011
Department Employees/Volunteers	566	536	976	490
Court Appointed Guardians/Conservators	0	472	596	599



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Bureau Mission

Although each of our four units has a distinctly different mission, we all share a common vision.

- We will maximize the value of our services to the Department by improving our effectiveness and efficiency
- We will pursue "best practices" within our own areas of operations
- We will reach out and become excellent communicators with each other, our leaders, customers, and the public
- We will develop and maintain a highly skilled and knowledgeable cadre of experts in our fields

Unit Mission

To protect the vulnerable citizens involved in the many Department programs by administering a criminal history background check system.

How We Have Progressed

2016 Accomplishments

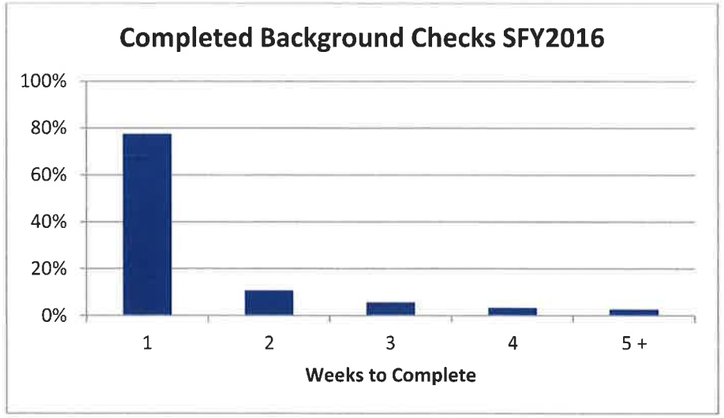
- Established an additional processing center for mailed background check applications in eastern Idaho. New processing capability decreased resolution time for these applications by one day.
- Reinvested prior year savings in the acquisition of software solutions that enhanced the security and reliability of the Department's fingerprint transmission infrastructure.
- Actively listened to stakeholders concerns by changing administrative rules, business practices and improving web-based services to meet their business needs
- Deployed option to providers to pay for their employees background check fees with credit/debit cards
- Made 25 referrals to the Medicaid Program Integrity Unit resulting in the collection of $248K in penalties from providers that were not compliant with the Department background check program

CHU Performance Measures	SFY2013	SFY2014	SFY2015	SFY2016
Applications Submitted	26,629	27,881	28,642	29,520
Individuals Fingerprinted	22,869	21,315	24,998	25,490
Fingerprint Reject Rate	2.3%	2.2%	2.3%	1.7%
Individuals Denied	263	277	303	339
No Show rate	20%	20%	19%	18%

Location	Appointments Available *		
	Week 1	Week 2	Week 3
Coeur D'Alene			
Moscow			
Lewiston			
Nampa			
Boise			
Mountain Home			
Twin Falls			
Burley			
Pocatello			
Idaho Falls			
Rexburg			

Available
- 75 - 100 %
- 50 - 75 %
- 25 - 50 %
- 0 - 25 %

** This chart represents the usual availability of our appointments in SFY 2016*



Some of the measures reported on this report were included in the Facts Figures and Trends Report which is published annually by the Department of Health and Welfare at the following address:
http://www.healthandwelfare.idaho.gov/AboutUs/Facts,FiguresTrends

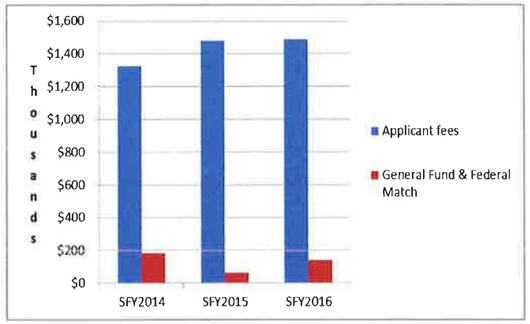
Our Finances

What are the costs of the Criminal History Unit and how are those costs paid?

Unlike other state agencies, 90% of our revenue consists of fees collected from the applicant to process their background check. The remaining 10% of the total revenue comes from a near even split from the state General Fund and corresponding federal match. State statute requires that our applicants pay for their background check. Some of our stakeholders do pay for their employees' background check as a recruiting and retention measure. The Department pays for the background checks of its employees and those of persons that participate in programs that benefit directly children at risk such as adoption and foster care. The current fee for the background check is $65.00 per person

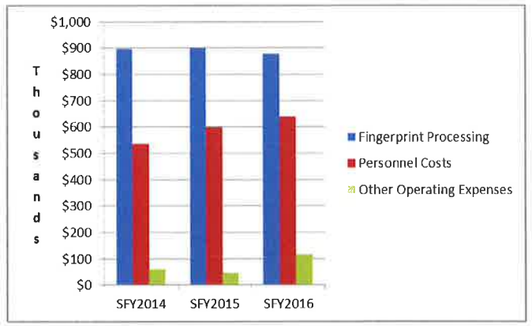
Revenue by Source (in thousands)

	SFY2014	SFY2015	SFY2016
Applicant fees	$1,329.0	$1,481.0	$1,491.0
General Fund & Federal Match	$165.3	$65.4	$141.0
Total revenues	**$1,494.3**	**$1,546.4**	**$1,632.0**



Expenditures by Area (in thousands)

	SFY2014	SFY2015	SFY2016
Fingerprint Processing	$897.5	$899.9	$877.3
Personnel Costs	$535.9	$598.6	$639.0
Other Operating Expenses	$60.9	$47.9	$115.7
Total expenditures	**$1,494.3**	**$1546.4**	**$1632.0**



Independent Audit

Independent audits of the State of Idaho can be found at **http://legislature.idaho.gov/audit/statewidereports.htm**.

JOINT

SENATE HEALTH & WELFARE COMMITTEE
AND
HOUSE HEALTH & WELFARE COMMITTEE

8:00 A.M.
Lincoln Auditorium
Friday, January 27, 2017

SUBJECT	DESCRIPTION	PRESENTER
	Public Hearing on Health and Welfare Issues	

Testimony will be limited to 3 minutes per person.

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
JOINT MEETING

SENATE HEALTH & WELFARE COMMITTEE
HOUSE HEALTH & WELFARE COMMITTEE

DATE: Friday, January 27, 2017

TIME: 8:00 A.M.

PLACE: Lincoln Auditorium

MEMBERS PRESENT: Chairman Heider, Vice Chairman Souza, Senators Lee, Anthon, Foreman, and Jordan

Chairman Wood, Vice Chairman Packer, Representatives Hixon, Perry, Vander Woude, Redman, Gibbs, Blanksma, Hanks, Kingsley, Zollinger, Chew, and Rubel

ABSENT/ EXCUSED: Senators Martin, Harris, and Agenbroad

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the Joint Meeting of the Senate Health and Welfare Committee and the House Health and Welfare Committee (Committee) to order at 8:00 a.m.

TESTIMONY: The following persons provided testimony regarding the Non-Emergency Medical Transportation (NEMT) provider contract with Veyo:

- **Darren Talley** with White Tail Transportation, testified on behalf of NEMT providers in support of restoring funding for the NEMT program to 2009 levels;
- **Vanessa Johnson** of Access Behavioral Health spoke about problems with Veyo customer service and the need to improve staffing and funding for transportation;
- **Jenna Dewitz** from Pathways of Idaho testified about problems with transportation service provided by Veyo;
- **Josh Komenda**, President of Veyo, testified in support of its NEMT contract and reaffirmed his commitment to Idaho caregivers and patients to improve service;
- **Beverly Hines** , a licensed professional counselor, testified regarding Veyo customer service problems and lost revenue she experienced as a result of patients' missed appointments;
- **Amber Irish**, former transportation company owner, testified regarding problems with the Veyo contract and the closing of her business since Veyo became the broker;
- **Kleeta Newby** of KBM Transportation testified regarding customer service problems with the Veyo contract and her loss of clientele since Veyo became the broker.

The following persons provided testimony regarding Medicaid expansion:

- **Joe Raiden** testified in support of increasing Medicaid funding to close the "gap" for working poor and maintain funding for mental health treatment;
- **Lauren Necochea** with Health Voices for Children testified in favor of expanding Medicaid in order for Idaho to get its fair share of federal funding;
- **Kara Kuntz**, a family practice physician, spoke in favor of Medicaid expansion and in support of unpaid caregivers;
- **Jessica Chilcott** testified in favor of Medicaid expansion and maintaining the Affordable Care Act;
- **Ada Casaza** testified in support of the work of the interim work group and urged a solution to close the gap in health insurance coverage;
- **Linda Anderson** testified in support of expanding Medicaid funding;
- **Russ Duke**, Director for Idaho Central District Health Department, spoke in favor of closing the health insurance coverage gap;
- **Kiran Spees** testified in support of expanding Medicaid and described her experience with another state's health care system;
- **Melody Hayden** testified in support of closing the health care coverage gap;
- **Robert Gehrke**, Chair of the Recovery Support Services Committee of the Region 6 Behavioral Health Board, testified in support of Medicaid expansion and increased funding for mental health and drug treatment for inmates after release from custody;
- **Cathy Deckys**, a nursing professor at Boise State University, testified in support of closing the health insurance gap.

Patrick and Jessica Rachels testified in support of passing a bill requiring doctors to provide educational information on the effects of cytomegalovirus.

Mike Berlin spoke on behalf of Idaho Alzheimer's Planning Group relating to need to improve care options for Alzheimer's patients with behavioral issues.

Michelle Sterling testified about her family's difficulties obtaining mental health care treatment and assistance in Idaho for her son.

Laura Scuri, owner of Access Behavioral Health, spoke about the need to develop a comprehensive plan for care and funding for behavioral health issues.

Doug Loertscher testified in support of increasing funding for services to treat developmental disabilities and improving the assessment process to start services for disabled persons sooner.

Dan Chadwick, on behalf of the Idaho Association of Counties, testified in support of increasing available treatment facilities and peace officer training for adults with behavior health issues.

Hannah Stern testified in support of universal health care and agencies such as Planned Parenthood.

Nicole Sherwood of Developmental Concepts spoke in favor of providing appropriate funding for treatment of developmental disabilities and the importance of paying higher than entry-level wages for caregivers.

Jenny Willison spoke in support of repealing the faith healing exemption.

Jinny Peterson of Health Freedom Idaho spoke in support of her right to choose treatment options for herself and her family.

Valerie Charles of Health Freedom Idaho spoke in support of revising the immunization exemption law to eliminate the use of the Department of Health & Welfare form.

Andra Wilson testified in support of privatizing health care.

Jennifer Zielinski of Idaho Parents Unlimited testified in support of providing additional resources to assist parents with children with behavioral health disabilities.

Rev. Edwin Keener expressed his opinion that the State surplus should be used to better fund education in Idaho and spoke in support of universal health care and immigrants.

Brian Hoyt testified in support of repealing the faith healing exemption.

Alan Hansen testified in support of raising wages for caregivers of patients with disabilities.

David DeHaas testified in favor of eliminating the Department of Health & Welfare immunization exemption form.

Ahniah Selene-Summer testified in opposition to reducing Medicaid reimbursements.

Mary Nyland testified in favor of expanding Medicaid for the working poor and increasing reimbursement rates for treating developmental disabilities.

See Attachment 1 for a copy of all testimony provided to the Committee.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 10:56 a.m.

Senator Heider
Chair

Jeanne Jackson-Heim
Secretary

Health and Welfare Testimonies

1. NEMT/Veyo/Liberty Healthcare
    a. Browning, Teresa
    b. Johnson, Vanessa
    c. Loertscher, Doug
    d. Newby, Kleeta
    e. Osborn, Pat
    f. Romeo, Frank
    g. Talley, Darren
2. Provider Compensation
    a. Benkula, Bill
    b. Sherwood, Nicole
3. Healthcare Coverage
    a. Allen, Emily
    b. Chilcott, Jessica
    c. Cross, Judy
    d. Gehrke, Robert (Bob)
    e. Gittins, Thomas
    f. Gold, Deborah
    g. Haley, Kathyrn
    h. Kuntz, Kara
    i. Necochea, Lauren
    j. Parodi, Bonita
4. Faith Healing
    a. Charles, Valerie
    b. Glass, Marci
    c. Health Freedom Idaho
    d. Hoy, April
    e. Peterson, Jinny
    f. Sherman, Roger
    g.
5. Misc. (CMV, Medical Startup, Optum)
    a. Dulaney, Veronica
    b. Kole, Maureen
    c. Rachels, Jessica and Patrick

Members of the committee, thank you

Teresa Browning - En Route Transportation

I would like the record to show that I'm not only representing myself but Eric and Alan Boyce with ABC Transportation.

Its my understanding there was a submission of documents from Veyo that I'd like to address

I have worked in the Medicaid transportation industry since 2006. First as a driver, then company manager (non emergency) until my husband and I started our company in 2013.

When Health and Welfare decided to implement a brokage to mange Medicaid transportation providers were hesitant. However, we all merged together with a few complications but it was a much needed implantation to filter out the waste, fraud and abuse of the system by those providers who were taking advantage of it. American Medical Response came in and set the standards and we have looked for those standards with Veyo. Most of us felt and still feel Veyo was dishonest from the beginning and continue to be dishonest. They have painted a pretty picture.

We work, drive and deal with situations in real time. I have called into the call center and been placed on hold, once for 43 minutes, 43 minutes, been told to email provider support and wait for a response. With AMR I could get a response in minutes, not being put on hold for extended periods of time, or receiving a response the next day or 2 days later. I currently have an open ticket with Veyo going on 3 days with no response.

I receive trips and phone calls about trips out of my service area. Boise, Twin Falls, Salmon. I serve the Idaho falls area. I received a call on January 24th from a customer service representative because we were delayed several hours digging ourselves out so we could get running, and I quote " I don't even know what snow is." Josh Komada sat in my dining room in my home and told me I could call him anytime and he would get back to me as soon as possible, I haven't received a return call from him since the middle of July. Jamie Deal, our regional contact I have spoke to her one time on the phone for 3 minutes in the last 6 months.

They don't know our area or the providers, ~~and we recieve no support~~, NEMT Providers carry the burden alone, yet make the least.

~~If I may submit~~ I've had to start recording my phone calls to protect myself a recording ~~s~~ of a phone call ~~or the typed out~~ conversation I had with a Customer service Representative just this Wednesday January 25th and an email communication I had with Sara Stith regarding Veyo scheduled pick up times, and a spreadsheet with PHI removed ~~but does include trip numbers for the~~

~~participants~~- the purpose is to show the communication that actually occurs with the call center staff, and this type of occurrence happens on a daily basis. The information they provide is false or misleading. CSR stated that participants with multiple legs on their trips are not given appointment times, you'll see on my spreadsheet several participants with multiple legs each with specific appointment times. CSR stated I am supposed to follow pick up times, even though this issue has been addressed multiple times, including with Sara Stith as you'll see in the email correspondence. CSR said appointment times are for informational purposes only, shouldn't I be informed of the correct information since I'm carry the responsibility of completing the trip?

Veyo Stated

Provider Challenges-

If I may submit an email correspondence between myself Luke Bouland and William Brown.

In the email correspondence, you'll read Luke confirmed with David he had all 238 pages of documentation and my records were updated on June 17th. On October 18th William Brown sent me an email that he only had credentialing for 3 drivers, almost 4 months later I was contacted that most of my 238 was gone.

Declining trips-

There becomes a point when we cannot accommodate a schedule therefore must decline a ride, or clients who chronically no show, we aren't going to continue to waste our resources to go be no showed for the 3rd or 4th time.

Not accepting trips 48 hours in advance-

I am contacted daily

~~If I may submit screen shots~~ from Veyo CSR's and myself in regards to trips being added to my port daily, with less than 24 hours' notice.

Providers earn more with Veyo

Regions 3-7 make more starting at mile 6. I am region 7

Out of the last 15,922 trips I have completed my average mileage is 4.13

1

Provider Challenges

- Not providing all required credentialing documents within a timely manner
  - Our Provider Network Coordinator had to follow-up with providers multiple times to get them to provide their insurance and other required credentialing documents
- Not accepting assigned trips on-time
  - Providers need to accept trips no later than 48 hours before the pick-up time
- Declining trips they are listed as the preferred provider for
- Not responding to all complaints within 72 hours

2

Providers Earn More with Veyo in Every Region

- In Regions 1-2, Providers make more starting at mile 3
- In Regions 3-7, Providers make more starting at mile 6
- Veyo rounds up all mileage while the previous broker rounded to the nearest mile, e.g., Veyo pays 4 miles for a trip that was only 3.1 miles whereas the previous broker only paid for 3 miles
- Providers had the option to choose the previous broker's legacy rates or the new Veyo rates

Region	Average Mileage per Trip
1	11.8
2	17.5
3	8.9
4	9.3
5	12.7
6	15.8
7	8.1

			Mile																			
Regions 1-2																						
VEYO	Base	$2.00	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
VEYO	Per Mile	$1.54	$3.54	$5.08	$6.62	$8.16	$9.70	$11.24	$12.78	$14.32	$15.86	$17.40	$18.94	$20.48	$22.02	$23.56	$25.10	$26.64	$28.18	$29.72	$31.26	$32.80
Previous Broker	Base (Includes 1st Mile)	$4.20																				
Previous Broker	Per Mile	$1.17	$4.20	$5.37	$6.54	$7.71	$8.88	$10.05	$11.22	$12.39	$13.56	$14.73	$15.90	$17.07	$18.24	$19.41	$20.58	$21.75	$22.92	$24.09	$25.26	$26.43
Regions 3-7			Mile																			
VEYO	Base	$2.50	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
VEYO	Per Mile	$1.26	$3.76	$5.02	$6.28	$7.54	$8.80	$10.06	$11.32	$12.58	$13.84	$15.10	$16.36	$17.62	$18.88	$20.14	$21.40	$22.66	$23.92	$25.18	$26.44	$27.70
Previous Broker	Base (Includes 1st Mile)	$4.20																				
Previous Broker	Per Mile	$1.17	$4.20	$5.37	$6.54	$7.71	$8.88	$10.05	$11.22	$12.39	$13.56	$14.73	$15.90	$17.07	$18.24	$19.41	$20.58	$21.75	$22.92	$24.09	$25.26	$26.43

LEGEND

Veyo Rates

Where providers make more money with Veyo.

Average trip
4.13 miles

I had to accept the legacy rates because 97% percent of my trips are less than 6 miles. An issue that was addressed early on with Veyo, I have a zero increase on profits.

Average mile per trip in region 3-7 is 8.1 miles, I have google map screen shots of city limits from North, East, West, South from one side to the other in Idaho Falls biggest distance is 7.0 miles. Anyone familiar with Idaho Falls knows we are a very centralized area.

IDP results-

Medicaid transportation was set up to be a ride sharing system, not a single rider system. Trandional providers can put 5-14 passengers in the vehicles which saves recources and is far more efficient.

I can put 4 riders in my van and have them dropped before Veyo's stated 32 mintutes.

Of course IDP's can accept trips faster than trandional providers, how many of them are doing a schedule with 35 people already on it?

Provider rewards-

Between July 1st-Dec 31st average reward payment was 5,924 per provider.

I would love to documentation that I received that amount of trip rewards because that is a lie.

Automatic trip acceptation-

A feature I have refused to use but am still affected by it. CSR's automatically accept trips for me, as you can see from the email from Karla @ Veyo. I have automatically accepted trips all the time, trips I didn't even know about but am on the hook for.

~~I truly hope you'll verify everything I've said but~~

Before I close, I would like to challenge each of you to ~~Call Veyo and set up a ride for a minor anonymously and to experience what parents and Case managers have to go through.~~

~~Thank you~~

IDP Results

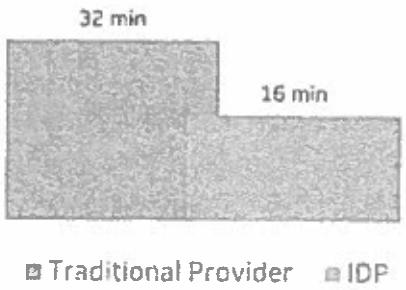
1. Less time in the vehicle

- Participants only spend an average of 16 minutes from pick-up to drop-off

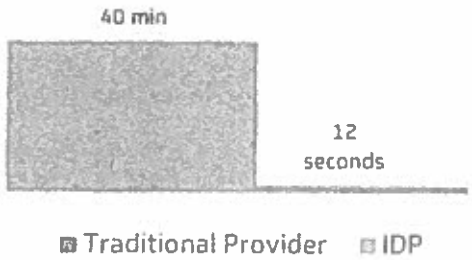
2. Less time to dispatch trips

- For last-minute, urgent trips, on average, Veyo can get an IDP to take the trip within 12 seconds vs. 40 minutes for traditional providers

Minutes in Vehicle



Last-minute Trip Acceptance Time



Provider Rewards

- Between July 1 and December 31, 2016, average reward payment was $5,924 per provider
- White Tail has been paid the most rewards out of all the providers with over $100K in rewards

Top 10 Providers with the Highest Reward Payout

Rank	Operator Name	Reward Total
1	White Tail Transportation, Inc.	$104.2k
2	Sprinter Shuttle Service, Inc.	$30.8k
3	Round-Up Transportation	$29.1k
4	A to B Services	$26.5k
5	AJ Transport	$18.9k
6	Victory Medical Transport (Gurney)	$17.7k
7	Wildwood Transportation	$16.3k
8	Idaho Transportation Company, Inc.	$15.2k
9	KDN Transportation LLC	$13.0k
10	Green Zone	$9.6k

I truely hope you will verify everything I've said but more importantly hold Veyo accountable for everything they have said.

~~Before I close I challenge each of you anonoymsouly to call Veyo and schedule a ride for a minor child, or special needs. to experience what parents and Care managers experience when setting up transportation.~~

Thank you

Trip #	Member Name	Scheduled Pickup Date	Appointment Date
4305538	RICHARD T	1/25/17 9:30 AM	1/25/17 10:00 AM
4305555	RICHARD T	1/25/17 12:20 PM	1/25/17 12:20 PM
4305570	RICHARD T	1/25/17 2:00 PM	1/25/17 2:00 PM
4305571	RICHARD T	1/25/17 4:00 PM	1/25/17 4:00 PM
4158211	ALEX G	1/26/17 9:15 AM	1/26/17 9:45 AM
4158598	ALEX G	1/26/17 10:30 AM	
4159137	ALEX G	1/26/17 12:00 PM	1/26/17 12:30 PM
4161751	ALEX G	1/26/17 3:30 PM	
4160419	BLAKE P	1/26/17 2:45 PM	1/26/17 3:30 PM
4162166	BLAKE P	1/26/17 4:00 PM	1/26/17 4:15 PM
4162642	BLAKE P	1/26/17 5:00 PM	1/26/17 5:00 PM
4158057	DALON P	1/26/17 7:30 AM	1/26/17 8:30 AM
4291763	DALON P	1/26/17 9:30 AM	1/26/17 10:00 AM
4161600	DALON P	1/26/17 11:00 AM	1/26/17 11:00 AM
4291834	DALON P	1/26/17 3:30 PM	1/26/17 3:30 PM
4157744	DESARAY G	1/26/17 8:30 AM	1/26/17 9:30 AM
4158569	DESARAY G	1/26/17 10:30 AM	1/26/17 11:30 AM
4159621	DESARAY G	1/26/17 1:30 PM	1/26/17 2:30 PM
4161988	DESARAY G	1/26/17 4:00 PM	1/26/17 5:00 PM
4161414	FAITH M	1/26/17 3:15 PM	1/26/17 3:30 PM
4162217	FAITH M	1/26/17 4:15 PM	1/26/17 4:30 PM
4162765	FAITH M	1/26/17 5:30 PM	1/26/17 6:30 PM
4159646	GUILLERMO A	1/26/17 1:30 PM	1/26/17 2:00 PM
4161677	GUILLERMO A	1/26/17 3:30 PM	1/26/17 3:30 PM
4246221	GUILLERMO A	1/26/17 6:00 PM	1/26/17 6:00 PM
4439632	JOE R	1/26/17 8:15 AM	1/26/17 9:00 AM
4439704	JOE R	1/26/17 9:45 AM	1/26/17 9:45 AM
4439746	JOE R	1/26/17 12:15 PM	1/26/17 12:15 PM
4156720	MAX C	1/26/17 7:30 AM	1/26/17 8:00 AM
4157978	MAX C	1/26/17 8:45 AM	
4277007	MAX C	1/26/17 10:00 AM	1/26/17 10:45 AM
4277008	MAX C	1/26/17 11:30 AM	
4161217	MAX C	1/26/17 3:00 PM	1/26/17 3:30 PM
4162219	MAX C	1/26/17 4:15 PM	
4156863	MIGUEL G	1/26/17 8:00 AM	1/26/17 9:00 AM
4158729	MIGUEL G	1/26/17 11:00 AM	
4159295	MIGUEL G	1/26/17 12:30 PM	1/26/17 1:15 PM
4159944	MIGUEL G	1/26/17 2:00 PM	
4156634	TYLER N	1/26/17 7:30 AM	1/26/17 8:30 AM
4157959	TYLER N	1/26/17 8:45 AM	1/26/17 9:45 AM
4161621	TYLER N	1/26/17 3:30 PM	

Gmail

Teresa Brasure <terebras@gmail.com>

Pick up times per Veyo

4 messages

Teresa Brasure <terebras@gmail.com> Tue, Jul 26, 2016 at 8:08 PM
To: Sara - Medicaid Stith <stiths@dhw.idaho.gov>, "Boyle, Dori - Medicaid" <BoyleD@dhw.idaho.gov>

I am really having issue's with Veyo's CSR's who call and dictate pick up times for participants. Participants are told to be ready 60 minutes prior to their appointments and pick up times are designated in the dashboard anywhere from 1 hour before before the appointment to 30 minutes, as well as actual appointment times. My schedules are set up per appointments times, not Veyo pick up times, Idaho Falls is not Tuscon, Arizona or even Boise, Idaho traffic. You can pretty much get anywhere in this town in 20 minutes. I know almost every participant we drive and can most often confirm every appointment. I have built my reputation with facilities and participants in regards to this exact scenario, I only schedule reasonable transportation time for participants, and I don't drop off anyone earlier than 15 minutes before their appointments, 90% are usually only 5 to 10 minutes early. I have never scheduled any participants 59 minutes early for pick up in the last 5 years of doing transportation in Idaho Falls and I run anywhere from 150-180 trips per day. As you can see from my attachment, majority of trips I have confirmed are under 6 miles, it's an unreasonable expectation that I would pick any participant up 59 minutes before their appointment for a 4 to 5 miles trip, even 45 minutes early, a 2 mile trip doesn't need 30 minutes transportation time etc etc. I also don't recall designated pick up times per the agreement I signed with Veyo, and when previous questions to pick up times were brought up (see attachment, Question 12) with Veyo their answer has been completely opposite. Several CSR's have stated they're "going to report me to the supervisor" upon calling and me reaffirming to them I am not going to pick up said participant 1 hour, 45 minutes, even 30 minutes prior if it's not necessary. For example today this situation happened, appointment was at 3:30 and I scheduled participant at 3:10 per attachment the trip would take approximately 13 minutes to complete for an almost 6 mile trip, driver had no other pick up in between and was instructed to not pick up until 3:10 giving the driver 20 minutes to get the participant on time to his appointment, traffic is slower at this this time of day and US 20 BUS is a direct connector to Lincoln Rd which is the route the driver took. I stated multiple times to the CSR that it would not take 45 minutes, even 30 minutes to get the participant there, on time. Participant was signed in at 3:26 pm, hardly any wait time for the minor child or facility we're leaving participant at. I take into consideration every day, peak traffic times, dead times, current construction in our area, the participant needs even the particular driver before assigning trips, I don't accept rides I can't deliver on time with a reasonable expectation of transportation time with all variables considered, I also know where every driver is at any given time and match routes if there should happen to be a deviation I didn't fore see, a special needs client who is having a rough day for example, that I cannot divert said driver. My driver's are also not amateurs, many have been in this field for over 5 years, and I have built my team very meticulously and all can deliver to my company standards. I also drive, 3 quarters of the day so I know whats going on in the area at all times, meet all new participants that I accept blanket rides for so I can schedule them accordingly. The CSR's in California and Arizona are not familiar with this area, they are basing everything off what a computer tells them.

Teresa Browning
En Route Transportation, Owner
(208) 227-6329
enrouteidahofalls@gmail.com

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3 attachments

Google map.docx
193K

Q and A from Veyo.docx
113K

ConfirmedTrips_2016-07-26.xlsx
13K

Stith, Sara - Medicaid <StithS@dhw.idaho.gov> Wed, Aug 3, 2016 at 10:26 AM
To: Teresa Brasure <terebras@gmail.com>, "Boyle, Dori - Medicaid" <BoyleD@dhw.idaho.gov>

Teresa,

Our understanding from Veyo is they encourage providers to build their manifests based on the appointment times rather than the suggested pick up times generated in the provider portal. The Veyo system does add a suggested pick up time to ensure participants are ready when the provider arrives however you are not required to build your manifest around these suggested times.

Veyo is working with the call center agents to ensure consistent communication is occurring. Please let us know if you have additional questions.

Sara Stith

Grants/Contracts Management Supervisor

Medical Care Bureau

Division of Medicaid

Idaho Dept of Health & Welfare

P:208.287.1173

F:208.332.7280

From: Teresa Brasure [mailto:terebras@gmail.com]
Sent: Tuesday, July 26, 2016 8:09 PM
To: Stith, Sara - Medicaid; Boyle, Dori - Medicaid
Subject: Pick up times per Veyo

[Quoted text hidden]

NOTICE: THIS ELECTRONIC MESSAGE TRANSMISSION CONTAINS INFORMATION WHICH MAY BE CONFIDENTIAL OR PRIVILEGED. THE INFORMATION IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL(S) OR ENTITY(IES) NAMED ABOVE. IF YOU ARE NOT THE INTENDED RECIPIENT, PLEASE BE AWARE THAT ANY DISCLOSURE, COPYING, DISTRIBUTION, OR USE OF THE CONTENTS OF THIS INFORMATION IS PROHIBITED. IF YOU HAVE RECEIVED THIS ELECTRONIC TRANSMISSION IN ERROR, PLEASE IMMEDIATELY NOTIFY THE SENDER AND DELETE THE COPY YOU RECEIVED.

Gmail

Teresa Brasure <terebras@gmail.com>

Veyo Portal Admin

5 messages

Luke Boehland <lboehland@veyo.com> Fri, Jun 17, 2016 at 8:52 AM
Bcc: terebras@gmail.com

Good morning,

We are almost ready to activate your Veyo Portal account!

Please provide the name of the person that will be the Portal Administrator for your company ASAP.

Thanks,

Luke Boehland

Idaho Regional Manager

8150 W. Emerald St.

Suite 170 & 180

Boise, ID 83704

208.996.0178

veyo

This email and any files transmitted with it are confidential and intended solely for the use of the individual or entity to which they are addressed. If you have received this email in error, please notify the sender.

Teresa Brasure <terebras@gmail.com> Fri, Jun 17, 2016 at 9:04 AM
To: Luke Boehland <lboehland@veyo.com>

Good morning. I will be the admin, Teresa Browning, but will I be able to add user's? Also, I've had several calls about credentialing, I spent 3.5 hours with David at the Hilton last Saturday the 11th doing vehicles and copying 238 pages of required documents, policies and procedures, business documents, employee files to be told yesterday they don't have

any of it. Emailed my W-9 and National Provider ID # on Tuesday which they also have not received. This contains personal information including all my drivers personal info. Can I get confirmation it was received?

[Quoted text hidden]

Luke Boehland <lboehland@veyo.com> Fri, Jun 17, 2016 at 9:13 AM
To: Teresa Brasure <terebras@gmail.com>

Hi Teresa,

My understanding is that the admin will use the email address listed as the login, and you can setup a password. I'm not sure on the additional users at this point.

I will check with David and what email address did you send the other information into?

Luke Boehland

Idaho Regional Manager

[redacted]

8150 W. Emerald St.

Suite 170 & 180

Boise, ID 83704

208.996.0178

veyo

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From: Teresa Brasure [mailto:terebras@gmail.com]
Sent: Friday, June 17, 2016 9:05 AM
To: Luke Boehland <lboehland@veyo.com>
Subject: Re: Veyo Portal Admin

[Quoted text hidden]

Teresa Brasure <terebras@gmail.com> Fri, Jun 17, 2016 at 9:18 AM
To: Luke Boehland <lboehland@veyo.com>

Providersupport@Veyo.com

[Quoted text hidden]

Luke Boehland <lboehland@veyo.com> Fri, Jun 17, 2016 at 1:40 PM
To: Teresa Brasure <terebras@gmail.com>

Hi Teresa,

I checked with David and he has all your documents you provided to him and we have updated our records accordingly.

We do still need a copy of your Insurance Acord. Do you have that available?

Thanks,

Luke Boehland

Idaho Regional Manager

[redacted]

8150 W. Emerald St.

Suite 170 & 180

Boise, ID 83704

208.996.0178

veyo

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rom: Teresa Brasure [mailto:terebras@gmail.com]
Sent: Friday, June 17, 2016 9:18 AM
To: Luke Boehland <lboehland@veyo.com>
Subject: RE: Veyo Portal Admin

[Quoted text hidden]

Gmail

Teresa Brasure <terebras@gmail.com>

Fwd: Drivers

7 messages

William Brown <wbrown@veyo.com> Fri, Oct 14, 2016 at 3:08 PM
To: terebras@gmail.com

——— Forwarded message ———
From: **William Brown** <wbrown@veyo.com>
Date: Fri, Oct 14, 2016 at 1:11 PM
Subject: Re: Drivers
To: Teresa Brasure <enrouteidahofalls@gmail.com>
Cc: Jaime Deal <jdeal@veyo.com>

I apologize for both my initial email and the delayed response. I was able to find a significant portion of the rest of your driver documents. They just weren't where I was expecting them to be.

That said, we are still missing various documentation for all your drivers. Also, the driver roster we have on file currently lists 7 active drivers. Who is the 8th? I have credentialing paperwork for a Jared Taylor and Tonya Sistruck. Is one of them the 8th?

Here is a list of what we are currently missing for each driver as of now:

Elmo Allen: Background check, CPR/First Aid.
Lori Bateman: CPR/First Aid, Veyo Compliance letter
Mark Browning: Veyo Compliance letter, Defensive Driving Certificate, Motor-vehicle report.
Phillip Howard: Motor-Vehicle Report, Veyo Compliance letter.
Rick Castro: Motor-Vehicle Report, Veyo Compliance letter.
Sally Cherry: Motor-Vehicle Report, Veyo Compliance letter.
Teresa Browing: Defensive driving cert, Motor-vehicle report, Veyo-Compliance letter.

We also need En Route's Disclosure of Ownership form filled out. I have attached that form as well as a blank Veyo Compliance letter to this email.

Please respond with all missing items included.

Feel free to reach out with any questions you may have.

Thanks!

On Thu, Oct 6, 2016 at 3:08 PM, Teresa Brasure <enrouteidahofalls@gmail.com> wrote:

> All of my drivers are active, 8 of us. I spent almost 4 hours on a Saturday with David at the Hilton Garden Inn and received an email 2 months ago confirming all documents for Rick, Sally, Phil, Lori, Mark and myself Teresa had all been uploaded, all of it. The other 2 Butch and Sioux was sent into provider support which I also still have those emails.
>
> On Oct 6, 2016 2:43 PM, "William Brown" <wbrown@veyo.com> wrote:
>
> > Hello!

I am just looking for some clarification as to how many drivers you have.

I see that you have sent in a driver roster with 7 people on it. Are they all still active because we only have credentialing paperwork for three of them.

Thanks in advance for the help.

–
Wil Brown
Provider Network Specialist
208-985-8810

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–
Wil Brown
Provider Network Specialist
208-985-8810

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–
Wil Brown
Provider Network Specialist
208-985-8810

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---

2 attachments

Disclosure_of_Ownership.pdf
442K

Driver_Compliance_Communication_Veyo_2016.docx
42K

Teresa Brasure <terebras@gmail.com> Sat, Oct 15, 2016 at 1:17 PM

To: William Brown <wbrown@veyo.com>

1 of 2 emails.. attached are copies of what I've currently gathered for you. Let me know you received both emails with a total of 11 attachments. Thanks

Teresa Browning
En Route Transportation, Owner
(208) 227-6329
enrouteidahofalls@gmail.com

DISCLOSURE:
This message is intended only for the use of the individual(s) to whom it is addressed and contains information that is privileged, confidential, and exempt from disclosure under applicable law. Any further dissemination or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone or email as listed in our signature above. This message is provided in accordance with HIPAA Omnibus Rule of 2013.

---

6 attachments

Disclosure of ownership p.1.jpg
469K

Disclosure of ownership p.2.jpg
307K

Elmo's CPR-First Aid.jpg
162K

Lori's Compliance.jpg

444K

Lori's CPR-First Aid.jpg
159K

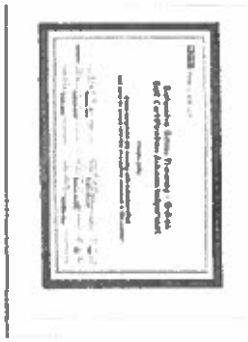
Mark's Compliance.jpg
424K

Teresa Brasure <terebras@gmail.com> Sat, Oct 15, 2016 at 1:18 PM
To: William Brown <wbrown@veyo.com>

[Quoted text hidden]

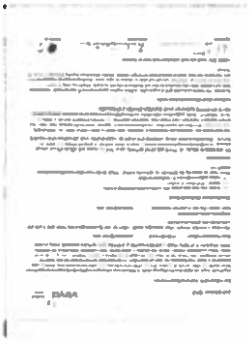
---

5 attachments

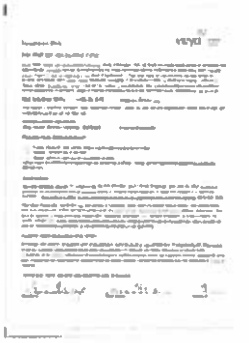


Mark's Defensive Driving.jpg
404K

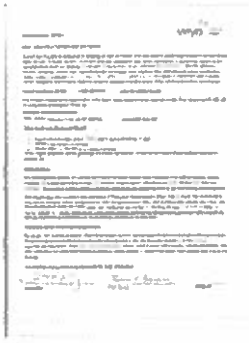
Rick's Compliance.jpg



437K



Sally's Compliance.jpg
431K



Teresa's Compliance.jpg
433K

Teresa's Defensive Driving.jpg
399K

William Brown <wbrown@veyo.com> Mon, Oct 17, 2016 at 9:57 AM
To: Teresa Brasure <terebras@gmail.com>

Thanks, Teresa!

Received and processed all 11 of those attachments.

Looks like the only thing we are still missing is a Background check for Elmo.
[Quoted text hidden]

—

Wil Brown
Provider Network Specialist
208-985-8810

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Teresa Brasure <terebras@gmail.com> Tue, Oct 18, 2016 at 10:51 AM
To: William Brown <wbrown@veyo.com>

1 attachment- insurance accord
Teresa Browning
En Route Transportation, Owner
(208) 227-6329
enrouteidahofalls@gmail.com

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16-17 GL.pdf
35K

William Brown <wbrown@veyo.com> Tue, Oct 18, 2016 at 10:58 AM
To: Teresa Brasure <terebras@gmail.com>
Cc: Jaime Deal <jdeal@veyo.com>

Excellent! do you have the one for the auto liability policy?

How about Elmo's background check?

Both those items should get you up to date.
[Quoted text hidden]
–
Wil Brown
Provider Network Specialist
208-985-8810

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Teresa Brasure <terebras@gmail.com> Tue, Oct 18, 2016 at 11:08 AM
To: William Brown <wbrown@veyo.com>

I emailed our agent because she said she sent the accord for auto on Sept 26th. Idaho criminal history unit is closed this week for training so I won't be able to speak with our contact Susan because I can't log in and she's the only one who can reset my password.

[Quoted text hidden]

Idaho | Reporters Comm

(no subject) - terebras@

Secure | https://mail.google.com/mail/u/0/#label/Veyo/159e92344b5c9b36

Google

label:veyo

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1 of 86

COMPOSE

Inbox (26)
Starred
Important
Sent Mail
Drafts (7)
Circles
Hilary
Jubilation house (7)
Personal (2)
Veyo (9)
More

Teresa

(no subject) Veyo x

Teresa Brasure <terebras@gmail.com>
to me

9:58 PM (11 minutes ago)

16 Attachments

(619) 241-4445
Good Morning! We added several trips for tomorrow whenever you have a chance to take a look. Thank you in advance!

(619) 241-4445
Good Morning. It appears that there were a few trips added into the portal for Monday whenever you have a chance to take a look.

Added a few trips for tomorrow whenever you have a moment to take a look.

Thanks

Screenshot_201...

Good Morning! I am adding a bunch of trips into the portal for tomorrow if you can pl take a look.

Good Morning! Would you be able to accommodate a trip for today next available pickup from Idaho Falls to Blackfoot?

Good afternoon! Do you have any more availability for trips for tomorrow?

We have taken everything we possibly can for tomorrow

Good evening! Do you have any more availability for tomorrow?

Somebody told you had some vehicles down so I wasn't sure. Sorry about the long text as well.

(619) 241-4445
Do you have more availability for to

(619) 241-4445
I added way too many trip for tomorrow if you can p take a look as soon as you have a moment

I'm adding some stuff for Monday but we still have quite a few trips for tomorrow so I'm sure there will be more

(619) 241-4445
Added a few more for tomorrow if you can take look whenever you have a moment

Screenshot_201...

Do you have any more availability for tomorrow?

because I just added quite a

Good evening! Would you have any more availability for trips tomorrow?

No Hangouts Contacts
Find someone

Click here to Reply or Forward

(619) 241-4445 1/14/17 10:31 AM

Good Morning. It appears that there were a few trips added into the portal for Monday whenever you have a chance to take a look.

(619) 241-4445
Mobile

MESSAGES PHOTOS & VIDEOS eGIFT CONTACTS

Good evening! Do you have any more avialability for tomorrow?

(619) 241-4445 10/19/16 6:26 PM

Somebody said you had some vehicles down so I wasnt sure. Sorry about the late text as well.

(619) 241-4445 12/19/16 7:52 AM

Good Morning! I am adding a bunch of trips into the portal for tomorrow if you can plz take a look.

Me 12/19/16 8:21 AM

Ok thanks, currently driving but as soon as I'm done.

(619) 241-4445 12/19/16 8:21 AM

Alrighty, thank you ☺

Google

Gmail

Click here to enable desktop notifications for Gmail. Learn more Hide

Inbox (26)
Starred
Important
Sent Mail
Drafts (7)
Circles
Hillary
Jubilation house (7)
Personal (2)
Veyo (9)
More

Teresa

(no subject) Inbox

Teresa Brasure <terebras@gmail.com> 10:03 PM (0 minutes ago)

17 Attachments

(619) 241-4445
Good Evening! It looks like there were a few more trips added into the portal for Monday whenever you have a chance to take a look.

(619) 241-4445
Good Afternoon! I add few more trips into th portal for tomorrow

(619) 241-4445
Hey we added a few mor trips for Monday if you c take a look whenever you have a moment

(619) 241-4445
Would you be availabl take some more trips Monday?

(619) 241-4445
We sent them over they are out of your service area again if you can plz take a look and see what you can do. We need help again :D

(619) 241-4445
Good Morning, It appears that there were a few trips added into the portal for Monday whenever you have a chance to take a look.

(619) 778-6986
It's like Christmas fo Monday I sent over 7 thank you again

(619) 778-6986
How Are we looking fo tomorrow? Can we tak more trips?

(619) 778-6986
Ok I added a few for tomorrow

(619) 778-6986
Hello, do you think you take more trips for tomorrow?

(619) 778-6986
Hello, I have assigned a fe more trips for tomorrow your portal Can we take a look please? Thank you!

(619) 778-6986
I added a few mor tomorrow.

(619) 778-6986
Hello, I added a fe trips for tomorro

Click here to Reply or Forward

No Hangouts Contacts
Find someone

1.31 GB (8%) of 15 GB used
Manage

Terms - Privacy

Last account activity: 0 minutes ago
Details

Reply-To: Provider Support <providersupport@veyo.com>
To: terebras <terebras@gmail.com>

##- Please type your reply above this line -##

Aaron A. (Veyo)
Nov 16, 11:38 MST

Hello,

After looking into these trips, I can see that they were auto-confirmed by the system after being assigned to you.
This generally happens for two reasons. This can occur when "Auto-Accept" is enabled for a specific member on the provider's portal, or it can occur when trips are confirmed by a provider and then revised.

In order to prevent this from happening with future trips you must verify that member JACQUELYNN MARTINEZ does not have "Auto-Accept" enabled. If "Auto-Accept" is not enabled for this member then this issue might be due to a revision to an accepted trip. If this was the case you should have received a call from either our call center or command center about the revision.

Please let me know if there is anything else I can help you with.

Thank you,

Aaron Anderson

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terebras
Nov 16, 11:14 MST

[Quoted text hidden]

Attachment(s)
ConfirmedTrips_ConsolidatedAddresses-2016-11-16-012721.xlsx
Excel Document 012721.docx

RE: Health and Welfare Programs

Chairman Heider, Vice Chair Souza, and Esteemed members of the health and welfare committee.

Good Morning and Thank you for giving me the opportunity to speak today.

My name is Vanessa Johnson, I have worked in our community serving our citizens who have been diagnosed with a severe mental illness for the past 10 years, currently I am the director of community based services at Access Behavioral Health and I am a graduate student at Simmons College.

I come to you today due to concerns regarding individuals accessing needed treatment and the barriers in place that place those in need at risk. I have obtained consent to share a few stories.

Veyo is the contracted nonemergency transport

1. Veyo driver drove by their home 3-4 times not stopping, individual called driver to tell them they were ready for pick up, veyo driver told the individual they had cancelled transportation and argues to pick them up. Veyo driver finally agrees to pick individual up with their small child. Individual witnesses veyo driver participating in a drug deal over the phone on the way.

2. Veyo driver picks up individual from an appointment, veyo driver speeds through traffic while texting on cell phone. Again a small child is also in the car.

3. Individual calls veyo the day before to confirm transportation to a doctor appointment for an injury from falling on the ice. Veyo never arrives for appointment, individual calls to find out

why, individual is told she has no ride and is scheduled to take the bus, individual was injured from fall and never received a bus pass.

4. Individual missed 3 medication management appointments in a row, veyo drivers either did not arrive at all, or individual was told there were no driver to get them despite confirming transportation.

5. Veyo driver arrived over 1 hour early, individual asked driver to wait while they gather their belongings not expecting them that early, individual took less than 5 minutes, when they went back out veyo was gone, individual called veyo and was told the driver waited 45 minutes so they left.

I witness individuals every day waiting for hours in my lobby, a 15 minute appointment can easily become an all-day event, if they ever make it to their appointment. Missed appointments have resulted in preventable crisis, emergency room visits, hospitalizations, police involvement, relapse, and delayed recovery. Individuals actively participating in treatment is known to decrease the impact of mental illness and our current transportation system is a barrier. It is under staffed, uneducated on mental health, and underfunded.

The impact on this does not just effect the individuals in need of treatment , but effects local businesses. My office receives 16-20 calls from veyo every hour, asking individuals to come out for their ride. You may ask why the individuals were not outside waiting, please remember they have been waiting for hours for someone to arrive. This increases the need of administrative staff to simply answer the phones.

Transportation is one piece of a larger puzzle that is placing our citizens who live with a mental illness at an even greater disadvantage to receive the needed treatment, at the needed intensity and level of care.

Cuts from mental health treatment, the closures of group homes due to funding limitation, and transportation combined has resulted in a surplus of hospitalizations. When a serious mental health crisis occurs individuals are waiting in the hospitals for a bed in the psychiatric hospital, once there, if needed, they wait even longer for a bed at one of our state hospitals. The state hospitals are so full their stays are short and individuals are prematurely discharged back to the community. The same community that was unable to meet their needs in the first place. This is a revolving door which needs to end.

Please be consciousness in your decisions that cutting costs to services and programs that support recovery costs our citizens, not just in quality of life, but monetarily with higher cost emergent care.

Thank you for your time,

Vanessa Johnson

vanessa@accessbhs.com

608-0237

Testimony to Joint Health and Welfare Committee on January 27, 2017

Subject: Transition to new service providers for Adults with Developmental Disabilities

Submitted by: Doug Loertscher, 10270 W. La Hontan Dr., Boise ID 83709

Home: 658-1707, Cell: 250-4561, Email: Doug.L@starrfbh.com

I would like to thank you for the opportunity to share some experiences and give feedback on the transition to two new service providers that serve the adults with developmental disabilities population. The two new service providers are: Liberty Healthcare Corporation – provides developmental disability assessments and Veyo- provides non-emergency medical transportation. I own a company called unBefuddled. unBefuddled provides Targeted Service Coordination for adults that have a developmental disability. We provide these services to adults throughout the Treasure Valley and have experienced some very concerning things recently with these two companies. I have had private conversations with many of you and I know you have a sincere desire to make this work for all of the parties involved. I appreciate your service and also look forward to the day when we can simply go about the business of helping those at risk. I will begin by explaining some of the processes and then address my ongoing concerns.

Liberty Healthcare Corporation

The process of seeking services and determining eligibility can be somewhat daunting, especially for those that have been diagnosed with a developmental disability and/or their guardian. I will attempt to simplify these steps in order for you to better understand the process.

Step 1 – Complete an *Eligibility Application for Adults with Developmental Disabilities* and gather all supporting documents that "prove" your disability. Submit this packet to DHW.

Step 2 – Application gets reviewed by Department to determine Medicaid eligibility. If applicant is actively on Medicaid, then the application gets forwarded to Liberty Healthcare for an assessment.

Step 3 – Liberty does a prescreening of application to determine if all paper work is included in application. If not, the individual is contacted to request missing paperwork and resubmit. If all is in place, the application gets moved forward to a scheduler.

Step 4 – The scheduler will contact the applicant and schedule an assessment with an assessor.

Step 5 – The applicant, and usually their guardian or caregiver, will meet with the assessor for 1-2 hours.

Step 6 – Assessor has 30 days to write the assessment. Based on the finding of the assessment, a level of service eligibility will be determined: State Plan or DD Waiver. This will also determine the amount of the applicant's annual budget. Once it is complete they will send it to the applicant or to the plan developer if one has been identified.

Step 7 – Applicant must find and identify a plan developer if they have not done so already.

Step 8 – Plan developer coordinates all the service providers that will be providing services for the applicant. A meeting is held and the team develops the plan for the upcoming year. As part of the plan they will determine how the annual budget will be spent.

Step 9 – Plan developer writes up the plan. Once completed they forward it to DHW for approval.

Step 10 – An assigned Care Manager has 30 days to approve the plan. Once the plan is approved it is returned to the plan developer.

Step 11 – Upon receiving an approved plan the plan developer becomes the "case manager" to oversee the implementation of the plan for the year. They then communicate back to all of the service providers and the applicant the approval.

Step 12 – Services begin!

In this process, there have been two potential points of "bottle necking", steps 3-5 when an assessment is completed and step 10 when the care manager approves the plan. At step 10, while the department has 30 days to approve, they rarely take that long and this historically has not been a problem. And, until about six (6) months ago, a company called the Idaho Center for Disabilities Evaluation (ICDE) completed the assessments. While this still took some time, it was not stopping the process. On approximately July 27, 2016 Liberty Healthcare Corporation (Liberty) took over as the contracted assessors and that is when the problems began.

The Concern

Prior to Liberty, the process would take about two (2) months from beginning to end. **Since Liberty took over the process has expanded to about six (6) months.** For some it has been even longer.

There are four (4) situations when an assessment is required:

1. When a child is moving from children's services to adult services,
2. When an adult is requesting services for the first time,
3. When an adult has been receiving services and their annual plan is expiring, and
4. When an adult has been receiving services, and is requesting to receive higher intensity services (move from the State Plan to the DD Waiver).

Liberty has no internal process to prioritize these requests or to send them down different tracks. It is as if the applicants must all wait in a line and if any questions come up you go to the back of the line and must wait until you reach the front again.

Currently in Region 3 Liberty has only recently begun the step 3 process for individuals that submitted their application at the end of October. This means these individuals may not finally start receiving their services until sometime at the end of March, April, or possibly May.

The Result

Individuals with disabilities are losing their services. In some cases, **this is putting some of our most vulnerable citizens at risk.**

Some real cases from my Agency.

Jon is an individual that moved to Idaho from another State so is requesting services for the first time. He submitted his application on July 27, 2016, the first day for Liberty. Liberty was already behind when they started because ICDE had not been processing new applicants for the last month of their contract, instead they were focused on completing annual assessments to ensure individuals were able to continue receiving services. As a result, Liberty did not review Jon's application until September. At this time, they requested additional documents from Jon. When he went to submit these requested documents, they could not find his application and so he had to submit another one. Instead of moving him to the front of the line he went to the end and so stands on October 24, 2017, the day the sent the new application. As of Today, January 26, 2017 Jon still has not been assessed. It has been six (6) months and Jon has only completed Step 3 of the process.

Steve is an individual that has been receiving services in Idaho and within the last month completed his annual assessment. This assessment determined that he qualified for the DD Waiver services (higher intensity, larger budget). However, at the plan meeting Steve and his parents declined to receive the increased services and higher budget because he lives with them and they feel like they are able to meet his needs with the lower level of support. The only thing Steve wants to do is get a job. That plan was developed and submitted to DHW. They moved him back to State Services and approved the plan. Well, less than a week ago, Steve found a job at Uhaul cleaning the returned trucks. Steve and his parents are now requesting he receive a DD Waiver, in order to receive community supported employment. Even though he was just assessed and approved for these services within the past month, since he technically is on the State Plan, this would be a step up. Because of this, he will go to the end of the line and wait to be reassessed. In the meantime, he will likely lose his job because he will not have the job support.

When these cases and these types of concerns are brought to the attention of Liberty they pass blame to ICDE saying that because of their practices, Liberty began the process behind. They also blame the Department saying they are not funded sufficiently to staff what would be necessary to process the number of applications they receive.

The bottom line is that Liberty is getting further and further behind and the adults in Idaho that need these services are losing out!

Request

What can you do as Legislators? Put pressure on the Department's contract managers to do their job and oversee this contract. Have them review Liberty's practices, audit their time lines, hold them accountable. And, if they truly are not funded sufficiently, grant emergency funding to contract other assessors to get the back log cleaned out.

Veyo

Currently is the contracted service provider to provide non-emergency medical transportation. This simply means they drive those that are on Medicaid and do not have their own transportation to and from their medical appointments. These trips can be set up by the individual themselves or they can be set up on their behalf by one of their medical providers. These trips can also be scheduled in advance and be reoccurring – such as transportation to a psychotherapy appointment every Thurs and 2pm. Veyo has elected to use a business model similar to Uber. That is any individual can sign up to be a driver for Veyo and then decide when, where, and how often to pick up a trip. Since Veyo took over the contract there are significantly glaring problems. Most of these problems stem from the lack of consistency – since the drivers can elect when to take a trip sometimes they will take the drop off and someone else will take the pick up. The driver may drive this week but someone else will do next weeks. There may even be trips that are not pick up. These are the problems we have seen in our Agency:

1. Transportation scheduled in advance but no one picks up the trip so they miss their appointment. This may impact eligibility for others services as well, such as, no assessment means they don't get the services. Many of our clients have missed psychotherapy or medication management appointments due to not being picked up. This in turn impacts their eligibility for CBRS.
2. Only half of the trip performed. Last week we had a 10-year-old boy dropped off for his appointment by nobody came back to pick him up. He waited in our lobby for over 3 hours until him Mom could get off work and come and get him.
3. Dropped off at wrong locations. Another younger teen was picked up after his appointment and instead of taken to his home he was taken back to his school and dropped off. This was after school hours and after some time his mom was calling us to find out where her son was and why he wasn't home yet.
4. Another time a developmentally delayed adult was dropped off at a closed agency. They were left standing outside a locked door.
5. More and more agency time is spent trying to problem solve transportation problems and it usually means trying to find where the client ended up or trying to find a driver.

This is not working! There has got to be more oversight for this contract. These problems have been reported to both Veyo and the Department and things are not improving, in fact, since the beginning of the year things seem to have gotten worse. This is becoming dangerous and with the weather we have been having, potentially life threatening.

EMT Providers of Idaho

Hello, my name is Kleeta Newby, the owner of KDN Transportaion. I started ~~my~~ have been trans Idaho transportation from the ground up nearly 14 years ago and am truly proud with my success. I am the most requested company with the least amount of complaints. My staff and I transport a large amount of the D.D population and a large amount of the refugee population. My first concern with these two populations is they all have a story or they would not need our services. They are fragile. They do not readily trust. You must earn their trust. Friendship and trust is not based on language but kindness and consistency. When veyo took over, I lost many of my refuge clients to veyos independent drivers. The odd thing is those clients still show up on my auto accept list as I am requested as the preferred provider. But when my clients call and request KDN they are often told that I am full. This however is not the case as I am sending home my employees because there is not enough work to go around, and yet I see Veyo Independent drivers taking the clients I used to have, and should have. It pains me greatly to see my previous clients left behind for hours waiting for a ride or not ~~being~~ willing to be transported by a complete stranger. One instance in particular stands out to me in which a previous client was left waiting for hours, elderly, and ~~did not~~ had no ~~have enough~~ oxygen left in her tank. Because she had ridden with KDN in the past, she begged me to take her home, and I did even though she was not on my list. Its awful to pick up the clients on my list at a facility when I see my past clients sitting there waiting so long for ~~their designated transportation~~ a veyo driver, and knowing that I could provide a timely ride but they are not on my list. Another frustration I have is that Veyo calls me daily for an ETA on a client that I have had previously but is not on my list for the day. They insist that I am the preferred provider but the trips did not come to me on the portal. Another issue that has arisen is Veyo says that only the clients or providers can call in for transportation services. The Refugee population has interpreters that translate for them, however Veyo is not accepting their requests, and yet Veyo does not have interpreters on staff? My Second major concern is with the D.D population and the Independent drivers for Veyo. No Mom or Dad or CFH provider wants a new stranger showing up everyday. Change is difficult for most of the DD population. The previous transportation system worked, with no independent drivers. Why fix something that wasn't broken. The new system has forced many Transportation

such as counseling

companies to go out of business. My hope is that we can adjust things so everyones needs are met. THANK YOU!!

January 25, 2017

To: Idaho Legislators and the Department of Health and Welfare, Division of Medicaid

My name is Pat Osborn.

I have a 46 year old developmentally disabled daughter who receives transportation services through Idaho Medicaid. I am 81 years old and my husband is 84 and has health issues where he is not to be left alone. Our daughter has been disabled since birth. We have provided her transportation to have access to her services and work until the last few years. She has a set schedule 5 days a week, 52 weeks a year. She is to be picked up at 8:15 every morning and taken to the ARC where she is employed. She is to be picked up at the ARC at 3:30 on Monday, Tuesday, Thursday and Friday and at 4:30 on Wednesday and returned home.

Transportation has been a constant problem since Veyo took over the contract, but, I will summarize only what has happened in the last 9 weeks.

I have called Veyo 15 times in the mornings because no one had arrived or called by the scheduled pick up time.

Seven times, she was picked up around 9:00 or later which made her late for work.

Four times, she was not picked up in the afternoon.

Two times she was pick up before the scheduled time in the afternoon, requiring her to leave work early.

Five times she did not receive transportation because of weather.

Ten times she arrived home more than 30 minutes after the scheduled pick up time. (She arrived home after 4:00 on Monday, Tuesday, Thursday, or Friday or after 5:00 on Wednesday). It is less than 3 miles and 8 minutes from the ARC to our house.

Transportation was denied on 12-1-16 because Veyo said she had a vehicle registered in her name. They had only checked for first and last names and hadn't bothered to use middle names, initials, addresses or birth dates. I don't understand why a check was required in the first place because she is evaluated every year by Idaho Medicaid and they are very aware of her condition and abilities. After I was told it was an error and the issue was settled, I received 4 letters which denied her transportation on December 1st, 2nd, 6th, and 9th. The letters said transportation was denied because she "refused appropriate mode" which I don't understand. She did not refuse any mode of transportation.

JILL OSBORN

JILL IS 46 YEARS OLD & MENTALLY & PHYSICALLY HANDICAPPED. SHE HAS HYDROCEPHALUS & HAS A SHUNT IMPLANTED. SHE IS A RIGHT HEMI-PLEGIA & HAS VERY LITTLE USE OF HER RIGHT ARM. SHE WEARS AN AFO SPLINT ON HER RIGHT LEG & IS AMBULATORY. SHE USES A CANE FOR STABILITY WHICH SHE HAS TO USE WITH HER LEFT ARM & HAND. SHE IS VERY VERBAL & SOCIAL. SHE HAS BEEN GOING TO THE ARC (WHERE SHE IS EMPLOYED) SINCE SHE GRADUATED FROM SCHOOL IN MAY 1991. UNTIL JUNE 2015 (24 YRS) WE TRANSPORTED HER OURSELVES & NEVER ASKED FOR REIMBURSEMENT.

IN NOV 2012 MY HUSBAND'S COPD & ASTHMA WORSENED TO THE DEGREE THAT HE HAD TO GO ON OXYGEN FULL TIME. IN JUNE 2015 HE WAS DIAGNOSED WITH ALZHEIMER'S & WAS NO LONGER ABLE TO DRIVE. AT THIS TIME IT WAS DIFFICULT FOR ME TO CARE FOR HIM & ALSO TRANSPORT JILL TWICE A DAY, 5 DAYS A WEEK, 52 WEEKS A YEAR, SO WE REQUESTED TRANSPORTATION WITH IDAHO MEDICAID WHICH SHE QUALIFIES FOR. MY HUSBAND, GLENN, IS 84 YEARS OLD & IN 2 WKS I WILL BE 82.

THERE HAVE BEEN MANY PROBLEMS WITH HER TRANSPORTATION SINCE THE BEGINNING BUT THE PROBLEMS REALLY ESCALATED WHEN THE CONTRACT WAS CHANGED TO VEYO ON 1 JULY 2016.

I DREAD CALLING VEYO IN THE MORNINGS WHEN SHE DOESN'T RECEIVE TRANSPORTATION BECAUSE IT IS SUCH AN UNPLEASANT & TIME CONSUMING EXPERIENCE. FIRST YOU ARE TOLD TO PRESS ONE FOR ENGLISH, THEN YOU ARE TOLD THIS IS BEING RECORDED & IF YOU WANT TO CHECK ON YOUR PRIVACY RIGHTS YOU CAN GO TO THEIR WEBSITE FOR FURTHER INFORMATION. THEN YOU ARE TOLD TO PRESS ONE TO RECEIVE A CALL BACK FROM AN AGENT OR REMAIN ON THE LINE TO SPEAK TO AN AGENT. THEN IMMEDIATELY YOU ARE TOLD TO PRESS ONE TO RECEIVE A CALL BACK FROM AN AGENT OR PRESS TWO TO REMAIN ON THE LINE TO SPEAK TO AN AGENT WHEN IT'S YOUR TURN. IF YOU REMAIN ON THE LINE YOU ARE SUBJECTED TO A MESSAGE FOR IDAHO SMILES THAT PROVIDES DENTAL CARE FOR YOUNG CHILDREN. THIS IS TOTALLY IRRELEVANT TO ME & MOST OF THE PEOPLE WHO ARE RECEIVING TRANSPORTATION. NONE OF US HAVE SMALL CHILDREN. I KEPT A TALLY ON ONE CALL & LISTENED TO THE RECORDING 17 TIMES. WHEN YOU FINALLY GET TO SPEAK TO AN AGENT YOU ARE ASKED FOR THE REASON FOR THE

CALL & THEN FOR HER MEDICAID NUMBER OR BIRTHDATE, PICK UP TIME & ADDRESS. THEN YOU ARE PUT ON HOLD WHILE THEY TRY TO DECIDE WHO IS SUPPOSED TO BE THE COMPANY PICKING HER UP THAT MORNING. I'VE BEEN ON HOLD AS LONG AS 14 MINUTES. THEN THEY TELL YOU WHO THE COMPANY IS & YOU ARE PUT ON HOLD AGAIN WHILE THEY TRY TO CONTACT THE COMPANY TO SEE WHAT TIME THEY WILL ARRIVE OR IF THEY ARE GOING TO ARRIVE AT ALL. SOME AGENTS ARE NICE & TRY TO HELP BUT SOME ARE VERY RUDE. EVERY TIME YOU CALL YOU GET A DIFFERENT AGENT SO YOU HAVE TO EXPLAIN EVERYTHING EVERY TIME. IT WOULD BE HELPFUL IF YOU COULD JUST IDENTIFY YOURSELF & THEY COULD LOOK UP YOUR INFORMATION.

I AM TOLD BY IDAHO MEDICAID & VEYO THAT THE DRIVER IS SUPPOSED TO CALL IN THE MORNING & LET US KNOW WHEN THEY WILL ARRIVE. THEN WHEN THEY ARRIVE THEY ARE SUPPOSED TO COME TO THE DOOR. THIS RARELY EVER HAPPENS. WE RARELY RECEIVE CALLS & MOST OF THE DRIVERS DON'T EVEN GET OUT OF THE VEHICLE LET ALONE COME TO THE DOOR. SEEMS THERE IS A BREAK DOWN IN TRAINING SOMEWHERE.

I RECEIVED A CALL ON 12/6/16 FROM HUNTER WITH VEYO, THE QUALITY ASSURANCE DIRECTOR FOR IDAHO, WHO TOLD ME SHE WOULD TRY TO HELP WITH MY PROBLEMS. SHE GAVE ME HER NUMBER & TOLD ME TO CALL HER ANY TIME. I TALKED TO HER TWICE AFTER THAT. I LEFT A MESSAGE FOR HER ON 12/20/16 ABOUT 4:50 PM & HAVE NEVER RECEIVED A RETURN CALL.

I RECEIVED A CALL ON 12/29/16 FROM WES WITH VEYO WHO IS ON THE QUALITY MANAGEMENT TEAM. HE WAS CALLING ABOUT MY REQUEST TO HAVE GREEN ZONE AS OUR PREFERRED COMPANY. HE SAID HE WOULD CONTACT GEORGE, THE OWNER OF GREEN ZONE, & HAVE HIM CALL ME. I RECEIVED A CALL FROM GEORGE & HE TOLD ME HE WAS MEETING WITH HIS DRIVER IN 30 MIN & THEY WOULD SEE IF THEY COULD FIT JILL INTO THEIR SCHEDULE. HE SAID HE WOULD CALL ME BACK IN AN HOUR. I NEVER DID GET A RETURN CALL. IN THE 4 WKS THAT GREEN ZONE HAS BEEN OUR PREFERRED COMPANY THEY HAVE PICKED HER UP 3 TIMES IN THE MORNINGS; ONE TIME THEY PICKED HER UP 45 MINUTES EARLY IN THE AFTERNOON; ONE TIME THEY DIDN'T PICK HER UP AT ALL IN THE AFTERNOON & 4 DAYS THEY DIDN'T WORK BECAUSE OF THE WEATHER.

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NOTICE OF DENIAL DECISION

JILL OSBORN
6401 GRANDVIEW DR, BOISE, ID 83709

12/1/2016

Dear JILL OSBORN (302657)

A transportation request was made for a trip on 12/1/2016 8:15:00 AM for the above named individual.

The transportation request has been denied for the following reason:
Refused Appropriate Mode

If you disagree with the decision on this notice you may request a DHW appeal. Your request for an appeal must be received in writing by DHW within 28 days from the date this letter was mailed. To appeal this decision, please include a copy of this notice and a written statement of why you disagree with the decision. You may submit the appeal request by mailing, faxing, or emailing to the contact below:

Hearings Coordinator
Department of Health and Welfare
Administrative Procedures Section
PO box 83720
Boise, Idaho 83720-0036
Phone: 208-334-5564 FAX: 208-639-5741
E-Mail: APS@dhw.idaho.gov

Once received, DHW will review the documentation sent in with your appeal. If DHW still feels the denial was appropriate, you will be able to have a fair hearing regarding your case.

If previously approved transportation is being terminated or reduced and you request a hearing within ten (10) days of the postmark of this notice, you may continue receiving benefits until the fair hearing is held and a decision is mailed to you. If the hearing office decides that the DHW's action was correct, the transportation broker may take action to collect the cost of those benefits from you, as allowed by 42 CFR 431.230(b).

At the hearing you may represent yourself, choose a friend, relative or advocate to represent you or you may be represented by an attorney. You may contact Idaho Legal Aid at 208-336-8980 or Disability Rights Idaho at 1-866-262-3462 if you need help finding an attorney.

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NOTICE OF DENIAL DECISION

You are welcome to contact Medicaid's central office at 208-334-5747 or 877-200-5441 if you want to discuss this matter, ask any questions about the appeal process or to find out how to contact an attorney. You may also contact the office by email at MedicaidTransport@dhw.idaho.gov

Remember your fair hearing request *must* be filed by: _____
If you wish to continue your services, your request must be postmarked within ten (10) days of this letter.

Sincerely,

Rosalind Weekly
Call Center Manager

If you need help with this notice, please call 1-877-503-1261
Si usted necesita ayuda con este aviso, por favor llame al 1-877-503-1261

I RECEIVED THIS NOTICE ON 12/6/16

I THEN RECEIVED 3 MORE OF THESE LETTERS ON 12/6/16 - 12/9/16 - 12/12/16 WHICH DENIED HER TRANSPORTATION ON 12/2/16 - 12/6/16 - 12/9/16

ALL OF THESE NOTICES WERE RECEIVED AFTER I WAS TOLD THE SITUATION WAS SETTLED.

NOTES ON TRANSPORTATION FOR JILL OSBORN

PAT OSBORN (MOTHER & LEGAL GUARDIAN)
6401 GRANDVIEW DR
BOISE, IDAHO 83709
208-375-8459

JILL OSBORN
TRANSPORTATION

AM PICK UP AT 6401 GRANDVIEW DR MON – FRI 8:10

PM PICK UP AT 4402 ALBION MON - TUES - THUR - FRI 3:30
WED 4:30

AM PICK UP CHANGED ON NOV 18 TO 8:15

TSC - ISSABELL SMITH 908-9456

ARC - 343-5583

DORI BOYLE - IDAHO MEDICAID - QUALITY MANAGEMENT TEAM 364-1835

HUNTER - VEZO - QUALITY ASSURANCE DIRECTOR FOR IDAHO 1-858-225-8482

CHRISTINE PISANI 334-2178
EXECUTIVE DIRECTOR IDAHO COUNCIL ON DEVELOPMENT DISABILITIES

AM TIMES ARE WHEN SHE WAS PICKED UP AT HOME IN THE MORNINGS
PM TIMES ARE WHEN SHE ARRIVED HOME IN THE AFTERNOON

DAY	DATE	TIME	TRANS CO.	NOTES
MON	OCT 31	8:20A	EXTRA MILE	
		4:20P	EXTRA MILE	
TUE	NOV 1	8:33A	TRINITY	
		3:50P	"	
WED	NOV 2	8:20A	TRINITY	
		4:40P	"	
THU	NOV 3	8:20A	ALL CITY	
		3:40P	" "	
FRI	NOV 4	8:30A	ALL CITY	
		3:45P	" "	
MON	NOV 7	8:30A	TRINITY	
		3:50P	"	
TUE	NOV 8	8:40A	TRINITY	
		3:45P	"	
WED	NOV 9	8:52A	TRINITY	
		4:50P	"	
THU	NOV 10	8:13A	ALL CITY	
		3:40P	" "	
FRI	NOV 11	8:23A	ALL CITY	
		3:43P	" "	

DAY	DATE	TIME	TRANS CO.	NOTES
MON	NOV 14	NO ARRIVAL	I TOOK HER	CALLED VEYO AT 8:45 TO SEE WHERE TRANS WAS. ON HOLD FOR 10 MIN & THEN TOLD JILL NOT SCHEDULED FOR TODAY (SUN EVE, NOV 14, AT 5:25 I RECEIVED A CALL CONFIRMING HER TRANS FOR MON MORN) THEY ASKED IF IT WAS OK IF SHE WAS LATE FOR WORK & THEY WOULD TRY TO FIND TRANS. IT WAS NOW 9:00 AM & SHE WAS ALREADY LATE FOR WORK SO I TOLD THEM TO FORGET IT & I WOULD GET HER THERE. I ASKED IF THEY WOULD ASSURE ME THAT SHE WOULD BE PICKED UP IN THE AFTERNOON & THEY SAID YES. ABOUT 1:00 PM I RECEIVED A CALL FROM TRINITY WANTING TO KNOW IF JILL HAD BEEN PICKED UP THAT MORN. THEY SAID THEY DIDN'T RECEIVE THEIR SCHEDULE UNTIL 11:30 AM. I TOLD THEM SHE WAS AT THE ARC & THEY SAID THEY WOULD PICK HER UP IN THE AFT.
		3:40 P	TRINITY	
TUE	NOV 15	9:00 A	TRINITY	CALLED VEYO AT 8:30 TO SEE WHERE TRANS WAS. ON HOLD 10 MIN WHILE THEY CONTACTED DRIVER. WAS TOLD THEY WERE ON THE WAY. TRINITY ARRIVED AT 9:00 WHICH MEANT JILL WAS LATE FOR WORK A 2ND DAY. CALLED JILL'S TSC TO LET HER KNOW & SEE WHAT SHE COULD DO.
		4:00 P	TRINITY	
WED	NOV 16	8:30 A	IND VEYO	REC CALL FROM VEYO AT 8:07 WANTING TO KNOW IF IT WAS OK TO HAVE JILL TRANSPORTED BY AN INDEPENDANT VEYO DRIVER. I SAID YES AS LONG AS SHE GOT TO WORK ON TIME & SAFELY. THEY SAID A CAR WOULD ARRIVE IN 10 MIN. AT

				8:18 I REC CALL FROM DRIVER SAYING SHE WOULD BE HERE IN 10 MIN. ARRIVED 8:30
		4:40P	IND VEYO	
THU	NOV 17	8:00A	IND VEYO	CALL FROM DRIVER AT 7:49 SAYING WOULD ARRIVE IN 10 MIN
		4:45P	IND VEYO	
FRI	NOV 18	8:00A	IND VEYO	CALL FROM DRIVER AT 7:49 SAYING WOULD ARRIVE IN 10 MIN. I CALLED VEYO TO SEE IF WE COULD GET TIME WORKED OUT. TARGET PICK UP IS 8:10 & WE HAVE NOW GONE FROM ALWAYS BEING LATE TO NOW BEING TOO EARLY. JILL STARTS WORK AT 9:00 SO SHOULD ARRIVE ABOUT 8:50 TO BE PREPARED TO START AT 9:00. FROM HOME TO ARC IS ABOUT AN 8 MIN TRIP. IF SHE IS PICKED UP AT 8:00 SHE HAS TO SIT AT ARC ABT 50 MIN BEF WORK. DON'T UNDERSTAND WHY AN INDEPENDANT DRIVER CAN'T SCHEDULE THEIR TIME BETTER. VEYO SAID THEY WOULD CHANGE PICK UP TIME TO 8:15. I ASKED THEM TO PLEASE NOT CALL ME BEF 8:00 AM BECAUSE I'M BUSY DOING BREATHING TREATMENTS FOR MY HUSBAND AT THAT TIME.
		3:27P	IND VEYO	JILL ARRIVED HOME AT 3:27 & SHE IS NOT SUPPOSED TO BE OFF WORK UNTIL 3:30. JILL TOLD ME THAT TIFFANY CAME IN & TOLD HER THE VAN WAS THERE & SHE SHOULD LEAVE. I CALLED ARC & LEFT MESSAGE FOR TIFFANY TO CALL ME. TRIED TO REACH IAN & WAS TOLD HE WASN'T THERE. CALLED TSC & ASKED HER TO CALL VEYO & ARC & TRY TO RESOLVE THIS.

MON	NOV 21	8:08 A	IND VEYO	CALL FROM DRIVER 7:58. ETA UNKNOWN WAS BY BORAH HIGH SCHOOL AT THE TIME. ARRIVED 8:08 IN UNMARKED CAR. NO RETURN CALL FROM ARC OR TSC
		3:36 P	IND VEYO	
TUE	NOV 22	8:15 A	IND VEYO	CALL FROM DRIVER (DALE) 7:59. ETA 8:15
		3:40 P	IND VEYO	
WED	NOV 23	8:09 A	IND VEYO	CALL FROM DRIVER 7:58 - ARRIVED IN UNMARKED WHITE SEDAN. ISSABELL (TSC) CALLED AT 1:32 PM TO SEE HOW THINGS ARE GOING. SHE TALKED TO ARC & VEYO ABOUT PICK UP TIMES. TOLD ARC NOT TO RELEASE JILL BEF TIME SHE IS SCHEDULED TO BE RELEASED.
		4:40 P	IND VEYO	
MON	NOV 28	8:25 A	IND VEYO	CALL FROM DRIVER (DALE) 8:02 ETA 8:20
		3:38 P	IND VEYO	
TUE	NOV 29	8:19 A	IND VEYO	CALL 8:01. ETA 15 MIN. ARRIVED 8:19 IN WHITE UNMARKED TOYOTA SEDAN
		3:48 P	IND VEYO	
WED	NOV 30	8:12 A	IND VEYO	CALL 8:08. ETA 5 MIN
		4:45 P	IND VEYO	
THU	DEC 1	9:10 A	IND VEYO	CALLED VEYO 8:30. TALKED TO SHEINA. WAS TOLD JILL'S TRANS WAS DENIED BECAUSE THERE IS A VEHICLE REGISTERED IN HER NAME. I ASKED WHERE THIS INFO CAME FROM. I WAS

			TOLD THIS IS A NEW REQUIREMENT BY THE STATE OF IDAHO. VEYO IS REQUIRED TO CHECK EVERYONE TO SEE IF THEY HAVE A VEHICLE REGIS TO THEM. I WAS THEN GIVEN A LECTURE ON PEOPLE WHO CHEAT THE SYSTEM. I EXPLAINED JILL'S CONDITION & EXPLAINED THAT SHE NEVER OWNED A VEHICLE OR HAD A DRIVERS LISCENSE & THAT IDAHO MEDICAID SHOULD HAVE ALL THAT INFO. I WAS THEN TOLD I WOULD NEED TO CONTACT JILL'S DOCTOR & HAVE HER WRITE A LETTER SAYING JILL COULDN'T DRIVE. I WAS THEN TOLD SHE WOULD TRY TO FIND TRANS FOR JILL. (ON PHONE WITH SHEINA 25min) AT 8:49 (WHILE I WAS ON THE PHONE WITH SHEINA) A VOICEMAIL WAS LEFT WANTING TO KNOW IF JILL NEEDED TRANS & TO CALL BACK BUT NO # WAS GIVEN. I CALLED SHEINA BACK TO REPORT THIS & SHE CONTACTED THE DRIVER. CAR ARRIVED AT 9:10. LATE FOR WORK AGAIN! TRIED TO CONTACT TSC. ANS MACH. DIDN'T LEAVE MESSAGE. CALLED SARA STITH (ID MED) AT 9:12 & LEFT MESSAGE. CALLED TSC 9:23 & LEFT MESSAGE TO CALL ME. LEFT ANOTHER MESSAGE FOR SARA STITH AT 1:08. LEFT ANOTHER MESSAGE FOR ISSABELL AT 1:14. CALLED BOTH ASPIRE & BARBIE AT 1:20 & ONLY GOT ANS MACH. LEFT MESSAGE FOR BARBIE AT 1:26. REC CALL FROM TSC AT 1:32.
	3:44	IND VEYO	

FRI	DEC 2	8:05	VEYO	CALL 7:59 ETA 5 MIN LEFT MESSAGE FOR SARA STITH 8:55 REC CALL FROM DORI BOYLE (ID MED) 10:52 CALL ENDED 11:17. SHE WAS RETURNING CALL I MADE TO SARA STITH. SHE IS ON QUALITY MANAGEMENT TEAM FOR THE TRANS. WE DISCUSSED THE VEHICLE & REGIS SITUATION & OTHER PROBLEMS & SHE SAID SHE WOULD LOOK INTO ALL MY PROBLEMS. LEFT MESSAGE FOR ISSABELL AT 11:28 CALL FROM ISSABELL AT 12:39
		3:42	VEYO	
MON	DEC 5	8:06	VEYO	CALL 7:59 - DIDN'T KNOW WHEN HE WOULD BE HERE BECAUSE HE "DIDN'T KNOW WHERE WE BE LIVING" MAYBE TAKE ABT 10 MIN
		3:47	VEYO	
TUE	DEC 6	8:30	VEYO	CALL 8:00 (DALE) ETA 8:30 REC CALL FROM HUNTER AT VEYO AT 12:48 ABT MY COMPLAINT. I EXPLAINED ALL MY CONCERNS. SHE TOLD ME THE VEHICLE PROBLEM WAS AN ERROR ON THEIR PART. THE PERSON WHO DID THE CHECKING ONLY USED FIRST & LAST NAMES & DIDN'T USE MIDDLE NAMES, INITIALS ADDRESS OR BIRTHDATE. TOTAL INCOMPETENCE! SHE TOLD ME SHE WOULD MAKE A NOTE THAT JILL QUALIFIES FOR TRANS & I WOULDN'T HAVE TO SUBMIT ANY PAPERWORK. BIG OF THEM! CALL LASTED 37 MIN 52 SEC. LOTS OF BACKGROUND NOISE & DIFFICULT TO HEAR HER. (SHE HAD

				ASKED IF SHE COULD TAPE THE CONVERSATION & I AGREED SO THERE SHOULD BE A RECORD). I RECEIVED 2 LETTERS FROM VEYO ON "NOTICE OF DENIAL DECISION" SAYING SHE WAS DENIED TRANS ON 12-1 & 12-2 & THE REASON WAS "REFUSED APPROPRIATE MODE". I DIDN'T UNDERSTAND THE LETTERS SO TRIED TO CONTACT HUNTER. GOT ANSWERING MACH & LEFT MESSAGE ABT 2:00. CALLED ID MED AT 3:05 & LEFT MESSAGE.
		3:38	VEYO	
WED	DEC 7	8:33	VEYO	CALL 8:00 (DALE) ETA 8:25-8:30
		4:47	VEYO	← UNMARKED WHITE CAR
THU	DEC 8	8:12	VEYO	CALL 7:59 ETA 10 MIN - UNMARKED WHITE OR SILVER TOYOTA - I ASKED HIM WHY HIS CAR WAS NOT MARKED & HE GOT OUT THE SIGN & PUT IT ON. MESSAGE LEFT BY DORI BOYLE 9:11. CALLED HER BACK & LEFT MESSAGE ABT 2:30. CALLED ARC AT 4:15 & JILL STILL THERE. CALLED VEYO 4:16 - ON HOLD 8 MIN THEN TOLD DRIVER EN ROUTE. THEY SAID THEY HAD A PICK UP TIME OF 4:17 BUT COULDN'T EXPLAIN WHY. I REC VOICEMAIL FROM ARC AT 4:17 WHILE I WAS ON PHONE WITH VEYO. I RETURNED CALL AT 4:30 & TALKED TO TIFFANY. SHE SAID SHE HAD CALLED VEYO A LITTLE AFTER 4:00 & WAS TOLD THEY COULDN'T GET SOMEONE THERE FOR AN HOUR SO IAN WOULD

				BRING JILL HOME. REC CALL FROM IAN AT 4:42 SAYING HE WAS BRINGING JILL HOME
		5:15	ARC STAFF	ARRIVED 5:15
				REC CALL AT 7:38 PM FROM HUNTER AT VEYO SAID I CAN DISREGARD LETTERS FROM VEYO. DISCUSSED NO ONE ARRIVING FOR PICK UP THIS AFTERNOON & SHE BLAMED IT ON THE WEATHER. TOLD HER NOT A GOOD EXCUSE. THEY SHOULD HAVE DRIVERS WHO CAN DRIVE IN THIS WEATHER BECAUSE WINTER IS JUST STARTING & WE HAVE ANOTHER 2 OR 3 MONTHS OF THIS. BESIDES ARC STAFF WAS ABLE TO GET HER HOME & THEY'RE NOT PAID FOR IT. TOLD HER ABT UNMARKED CARS. CALL ENDED ABT 8:13 (36 MIN 13 SEC)
FRI	DEC 9	8:16	VEYO	CALL 7:59 - NO ETA - JUST COMING REC. CALL FROM DORI BOYLE 10:36. I EXPLAINED MY PROBLEMS & SHE SAID SHE WOULD SEE IF THE MANAGEMENT TEAM COULD RESOLVE THEM. (CALL ENDED 10:55)
		4:12	VEYO	DIDN'T GET HOME UNTIL 4:12 BUT DRIVER JAIMIE WALKED HER TO THE DOOR. REC ANOTHER LETTER FROM VEYO SAYING SHE WAS DENIED TRANS ON 12/6 BUT SHE RECEIVED TRANS THAT DAY
MON	DEC 12	8:05	VEYO	CALL 7:55 WHEN I ASK FOR ETA HE SAID HE DIDN'T KNOW - HE WAS BY BORAH HS & DIDN'T KNOW HOW LONG IT WOULD TAKE
		4:12	ARC STAFF	CALLED ARC AT 4:15 & WAS TOLD THEY CONTACTED VEYO & WAS TOLD THAT VEYO TRIED

				TO CALL THE ARC & WAS NOT ABLE TO TALK TO JILL TO VERIFY SHE WAS THERE SO THEY TOOK HER NAME OFF THE LIST.
				I CALLED HUNTER AT 4:25. SHE DIDN'T KNOW WHAT HAPPENED BUT SAID SHE WOULD INVESTIGATE IT. SHE SUGGESTED I CALL THE CALL CENTER TO SEE IF THEY COULD TELL ME WHAT HAPPENED (CALL ENDED 4:41)
				TALKED TO LAURIE AT CALL CENTER AT 4:42. SHE SAID JILL WAS SUPPOSED TO BE PICKED UP AT 3:30 BUT FOR SOME REASON THE TRIP WAS CANCELLED. SHE DIDN'T KNOW WHY. I EXPLAINED THAT THINGS WERE GETTING WORSE INSTEAD OF BETTER BUT SHE DIDN'T HAVE ANY ANSWERS. CALL ENDED 5:04 (22m 73s)
				REC ANOTHER LETTER FROM VEYO SAYING SHE WAS DENIED TRANS ON 12/9 BUT SHE RECEIVED TRANS THAT DAY.
TUE	DEC 13	8:10	VEYO	CALL 8:00 ETA 5MIN
				LEFT MESSAGE FOR DORI BOYCE ABT 9:15
				LEFT MESSAGE FOR ISSABELL ABT 9:16
				I PICKED UP JILL AT 3:30 FOR APPT WITH TONI SPARKS
				NO RETURN CALLS FROM DORI OR ISSABELL
WED	DEC 14	8:10	VEYO	CALL 8:00 COULDN'T UNDERSTAND ETA
				LEFT MESSAGE FOR DORI BOYLE 9:13
				CALLED ISSABELL AT 9:15. SHE WAS OUT OF TOWN. EXPLAINED WHAT WAS GOING ON & SHE SAID SHE'D CALL ME NEXT WEEK.
				DORI BOYLE LEFT VOICE MAIL WHILE I WAS ON

				PHONE WITH ISSABELL. CALLED DORI AT 9:28 & EXPLAINED WHAT WAS GOING ON. WE TALKED ABOUT TRYING TO GET A PREFERRED DRIVER & SHE SAID SHE WOULD SEE WHAT SHE COULD DO. SAID SHE WOULD DISCUSS MY PROBLEMS WITH MANAGEMENT TEAM. CALL ENDED 9:53 (25 MIN 51 SEC)
		4:43	VEYO	NICE DRIVER - WALKED HER TO THE DOOR
THU	DEC 15	8:25	VEYO	CALL 8:01 (DALE) ETA 8:25 I PICKED HER UP AT 3:30 FOR DENTIST APPT
FRI	DEC 16	8:06	VEYO	CALL 7:55 ETA 9 MIN - CALL 8:04 SAYING HE WAS OUT FRONT BUT I LOOKED OUT & DIDN'T SEE HIM. I TOLD HIM HE WASN'T OUT FRONT & HE ARGUED HE WAS. I WENT OUT FRONT & TOLD HIM I WAS STANDING THERE & HE WASN'T THERE. I THEN WALKED OUT TO THE STREET & NOTICED A CAR IN FRONT OF A HOUSE ABT 1 1/2 BLKS TO THE WEST. I WAVED MY ARMS TO GET HIS ATTENTION & TOLD HIM HE WAS AT THE WRONG HOUSE. HE WAS IN A GOLD UNMARKED NISSAN. I PICKED HER UP AT 3:30 FOR DR APPT
MON	DEC 19	8:14	VEYO	NO CALL - ARRIVED 8:14 - I WAS ON PHONE WITH VEYO AT THE TIME. I HUNG UP & WENT OUT TO TALK TO DRIVER. HE TRIED TO AVOID ME & WOULDN'T MAKE EYE CONTACT. I ASKED WHY HE DIDN'T CALL TO SAY HE WAS COMING & HE SAID WHEN HE GOT HERE IF SHE DIDN'T COME OUT THEN HE WOULD CALL. I TOLD HIM HE WAS

				SUPPOSED TO CALL TO LET US KNOW HE WAS COMING. CALLED VEYO AT 8:16 & FILED A COMPLAINT WITH BECKY.
		3:40	VEYO	NICE & HELPFUL DRIVER
TUE	DEC 20	8:35	VEYO	CALL 8:04 COULDN'T UNDERSTAND ETA. ASKED HIM 3 TIMES & NEVER COULD UNDERSTAND HIM. ARRIVED 8:35 UNMARKED SILVER KIA. DIDN'T STOP AT DRIVEWAY BUT STOPPED FARTHER DOWN. DIDN'T GET OUT OF CAR. RUDE WHEN I CONFRONTED HIM. CALLED VEYO TO REPORT HIM. TALKED TO SHEINA & THEN TO ESMERALDA ON THE ESCALATION TEAM.
				CALLED & LEFT MESSAGE FOR DORI BOYLE. SHE RETURNED CALL AT 10:27. SAID SHE WOULD SEND COMPLAINT TO HUNTER & TRY TO GET IT RESOLVED.
				I RECEIVED A CALL FROM JILL AT 4:12 & SHE WAS STILL AT THE ARC. TALKED TO SARAH & SHE SAID THEY CALLED VEYO & VEYO DIDN'T KNOW WHEN THEY COULD GET SOMEONE THERE. NO ONE HAD BEEN DISPATCHED YET. I TOLD SARAH I WOULD COME & GET HER MYSELF. WHILE I WAS AT THE ARC AT 4:30 A BLACK UNMARKED CHEVIE ARRIVED & SAID HE WAS THERE FOR JILL OSBORN. SARAH TOLD HIM I WAS PICKING HER UP. I ASKED HIM WHERE HE HAD BEEN THAT SHE WAS SUPPOSED TO BE PICKED UP AT 3:30. HE SAID IT WASN'T HIS FAULT & ASKED IF I KNEW THE COMPANY. I TOLD HIM I KNOW THE COMPANY

				ALL TOO WELL. HE LEFT. I CAME HOME & LEFT A MESSAGE FOR DORI BOYLE & ONE FOR HUNTER. AT 4:55 I TALKED TO TRACY AT VEYO CALL CENTER & SHE TRANSFERRED ME TO A MAN NAMED DAP. AS USUAL HE APPOLOGIZED & TRIED TO BLAME IT ON THE WEATHER. I TOLD HIM THAT WASN'T A VERY GOOD EXCUSE BECAUSE VEYO IS IN THE TRANSPORTATION BUSINESS & THIS IS NORMAL WINTER WEATHER HERE. THEY SHOULD BE ABLE TO PLAN FOR THE WEATHER. I TOLD HIM WEATHER ISN'T RESPONSIBLE FOR UNMARKED CARS & RUDE DRIVERS. ONCE AGAIN HE STARTED IN ON THE REIMBURSEMENT ISSUE. THIS IS SOMETHING THEY HAVE BROUGHT UP SEVERAL TIMES. I EXPLAINED ONCE AGAIN THAT I AM NOT ABLE TO TRANSPORT HER TWICE A DAY MYSELF & I DON'T HAVE ANYONE WHO CAN. SHE QUALIFIES FOR TRANSPORTATION & I'M GOING TO INSIST SHE GET IT. HE TOLD ME THAT INDEPENDANT DRIVERS ARE NOT ABLE TO ASSIST HER BECAUSE OF LIABILITY. I WAS TOLD BY DORI BOYLE THAT THE DRIVER IS SUPPOSED TO COME TO THE DOOR. IT WAS APPARENT I WAS NOT GETTING ANYWHERE WITH DAP SO I TOLD HIM THAT & HUNG UP.
WED	DEC 21	8:37	VEYO	CALLED VEYO AT 8:18 TO SEE WHERE TRANS WAS. TOLD THEY DIDN'T HAVE ANYONE YET & ONCE AGAIN TRIED TO BLAME THE WEATHER. TOLD HIM IT WAS MORE LIKE POOR ORGANIZATION.

HE ASKED IF I WANTED TO SPEAK TO A SUPERVISOR & I SAID YES. I WAS PUT ON HOLD & THEN HE CAME BACK ON & SAID THERE WAS A DRIVER EN ROUTE. HE CALLED THE DRIVER & THEN TOLD ME HE WOULD ARRIVE IN 7 OR 8 MIN. CALL ENDED 8:26
AT 8:26 I RECEIVED A VOICE MAIL FROM THE DRIVER SAYING HE WOULD ARRIVE IN 9 OR 10 MIN. ARRIVED 8:37
LEFT MESSAGE FOR ISSABELL AT 9:05.
REC CALL FROM DORI BOYLE 9:08. I EXPLAINED YESTERDAY AFTERNOON PICKUP PROBLEMS & THIS MORN PROBLEMS. SAID SHE WOULD CONTACT HUNTER & SEE WHAT THEY COULD DO. SHE SAID HUNTER IS THE QUALITY ASSURANCE DIRECTOR FOR IDAHO.
CALL ENDED 9:25 (16 MIN 59 SEC)
REC CALL FROM ISSABELL 10:21. SAID SHE WOULD CALL VEYO & SEE WHAT SHE COULD DO. (CALL ENDED 10:38)
REC CALL FROM ISSABELL AT 12:53. SHE TALKED TO ESMERALDA ON THE ESCALATION TEAM AT VEYO & REGISTERED A COMPLAINT. SHE WAS TOLD A CALL IS ONLY PUT OUT 15 MIN BEF A PICKUP TIME & THEN THEY WAIT FOR A DRIVER TO RESPOND. SHE WAS TOLD THAT WE CAN CHOOSE A TRANS COMPANY BUT CAN NOT CHOOSE AN INDEPENDANT DRIVER. THEY AGAIN BLAMED THEIR PROBLEMS ON THE WEATHER. WE DECIDED TO WAIT UNTIL AFTER THE HOLIDAYS & THEN TRY TO DECIDE WHAT TO DO. CALL ENDED 1:18

4:40 VEYO

THU	DEC 22	8:08	TRINITY	CALL AT 7:21 FROM TRINITY TRANS SAYING THEY WOULD PICK JILL UP AT 8:15. CALL AT 1:30 FROM ARC SAYING JILL WASN'T FEELING WELL SO I WENT & PICKED HER UP
FRI	DEC 23			HOME SICK
TUE	DEC 27	9:08	GREEN ZONE	CALLED VEYO AT 8:15 TO SEE WHERE TRANS WAS ON HOLD FOR 9 MIN THEN TOLD THEY THOUGHT A+ WAS GOING TO PICK HER UP BUT FOR SOME REASON THEY (A+) HAD REJECTED THE TRIP. I WAS TOLD THEY WOULD TRY TO FIND SOMEONE. CALL AT 8:34 FROM AARON AT VEYO. SAID JILL HAD BEEN EXCLUDED FROM INDEPENDANT DRIVERS BUT COULDN'T TELL ME WHY. SAID GREEN ZONE WOULD PICK HER UP ABT 9:00. CALL ENDED 8:41. GREEN ZONE ARRIVED AT 9:08. I EXPRESSED MY FRUSTRATION TO THE DRIVER. SHE WAS LATE FOR WORK AGAIN. LEFT MESSAGES FOR DORI BOYLE & ISSABELL AT 9:15
		3:50	GREEN ZONE	VERY NICE & HELPFUL DRIVER. BROUGHT JILL TO DOOR. TOLD ME IF WE WERE HAVING PROBLEMS I COULD REQUEST HIS COMPANY & THEY WOULD PICK JILL UP.
				RECEIVED AUTOMATED CALL FROM VEYO AT 7:35 PM (855-611-0119) REMINDING US TO BE SURE & SCHEDULE OUR "THANKSGIVING" WEEK TRIPS! TOTAL INCOMPETENCE!

WED	DEC 28	9:00	TRINITY	CALLED VEYO AT 8:17 TO CHECK ON TRANS. ON HOLD FOR 8 MIN. FINALLY TOLD TRINITY WOULD ARRIVE IN 10 MIN. I ASKED IF I COULD CHANGE OUR PREFERRED COMPANY & SHE ASKED IF I WAS SCHEDULING TRANS. I TOLD HER NO JILL WAS ALREADY SCHEDULED. & SHE SAID THAT NO I COULDN'T CHANGE OUR PREFERRED COMPANY. CALL ENDED 8:28 (11 min) CALL AT 8:44 FROM TRINITY DRIVER SAYING SHE WAS SORRY BUT SHE WAS RUNNING LATE. SHE DIDN'T HEAR HER ALARM THIS MORNING. SHE HAD TO WORK LATE AT HER OTHER JOB & DIDN'T GET HOME UNTIL 1:00 AM. WOULD ARRIVE IN ABT 15 MIN. SHE ARRIVED AT 9:00. I WALKED JILL OUT & PUT HER IN THE VAN. DRIVER NEVER GOT OUT & NEVER SPOKE TO OR ACKNOWLEDGED ME. SHE WAS ON THE PHONE THE WHOLE TIME. LEFT MESSAGE FOR DORI BOYLE AT 9:14. LEFT MESSAGE FOR ISSABELL AT 9:17. CALL FROM DORI BOYLE AT 9:22. I TOLD HER I WOULD LIKE TO REQUEST GREEN ZONE AS OUR PREFERRED TRANS & SHE SAID SHE WOULD PUT IN THE REQUEST. CALL END 9:39 CALL FROM ISSABELL 12:46. SHE WILL ALSO CALL VEYO & REQUEST GREEN ZONE. CALL FROM ISSABELL 3:18. SHE CALLED VEYO & REQUESTED GREEN ZONE. NOT SURE THEY CAN GET IT DONE THIS WEEK BUT WILL TRY FOR NEXT WEEK.
		4:56	TRINITY	

THU	DEC 29	8:20	ALL CITY	ARRIVED 8:20 - NO CALL - DRIVER NEVER GOT OUT CALL FROM WES (SAN DIEGO) AT VEYO AT 3:35. HE WOULD TRY TO HELP WITH OUR PROBLEMS. HE WOULD CHECK WITH GREEN ZONE TO SEE IF THEY COULD FIT HER INTO THEIR SCHEDULE. CALL ENDED 3:56 CALL FROM ALL CITY AT 4:00 SAYING THEY WOULD BE PICKING JILL UP IN A FEW MINUTES & SHE SHOULD BE HOME IN ABT 15
		4:10	ALL CITY	MIN. ARRIVED HOME 4:10. JUST DUMPED OFF. NO ASSISTANCE. CALL AT 4:08 FROM GEORGE, OWNER OF GREEN ZONE. THEY HAVE A CONFLICT IN THE AM BUT WOULD SEE IF THEY CAN FIT HER INTO THEIR SCHEDULE. SAID HE WAS MEETING WITH THE DRIVER IN 30 MIN & WOULD CALL ME BACK IN ABOUT AN HOUR. NO RETURN CALL.
FRI	DEC 30	8:30	ALL CITY	CALLED VEYO AT 8:12 TO CHECK ON TRANS. PUT ON HOLD 3 MIN. TOLD DRIVER SHOULD BE HERE IN LESS THAN 10 MIN. CALL ENDED 8:26
		4:08	ALL CITY	
MON	JAN 2	HOLIDAY		REC CALL FROM TRINITY AT 8:19 TO CONFIRM JILL'S PICK UP. I HAD NOTIFIED VEYO OF ARC'S CLOSURES ON DEC 26 & JAN 2 & WAS TOLD THEY WERE AWARE OF THEM. THEY EVIDENTLY DIDN'T LET THEIR COMPANIES KNOW.
TUE	JAN 3	8:36	GREEN ZONE	CALLED VEYO AT 8:20 TO CHECK ON TRANS. ON HOLD FOR 6 MIN & THEN CUT OFF. CALLED

				BACK, MADE IT THROUGH MESSAGES & THEN NOTHING. CALLED BACK 3RD TIME, PUT ON HOLD & THEN TOLD DRIVER WOULD ARRIVE IN ABT 5 MIN. ARRIVED 8:36.
		3:50	GREEN ZONE	
WED	JAN 4	MISSED	WORK	CALL AT 7:02 FROM TRINITY SAYING SHE WOULD BE HERE AT 8:00. CALL FROM TRINITY AT 7:54 SAYING SHE COULDN'T MAKE IT BECAUSE OF THE ROADS.
THU	JAN 5	MISSED	WORK	CALLED VEYO AT 8:15 & WAS TOLD THEY DIDN'T HAVE ANY TRANS BECAUSE OF WEATHER
FRI	JAN 6	8:20	TRINITY	NO CALL - ARRIVED 8:20
		3:45	TRINITY	
MON	JAN 9	8:41	GREEN ZONE	CALLED VEYO 8:20 TO CHECK ON TRANS. ON HOLD 9 MIN. TOLD DRIVER EN ROUTE SHOULD ARRIVE ABT 5 TO 10 MIN (CALL LASTED 10 MIN 37 SEC).
		3:50	GREEN ZONE	DRIVER JEREMY ASKED IF I WOULD CALL THEM INSTEAD OF VEYO. I TOLD HIM I DIDN'T HAVE THEIR NUMBER & THAT I HAD BEEN TOLD IN THE PAST THAT I SHOULD CALL VEYO & NOT THE TRANS COMPANY. HE GAVE ME HIS NO. & A NO. FOR GEORGE. I GAVE HIM MY NO. & TOLD HIM IT WOULD BE BEST IF HE CALLED ME TO LET ME KNOW WHEN THEY ARE COMING.
TUE	JAN 10	MISSED	WORK	CALLED JEREMY AT GREEN ZONE AT 8:30. HE TOLD ME HE COULDN'T GET HERE BECAUSE

				OF THE ROADS. I ASKED IF VEYO WAS AWARE OF THIS & DID THEY HAVE ANYONE ELSE. HE DIDN'T KNOW. CALLED VEYO, WAS PUT ON HOLD & THEN TOLD THE DRIVER SAID HE HAD TALKED TO ME. I SAID YES HE DID BUT I WAS CHECKING TO SEE IF THEY HAD ANYONE ELSE. THEY DIDN'T.
WED	JAN 11	NO PICKUP	I TOOK HER	CALLED JEREMY (GZ) AT 8:15. SAID IT WAS HIS DAY OFF & TO CALL GEORGE. CALLED GEORGE & GOT VOICEMAIL. DIDN'T LEAVE MESSAGE. CALLED VEYO, ON HOLD & THEN TOLD GREEN ZONE'S CAR BROKE DOWN & THEY WOULD HAVE TO GET ONE OUT OF NAMPA & IT WOULD BE 30 MIN OR MORE. I CALLED VEYO BACK AT 8:50 & TOLD THEM TO JUST CANCEL THE AM PICK UP & I'D GET HER THERE. I ASKED IF THEY COULD ASSURE ME THAT SHE WOULD BE PICKED UP IN THE AFTERNOON. THEY CHECKED WITH GREEN ZONE & CONFIRMED AN AFTERNOON PICKUP AT 4:30
		4:05	GREEN ZONE	JILL ARRIVED HOME AT 4:05 BUT WAS NOT SUPPOSED TO BE PICKED UP UNTIL 4:30. JILL TOLD ME IAN CAME INTO GROUP & TOLD HER THE VAN WAS THERE & SHE SHOULD LEAVE. I CALLED THE ARC AT 4:07 TO SPEAK TO IAN BUT HE WAS NOT THERE. TALKED TO LISA CAHILL. TIFFANY OR ROB WERE NOT AVAILABLE EITHER. EXPLAINED SITUATION TO LISA & TOLD HER THIS HAD HAPPENED BEFORE & THOUGHT WE HAD IT SETTLED. JILL IS NOT TO LEAVE UNTIL SHE IS SCHEDULED

				TO LEAVE. LISA SAID SHE WOULD HAVE SOMEONE CALL ME TOMORROW. CALLED VEYO & THEY CONFIRMED SHE WAS SUPPOSED TO BE PICKED UP AT 4:30 & DIDN'T KNOW WHAT HAPPENED. TALKED TO FERNANDA & REGISTERED A COMPLAINT. EXPLAINED THAT I DIDN'T WANT HER PICKED UP BEFORE THE SCHEDULED TIME. SHE ASKED IF I WANTED TO CHOOSE ANOTHER COMPANY AS OUR PREFERRED ONE & I TOLD HER NOT AT THIS TIME. I DON'T HAVE A LIST OF COMPANIES & DON'T KNOW WHO IS AVAILABLE. CALLED ISSABELL TO INFORM HER OF WHAT IS HAPPENING. SHE SAID SHE WOULD CALL ARC & VEYO TOMORROW TO SEE WHAT SHE CAN DO.
THU	JAN 12	8:27	TRINITY	CALL AT 7:17 FROM TRINITY TO SEE IF JILL IS GOING TO WORK TODAY. ETA ABT 8:30. LEFT MESSAGE FOR DORI BOYLE. NO RETURN CALL FROM ARC OR ISSABELL.
		3:45	TRINITY	
FRI	JAN 13	8:17	TRINITY	CALL AT 8:04 ETA 10MIN RETURNED CALL FROM DORI BOYLE AT 9:59. SAID SHE WOULD TAKE MY COMPLAINTS TO THE MANAGEMENT TEAM. TOLD ME THEY ARE WORKING ON AMENDING THE CONTRACT & TRYING TO SOLVE SOME OF THE PROBLEMS REPORTED TO THEM. NO RETURN CALL FROM ARC SO LEFT MESSAGE FOR ROB AT 11:30. HE RETURNED CALL AT

				9:36. He was not aware of problems on Wed but said he would check it out & try to get it resolved. No return call from Issabell.
		4:10	Trinity	
Mon	Jan 16	8:36	Trinity	Called Veyo at 8:16 to see where trans is. On hold & then told they couldn't reach driver. Asked if I wanted her to try again & I said yes. Still no answer. She said today is a holiday so maybe the trans co. wasn't working. Wanted to give me the number & have me keep trying to reach them. I told her no, that's their job. Call ended at 8:24. Rec call at 8:33 from Trinity (Jeremy) & said he'd be here in one minute. Arrived 8:36. Rec call from Rob at ARC 9:39 am. Discussed Jill being picked up early with ARC staff. Will tell driver to wait or come back at scheduled time. If driver won't do this then ARC will call me to come pick her up. Call ended 9:48 (9 min 30 sec)
		3:53	Trinity	Driver Casey - Helped Jill out of the car & part way up the driveway - he told her they are not supposed to help but he would help her because he wouldn't want to see anyone fall. No return call from Issabell.
Tue	Jan 17	8:54	Trinity	Called Veyo at 8:18 to check on trans. Told trans would arrive in 5 min. Call

				ENDED 8:23. NO ONE ARRIVED. CALLED VEYO AT 8:53 TO SEE WHERE TRANS WAS. WHILE ON THE PHONE I LOOKED OUT & DRIVER WAS OUT FRONT. SO I HUNG UP. I WAS TAKING JILL OUT & CAR STARTED TO LEAVE. WHEN HE SAW US HE PULLED BACK INTO DRIVEWAY. I TOOK HER OUT & PUT HER IN THE CAR. DRIVER, CASEY, NEVER OFFERED TO HELP. I TOLD HIM HE WAS LATE & HE SAID HE'D BEEN OUT THERE 10 MIN. THAT WAS A LIE. I TOLD HIM I LOOKED OUT AT 8:53 & HE WASN'T THERE & IT WAS NOW 8:55. SHE WAS NOW GOING TO BE LATE FOR WORK. CALLED TRINITY TO COMPLAIN. LEFT MESSAGE FOR DORI BOYLE. CALLED VEYO AT 9:18 TO REGISTER COMPLAINT. CALL ENDED 9:28.
		3:45	TRINITY	STILL NO RETURN CALL FROM TSC. NO RETURN CALL FROM DORI BOYLE.
WED	JAN 18	8:13	GREEN ZONE	CAR ARRIVED 8:13. NO CALL AHEAD OF TIME. NO CALL WHEN HE GOT HERE. DIDN'T COME TO DOOR. I ~~TOOK~~ HER OUT. ASK WHO HE WAS & HE SAID GEORGE WITH GREEN ZONE. I HAD TO TAKE GLENN TO 2 DOCTORS APTS & GOT HOME AT 2:30. HAD A MESSAGE FROM GEORGE AT GREEN ZONE THAT WAS LEFT AT 12:12. IT ONLY SAID TO CALL HIM. I RETURNED THE CALL AT 12:44. GOT HIS VOICEMAIL & LEFT A MESSAGE THAT I WAS RETURNING HIS CALL. AT 4:21 I RECEIVED A CALL FROM IAN AT THE ARC SAYING THAT THEY HAD RECEIVED A CALL FROM VEYO SAYING THAT THEY WOULD HAVE TO PICK

				JILL UP AT 2:30 OR THEY COULDN'T PICK HER UP AT ALL. THEY (ARC) TOLD VEYD THAT JILL DIDN'T GET THROUGH UNTIL 4:30. I TOLD IAN THAT I WOULD COME & GET HER MYSELF. AT 4:26 I CALLED VEYD TO SEE WHAT WAS GOING ON. BECKY SAID JILL WAS SUPPOSED TO BE PICKED UP BY GREEN ZONE AT 4:30 & SHE WOULD CONTACT GEORGE TO SEE WHAT HAPPENED. I WAS THEN TOLD THAT GREEN ZONE HAD ONE VAN STUCK IN THE SNOW & THE OTHER ONE WAS BUSY. THEY ONLY HAVE 2 VANS. SHE (BECKY) SAID SHE WOULD SEND OUT AN EMAIL & SEE IF THEY COULD FIND SOMEONE TO PICK JILL UP. I TOLD HER TO JUST FORGET IT BECAUSE IT WAS NOW 4:30 & SHE NEEDED TO BE PICKED UP & THEY COULDN'T GUARANTEE ME THEY COULD FIND SOMEONE. I TOLD HER I WOULD GO GET HER MYSELF. I ARRIVED AT THE ARC AT 4:44 & WAS MET BY ROB WHO TOLD ME THAT SOMEONE HAD JUST PICKED UP JILL. HE WAS ON THE PHONE TRYING TO SOLVE TRANS PROBLEMS FOR ANOTHER CLIENT & ANOTHER STAFF PERSON ALLOWED JILL TO GO WITH THE VAN DRIVER WHO I FOUND OUT LATER WAS WITH IMPERIAL TRANSPORT. I DON'T KNOW WHAT TIME SHE GOT HOME BECAUSE I GOT CAUGHT IN THE TRAFFIC &
			IMPERIAL TRNS	DIDN'T GET HOME UNTIL 5:40.
				NO RETURN CALL FROM GEORGE.
THU	JAN 19		I TOOK HER	CALLED VEYD AT 8:20 TO CHECK ON TRANS. THEY SAID GREEN ZONE WAS SUPPOSED TO PICK HER UP. THEY CONTACTED GREEN ZONE

				& THEN TOLD ME THAT THEY (GREEN ZONE) WERE'NT WORKING TODAY BECAUSE OF THE WEATHER. I WAS TOLD THAT A DISPATCHER WAS SUPPOSED TO HAVE LEFT A MESSAGE LAST NIGHT BUT I NEVER RECEIVED ANY MESSAGE. I TOOK JILL TO WORK & TALKED TO IAN & ROB TO TRY TO FIND OUT WHAT HAPPENED YESTERDAY AFTERNOON & WHY I WASN'T NOTIFIED SOONER ABOUT THE PROBLEM. AS USUAL THERE ARE NO ANSWERS. CALLED DORI BOYLE AT 2:11 TO REGISTER A COMPLAINT. CALL LASTED 17 MIN 39 SEC. EXPLAINED TO HER WHAT HAD HAPPENED THIS WEEK. I PICKED HER UP IN THE AFTERNOON.
FRI	JAN 20	9:05	GREEN ZONE	REC CALL AT 8:09 FROM GEORGE WITH GREEN ZONE. HE FELL ON THE ICE & HURT HIS ELBOW SO HAS TO GO TO WALGREEN'S TO GET AN ICE PACK. WON'T BE ABLE TO GET HERE UNTIL ABT 9:00. ARRIVED 9:05. LATE FOR WORK AGAIN. CALLED TSC TO LET HER KNOW WHAT IS GOING ON. SAID SHE WOULD CALL ME BACK.
		3:38	GREEN ZONE	NO RETURN CALL FROM TSC
MON	JAN 23		I TOOK HER	CALLED VEYD AT 8:21 ON HOLD 3 MIN. THEN TOLD GREEN ZONE WAS SUPPOSED TO PICK HER UP. ON HOLD ANOTHER 3 MIN & THEN TOLD GREEN ZONE DIDN'T PICK UP THE TRIP SO THEY WOULD TRY TO FIND SOMEONE ELSE. ASKED ME IF SHE COULD SEE HER DOCTOR AT A LATER TIME. I TOLD HIM

				IT WASN'T FOR A DOCTOR'S APPT, IT'S A STANDARD PICK UP 5 DAYS A WEEK FOR WORK. HE SAID THEY'D TRY TO FIND SOMEONE & WOULD CALL ME WHEN THEY HAD SOMEONE. 9 MIN CALL. NO WORD FROM VEYO SO CALLED AGAIN AT 8:52. ON HOLD FOR 2 MIN THEN GOT AGENT & AS I STARTED TO EXPLAIN THE SITUATION I GOT CUT OFF. CALLED BACK, ON HOLD FOR 2 MIN. GOT AGENT & EXPLAINED WHAT WAS HAPPENING & THEN PUT ON HOLD FOR 3 MIN WHILE HE TRIED TO FIND OUT WHAT'S GOING ON. THEN I WAS TOLD THEY DIDN'T HAVE ANYONE BUT WOULD SEE IF THEY COULD FIND SOMEONE. I TOLD THEM TO JUST FORGET IT, SHE'S ALREADY LATE FOR WORK NOW & I'LL JUST TAKE HER MYSELF. LATE FOR WORK AGAIN!! LEFT MESSAGE FOR CHRISTINE PISANI, IDA COUNCIL ON DEV DIS AT 9:55. REC CALL FROM TONI (ICDD) AT 3:06. EXPLAINED WHAT HAD BEEN GOING ON & SHE TOLD ME WHAT THEY WERE TRYING TO DO OR TO GET DONE. SHE DOESN'T THINK ANYTHING WILL BE RESOLVED VERY SOON BECAUSE IT'S A 3 YR CONTRACT. I PICKED HER UP IN THE AFTERNOON.
TUE	JAN 24	8:30	TRINITY	CALLED VEYO AT 8:20 ON HOLD THEN TOLD DRIVER WOULD ARRIVE ABT 8:30
		4:05	TRINITY	
WED	JAN 25	HOME SICK		CALLED VEYO AT 8:00 TO CANCEL TRANS BECAUSE JILL IS SICK THIS MORN. ON

				HOLD FOR 3 MIN. TOLD THEY COULDN'T REACH THE COMPANY BUT THEY LEFT A MESSAGE TO CANCEL FOR TODAY. ALLCITY SHOWED UP AT 8:20.
THU	JAN 26	HOME	SICK	CALLED VEYO AT 7:45 TO CANCEL TRANS. THEY TOLD ME IT WAS CANCELED. AT 8:40 TRINITY TRANSPORT ARRIVED & SAID THEY HAD NOT BEEN NOTIFIED.

IN THE LAST 45 DAY PERIOD (11-14-16 THRU 1-19-17)

I'VE HAD TO CALL VEYO 15 TIMES IN THE MORNINGS BECAUSE NO ONE HAD ARRIVED OR CALLED BY THE SCHEDULED PICK UP TIME

~~SIX~~ 7 TIMES SHE WAS PICKED UP AT 9:00 OR ABOUT THEN WHICH MADE HER LATE FOR WORK

FOUR TIMES SHE WAS NOT PICKED UP IN THE AFTERNOON

TWO TIMES SHE WAS PICKED UP BEFORE THE SCHEDULED TIME IN THE AFTERNOON

FOUR TIMES SHE DID NOT RECEIVE TRANSPORTATION BECAUSE OF WEATHER

NINE TIMES SHE ARRIVED HOME MORE THAN 30 MIN AFTER SCHEDULED PICK UP TIME (ARRIVED HOME AFTER 4:00 ON MON-TUE-THU-FRI OR AFTER 5:00 ON WED)

TRANSPORTATION WAS DENIED ON 12/1/16 BECAUSE THEY SAID SHE HAD A VEHICLE REGISTERED IN HER NAME. THEY HAD ONLY CHECKED FOR FIRST & LAST NAME & HADN'T BOTHERED TO USE MIDDLE NAME, INITIAL, ADDRESS OR BIRTHDATE. AFTER I WAS TOLD IT WAS AN ERROR & THE ISSUE WAS SETTLED I RECEIVED 4 LETTERS (2 ON 12/6/16 - 1 ON 12/9/16 - 1 ON 12-12-16 WHICH DENIED HER TRANS ON 12/1 - 12/2 - 12/6 - 12/9). THE LETTERS SAID THE TRANS WAS DENIED BECAUSE SHE "REFUSED APPROPRIATE MODE" WHICH I DON'T UNDERSTAND. SHE DIDN'T REFUSE ANYTHING.

I'VE SPENT NUMEROUS HOURS ON THE PHONE WITH VEYO, IDAHO MEDICAID, ARC & TSC & NOTHING IS IMPROVING. ALL I EVER GET IS APOLOGIES & EXCUSES

CALLING VEYO IS NOT A PLEASANT EXPERIENCE. AFTER ALL THE INFINK INSTRUCTIONS & PUSHING BUTTONS YOU GET A DIFFERENT PERSON EVERY TIME & YOU HAVE TO EXPLAIN THE SITUATION OVER & OVER AGAIN. IT IS VERY FRUSTRATING & EXHAUSTING.

VEYO KEEPS ASKING US TO CHOOSE A PREFERRED COMPANY BUT THAT IS HARD TO DO SINCE WE DON'T KNOW THE NAMES OF THE COMPANIES. IT WOULD BE HELPFUL IF VEYO PROVIDED US WITH A LIST OF ALL THE COMPANIES & MAYBE ASKED US TO CHOOSE A 1ST, 2ND & 3RD CHOICE. THEY NEED TO CHANGE THEIR METHOD OF DOING THINGS.

Frank Romeo, Pocatello, a previous certified medical driver in San Jose, CA

Some of the recommendations I would make are for the Idaho House and Senate to send representatives to investigate the method of operations of a program called Outreach in San Jose, California. The program in San Jose includes Medicare and Medicaid patients. I would recommend that these representatives look into the program with the mindset to get a program based on Outreach in the works in Idaho that would be efficient.

My second recommendation is that instead of having brokers have a program that handles Medicaid patients on a statewide basis, to do it on a regional basis. The dispatchers do not have a concept of the geography of Idaho.

The insurance required by the Health and Welfare Department on this year's program is $2 million. No one required the cab companies in Pocatello to have more that the standard $100,000 insurance required by the city of Pocatello to operate a cab company; I am unaware of the amount of insurance the transportation companies have. These cab companies do not have proper insurance; if they were in an accident where the passengers received severe bodily injury, then Idaho would be at risk for liability. Compounding the problem of potential liability is that the city of Pocatello does not require transport or cab companies to have a yearly safety inspection.

The present method of operations used by Veyo does not take into consideration or provide accountability for people not being picked up at all, or picked up late, or picked up early. Plus, the order takers do not update the information on the orders in such instances as when a wrong vehicle is sent to pick up people with specific needs: for example, a sedan was sent to pick up a woman in an electric wheelchair instead of sending a van with a lift.

Also, there is no accountability on the billing. A driver can put in erroneous information to the company—or the company can put in erroneous information on the billing with Veyo—and yet the ride has not been provided for the client: either in picking the client up or in the return trip. (I have documents attested to this situation). Overall, the system is very inefficient. I feel that the government is obligated to better the quality of life for citizens, and when a person becomes of an age when they cannot drive or they cannot drive because of a disability, their quality of life diminishes.

Thank you,

Frank Romeo

Thank you Senators and Representatives

My name is Darren Talley with White Tail Transportation in Priest River, Idaho

I represent the NEMT Providers who transport Idaho residents many with disabilities and special needs to their non-emergency medical appointments.

The NEMT Providers of the State of Idaho request that you legislators restore our funding back to 2009 levels.

In 2009 prior to the brokerage model being adopted NEMT Providers funding was $7.67 PPPM (Per Participant Per Month).

In 2009 during the "Great Recession" Idaho State adopted the brokerage model and awarded AMR the brokerage contract at AMR's bid of $7.04 PPPM.

AMR's contract allowed AMR to keep up to 25% of the PPPM and to try and run all the NEMT Providers on the remaining 75%.

This meant NEMT Providers went from $7.67 across Idaho State to $5.28 a 31% cut in revenue overnight.

In 2014 the NEMT Brokerage contract was again bid on and AMR was selected as the winning broker at $7.00 PPPM.

Another cut in total finances.

NEMT Providers 75% of $7.00 would mean we are now operating on $5.25.

In 2016 the NEMT Brokerage contract was again bid on and VEYO was selected as the winning broker at $6.59 PPPM.

Another cut in total finances.

One change in this contract states that the struggling NEMT Providers must receive 80% of the $6.59 up from 75%.

NEMT Providers would now be operating on $5.27 PPPM a 2 cent increase the first since 2009.

This is still 31% below our 2009 NEMT Provider funding.

Most businesses in Idaho could not withstand a 31% cut in revenue.

When the brokerage system was implemented many NEMT Providers immediately went out of business and many more struggled using all their life savings and retirement assets until they had to close down.

Have costs gone up for all businesses since 2009 – YES!

One example is our White Tail Transportation insurance has gone up 83% in just the past two years.

That is with a clean record and no insurance claims. It is just the insurance industry we are part of.

Have fuel prices fluctuated since 2009? Have vehicle purchase costs and maintenance gone up since 2009?

We are not asking for any inflation adjustment since 2009 unless you want to add that.

We are asking that you restore the NEMT Provider funding to $7.67 that NEMT Providers received in 2009 prior to the brokerage system implementation.

Thank you.

Darren J. Talley
White Tail Transportation, Inc.

5486 Hwy 2 #102
Priest River, ID 83856
360.425.2400 – cell Darren
208.448.0848 - Priest River Office
Darren@WhiteTailTransportation.com
www.WhiteTailTransportation.com

Pricing

Access2Care has a well-documented history of saving money in the NEMT program for the State of Idaho. Prior to Access2Care's award in 2010, Idaho reported NEMT cost in SFY 2009 of $17,675,587 for an average of 191,960 monthly participants. This calculates to a PPPM of $7.67. **Our initial PPPM of $7.04 was regarded as nonviable by our competitors**, yet we were successful in providing the state $6.3M in estimated savings from September 2010 through March 2014 when compared to the $7.67 rate. In April 2014, we reduced our rate even further to $7.00 PPPM expanding our total savings to Idaho to total over $10M before our contract ends in March 2016. We continue this tradition by further reducing our current rate by $0.05 to $6.95. This rate reduction coupled with our proposed rate increase to providers, all while continuing to operate a large call center operation in the State keeps more money in the State of Idaho and helps boost Idaho's economy. No broker is better positioned to partner with the State of Idaho than Access2Care.

Presented by:

Darren J. Talley
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January 27, 2017

Chairs of the House and Senate Health and Welfare and JFAC Committees:

My name is Bill Benkula I am here representing the Idaho Association of Community Providers. This association represents community based Mental Health, Substance Abuse, Developmental Disabilities Agencies, Residential Habilitation providers and Targeted Service Coordinators.

In 2012 we worked both with the House Health and Welfare committee on HB260, and the Senate on changes that the department of Health and Welfare wanted to IDAPA 16.03.10.706.05. This is the code relating to paying the fee for service rates for the business entities. Various representatives of DD services now represented by this association and Vocational Service Providers worked with The department and Senator Heider to reach agreement between the Department and the community based service agencies affected by this change to IDAPA. These service agencies, agreed to support these changes if the Department agreed to some sideboards to the change in rule. These sideboards included 1. paying a fair livable wage to Direct Support staff and 2. using the approved reimbursement methodology for setting any new rates in the future commonly know nationwide as the "Brick Method".

During the last year, Supported Living Providers participated in the first rate study since 2007. From the beginning of this study we continued to insist that the approved method to set rates be used. It was not until the results were shared with us did the department acknowledge that they did not follow the approved "Brick Method" to establish these rates. We have several concerns with the way that the study was done and do not believe that is accurately represents the costs of offering these service and most certainly did not follow the approved "Brick Method". While these concerns must be addressed, our most prevalent concern is the proposed average wage for our Direct Support staff. The department has proposed that these critical employees be paid an average wage of $10.19 per hour. To pay that as an average wage, this means is we must either start someone less than $10.19 to allow for some ability to pay someone else a little higher than the $10.19 per hour or simply start folks at that wage and let them know that there is no option for wage increases. Agencies are reporting unprecedented staff turnover, and staff vacancies that remain unfilled. This proposed wage will simply not allow us to compete on the open market to hire and retain staff. It should be noted that the study did even identify the vacancies which results in not building in the rate the necessary overtime costs that we incur to fill these vacancies.

When this issue was brought to the department's attention in industry wide numbers, Director Armstrong asked to meet with us. I have provided each of you a letter we send to Director Armstrong earlier this month summarizing the discussion we had with him in person. In it we outlined the wages we are having to compete with to hire and retain direct support staff, turnover that average industry wide

at over 100% annually as well as supporting documentation from Theresa Cosca from National BLS and what BLS categories should be used.

The department finished receiving public comments on the State Plan Amendment that would allow the Division of Medicaid to change the rates based on this study and these wages if the Centers of Medicaid and Medicare Services approves the reduction. They received 40 sets of comments during the comments period. We sincerely hope that based on these comments the Division of Medicaid decide to hold off submitting the amendment until these flaws can be identified and rectified and that these rates include a reasonable Direct Support staff wage that will allow us as an industry to hire and retain staff.

We ask you to urge the division of Medicaid to hire a professional who is skilled in developing fee for services rates to validate their numbers prior to implementing the new rates. The Idaho Association of Community Providers are currently waiting to hear back from Director Armstrong as we offered solutions in our letter to current situation we find ourselves in. Depending upon his response we may be asking for some of Germaine Committee Chairs time to develop a more equitable rate setting process to be put into IDAPA. Thank you for your time and I stand for any questions.

Bill Benkula Past President, Legislative Chair IACP

January 12, 2017

Director Richard Armstrong
Deputy Director Lisa Hettinger
Idaho Department of Health and Welfare
PO Box 83720
450 W. State Street, 10th floor
Boise, ID 83720-0036

Dear Director Armstrong and Deputy Director Hettinger:

On behalf of the Idaho Association of Community Providers (IACP), we want to thank you for meeting with us last week to discuss the current challenges the home and community based services industry as a whole faces in hiring and retaining Direct Support Professionals. I hope you found the information we shared helpful. As an Association, we share your goal of continuing to partner in completing the cost study and in all efforts to ensure the best possible service provision and outcomes for Idaho's most vulnerable citizens.

In follow-up, we want to summarize for you the issues from our perspective. The primary issue impacting the future sustainability of Residential Habilitation service provision is the inability to hire and retain staff in a fashion that lends itself to high quality, safe and consistent supports for the people we serve. Workforce data for ten Residential Habilitation agencies was submitted to you and your staff during our meeting that demonstrated the alarming levels of staff turnover and employee vacancy rates within our industry.

- Turnover ranging 65% to 206% with an average of over 100% turnover for the reporting agencies.
- Direct Support Professional position vacancy rates consistently running 20 and 30%.

These levels are unprecedented in our history of service provision and require immediate action to address as the levels continue to rise year over year.

As shared in our meeting, we are competing for the same employee base with other industries such as retail, food service, and production. Below are BLS average wages for these occupational categories based on May 2015 data for Idaho:

- Waitresses $9.48/hour
- Retail sales $13.01/hour
- Production workers $13.19/hour

We appreciated Ms. Hettinger's question as to why she is not hearing from skilled nursing facilities about similar staffing issues. It may be helpful to gather workforce data from those facilities to gain a better understanding of whether they have similar challenges. The Idaho Division of Human Services facilities providing the same services and support as Residential Habilitation agencies have the following pay rates based on June 2016 data:

- Therapy Tech $13.66-24.40/hour
- Developmental Disabilities Technician $11.70-20.89/hour

Based on BLS data for May 2015, skilled nursing and similar facilities pay the following average wages for Idaho:

- Nursing Assistant $11.70/hour
- Psychiatric Technician $15.11/hour

Based on the above wage data in addition to the agency workforce data, it is clear the Department proposed occupational category of Personal Care Aid and associated wage of $10.19/hour used in the current study is insufficient to compete with the market and to begin to positively impact turnover and vacancy rates. From the beginning of the study, providers have consistently messaged that **the most important thing that we absolutely must get right in this study is the direct care staff wage.** Given the Department's continued pushback, IACP reached out directly to BLS representatives to seek clarity on the occupational category(s) most closely aligned with the duties and activities of Residential Habilitation Direct Support Professionals. IACP also formally requested that the Department meet with BLS and to share the specific IDAPA rules governing Residential Habilitation services. Following their review of IDAPA, BLS Lead Economist Theresa Cosca stated the BLS positon in an email to Art Evans dated December 9, 2016. Please Reference Exhibit A for the specific BLS response. It should be noted that the BLS response aligns with what providers were messaging to the Department and Myers and Stauffer from the beginning of the study.

Following the response and guidance from BLS, IACP representatives put together a formal request to Matt Wimmer with supporting documentation comparing the duties and responsibilities of Residential Habilitation Direct Support Professionals, Personal Care Aides, Homes Health Aides, and Psychiatric Aides. Please reference the letter dated December 21, 2016 included herein as Exhibit B.

While arguments can be made for which occupational category most closely aligns with the role of a DSP, **what is most important is not the occupational category itself but that we are able to agree on a wage for use in setting rates that will allow providers to hire and retain a stable and consistent workforce.** The current Department proposed wage does not meet that criteria as evidenced by the information submitted. Additionally, some providers are already paying averages wages well in excess of $10.19/hour.

We also have significant outstanding concerns about the validity of the overall cost study. The specifics of those concerns are outlined in the IACP public comments submitted in response to the draft Waiver

Amendment so we will not reiterate them here. A comparison of the results of the last rate study versus the currently proposed rates do not even make sense from a logical or common sense approach:

	2007 Study	2017 Proposed	% Change
Hourly Res Hab			
Group	$8.28/hr	$7.88/hr	-4.8%
Individual	$20.68/hr	$19.68/hr	-4.8%
High Support (24 hr)	$248.40/day	$236.16/day	-4.9%
Intense Support (24 hr 1:1)	$496.56/day	$472.32/day	-4.9%

No business from McDonalds to St. Lukes Hospital that was in operation in 2007 has **decreased** their costs or what they charge for goods and services ten years later. Across the board decreases in proposed Residential Habilitation reimbursement rates becomes even more illogical when one considers the significant additional costs incurred as a result of new federal mandates and changes in the market/economy that we have seen in that same timeframe. These changes include the Affordable Care Act, requirement to pay overtime per changes in DOL rules, and the continued increases in wages in order to attract employees in a market where unemployment rates continue to decline. Our Association and individual provider comments to the draft Waiver Amendment give the specific details around the significant flaws identified in the current cost study. Even in the absence of the obvious flaws as captured in the public comments, any logical individual, particularly any business person, would question the results based on the outcomes comparing 2007 to 2017.

In light of the highly questionable results of the current cost study, the Idaho Association of Community Providers cannot in good conscience agree with or accept the study as a valid representation of the costs of our services nor do we support the proposed rates. We are formally requesting that the Department go forward with one of the following two options:

Option 1: Contract with a third party independent consultant experienced in rate setting in a fee for service home and community based services system to review the process, methodology, and results utilized in the current study and provide consultation to the Department and Myers and Stauffer on needed changes to ensure validity of the study as well as adequacy of proposed rates. This will ensure that the identified concerns and known flaws in the current study are corrected.

Option 2: Start over with another cost study as soon as possible ensuring that the study is completed in alignment with a valid rate methodology as evidenced by use in multiple states and approved by CMS. Ensure all provider costs are vetted by independent review of provider Profit and Loss statements to ensure accuracy of cost data. It should be noted that this step was not completed by Myers and Stauffer.

In our discussion last week, we briefly touched on circumstances that should trigger another cost study. In follow-up, we wanted to share the same triggers and timelines that we suggested in prior correspondence with Department representatives. Per Mr. Wimmer's request, the IACP submitted a letter to Mr. Wimmer, dated September 19, 2016, with the following proposed list of triggers and timelines for revisiting the cost study and rates:

We recommend the following items as triggers:

- *Any regulatory federal or state changes/mandates including, but not limited to:*
    - *Minimum wage increases*
    - *Department of Labor regulations*
    - *ACA compliance*
    - *IDAPA*
    - *Medicaid*
    - *3% increase from the direct care staff wage basis used in the most recent cost study. This could be triggered by changes in minimum wage or changes in the competitive environment.*

We recommend the rate study be completed upon each trigger and no less than every 5 years.

Based on the above recommended triggers, we are due to complete another study as a minimum of two significant changes have occurred that were not fully captured or accounted for in the data collected by Myers and Stauffer as follows: (1) Change in Department of Labor regulations requiring providers to pay overtime effective January 1, 2016, (2) Wage increases implemented by multiples agencies throughout 2016 in an effort to combat staffing shortages. For this reason, we would request that the Department proceed with Option 2 as outlined earlier in this letter. Despite which option is chosen, we would request that the current rates continue until either the current study is corrected and validated by an outside entity or a new rate study is completed entirely. Providers are appreciative of the Department's decision to not go forward with recoupment for any rates that are 5% or more below prior rates. In the same token, as a provider group, we are open to the Department not having to provide any back pay to providers should proposed future rates come out 5% or higher than prior rates.

As you know, JVGA was the third party consultant selected for the 2007 Idaho rate study. JVGA had completed rate work in Delaware, Florida, California and Montana prior to doing the work for Idaho. During the last 10 years, JVGA has also done rate work in Oregon, New York, New Jersey and North Dakota and is currently working in Maryland. JVGA has a solid history and experience in developing rates for home and community based services for individuals with developmental disabilities. For this reason, the Provider Association is formally requesting that JVGA be utilized in either of the two options suggested earlier in this letter. Based on prior work in Idaho, JVGA knows our services and can educate the provider industry, the Department, and Meyers and Stauffer on the specifics of doing a fee for services cost study. Of note, JVGA has worked under contract with Meyers and Stauffer in the State of New Jersey. Doing the same here would alleviate Ms. Hettinger's concern about having to offer a Request for Proposals and perhaps ending up with an unknown entity. We know that this has been done in other circumstances within the state of Idaho as evidenced by the Attorney General's office sub-contracting with Bracke and Associates to facilitate the issues associated with the K.W. versus Armstrong case.

In closing, representatives of the Association look forward to your response to our concerns and the two options offered as solutions. We would request your formal written response no later than the end of

January 2017. As evidenced by our actions to date, we are committed to partnering with the Department in our united efforts to ensure quality, accessible, and sustainable services to individuals with developmental disabilities across Idaho.

Respectfully Submitted on Behalf of the IACP,

Becky Novak	*Bill Benkula*	*Teronda Robinson*
Becky Novak IACP Vice-President	Bill Benkula Immediate Past President	Teronda Robinson IACP Secretary

Cc: Jim Baugh, Disability Right Idaho
Christine Pisani, DD Council
Angela Lindig, Idaho Parents Unlimited
Sen. Lee Heider
Rep. Fred Wood
Sen. Shawn Keough
Rep. Maxine Bell
Mike Skelton, Consortium for Idahoans with Disabilities

Exhibit A

Exhibit A

From: "Cosca, Theresa - BLS" <Cosca.Theresa@bls.gov>
Date: December 9, 2016 at 5:11:56 AM PST
To: "kelly@westcaremgt.com" <kelly@westcaremgt.com>
Cc: "Rust, Rebecca - BLS" <Rust.Rebecca@bls.gov>, "Salmon, Laurie - BLS" <Salmon.Laurie@bls.gov>, SOC <SOC@bls.gov>, "Arthur.Evans@dhw.idaho.gov" <Arthur.Evans@dhw.idaho.gov>
Subject: RE: Direct Support Professional Classification Question

Dear Kelly Head,

The Standard Occupational Classification (SOC) information desk at the Bureau of Labor Statistics (BLS) received some feedback regarding the recommendation we previously provided to you in response to your email below to the BLS Commissioner.

On October 5, 2016, I responded to your inquiry and stated that "based on the duties you describe, these workers would be classified in SOC 31-1011 Home Health Aides." At this time, I would like to reiterate that the response provided was based solely on the information contained in the email and is in accordance with the 2010 SOC Classification Principles and Coding Guidelines. The Classification Principles form the basis on which the SOC system is structured. The Coding Guidelines are intended to assist users in the federal statistical agencies in consistently assigning SOC codes and titles to survey responses and in other coding activities.

Warranting specific mention in this case are Classification Principles 1 and 2 as well as Coding Guideline 2. Classification Principle 1 states that "Each occupation is assigned to only one occupational category at the lowest level of the classification." Classification Principle 2 states that "Occupations are classified based on work performed and, in some cases, on the skills, education, and/or training needed to perform the work at a competent level." Coding Guideline 2 states that "When workers in a single job could be coded in more than one occupation, they should be coded in the occupation that requires the highest level of skill. If there is no measurable difference in skill requirements, workers should be coded in the occupation in which they spend the most time." The full list of 2010 SOC classification principles and coding guidelines are available on the SOC website at: http://www.bls.gov/soc/home.htm.

With that being said, given additional information regarding specific activities of workers with a job title such as 'direct support professionals' it is possible that these workers could be coded elsewhere including **31-1013 Psychiatric Aides** and **39-9021 Personal Care Aides**, in addition to **31-1011 Home Health Aides**. It is up to customers using the SOC for non-statistical purposes, who will have considerably more information than was provided to BLS, to review the various detailed definitions for the SOC codes and determine which best matches the work being performed by the individual being coded, in light of their own program and policy purposes. Such users are not limited to following the above classification principles and coding guidelines used by federal statistical agencies. For example, users may develop their own policies concerning workers that meet the definition of two or more occupations.

Please also keep in mind that the SOC was not designed for non-statistical purposes. Frequently Asked Question (FAQ) number 13 found within the 2010 SOC User Guide states the following:

> *The 2010 SOC was designed solely for statistical purposes. Although it is likely that the 2010 SOC also will be used for various non-statistical purposes (e.g., for administrative, regulatory, or taxation functions), the requirements of government agencies or private users that choose to use the 2010 SOC for non-*

> *statistical purposes have played no role in its development, nor will OMB modify the classification to meet the requirements of any non-statistical program. Consequently, the 2010 SOC is not to be used in any administrative, regulatory, or tax program unless the head of the agency administering that program has first determined that the use of such occupational definitions is appropriate to the implementation of the program's objectives.*

The 2010 SOC is used by various federal statistical agencies to classify workers into occupational categories for the purpose of collecting, calculating, or disseminating data. Therefore, recommendations on classification provided by the SOC information desk are not to be interpreted as policy directives, but rather guidance on where statistical data collectors and users of statistical data can find workers who perform a specific set of work activities. Please contact us again if you have any additional questions regarding the SOC.

Sincerely,

Theresa Cosca, Lead Economist
Bureau of Labor Statistics
SOC Information Desk

Exhibit B

Exhibit B

December 21, 2016

Matt Wimmer
Deputy Administrator
Division of Medicaid
Idaho Department of Health and Welfare
3232 Elder Street
Boise, ID 83705

Re: Comparison of IDAPA requirements of multiple potential BLS Occupational Categories

Dear Mr. Wimmer,

In several meetings that have occurred since December 2015, the Department has insisted that the BLS Occupational Category of Personal Care Aide most clearly represents the rule required services and expected outcomes of supported living. The Idaho Association of Community Providers (IACP) has consistently refuted this assertion and finds that there are no grounds founded in rule to conclusively support this category. The Department has conceded that there is not one occupational category that conclusively meets all the requirements of the services in question. The IACP similarly agrees that there is not one BLS Occupational Category that accurately summarizes all the requirements put forth in IDAPA.

Per request of the Department and IACP, representatives of the Bureau of Labor Statistics reviewed the IDAPA rules that outline the responsibilities of direct care staff delivering Supported Living services and made a recommendation on the BLS occupational category(s) which most closely align with the duties and activities of Supported Living direct care staff (i.e. Direct Support Professional). In an email dated December 9, 2016 BLS Lead Economist Theresa Cosca stated the following regarding the duties and activities of Supported Living direct care staff (i.e. Direct Support Professionals) and the BLS occupational categories that align with the staff role:

> *"given additional information regarding specific activities of workers with a job title such as 'direct support professionals' it is possible that these workers could be coded elsewhere including **31-1013 Psychiatric Aides** and **39-9021 Personal Care Aides,** in addition to **31-1011 Home Health Aides**. It is up to customers using the SOC for non-statistical purposes, who will have considerably more information than was provided to BLS, to review the various detailed definitions for the SOC codes and determine which best matches the work being performed by the individual being coded, in light of their own program and policy purposes."*

Bureau of Labor Statistics Classification Principles and Coding Guidelines, 2010 SOC state, and Theresa Cosca confirms in the above stated email, the following:

1) BLS Classification Principle 1 states that "Each occupation is assigned to only one occupational category at the lowest level of the classification."
2) BLS Classification Principle 2 states that "**Occupations are classified based on work performed** and, in some cases, on the skills, education, and/or training needed to perform the work at a competent level."
3) BLS Coding Guideline 2 states that "When workers in a single job could be coded in more than one occupation, they should be coded in the occupation that requires the highest level of skill. If there is no measurable difference in skill requirements, **workers should be coded in the occupation in which they spend the most time.**"

The attached table captures the differences between the BLS recommended occupations of Home Health Aide, Personal Care Aide, Psychiatric Aide, and Supported Living Services direct care staff. As noted in the attached table, while all three categories capture elements of the Supported Living direct care staff role, the occupation which most closely aligns with the responsibilities of direct care staff is Psychiatric Aide. In keeping with BLS Principle #2, this category should be chosen as the basis for determining the direct care staff wage in the rate calculation. IACP is formally requesting use of the category in determining future reimbursement rates for Supported Living services.

If the Department finds this recommendation unsatisfactory, IACP would be open to considering a blend of the 3 occupations at the following weights based on match to responsibilities as captured in the table:

- Psychiatric Aide 43%
- Home Health Aide 28.5%
- Personal Care Aid 28.5%

The resultant wage based on this weighting is $11.57 prior to inflation.

In addition to those responsibilities that align with Psychiatric Aide, Home Health Aide, and Personal Care Aide, Supported Living direct care staff are required to provide skills training and behavior management/shaping, which is a duty above and beyond any of the other categories and should serve as the impetus for a wage basis at or above these three categories.

As a provider association, we continue to urge the Department to take into account the consistent input and feedback providers have given regarding the wage basis throughout the rate study process that to date has been ignored. As providers, we are intimately familiar with the day to day duties of providing supported living services. Our recommendations are now also supported by the response from the Bureau of Labor Statistics following their review of IDAPA rules for Supported Living services.

We formally request that the Department's basis for direct care wages accurately capture the responsibilities of the position as well as lead to a wage rate that will allow providers to recruit and retain adequate staff who can carry out the required responsibilities of the job.

On behalf of Idaho Association of Community Providers,

Shaun Bills	Becky Novak	Bill Benkula
IACP President	IACP Vice-President	Immediate Past President

Exhibit B

BLS Occupational Category Skills and Outcomes Weighting

Category	IDAPA Requirements for Supported Living	Home Health Aide	Personal Care Aide	Psychiatric Aide
BLS Wage (based on 2015 BLS data)	** $11.57 recommended wage before inflation.	$10.44	$9.73	$13.55
Weighting*		28.5%	28.5%	43%
Description	**01. Residential Habilitation. Residential habilitation services consist of an integrated array of individually tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in certified family homes. The services and supports that may be furnished consist of the following.**	**24. Homemaker/Home Health Aide. A person who has successfully completed a basic prescribed course or its equivalent and has been placed on the Home Health Aide Registry by the state of Idaho, Board of Nursing. (IDAPA 16.03.07.002.24)**	**03. Personal Care Services (PCS). A range of medically-oriented care services related to a participant's physical or functional requirements. These services are provided in the participant's home or personal residence, but do not include housekeeping or skilled nursing care. (IDAPA 16.03.10.301.03)**	**Assist mentally impaired or emotionally disturbed patients, working under direction of nursing and medical staff. May assist with daily living activities, lead patients in educational and recreational activities, or accompany patients to and from examinations and treatments. May restrain violent patients.**
BLS Description	a. Habilitation services aimed at assisting the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. (IDAPA)	Home health aides help people with disabilities, chronic illness, or cognitive impairment with activities of daily living. They often help older adults who need assistance. In some states, home health aides may be able to give a client medication or check the client's vital signs under the direction of a nurse or another healthcare practitioner.	Personal care aides help clients with self-care and everyday tasks. They also provide social supports and assistance that enable clients to participate in their communities.	Psychiatric technicians and aides care for people who have mental illness and developmental disabilities. Technicians typically provide therapeutic care and monitor their patients' conditions. Aides help patients in their daily activities and ensure a safe, clean environment.
Self-Direction	i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities	No requirements outlined in rule.	No requirements outlined in rule.	Self-direction addressed as a stabilization tool for community reintegration. Emphasis placed on making and initiating changes to allow for a stable residential setting.
Financial	ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations	No requirements outlined in rule.	Money management habilitation skills training outcomes not required. "Shopping for groceries or other household items" assistance is included in personal care aid services.	No requirements outlined.
Daily Living Skills	iii. Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures	Daily living skills trainings is not an anticipated outcome. Less prescriptive requirements outlined in Home Health IDAPA intended to simply provide this service in lieu of the individual served learning this skillset.	Daily living habilitation skills training outcomes not required. Assistance in these same categories is a component of personal care aide services.	Daily Living Skills training not an anticipated outcome from service provision. Assistance in these categories is provided. Oversight is generally provided by an RN
Socialization Training and Assistance	iv. Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. (Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and	The Home Health Service does reinforce delegated tasks as an extension of therapeutic services but do not have behavior shaping or habilitative outcomes tracked or assessed by the service provider. Less prescriptive Requirements Outlined in Home Health IDAPA.	No requirements outlined in rule.	Community based socialization through therapeutic care intended to result in successful reintegration into a community setting. Long-term independence through training is not an anticipated outcome.

BLS Occupational Category Skills and Outcomes Weighting

	identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in non-therapeutic activities which are merely diversional or recreational in nature)			
Mobility and Community Access	v. Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community	Much more limited in scope. Intended to access opportunities for ambulation and exercise. Defined in requirements outlined in Home Health IDAPA.	Mobility and Community Access training outcomes not required. Similar Requirements Outlined in Personal Care IDAPA.	Limited therapeutic care provided for basic understanding of community access to support re-integration into the community.
Behavior Shaping	vi. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs	No requirements outlined in rule.	No requirements outlined in rule.	Behavior interventions such as restraints of violent patients and other therapeutic based outcomes expected. An emphasis on stabilization. Behavior shaping and management not an expected outcome.
Personal Assistance	b. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf	Similar Requirements Outlined in Home Health IDAPA.	Similar Requirements Outlined in Personal Care IDAPA.	Basic personal assistance services necessary to assist individual served while awaiting community re-integration.
Skills Training	c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self-direction, money management, socialization, mobility and other therapeutic programs	No requirements outlined in rule.	No requirements outlined in rule.	No requirements outlined in rule.

green represents a demonstrable equality of requirements among rule set or best representation of service.

yellow represents a partial match to the requirements for the Supported Living direct care staff role

* The table shows the following

6 category matches for Psych Aide (6 divided by 14 = 43%)
4 category matches for Home Health Aide (4 divided by 14 = 28.5%)
4 category matches for Personal Care Aide (4 divided by 14 = 28.5%)

BLS DATA Idaho Wages			
Title	Wage	Weight	
HHA	10.44	0.285	2.98
PCA	9.73	0.285	2.77
Psych Aide	13.55	0.43	5.83
**			11.57

January 27, 2017

Dear Mr. Chairman and members of the committee,

My name is Nicole Sherwood. I am a Professional in the Developmental Disability Community and I also reside in Boise Idaho. I am providing a testimony to raise awareness regarding the cost study of Supported Living/Residential Habilitation Services that was completed in the spring of 2016. Providers attempted to work in partnership with the Department and Meyers and Stauffer with the expectation that the cost study would continue with the Brick Model methodology (formerly known as the Arizona model) that was previously approved in 2008. However, a deviation from the Brick Model Method occurred and an alternate method was chosen by the Department and was implemented but has yet to be validated. The results proposed from the alternate method used in the cost study does not accurately reflect the costs of direct care staff nor the program related expenses to provide safe, individualized, and quality level of services to individuals with developmental disabilities who show a medical necessity for the level of care that supported living offers. There is great concern that with the proposed rates access issues will be created.

Currently, the state of Idaho is very fortunate to be able to offer a variety of home and community based services to individuals with developmental disabilities which promotes independence and community integration. As providers continue to strive for participants to have full access to benefits of community living there are some concerns with proposed implementations that will affect access to services, quality of services and participant choices. Specifically for participants who receive supported living there are many concerns with the accessibility to services due to the proposed rate methodology that is being presented to take place in April of 2017. Currently, there are multiple situations where individuals receive 1:1 supported living services in order to meet participant needs and to promote participant choice. Such scenarios include but are not limited to individuals choosing to live alone in their own home, choosing a roommate who receives a different level of service (such as Intense or limited hourly supports), participants who don't want to attend the same activities as their roommate(s), behaviors, and medical concerns. These scenarios occur on a daily basis and providers are faced with many barriers to meet participant needs and still be able to meet the demands of business operations.

If a provider pays direct care staff $7.75/hour for a 24 hour period there is only $50.16 remaining (less if the hourly wage is raised to $10.19 which is what the department is proposing) per the proposed reimbursement rate ($236.16/day) from the spring 2016 cost study. Remaining costs consist of completing functional assessments, writing program implementation plans, reviewing monthly data, reviewing incident reports, observing participants to ensure needs are being met, pill counts, training staff, collaborating with other providers, assisting with behavior management, and on-call supports outside of an agency's normal business hours. Then there are costs such as workman's compensation, health insurance coverage, training costs, and costs that keep an office up and running. The expectations of providers have not decreased with the proposed rate cut and this will likely result in larger caseloads as a means to offset the expenses that are not accounted for in the rate cut. Larger caseloads would significantly impact the quality of care that participants will receive. Our agency typically sees an increase in incident reports when Qualified Intellectual Disabilities Professionals (QIDPs) and house managers/trainers have less availability (due to providing direct care themselves as a

result of multiple open shifts or attending participant's medical appointments). As a Targeted Service Coordinator (TSC) I have also seen the same patterns with participants who receive supported living from other providers. With the consistent pattern it can be projected that the frequency of behaviors will also increase if the caseloads for QIDPs increase as QIDPs have now had higher demands placed on them and less availability for participants.

Considering a reimbursement rate that would account for competitive direct care staff wages (which is of high importance to be able to higher and retain staff), administration costs, and general costs would be better supported. When considering the direct care wage it is important to consider the expectations that direct care staff need to uphold and present a wage that is competitive to other such employment opportunities opposed to entry level positions that require less training and expectations that are required throughout a shift. Supported Living direct care staff are responsible for implementing skill training goals, assist in behavior management, transport participants to appointments and activities, assist with medications, assist with household tasks, document services provided (via data collection, activity logs, and incident reports), and attend required trainings. The job description for the direct care staff seem to have similar responsibilities of a personal care aide, home health aide, and psychiatric assistant (please refer to the attached job descriptions for comparison). Without a competitive wage to offer direct care staff, house managers/trainers, and QIDPs providers will continue to face an alarming rate of open shifts, high staff turnover, and high levels of overtime pay which directly impacts the supports and services to individuals with developmental disabilities.

There is hope that with continuing awareness and by providing community based supports, every individual including those with a Developmental Disability, will have the opportunity to live independently. I am hopeful the issues related to appropriate funding for supported living services can be resolved to the satisfaction of the state, providers, and the participants that receive the service if further review of Idaho's rate study occurs, another cost study is completed and the rate methodology is validated.

Thank you for your consideration and your time.

Respectfully,

Nicole Sherwood, Quality Assurance Specialist and Targeted Service Coordinator.

Developmental Concepts, Inc.

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Rate study comparison of Hourly Supported Living/Residential Habilitation

	2007 Rate Study	2016 Rate Study
Group	$8.28/hour	$7.88/hour
Individual	$20.68/hour	$19.68/hour
High Support (24 hour support)	$248.40/day	$236.16/day
Intense Support (24 hour 1:1 support)	$496.56/day	$472.32/day

**There is a great amount of concern that the 2016 rate study shows a decrease in rate reimbursement when the cost of living has gone up over the last 10 years. In addition, no business that was in operation in 2007 has decreased their costs or what they charge for goods and services 10 years later.

Current Temporary Reimbursement Rates For Supported Living

H2015		**Individual Supported Living (1 unit = 15 Minutes)**	**$5.69**
H2015	**HQ**	**Group Supported Living (1 Unit = 15 Minutes)**	**$2.28**
H2016		**Daily Supported Living Services Intense Support (1 Unit = 1 Day)**	**$455.02**
H2016		**Daily Supported Living Services Intense Support School Based, School Days (1 Unit = 1 Day)**	**$360.21**
H2022		**Daily Supported Living Services High Support (1 Unit = 1 Day)**	**$273.13**
H2016		**Daily Supported Living Services High Support School Based, School Days (1 Unit = 1 Day)**	**$216.23**

BLS Categories that align with supported living direct care staff job description:

**BLS Wages data taken from May 2015*

- 31-1011 Home Health Aid: Provide routine individualized healthcare such as changing bandages and dressing wounds, and applying topical medications to the elderly, convalescents, or persons with disabilities at the patient's home or in a care facility. Monitor or report changes in health status. May also provide personal care such as bathing, dressing, and grooming of patient.
  - $11 (Mean)
  - $10.54 (Median)
  - $11.96 (75th percentile)
  - $10.44 (Idaho)

- 31-101. Psychiatric Aid: Assist mentally impaired or emotionally disturbed patients, working under direction of nursing and medical staff. May assist with daily living activities, lead patients in educational and recreational activities, or accompany patients to and from examinations and treatments. May restrain violent patients. Includes psychiatric orderlies.
  - $13.55 (Mean)
  - $12.59 (Median)
  - $15.67 (75th percentile)
  - No ID specific data

- 31-1014 Nursing Assistants: Provide basic patient care under direction of nursing staff. Perform duties such as feed, bathe, dress, groom, or move patients, or change linens. May transfer or transport patients.
  - $12.89 (Mean)
  - $12.36 (Median)
  - $14.68 (75th percentile)
  - $11.70 (Idaho)

Idaho Division of Human Services

- 07798 Developmental Disabilities Technician: To provide therapeutic training services and personal care for clients with intellectual disabilities; perform housekeeping activities; perform related work. Employees in this class work directly with individuals who have an intellectual disability and
  - $11.70-20.89 (June 2016)

BLS average wages for entry level occupational categories that supported living providers are competing with:

** Based on May 2015 data for Idaho*

- Waitresses $9.48/hour
- Retail Sales $13.01/hour
- Production workers $13.19/hour

Testimony for Joint Listening Session
Senate and House Health & Welfare Committees
January 27, 2017

Emily Allen
Idaho Asset Building Network
Boise, Idaho

Chairman Heider, Chairman Wood, and Members of the Committee,

Good morning. My name is Emily Allen and I am an intern at the Idaho Asset Building Network, an initiative focused on advancing family financial well-being in our state. While my internship is part of my curriculum, I am also a full-time Master's in Social Work student at Boise State. Given my specific educational training and my experiences with the Idaho Asset Building Network, I have a unique perspective while examining the status of healthcare in the state of Idaho.

One of the most rewarding parts of my internship is getting to speak directly with Idahoans who have once fallen into or are currently in the coverage gap and are uninsured. The "coverage gap" is a term used to describe 78,000 adults in Idaho between the ages of 18 and 64 who have no access to affordable health coverage. Idahoans in the gap do not qualify for traditional Medicaid and earn too little to qualify for assistance through the Your Health Idaho Insurance marketplace. The spectrum of folks who are affected by the coverage gap is broad. Some suffer from chronic illness and are unable to work. Some have experienced an unexpected medical emergency resulting in debilitating medical debt. Some have foregone necessary follow-up care due to costs they cannot afford.

Many of the 78,000 Idahoans in the healthcare coverage gap are working parents in low-wage jobs and small business owners. Almost every parent I've spoken with has had to make a terrible choice like deciding to purchase their prescriptions OR putting food on the table for their kids. These are entrepreneurs, service providers, and laborers like those we rely on to care for our children, cut our hair, clean our office buildings, grow our food.

Through these conversations, I have recognized a theme: they are not angry. Those who share their story with me are people who are always thinking about how they might help the next person who falls into the gap. They implore legislators to close the gap, but the part of their message they always emphasize is that they are hardworking people who want to be healthy so that they can give back to their communities and provide for their families.

The School of Public Service at Boise State's 2017 Idaho Public Policy Survey reported that over 70% "of Idahoans scored healthcare at least an 8 when asked how important it was on a

scale of 1-10 for the state legislature to address." Three quarters of those surveyed favor closing the health care coverage gap. Now, I get it. With the new administration and change in Congress, the game has changed. But the stakes are still the same in Idaho--78,000 Idahoans are still suffering in the coverage gap and some will die because they do not have access to affordable health care.

Prioritizing and protecting our families is an Idaho value. In my experience, what I have found in my conversations confirm this. The folks I talk to about their experiences in the gap are most worried about their children and loved ones. They are the best kind of Idahoans. They are faithful, incredibly resilient and creative problem solvers. They are business owners. They love their communities and are the best kind of neighbors you could want. Most of all, these are family-oriented people who are making the best possible decisions for their families everyday.

We are a state that prides ourselves in always doing what's best for Idahoans. I ask that you consider the coverage gap issue a crisis that needs your urgent attention. Take action to increase access to comprehensive health coverage for the hardworking uninsured families in Idaho this legislative session.

Thank you.

Members of the Joint Health and Welfare Committee

January, 27, 2017

I stand before you today first as a family member I have 2 nephews who have Type 1 diabetes I have watched as they have grown into fine young men. The oldest has a son of his own. Last year his son was diagnosed with an agressive form of Lukemia. He and his family have spent significant amounts of time in children's hospitals in Seattle and Spokane for treatment. Recently, we learned that his numbers look good and for the time being we are hopeful. From a practical standpoint this means that my nephews all have presisting conditions and that without the affordable care act they will be unable to access insurance and by extension health care. Without this care their prognosis, like so many in Idaho with out current access to care, is grim indeed. Pleaselet Congress know that Idaho does not support the Repeal of the Affordable Care Act without a meaningful Replacement. Please Make this the year that Idaho closes the Medicaid Gap.

Second, I come as a mental health professional. I wish to mention the ongoing administrative burdens that have been created by the contrators that have been created by the contractors that have been hired by the Department. The contracts with both OPtum and Vego are leaving our clients without access to care Small agencies and Rural communities experience a dispropoitinate effect when administrative burdens and unreasonable restrictions are placed on clients' access to care.

Friday, January 27, 2017
H&W Listening and Advocacy Day
Idaho Legislature
Testimony
Judy Cross

Senator Heider, Representative Wood, and Members of the Joint H&W Committee.
Thank you for holding this session to listen and gather information from your people.

My name is Judy Cross. I am a nurse, a Clinical Nurse Specialist, as well as the President of the Board of Directors for The Interfaith Alliance of Idaho. As a healthcare professional, I am deeply interested in issues affecting the health and wellbeing of our citizens. My colleagues and I, at the Interfaith Alliance, feel a strong moral obligation to speak up in support of legislation that would improve the health and care of our citizens.

We eagerly followed the legislative workgroup that met between sessions, and had great hope that a strong recommendation would emerge from the deliberations there. Your honest and diligent work brought hope. Now it is time to act upon that.

We believe that legislation to provide comprehensive health coverage with a complete Idaho-based solution is imperative! Thanks to the hard work of the interim legislative workgroup, promising headway was made toward this goal. Please don't waist all the time and energy that went into that effort. Studies and stats were presented that showed: with preventive care and client involvement in their own care, hundreds of lives can be saved every year. By putting our tax dollars to work, along with expansion of Medicaid dollars, we can build a much more healthy citizenry who will, in turn, build a stronger economy for future generations_

There are some problems with the current system which can be corrected. *For example, my son-in-law has insurance coverage through his work, but the cost of adding my daughter and granddaughter is prohibitive, and they found they made $51 too much to qualify for Medicaid, but not enough to qualify for subsidy. Such glitches can be identified and corrected to meet the intent of legislation.* A more efficient and cost effective health system can be created, that could also eliminate the very costly state and county indigent programs, by spending our tax dollars wisely and utilizing federal dollars available to us.

We should NOT wait to see what happens in Washington, DC! Regardless of the Administration, I have faith that our Senators and Representatives there will try to work with integrity to bolster a patient-centered health system. YOU, however, have the power and the ability to creatively increase access to coverage. YOU have the responsibility to use the work already done to move forward with integrity for your constituents. Please show that you have the courage and integrity to do the right thing that will save lives, save money, and improve health for generations forward.

As a healthcare professional, and a person of faith and conscience, I truly believe that promoting optimum health for all Idahoans, MORE THAN ANY OTHER FACTOR, will support our children's ability to learn, will foster educated and safe health practices for our adolescents, will ensure productivity for hard working Idaho adults, and will increase the independence and longer term health of our aging population.

Thank you very much for your attention and consideration.

Public Testimony to H&W Legislative Committees at a Listening Session Jan. 27, 2017

Hi, my name is Robert Gehrke, (Bob) and I am from Pocatello. I am also the Chair of the Recovery Support Services Subcommittee of the Region 6's Behavioral Health Board as a volunteer. I also have a daughter, Julie, who is 50 yrs old and severely mentally disabled since she was 1yr old due to epilepsy and intellectual disability. She lives in an ICF in Nampa Idaho and her care is provided by the state and federal governments through Medicaid and Medicare. Mary and I are eternally grateful for her care that after 9 years we could not continue the 24/7 intense care required. However, today, I am here to focus on the need for those released from local jails or the state penitentiary.

If Idaho is to succeed in its Criminal Justice Reform efforts and return those released to community life as productive members of society, they need to be provided continuing medical care. Further, it is essential to reduce the cost to our state due to the high populations in jails and prisons due to nonviolent offenders incarcerated due to drug abuse and mental health issues. The only way we will be able to reduce recidivism by our ex-incarcerated is to ensure that the medical care they received in prison continues when they are released. Once released, this is not a County's or State's responsibility nor do they have the budget to do this. We need to expand Medicaid with no waivers this session even realizing that Obama Care will be repealed. The reason I state no waivers is that they would just delay implementation and again Idaho would be left without any health care support. When the new health care law is passed by Congress and signed by the President, Idaho will be in the best

position to continue health care coverage to those in the gap including released prisoners.

I ask that you give this proposal serious consideration and pass Medicaid expansion. It will be at the earliest a couple of years before a new health care bill is written and passed through Congress and signed by the President and another year at best to implement it. Don't leave Idaho again without this needed comprehensive health care.

Sincerely,

Robert Gehrke
2279 Jacqueline Ln
Pocatello, Idaho
Cell: 208-680-4766

P.S. Our Bannock County jail requires an annex to meet regulatory requirements. The requested levy to the public last year for about $16 million dollars for an annex and for repairs to the present jail failed largely due to the present tax burden in our county.

Thu 1/26/2017

Hello Committee Members,

I've reviewed the PCAP that was proposed in 2016 by Otter; I find many parts of it disturbing;

- 1st) An eligibility requirement of income at $1000/month or less would not include anyone who had a mortgage or paid rent as that one bill alone would take the entire income after taxes.
- 2nd) The "must be pro-active on care and obey doctors orders" part within it; is even more concerning as it violates the very principle of freedom.

Granite; those who require others wealth to bail them out should be restricted, but putting them on the chopping block for missing an appointment or doing something a doctor says to do (which often is clearly wrong) is just too far.

The idea of restricting patients to low-cost Community and Rural Health Clinics who agree to cost terms is an AMAZING and well thought out idea. Patients using others wealth should not be granted the right to any service they so desire at any cost they want to throw others wealth at.

I'd like to filter out 1 & 2 above and add the below items to the PCAP model that would contain the following

1st) The State guarantees health services at all joining C&RHC's to any citizen with an income based fee at a percentage that would obviously cause high incomes to not be worth while. The clinic of course can charge what they want but in order to have state re-assurance must be % of patient income.

2nd) The state acts as an insurance for the C&RHC clinic for losses -- For example, losses recorded up to $25,000 (like auto requirements) can be re-reimbursed using taxes or tobacco settlements

3rd) The patient using the income based service will be accountable to the State and future tax returns will be deducted as appropriate until bill has been paid in full.

4th) Patients using the income based service will also be high-prioritized for State Jobs to fulfill their debt to society as well as gaining credit for working for the C&RHC. For Example; If an assistant nurse needs health care for her family from a doctor - the nurse will be allowed to work at the clinic to redeem credit on the State Bill. Other services that Idaho State does such as road maintenance or any such - able bodied patients can do to relieve their debt to society. I hope the point is clear - basically; those requiring wealth from others to fulfill their medical needs are given the highest amount of opportunity to work for the State to pay off the debt incurred.

Thank you,
Thomas Gittins of Burley
208-884-1669
Rural Idaho Resident

Health Care Public Input
1-27-17

I recently participated in a Conference Call sponsored by AARP with President Pro Tem Brent Hill and Speaker Scott Bedke. They were asked some questions about programs vital to persons with disabilities and health care for low income families. To my dismay, more often than not the response was "well, we usually rely on the Federal programs to provide those services, I guess they'll have to work on that."

This amazed me coming from a legislature that claims to be moving in the direction of getting out from under Federal programs. That was the primary reason, they said for not working on Health Care for the 70,000 Idahoans who are and will be left out if the Affordable Care Act is repealed without something almost identical to it's coverage in place. It appears that Congress has no plan that can come close to what the ACA provides.

Our legislature has also supported Congress' stand against Planned Parenthood. I am a Christian who believes life begins at conception, however, I know that PP has been instrumental in providing birth control, women's reproductive care, and sex education effectively and efficiently. Abortions are at the lowest number since and in spite of Roe v. Wade enactment. Perhaps the State of Idaho should consider funding Planned Parenthood for our citizens, minus abortions if necessary. This will fill the gap for low income and middle class families still under insured or not at all.

Truth be told, our legislature should have been formulating a plan long before now. We did a pretty good job with our insurance exchange and I feel we could accomplish even more.

I would appeal to our legislature to stop spreading fake news about the Affordable Care Act and Planned Parenthood and address our citizens needs in spite of what Congress MAY or MAY not do. Plans can be adjusted to accommodate any Federal system in which we wish to participate.

With 50% or more of Idaho's registered voters claiming no party affiliation, our purple state could find itself blue if it doesn't become proactive on behalf of it's citizens.

Deborah Gold
9157 W. Steve Street
Boise, ID 83714
208-258-5828

January 27, 2017

Honorable Members of the Joint Senate and House Health and Welfare Committee:

I am writing to express 1) support for closing the health care coverage gap and 2) concern that Your Health Idaho will be eliminated.

1) Healthcare is one of the most important economic concerns of most Americans. You know that 78,000 Idahoans (most working, with families) have been left out of the healthcare picture, as many legislators chose to kick the can down the road. This delay has caused needless suffering and financial instability, leading to an unnecessary negative impact on the quality of life of far too many.

Regardless of what happens with national healthcare reform, Idaho can still leverage current federal match rates to increase access to quality care and reduce costs in our healthcare system.

If Idaho continues to opt out, we may be left out of national reform. Now is not the time to pause and wait; now is the time for the Idaho Legislature to take action to provide essential coverage to uninsured Idahoans. This would save hundreds of lives each year, spend tax dollars wisely and create a more efficient and cost-effective health system in Idaho.

2) In light of threats to the Affordable Care Act, it is apparent that our entire health insurance industry could go back to the dark ages. As a person who has been in the individual market since 2000, I have experienced first hand the stressful days of exponential premium increases and high deductibles (high-risk pools) based on gender, age and a pre-existing condition. Although I was able to afford continuous coverage, paying those high premiums placed a burden on my family. It was partially thanks to the ACA's initial premium decreases that I was finally able to afford a decent 'gold' policy that provided the cure for my potentially life-threatening chronic condition. After years of dealing with expensive premiums for less and less coverage, it was such a relief to have access to the drugs I waited 20+ years for, and to be cured successfully.

So, of course I am feeling vulnerable again, as I over 60 and fear the risk associated with losing or being priced out of health insurance. I signed up for a policy on Your Health Idaho at my last renewal and things were looking positive. Thankfully my husband is on Medicare, but I am in this gray zone, facing uncertainty.

I urge you and your colleagues to develop a plan that serves all Idahoans, not just those with employer-based coverage and wealthier individuals. Please don't stall coverage for the 78,000, and please don't undo the exchange, which has proved beneficial for so many of my friends and family members. Please put in the hard work to address access for everyone, including our most vulnerable citizens.

Sincerely, Kathryn Haley

Kathryn Haley
4120 Shamrock St.
Boise 83713
haleykathy@gmail.com

Good morning chairmen and legislators, thank you for this opportunity to testify.

My name is Dr. Kara Kuntz, I live here in Boise and am a graduate of the WWAMI program. I a board-certified family physician and geriatrician. I care for patients of all ages and specialize in the care of older adults. I am here today to speak to you about closing the gap and supporting unpaid family caregivers.

I would like to share a story with you. While working as a family medicine resident here in Boise, I met a woman who found herself in the ICU due to severe illness. She was in the hospital for three months. She did not have health insurance. When she finally left the hospital, she experienced two weeks of absolute elation and a renewed sense of self. She felt she had escaped death and was grateful for her health care. Soon thereafter, however, her medical bills began to pile up. She found herself going through severe depression due to the financial stress complications of her medical illness. This woman who was once a productive member of her community, eventually went on to disability for severe depression. She no longer works and suffers every day.

It is imperative to the health of Idahoans and to our State's financial wellbeing that we close the gap in health care coverage for the citizens of this state. I urge you to be proactive, close the gap, allow for preventative health and health care coverage for all citizens.

Secondly, I'm here to speak in support of the Idaho Caregiver Alliance Idaho Lifespan Family Caregiver Action Plan. As a geriatrician, I care for many aging adults who have such severe illness or dementia that they can no longer care for themselves. These people are often cared for by a friend or family member who is unpaid for this challenging and stressful work. Regarding dementia alone there have been several studies that have demonstrated that supporting caregivers improves health outcomes and delays need for institutionalization for up approximately 1.5 years. (Mittelman et al, Neurology 2006). I urge you to support this action plan and help the caregivers of our state get the support they need to provide better care for loved ones, allow for better care of themselves and again ultimately decrease the health care costs in Idaho.

PubMed nuerology mittelman 2006 caregiver

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Neurology. **2006** Nov 14;67(9):1592-9.

Improving caregiver well-being delays nursing home placement of patients with Alzheimer disease.

Mittelman MS[1], Haley WE, Clay OJ, Roth DL.

Author information

Abstract

OBJECTIVE: To determine the effectiveness of a counseling and support intervention for spouse **caregivers** in delaying time to nursing home placement of patients with Alzheimer disease (AD), and identify the mechanisms through which the intervention accomplished this goal.

METHODS: We conducted a randomized controlled trial of an enhanced counseling and support intervention compared to usual care. Participants were a referred volunteer sample of 406 spouse **caregivers** of community-dwelling patients who had enrolled in the study over a 9.5-year period. The intervention consisted of six sessions of individual and family counseling, support group participation, and continuous availability of ad hoc telephone counseling. Structured questionnaires were administered at baseline and at regular follow-up intervals, every 4 months for the first year and every 6 months thereafter. Cox proportional hazard models were used to test the effects of the intervention on the time to nursing home placement for the patients after controlling for multiple time-invariant and time-dependent predictors of placement.

RESULTS: Patients whose spouses received the intervention experienced a 28.3% reduction in the rate of nursing home placement compared with usual care controls (hazard ratio = 0.717 after covariate adjustment, p = 0.025). The difference in model-predicted median time to placement was 557 days. Improvements in **caregivers'** satisfaction with social support, response to patient behavior problems, and symptoms of depression collectively accounted for 61.2% of the intervention's beneficial impact on placement.

CONCLUSION: Greater access to effective programs of counseling and support could yield considerable benefits for **caregivers**, patients with Alzheimer disease, and society.

PMID: 17101889 DOI: 10.1212/01.wnl.0000242727.81172.91

[PubMed - indexed for MEDLINE]

Publication Types, MeSH Terms, Grant Support

Joint Health and Welfare Listening Session

Remarks by Lauren Necochea, Director of Idaho Voices for Children

January 26, 2017

Idaho stands at a critical juncture. The next phase of national healthcare reform is rapidly approaching and we need to ask:

- What steps do we need to take today to ensure Idaho is in the strongest position possible in the coming months?
- How can we ensure we have the most control possible when it comes to our healthcare future?

The way national healthcare funds, including those for Medicaid, are divided is likely to change dramatically. And we can't count on that pie expanding. The decisions we make during this Legislative Session could determine whether Idaho is at the back of the line as those negotiations take place.

Failure to act now could lock us into position where the healthcare needs of Idahoans are lower priority than the healthcare needs of those in New York, Arizona, Nevada, Ohio, and a host of other states. Congress and the President will decide how to divide that pie and we know that governors in states that expanded Medicaid are already lobbying to maintain their share. When it comes to representation in both the U.S. House and the U.S. Senate, states that expanded Medicaid far outnumber the 19 states, like Idaho, that have been on the sidelines.

Inaction during this legislative session also creates a substantial long-term financial risk. In Washington, DC, lawmakers are discussing new financial schemes for Medicaid that gradually shift the costs to the states. These block grants would encompass all Medicaid funding – for traditional and expanded populations. While the flexibility they offer may be welcomed, these proposals can cut the support Idaho receives by 30% over 10 years. The increased pressure on our state budget cuts into other priorities, like education. If Idaho gets locked into a lower level of Medicaid support today, the fiscal impact for Idaho will be even more severe.

Of course, this issue is about much more than dollars and cents. It's about building an effective healthcare system that cares for Idahoans. It's about access to mental health treatment. It's about ensuring families facing the heartbreak of a cancer diagnosis aren't distracted by their potential financial ruin.

I urge you to consider carefully how we can best protect Idaho's healthcare future and our state budget, during this Session. That will probably need to include sideboards and escape clauses to ~~that~~ navigate what may be coming. Now is a dangerous time to pause because doors could be closing that leave Idaho shut out permanently.

Thu 1/26/2017

Unfortunately I am unable to attend the Friday hearing that may include information concerning the expansion of Medicaid in Idaho. For some of us, who take care of others, the timing of the hearings just does not work.
I urge the legislative body to expand Medicaid for the citizens of Idaho. It would improve quality of life for those who cannot afford health insurance and it can be done at a better cost to the state if you go forward now.

And why not? The Affordable Care Act gives you the opportunity to expand now, even if it is for a short time.

Then you can see how many people will benefit ; and give those in need opportunity to have better health.

Thank you for your time,

Bonita Parodi
310 S Garden ST
Boise, ID 83705

Valerie Charles, Health Freedom Idaho

HFI is here today on behalf of its membership who support a draft bill to amend I.C. Section 39-4802(2) to clarify that parents claiming an exemption from immunization have a right to submit such exemption on a simple, signed statement and give it to a school official as already codified in the statute. At issue is the Idaho Immunization Exemption Form. IDAPA 16.02.15.110.02 states that the form provided by IDHW may contain the (1) child's name, (2) date of birth and (3) grounds for exemption. Period.

All children have a legal right to attend school. However, many parents (1) are taking issue with the language on Page 1 of the form as written, (2) are encountering discrimination and (3) have been denied daycare/preschool/school entry, unless they agree to acknowledge, as fact, statements of risks that are IDHW's opinion. Many parents know such statements are one-sided, factually incomplete and amount to compelled speech in violation of freedom of speech under the First Amendment. I was told by 2 different schools that I was required to fill out the form in its entirety and that they would not accept it if I crossed through any language I found objectionable while otherwise trying to comply with the Idaho statute.

The chapter on immunizations states that immunizations are required unless an exemption is claimed.

A. I.C. Section 39-4802(2) provides that a parent has a right to submit **a signed statement pursuant to Section 39-4802** and I.C. 39-4804(2)(a) and subsection (3)(a) concur.

B. I.C. Section 39-4803 provides for a **voluntary** immunization registry maintained through the IDHW.

Subsection (2) provides that the name and immunization status of a child shall be collected and included in the registry UNLESS a parent chooses not to have the child included in the registry upon a specific written statement.

Subsection (3) provides the IDHW shall only disclose information relating to the child to the following:

> (b) Health records staff of **the school or school district** in which the child is enrolled; or
>
> (c) The operator of a **licensed daycare facility** in which the child is enrolled.

Subsection 4(a) requires that, in the event a parent submit a written request, IDHW **shall** "[c]ause all information relating to the child to be removed from the registry."

Therefore, neither (i) IDHW nor (ii)(a) the school district nor (b) a daycare facility have an automatic right to this information under this chapter of the Idaho Code.

POINT 1: Whether this is the intent or rather, the result, (i) the exemption form requirements **exceed** the administrative rule authority **AND** (ii) act as a go-around of the statutes to obtain indirectly information IDHW or schools/daycares cannot obtain directly through the voluntary immunization registry.

POINT 2: While IDHW may claim that it has a legal obligation to protect the public from the spread of infectious disease, it has been able to do so for decades WITHOUT a voluntary immunization registry and WITHOUT forcing parents to disclose confidential medical information coupled with initialing incriminatory language tantamount to compelled speech in violation of their 1st Amendment freedom of speech.

The incriminatory language per each vaccine on Page 1 of the Exemption Form is not relevant to nor required for the identification of individual vaccinations in the event of an outbreak. By the way, are children with hepatitis or HIV excluded from school?

Child's Name: _____

IDAHO CERTIFICATE OF IMMUNIZATION EXEMPTION

School Immunization Requirement

The Idaho Department of Health and Welfare strongly supports immunization as one of the easiest and most effective tools in preventing serious infectious diseases. These vaccine-preventable diseases can cause serious illness and even death. The Idaho Department of Health and Welfare also recognizes that individuals have the right to make the decision whether or not to vaccinate their children. If you have any questions about the benefits and risks of immunization, please contact your healthcare provider or local health department.

SECTION 1: ***Please read the following statements, check the box(es), and date each statement regarding vaccine-preventable diseases for which an exemption is claimed. Sections 1 and 2 must be completed for this exemption to be valid.***

☐ **Diphtheria (DTaP, DT, Tdap, Td):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing diphtheria if exposed to this disease. Serious symptoms and effects of this disease include: heart failure, paralysis (can't move parts of the body), breathing problems, coma, and death. _____ Date

☐ **Tetanus (DTaP, DT, Tdap, Td):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing tetanus if exposed to this disease. Serious symptoms and effects of this disease include: "locking" of the jaw, difficulty in swallowing and breathing, seizures (jerking and staring), painful tightening of muscles in the head and neck, and death. _____ Date

☐ **Pertussis (Whooping Cough) (DTaP, Tdap):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing pertussis (whooping cough) if exposed to this disease. Serious symptoms and effects of this disease include: severe coughing fits that can cause vomiting and exhaustion, pneumonia, seizures (jerking and staring), brain damage, and death. _____ Date

☐ **Polio:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing polio if exposed to this disease. Serious symptoms and effects of this disease include: paralysis (can't move parts of the body), meningitis (infection of the brain and spinal cord covering), permanent disability, and death. _____ Date

☐ **Measles, Mumps, Rubella (MMR):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing measles, mumps, and/or rubella if exposed to these diseases. Serious symptoms and effects of measles include: pneumonia, seizures (jerking and staring), brain damage, and death. Serious symptoms and effects of mumps include: meningitis (infection of the brain and spinal cord covering), painful swelling of the testicles or ovaries, sterility, deafness, and death. Serious symptoms and effects of rubella include: rash, arthritis, and muscle or joint pain. If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects such as deafness, heart problems, and mental retardation. _____ Date

☐ **Hepatitis B:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing hepatitis B if exposed to this disease. Serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), life-long liver problems, such as scarring and liver cancer, and death. _____ Date

☐ **Varicella (Chickenpox):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing varicella (chickenpox) if exposed to this disease. Serious symptoms and effects of this disease include: severe skin infections, pneumonia, brain damage, and death. A person who has had chickenpox can get a painful rash called shingles years later. _____ Date

☐ **Varicella Disease History:** I believe that my child has had chickenpox, but was <u>not</u> diagnosed by a licensed health care professional. _____ Date

☐ **Hepatitis A:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing hepatitis A if exposed to this disease. Serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), "flu-like" illness, hospitalization, and death. _____ Date

☐ **Meningococcal:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing meningococcal disease if exposed to this disease. Serious symptoms and effects of this disease include: meningitis (infection of the covering of the brain and spinal cord), blood infections, loss of arms or legs, problems with nervous system, deafness, mental retardation, seizures (jerking and staring), strokes, and death. _____ Date

Please continue to complete Section 2

SECTION 2: ***Please select ONE of the following exemption types (medical, religious, philosophical) for vaccines checked in Section 1.***

☐ MEDICAL EXEMPTION (This exemption requires the signature of a licensed physician)

As the child's physician, I certify that the physical condition of this child is such that the immunization(s) checked in Section 1 would endanger the health of the child.

- ☐ This medical exemption is permanent.
- ☐ This medical exemption is temporary. Duration of temporary exemption: _____/_____/_____

I hereby request that this child be exempted from the Immunization Requirements for Idaho School Children (IDAPA 16.02.15) due to a medical condition for which immunizations are contraindicated.

Name of Physician (PRINT) | Signature of Physician | Medical License # | Date

As the child's parent/guardian, I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak, both for his/her own protection and for the protection of others. I acknowledge that I have read this document in its entirety.

Name of Parent/Guardian (PRINT) | Signature of Parent/Guardian | Date

Full Name of Exempted Child (PRINT) | Child's Date of Birth (Month, Day, Year)

☐ RELIGIOUS EXEMPTION

As the child's parent/guardian, I certify that I am a member of a recognized religious organization which has doctrine that opposes immunizations for the following reason(s):

I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak, both for his/her own protection and for the protection of others. I acknowledge that I have read this document in its entirety.

Name of Parent/Guardian (PRINT) | Signature of Parent/Guardian | Date

Full Name of Exempted Child (PRINT) | Child's Date of Birth (Month, Day, Year)

☐ PHILOSOPHICAL EXEMPTION

As the child's parent/guardian, I am opposed to having my child receive the immunization(s) checked in Section 1 of this form for the following reason(s):

I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak, both for his/her own protection and for the protection of others. I acknowledge that I have read this document in its entirety.

Name of Parent/Guardian (PRINT) | Signature of Parent/Guardian | Date

Full Name of Exempted Child (PRINT) | Child's Date of Birth (Month, Day, Year)

Rev. Marci Auld Glass
Testimony to Health and Welfare Listening Session
January 27, 2017

My name is Marci Glass. I pastor Southminster Presbyterian Church here in Boise.

And I'm hear to speak on behalf of children in Idaho whose health, well being, and even lives are at risk because their parents claim their right to religious freedom is stronger than their child's right to live.

I am a strong believer in religious freedom. A faith exemption that keeps children from health and life, however, is not religious freedom. It is child abuse cloaked in the name of religion. It is state enforcement of one religion at the expense of children's lives.

The separation of church and state is central to our governance. It provides mutual respect for various religious traditions so people may connect with a spiritual home, free from the governance of the State. Religious freedom is not a shield from the laws and regulations that govern all people, nor should it be used as an excuse to keep children away from preventative, and even life saving, medical treatment. Religious freedom is the freedom to express our common spiritual nature in diverse ways. It has limits when religious practice endangers the adherents or the community at large.

As the pastor of a congregation here in Boise, I am grateful for the **separation of church and state.** I beg you to take seriously some ways we can work for the **separation of church and medical neglect** too. Adults can make their own religious decisions for themselves, even if I wish they, too, would seek medical care so they might live and be well.

Children need the protection of the state when they are in moments of risk.
In 1944 US Supreme Court Justice Wiley Rutledge wrote "Parents may be free to become martyrs themselves, but it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves."

Thank you for the work you will do this session to make Idaho safer for us all. As the federal government keeps claiming that states are the proper place for health care decisions to be made, and are threatening to overturn the Affordable Care Act, it is even more important that we do what we can, right here in Idaho, to provide medical care for Idahoans, and to ensure that all children will get the help they need, regardless of their parents religious views. If this state cannot, or will not step up to care for her people, we need you to let congressional leaders in DC know not to repeal the protections of the ACA as they seek to make ~~it better.~~ changes.

This final piece should go without saying, but if the bill comes to you that would criminalize women and their doctors for seeking a legal, safe, medical procedure—please do not even

give it a hearing. It is bad medicine. It is unconstitutional. It is cruel to women. It will keep businesses from locating to our great state because they will not want to subject their loved ones to medieval medical/legal policies.

Thank you for your time. I know these are not easy topics. If you would like a religious perspective to join in your conversations about how to navigate the tricky waters of the religious exemption issue, I would be happy to meet with you. We can do something. We must.

HEALTH FREEDOM IDAHO
Your life. Your health. Your Way.

NATUROPATHIC LICENSING

HEALTH FREEDOM IDAHO POSITION: OPPOSITION

Contact: Miste Karlfeldt phone: 830-3576
email: Miste.Karlfeldt@healthfreedomidaho.org

Licensing through the *state* is not necessary, and is not time or cost effective.

Licensing restricted to a *few accredited schools* would stifle and eventually destroy naturopathy in Idaho. This exclusivity would soon drive out competition, new ideas, and new practices that are the lifeblood of our state and country.
This would create unemployment for *most* of the naturopaths in Idaho.

REPEAL OF "FAITH HEALING" EXEMPTION

HEALTH FREEDOM IDAHO POSITION: OPPOSITION

Contact: Sara Brady phone: 890-4338
email: Sara.Brady@healthfreedomidaho.org

Removing this exemption is in *violation* of the constitution. The first amendment states that, "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof."

Alternative treatment choices by parents for their children should not be *criminalized*. Parents actively seeking healing and/or treatment for their child in means that differ from the AMA should not be subject to criminal charges of abuse or neglect. A recent Johns Hopkins study shows that medical errors are the 3rd leading cause of death in our nation. **There are already specific Idaho statutes in place to protect children from intentional physical abuse.**

IDHW IMMUNIZATION EXEMPTION FORM

HEALTH FREEDOM IDAHO POSITION: OPPOSITION

Contact: Sarah Clendenon phone: 571-1943
email: Sarah.Clendenon@healthfreedomidaho.org

Idaho Statute permits a parent/guardian:
1. The right to choose whether to vaccinate their child
2. The right to choose to participate or decline participation in the state vaccine registry system (IRIS).

IDHW REFUSES to accept the legally approved signed parental affidavits forcing schools to deny admission to children. Parents enrolling children in schools and daycare are being forced to complete IDHW's mandatory immunization form. The form is designed to make parents state they are guilty of medical neglect, denies parents' legally protected medical privacy, and violates their legally protected right to opt out of the State Registry.

Idaho Department of Health and Welfare has imposed IDAPA RULE 16.02.15 (110.02), creating the mandatory IDAHO CERTIFICATE OF IMMUNIZATION EXEMPTION for school and daycare admission. However, the only requirement of parents under Idaho Code is stated in 39-4802(2): to "submit a signed statement to school officials stating an objection on religious or other grounds." The state-prescribed form, based on IDAPA 16.02.15, is in violation of Code 39-4802 and 39-4804. The form developed by IDHW falls far outside the scope of Idaho Code 39-1118(2)and 39-4802(2).

OPPOSE

NATUROPATHIC LICENSING

Exclusive licensing, by the State of Idaho, for Naturopathy, has the potential to limit natural health care choices for Idaho citizens, while threatening new and existing natural health care practices, across the state. Exclusive licensing constricts the scope of practice, favors the few graduates from a few peer accredited naturopathic schools in this country, and effectively stifles all natural health care therapies, by allowing only the chosen few to collect third party payments. It fully restricts health freedom choices for all Idaho citizens and stands to destroy the businesses of the practitioners who they support.

LICENSING WILL RESTRICT THE PRACTICE OF ALL TRADITIONALLY TRAINED NATUROPATHS, AROMA-THERAPISTS, NUTRITIONISTS, HOMEOPATHS, & HERBALISTS

EXCLUSIVITY WILL DRIVE OUT COMPETITION, NEW IDEAS, AND PRACTICES

RESTRICTIONS IN LICENSING WILL DESTROY NATUROPATHY IN IDAHO

HEALTH FREEDOM IDAHO

Your life. Your health. Your Way.

www.HealthFreedomIdaho.org/licensing

Contact: Miste Karlfeldt

Miste.Karlfeldt@HealthFreedomIdaho.org phone: 830-3576

Health Freedom Idaho (HFI)

We are a concerned group of citizens, professionals and families in Idaho interested in preserving Idaho's health freedoms.

OPPOSE
REMOVAL OF

FAITH HEALING EXEMPTION

Health Freedom Idaho doesn't take a position on the faith healing aspect per se as much as a government mandate of the health/medical care involvement toward the parent. The government should not have the power to mandate choice of treatment or care over a child.

Removing this exemption is in *violation* of the constitution. The first amendment states that, "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof."

Alternative treatment choices by parents for their children should not be *criminalized*. Parents actively seeking healing and/or treatment for their child in means that differ from the AMA should not be subject to criminal charges of abuse or neglect. AMA protocol doesn't guarantee healing or recovery for a child. A recent Johns Hopkins study shows that medical errors are the 3rd leading cause of death in our nation.

There are already specific Idaho statutes in place to protect children from intentional physical abuse.

PARENTS HOLD THE RIGHT AND RESPONSIBILITY TO CARE FOR AND PROTECT THEIR CHILDREN.

THERE ARE ALREADY SPECIFIC LAWS IN PLACE TO PROTECT CHILDREN FROM ABUSE.

TRADITIONAL MEDICAL TREATMENT DOES NOT GUARANTEE A CHILD'S HEALTH OR HEALING.

HEALTH FREEDOM IDAHO

Your life. Your health. Your Way.

www.HealthFreedomIdaho.org/faith-healing.html

Contact: Sara Brady

Sara.Brady@HealthFreedomIdaho.org phone: 890-4338

Health Freedom Idaho (HFI)

We are a concerned group of citizens, professionals and families in Idaho interested in preserving Idaho's health freedoms.

When Parents Refuse to Sign
ILLEGAL IDHW Immunization Exemption Form

Idaho Children are DISCRIMINATED AGAINST and DENIED school admission

Why is IDHW allowed to create their own laws to discriminate against minority groups?

OPPOSE

IDHW VACCINE EXEMPTION FORM

Idaho Statute permits a parent/guardian:

1. The right to choose whether to vaccinate their child

2. The right to choose to participate or decline participation in the state vaccine registry system (IRIS).

Parents enrolling children in schools and daycare are being forced to sign IDHW's mandatory immunization form. It is discriminatory, denies parents' legally protected medical privacy, and is not required by Idaho Statute. When parents opt to submit the legally acceptable affidavit IDHW declines it and schools deny the children's registration.

IDHW IS FORCING PARENTS TO SIGN AN ILLEGAL EXEMPTION FORM FOR SCHOOL & DAYCARE ADMISSION.

THE FORM DESIGNED TO MAKE PARENTS STATE THEY ARE GUILTY OF MEDICAL NEGLECT.

THE FORM FORCES FAMILIES TO WAIVE THE RIGHT TO PRIVACY AND VIOLATES THEIR LEGALLY PROTECTED RIGHT TO OPT OUT OF THE STATE REGISTRY.

HEALTH FREEDOM IDAHO
Your life. Your health. Your Way.

www.HealthFreedomIdaho.org/Vaccine-Exemptions.html
Contact: Sarah Clendenon
Sarah.Clendenon@HealthFreedomIdaho.org phone: 571-1943

Health Freedom Idaho (HFI)

We are a concerned group of citizens, professionals and families in Idaho interested in preserving Idaho's health freedoms.

M. Chair, M. Chair

I've come here today to ask you to support a complete repeal of the faithhealing exemptions to Idaho's child neglect laws.

These exemtions give parents the right to deny their children necessary medical care, even if the child dies as a result, as long as they claim they were praying for the child to get better.

The Governor's Taskforce on Children at Risk has identified 10 cases in the three most recent years for which they have completed reports on child fatalities in Idaho, of children dying as a result of this form of neglect. They die needlessly from such treatable

conditions as diabetes, gastrointestinal illness, and sepsis; without medication to even ease their pain. One national study of ~~children who died while being~~ similar faith healing deaths found that 140 of 172 children who died would have had a 90% or higher chance of survival if they had recieved medical care. Only 3 of the 172 children would have had a less than 10% chance of survival and little reduced pain and suffering.

This cruel loophole is completely unnecessary. It was originally imposed in the 1970s as a requirement to recieve federal grant funding. It was never a reflection of Idaho's values, merely capitulation to federal pressure. With this grant requirement no

longer in effect, Idaho is free to protect all its children.

Throughout discussions of this faith healing loophole, some have proposed a partial repeal, to allow parents who neglect their children to be prosecuted only if their child is killed or maimed, only if the child is in imminent risk of death, or to prevent parents from being prosecuted at all. These half measures assume their is some kind of right of parents to practice passive child sacrifice which must be balanced against a child's interest in not dying needlessly and in pain.

A full repeal of all of the exemptions is

needed to remove confusion about the duty of parents to provide care. We need a full repeal so that parents who willfully neglect their children can't lean on the excuse that they didn't realize that their child's serious illness had put them in mortal danger. We need it so that parents being pressured by their families or communities to deny their children medical care can have an "out", an "excuse" to do the right thing; and we need it to deter parents who believe their own aversion to medicine is more important than their child's life. As a final resort, when the worst happens and a child dies, we need these laws as a way to protect the victim's surviving

siblings.

Some pose the question of how to account for reasonable differences in parenting style, the challenge of determining whether neglect has truly occurred, & consideration that a parent who has clearly violated the law may have meant well. We already have a system to address these issues — the system that addresses cases of child neglect cases for the overwhelming majority of Idahoans.

This is a simple problem with a clear & simple solution. Fully repeal the religious exemption from all laws in which it appears to protect Idaho children.

April Hoy
Children's Right to Live - Idaho
5212 W. Kootenai St.
Boise, ID 83705

Freedom to Choose

My name is Jinny Peterson, and I am representing Health Freedom Idaho & myself, and I would like to share some of my concerns.

As a citizen of this wonderful state, I have a concern that we have forgotten what "inalienable rights" means. Those are the rights we came into this world with, and government does not have the right to take those from us.

We are legislating more and more control over peoples' lives, because we want a feeling of safety and security, but we need to ask ourselves whether or not we **should** be legislating out those rights.

I have a concern that there are plans for legislation in Idaho that will limit my freedom to choose what I feel is best in taking care of my **own health** and the **health of my family**.

I have a concern that individual government departments are **creating their own rules** *without the voice of the people.*

I am deeply concerned that there are plans for legislation that will **violate the constitution of the United States** under the pretense of protecting our children.

I want the freedom to choose my wonderful **orthopedic surgeon** when my son breaks his arms severely.

I want the freedom to choose a **holistic practitioner** when trying to get to the source of long-term anxiety or painful migraines.

I want the freedom to choose whether I'm willing to **accept the risks** involved in vaccinating myself or my children.

I want my fellow Idahoans to have the choice of whether to **put their faith in God**, or to put their faith in a doctor to heal their child.

I would like all of us to ask ourselves if we are truly standing up and protecting Idahoan's rights to personal health and welfare. If we are a legislator, have we forgotten that we represent the voice of the people, have we lost sight of that and are focused on our own agendas?

The answers to our problems are not in making more of our inalienable rights **unlawful**.
The ***answer is*** **recognizing the constitutional right of each of us to make the choices our conscience directs.**

January 27, 2017

Testimony to the Legislative Interim Committee on Religious Exemptions to Idaho's Medical Neglect Statutes

Roger Sherman, Executive Director, Idaho Children's Trust Fund

I am Roger Sherman, Executive Director of the Idaho Children's Trust Fund which is the state affiliate of Prevent Child Abuse America. We are a legislatively created board whose mission is prevention of child abuse and neglect before it occurs. We partner with communities and organizations statewide to strengthen families and promote safe, stable and nurturing relationships and environments for all children.

When the Children's Trust Fund was established in 1985 the legislature provided this intent language in establishing our role: "The children of the state of Idaho are its single greatest resource and …these children require the utmost protection to guard their future and the future of the state."

With this charge in mind, the Trust Fund Board has been alarmed at the number of preventable child deaths as a result of religious exemption, documented in the last report from the Child Death Review team and supports their recommendation that the religious exemptions to the child neglect statute be re-evaluated in light of these deaths.

Idaho's statutes are strong in relation to abuse and neglect. Without the religious exemption the law holds Idaho parents to a strong standard of care which states that a child is neglected when he or she "is without proper parental care and control, or subsistence, *medical* or other care or control necessary for his well-being because of the conduct or omission of his parents, guardian or other custodian or their neglect or refusal to provide them."

This is a good standard which should apply to all parents and other caretakers.

This fall, I was at the legislative study committee on foster care. This committee looked at child protection and foster care with an eye towards "the best interest of the child" which is the overriding goal of the child welfare system and the state's interest in protecting children. "Best interests" determinations are generally made by considering a number of factors with the child's ultimate safety and well-being the paramount concern.

Veronica Dulany
208-830-8683
Veronicadulany@gmail.com

Hello Chairman ~~Wood~~ and members of the committee
My name is Veronica Dulany. ~~I am a very concerned mom~~

Children's Mental Health

I come before you as a very concerned, stressed out mom. Some of you were privileged to see my son, Dallas, two years ago.
~~the~~ In the last two years Dallas + I have been shuffled and tossed to ~~above~~ so many departments of Health + Welfare in try to receive help for Dallas. The problems were many, We were told to go to one ~~Dept~~ ~~Place~~ 1st, that dept said we had to go to a different dept 1st. Getting ~~the~~ approved funding from Optum was a long, tedious nightmare.

long list of mental diagnosis and medications

The whole system, ~~to~~ between health + welfare and Optum is so disconnected ~~espec~~ especially w/in themselves. ~~many~~ some employees don't even know what they're doing.
In November 2015 Dallas suffered a concussion due to being unbalance from a medicine change. ~~One week later he~~ One week later he ~~spe~~ had his 1st admittance to St Als Behavioral Hosp. From then ~~to~~ April, 2016 he had 6 stays in ~~Behavioral~~ + there ~~two~~ one time we were sent to Utah because the whole state of Idaho had no beds available

2

Veronica Dulany
208-830-8683
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Dallas's problems stem from prenatal exposure to drugs, alcohol, + physical abuse. Plus he inherited serious mental problems from his bio parents.
He's suffered bullying and abuse throughout his life from peers. The ~~worse~~ devestating thing is - the last year and a half he ~~suffered~~ was tortured, + abused by professionals at St Als + ~~at~~ at San Marcos residential treatment Center - RTC in Texas. Because ~~He~~ was too young to placement in Id.
I was told ~~on~~ on different occassion by these professionals - that - there was no hope for Dallas, in so many words told - he'd end up ~~for~~ an institution or jail
No empathy or Love in him
more than once I had to expect some ~~of~~ mishaps with these violent boys.
~~While~~ in Tx for 2 mos - ~~so~~ because of lack of ~~space~~ staff suppose to be 4 mos
why → He had 2 ~~fat~~ lips several bruises on his face scratches from his chin ~~to~~ down his neck.
The finalized my decision to take him out was - He was tackled, put in a choke hold + his neck was popped. I contacted IDHW She said she would hurry + get services to wrap around him for his transition back home Since then she has decided too, that should

3

Veronica Dulany
208-830-8683
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expected that w/ a group of violent boys. - No I expected positive treatment & intervention ~~Now how~~ Back home since the end of Nov, we are still working on getting his previous services back in order. because of approvals needed thru optum

more

Dallas has worse anxieties, nightmare every night about being taken away from his family. I, also have nightmare about him being abuse in facilities. ~~the~~ And of him not getting the help Dallas is loved and adored by all who know him & work with him ~~regular~~ regulary including his teachers. ~~My~~ ~~Fam~~ I must live with my daughter & son-in-law because Dallas is 150 lbs - 47" tall. what can I do & let ~~me~~ Dallas be ~~ab~~ terrorized in a RTC or possibly suffer injury my self during his meltdowns.

Thank you for listening to my ~~meltdowns~~ concerns

before he is an adult & ends up a criminal or psychopath

He's almost ~~to~~ next month he'll be 10. ~~Time is running out for him~~

I've searched and advocated for him since he was 3 wks old

Please excuse the format of this testimony.

Subject: Introduce an International Medical Startup Headquartered in Boise Idaho

Description: The presenter states her connections to Idaho, introduces her business explaining its significance to the health and welfare of Idaho, and describes the current state of her business.

Presenter: Maureen Kole – Founder, CEO, and Owner of The Applied Research Co. LLC

Hello Honored Legislatures.

Thank you for allowing me to speak at the Joint Health and Welfare Committee Meeting this morning. My name is Maureen Kole; I was born and raised in Boise Idaho and graduated from Timberline High School in 2004 with a 4.0+ GPA. I received several scholarship offers and ended up graduating from Seattle University Cum Laud in 2010. After working as a consultant in Seattle I applied for graduate school and subsequently received the meritorious graduate fellowship in 2012 upon enrolling at Montana State University to pursue a Masters of Science in Applied Economics.

Currently I am all but dissertation in my degree from Montana State, was awarded provisional admittance and funding to the Masters of Science in Computer Science at Boise State, and I am the owner, founder, and CEO of an international startup, The Applied Research Company (File Number W171010). This is currently a Limited Liability Company established in Idaho and operating out of its headquarters in Boise Idaho. I am located on the Central Bench off the corner of West Kootenai and Orchard.

The primary sources of revenue for this business, for which I am the sole employee: are driving for Uber and consulting on a variety topics including: analyses, statistics, business, and Internet technology. I present at and attend academic conferences, including conferences on health. The primary purpose of this company is to produce a product that decreases the rate of misdiagnoses in healthcare; as such I thought it important to introduce myself to you today and elaborate on this goal.

Many innovations in the area of health are meant to achieve this goal, and the approaches taken to achieve this goal are varied. I am currently gathering information on misdiagnosis rates. Essentially, the development of this product is currently iterating between two stages, The Investigation Stage and The Research and Development Stage. This iteration has been formally taking place since the business was established in late August in 2016. The result of this iteration process, if the endeavor is deemed viable, will be: the procurement of intellectual property rights and formalization of the business structure.

Thank you for allowing me to introduce myself.

Newborn Signs and Symptoms

- Hearing/Vision Loss
- Jaundice
- Pneumonia
- Rash
- Enlarged Liver/Spleen
- Small Head
- Seizures
- Failed Hearing Test

The best way to protect your baby is to protect yourself!

DO NOT share food, drinks, toothbrushes, etc. with your child.

AVOID kissing a child on the mouth and always wash your hands when in contact with saliva.

DO NOT put child's toys and pacifiers into or around your mouth.

Wash your hands, especially after:

- Handling children's toys
- Feeding a young child
- Wiping a young child's nose or mouth
- Changing Diapers

If you are pregnant, planning to become pregnant, or need more information, please contact your physician and visit:

IDAHO
CMV Advocacy Project

idahocmv.com

Cytomegalovirus (CMV)

What you NEED TO KNOW

What would CMV legislation mean for Idaho?

Every year, an estimated **150 babies** are born with CMV in Idaho.

Of those, an estimated **30 babies** will have permanent disabilities.

The healthcare costs for just one of these children can cost taxpayers as much as **$1,800,000.** This is for the care of just **ONE CHILD** through the age of 18.

A CMV bill in the state of Idaho would provide for:

Current focus

1. Increased **education** of healthcare providers
2. Increased **public awareness**
3. **Mandated CMV testing** for infants who fail their newborn hearing screens

It is estimated that to put this legislation into practice would cost the state of Idaho **$60,000** in the first year and **$26,000** each year after.

In other words, if CMV legislation led to the prevention of just one baby from having severe CMV related complications in the first year, it could potentially save the state **$482,000.**

Similar legislation has been passed in **Utah, Tennessee, Hawaii, Connecticut, Illinois and Texas.**

For more information please visit:

The National CMV Foundation	nationalcmv.org
Idaho CMV Advocacy Project	idahocmv.com

IDAHO
CMV Advocacy Project

For more information please visit
idahocmv.com

Or email us at
idahocmv@gmail.com

Jessica and Patrick Rachels
PO Box 402
Ponderay, ID 83852

To Whom it May Concern:

Hi, my name is Jessica Rachels, and I live in North Idaho. I would like to share with you a little about my daughter Natalie who is a beautiful, social, ten year old girl who caught a nasty virus that I had never heard of while she was still in the womb. My hope is that in educating you about this virus, you can share what you have learned, and we can lessen the chances of your loved ones ever being stricken with this virus. But first, allow me to tell you about Natalie.

Natalie Rachels was born with congenital Cytomegalovirus, (CMV). CMV is a nasty virus that is a member of the Herpesviridae (Herpes) family. It is common and affects people of all ages. By the age of forty, between 50% and 80% of people in the US have contracted CMV. Usually it presents itself as a common cold, although, if the person has a weakened immune system or is an unborn child, it can drastically affect the body. In Natalie's case we were unaware that anything was wrong for several weeks after birth. The first red flag was that her due date was off by a month because an ultrasound revealed that her head size was smaller than average. The obstetrician did not believe that this information was important. So nothing was done, no further tests were recommended and/or administered. After she was born, Natalie repeatedly failed her newborn hearing screenings. At first the nurses and doctors were not alarmed, since babies can be born with a thick coat of vernix which can coat the inside of the ear. She kept failing the screenings; therefore, we were sent to Kootenai Medical Center in Coeur d'Alene for more intensive testing, which showed that Natalie had profound and severe hearing loss. The doctor then ordered a CT Scan which showed that the ear structures were perfectly normal, but that her brain had been damaged. Blood work from Natalie and me showed that we both contracted the CMV virus. Natalie was about two and a half months old, and still seemed like a typical baby minus being deaf and having some reflux issues.

Today Natalie is ten years old. Her father and I were told years ago that she wouldn't make it to see her double digits. We celebrated her tenth birthday, and took her to a roller skating rink, where she seemed to enjoy being pushed around the floor in her wheel chair. Natalie has been in and out of the hospital over the years. She has had ten major surgeries and will have more in the future.

Her care—which includes medical care, therapy, surgeries, personal care items, medical equipment, and the aid of caregivers—over the past ten years has cost over $1,000,000.

The virus caused many different issues including Cerebral Palsy, hearing loss, feeding issues—she currently is fed with the aid of a gastrointestinal tube; scoliosis, hip displacement, muscle tone issues which creates stiffness in some areas of her body, and floppiness in other areas; seizures—thankfully no grand mal seizures, which are kept to a minimum with the help of the implantation of a Vagus Nerve Stimulator; minor visual issues, and pulmonary complications which includes asthma.

Even with all of her difficulties, she is such a happy little girl. Natalie is very social, and loves being around people. She loves toys that light up, and her favorite game is playing peek-a-boo with loved ones who go in and out of the front door. For some reason the door opening and closing makes her giggle and laugh. Thanks to modern medicine, she has bilateral cochlear implants and has the gift of hearing. She enjoys bike rides with her family on her special bike, which has a wheelchair in the front and the driver sits behind pedaling. She enjoys playing on her iPad with touch applications as well as cause and effect applications. She has such a sweet and tender soul that has touched many people. Her smile and laugh can light up a room. Yes, her time is limited, but what an impact and difference this little girl is making on the world!

Due to not being properly educated about the virus while pregnant with my daughter, I worked in a daycare center. My doctor did not think it was important to educate me about CMV; in doing so he

Introduction –Thank you Mr. Chairman and members of the committee for giving us this opportunity to speak with you. My name is Patrick Rachels and this is my wife Jessica, we are from Sandpoint.

Most have heard about Fetal Alcohol Syndrome, Down syndrome and Spina Bifida but few have heard about the Cytomegalovirus which is more common, also known as CMV. It is a virus of the herpes family that is spread through the direct contact of bodily fluids.

Most CMV infections are silent meaning women infected have no signs or symptoms. it would appear as a common cold or flu, however 40% of expecting mothers will pass the infection to their unborn child. This can drastically impact the unborn child's health. The National CMV foundation has stated that in the United States 1 out of 150 children that are born are inflicted with congenital CMV.

The disabilities resulting from the virus can vary from developmental delays to *Cerebral Palsy* and as drastic as death, however hearing loss is the most common disability. In our situation I was a child care provider which put me at a higher risk of exposure to CMV, my OB doctor knew my occupation and yet never told me about this virus and the risks of working with young children. I feel like he took my rights to protect my unborn child away by failing to educate me on CMV. As a result our 11 year old daughter is deaf, has cochlear implants, requires 24 hour care, she is unable to walk, talk, or sit up. We feed her through a G-tube, she has *seizures* and has had 10 surgeries and several hospitalizations due to the effects of CMV.

She has a beautiful smile and laugh that lights up a room. Her favorite game is peek-a-boo. Her joining our family has taught our other three children empathy and compassion. But as a result of not being educated we now get to slowly watch our child die. We are proposing an educational CMV bill to ensure that women of Idaho and their doctors have access to the most accurate and up to date information available regarding CMV prevention, infection and treatment.

Catching the virus while pregnant results in the greatest risk. Information is power! One can reduce their exposure to the virus by not sharing food, drinks, tooth brushes with children and others. It is also recommended to avoid kissing a child on the mouth. We are told to wash our hands but the why is left out. Failure to practice universal hand washing techniques can lead to multiple disabilities to an unborn child. Please help us protect families in Idaho from the horrific consequences of this virus. Mr. Chairman I have informational fliers for you and the members of the committee. Thank you for your time!

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Monday, January 30, 2017

SUBJECT	DESCRIPTION	PRESENTER
Gubernatorial Appointment	Reappointment of Sue Walker to the Idaho Commission for the Blind & Visually Impaired	Sue Walker
S 1004	Relating to the Board of Nursing	Sandra Evans, Executive Director Board of Nursing
H 0006	Relating to Controlled Substances	Alex Adams, Executive Director Board of Pharmacy
Presentation	First Annual Foster Care Report for Fiscal Year 2016	Miren Unsworth Division of Family & Community Services

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Monday, January 30, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Foreman, and Jordan
ABSENT/ EXCUSED:	Senator Agenbroad
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:16 p.m.
GUBERNATORIAL APPOINTMENT:	**Appointment of Sue Walker to the Idaho Commission for the Blind & Visually Impaired. Sue Walker** introduced herself to the Committee and stated she is seeking her first appointment. She has been the regional librarian for the Idaho Talking Book Service (Service) for 15 years. The Service loans audio and Braille books and magazines to Idahoans unable to read standard print due to a physical disability. Many of the 3,200 users have a visual disability or are legally blind. **Ms. Walker** commented while working with Service users, she has learned much about the challenges they face in daily life and is impressed with their persistence in overcoming them. She has worked collaboratively with the Commission for the Blind & Visually Impaired (Commission) to identify and serve eligible persons and has learned about the programs the Commission offers to help the visually impaired meet their goals. When she learned of a vacancy on the Commission, she saw it as an opportunity to serve the visually impaired in a broader capacity. Her knowledge of the programs available to this audience, her deep interest in serving them, and her ability to work collaboratively with diverse persons will allow her to serve in the position productively and support the Commission's mission. **Senator Martin** asked for what region is Ms. Walker the regional librarian, and what is her affiliation with the Service. **Ms. Walker** answered the Service is a national organization, and there is a regional library set up in each state. She is the regional librarian for the State of Idaho and works under the auspices of the Idaho Commission for Libraries. **Senator Martin** further inquired if there is a particular library Ms. Walker works from or does she work at multiple libraries. **Ms. Walker** replied she works at the physical library housed within the Idaho Commission for Libraries building. The Service serves the entire State of Idaho. **Vice Chairman Souza** asked how technology has changed the experience for visually impaired persons and what opportunities Ms. Walker sees coming in the future. **Ms. Walker** responded technology has a made a world of difference to help people access written materials that are now available digitally, and even Braille is now available digitally. Technology helps people learn to live independently and find employment, but she is primarily familiar with the Service. **Chairman Heider** advised Ms. Walker the Committee would vote on her appointment the following day.

S 1004 **Relating to the Board of Nursing. Sandra Evans,** Executive Director of the Idaho State Board of Nursing, introduced herself to the Committee to present **S 1004** which would amend Idaho Code § 54-1403. This legislation: 1.) makes non-substantive technical corrections; and 2.) increases compensation paid to appointed members of the Board of Nursing for their public service while serving. **Ms. Evans** explained statutory compensation paid to Board of Nursing members is set forth in Idaho Code § 59-509 (see Attachment 1). Current compensation for Board of Nursing members has remained static since 1998 at level (h) of the compensation schedule which is $50 per day. To adjust for inflation and for consistency with compensation paid to members of other Idaho professional licensing boards as well as other state boards of nursing, **S 1004** provides for an upward adjustment to $75 per day as provided in subsection (i) of the compensation schedule. **S 1004** will have a negative fiscal impact on the Board of Nursing's dedicated fund estimated at less than $5,000 per year. The Board of Nursing's fund balance supports this loss of revenue without the need to raise license fees in the foreseeable future. There is no fiscal impact on the General Fund.

Senator Martin asked how long it has been since the compensation was changed. **Ms. Evans** responded it was last changed in 1998.

MOTION: **Vice Chairman Souza** moved to send **S 1004** to the floor with a **do pass** recommendation. **Senator Jordan** seconded the motion. The motion carried by **voice vote.**

H 0006 **Relating to Controlled Substances. Alex Adams,** Executive Director of the Idaho State Board of Pharmacy, introduced himself to present **H 0006,** the Board of Pharmacy's annual update to the Controlled Substance Act. The Board of Pharmacy regularly schedules, reschedules, and de-schedules products in accordance with changes in federal law.

Mr. Adams informed the Committee the bill adds two new products that were approved by the Federal Drug Administration (FDA) and scheduled by the Drug Enforcement Administration (DEA): 1.) Eluxadoline, a product used for irritable bowel syndrome, placed in Schedule 4; and 2.) Briviact, used for partial-onset seizures, placed in Schedule 5. While updating the Controlled Substance Act, the Board of Pharmacy identified three products that were scheduled more stringently than federal law. **H 0006** makes the following changes: 1.) Butorphanol was moved to Schedule 4; 2.) Fospropofol was moved to the depressant section in Schedule 4; and 3.) Propylhexedrine was removed from the list of Idaho controlled substances. The bill adds two synthetic products to the Idaho schedule. One, called U47700, is a synthetic opioid that is reported to be more potent than morphine and has been linked to two deaths in the State. Because it was not scheduled either federally or in Idaho, individuals were buying it online and having it shipped to Idaho. The Board of Pharmacy did a temporary rule last year to schedule it as a Schedule 1 substance, and the temporary rule expires at the end of the session. The bill contains an emergency clause to avoid a gap between expiration of the temporary rule and the effective date of the legislation.

Mr. Adams explained the process the Board of Pharmacy uses to schedule, de-schedule, and reschedule products outside a legislative session is to promulgate a temporary rule. The bill codifies this process in statute.

Senator Jordan asked if there is a mechanism in place to address new drugs as they show up in communities. **Mr. Adams** responded the Board of Pharmacy works very closely with the Office of Drug Policy and Forensic Labs. These agencies are always identifying new products, and they apprise each other of new drugs. That is how U47700 came to light in July 2016, and by early August 2016, the Board of Pharmacy adopted a temporary rule to place the drug in Schedule 1. It was a quick and collaborative process. Since U47700 was placed in Schedule 1, Mr. Adams is not aware of anyone shipping it into the State or any additional deaths from the drug. This is one reason the Board of Pharmacy wanted to codify how a drug could be scheduled outside a legislative session.

Senator Martin asked if the list of controlled substances is federally mandated. **Mr. Adams** replied every state maintains its own schedule of controlled substances. Where something falls in the schedule determines who can prescribe the drug, how many refills are allowed, and how the drug is stored. By having a drug on both the State and federal schedules, there is dual State and federal jurisdiction to enforce the law. **Senator Martin** inquired if the Board of Pharmacy agrees with the additions to the list. **Mr. Adams** answered the Board of Pharmacy does agree. In general, the Board's approach is not to be more stringent than federal law and tries to harmonize with federal law.

MOTION: **Senator Harris** moved to send **H 0006** to the floor with a **do pass** recommendation. **Senator Anthon** seconded the motion. The motion carried by **voice vote.**

PRESENTATION: **First Annual Foster Care Report for Fiscal Year 2016. Miren Unsworth,** Deputy Administrator for the Division of Family and Community Services in the Department of Health and Welfare (Department), introduced herself to the Committee to present its first annual Foster Care Report for FY 2016 (see Attachment 2). The Child and Family Services Program (Program): 1.) receives reports of abuse and neglect; 2.) assesses allegations of abuse and neglect; 3.) provides ongoing case management services to children, either in their homes or in out-of-home placement settings; and 4.) assures children have safety and permanency in their homes. The Program has a centralized intake unit to receive reports of child abuse and neglect. The intake unit is staffed 24 hours a day, 7 days a week by licensed social workers. The reports are entered into a data system and prioritized for response.

Ms. Unsworth informed the Committee once a referral is prioritized, regional staff initiates a comprehensive safety assessment. Upon completion of that assessment, the Department must determine whether maltreatment occurred and whether a child is safe or unsafe. When a child is determined to be unsafe, the case remains open for services. If the child is determined to be safe, the case is closed with no additional intervention. When a safety threat exists, a safety plan must be put in place to manage the child's safety. Efforts are made to maintain the child in the home, or the safety plan may necessitate removal of the child. During FY 2016, the Department received 22,346 referrals for possible abuse, neglect, or abandonment. Of those referrals, 8,884 were assigned for completion of a comprehensive safety assessment, and 1,321 children were placed into foster care.

Ms. Unsworth explained there are several ways a child can be removed from his or her home in Idaho. First, law enforcement can determine a child is in a dangerous situation and declare the child to be in imminent danger. Such circumstances include when the home environment poses a significant health or safety hazard to the child, the child has serious physical injury as a result of maltreatment, or there is no caregiver in the home. This is the most common way children enter foster care in Idaho.

Ms. Unsworth said the Department can also petition the court for an order of removal after determining it is unsafe for a child to remain in the home. An example is when the caregiver is not providing adequate supervision due to mental health or substance use issues or when the safety plan has not or cannot adequately address the child's safety needs in the home.

Ms. Unsworth provided the third method is by Rule 16 expansion. In Idaho juvenile offenses are governed by the Juvenile Corrections Act (JCA) and the Idaho Juvenile Rules (IJR). Rule 16 of the IJR allows the court to expand a JCA proceeding into a Child Protective Act (CPA) proceeding whenever the court has reasonable cause to believe a juvenile living or found to be within the State comes within the jurisdiction of the CPA. Neglect accounts for the majority of cases involving the removal of children from their homes by the court system. The court has responsibility to determine whether the removal of the child is warranted and to make other key decisions throughout the proceeding.

Ms. Unsworth stated the total number of children served in the foster care program during the past five fiscal years has remained steady at an average of 2,477 children per year. Once a child has been removed from the home, the Department works closely with the family to resolve the safety issues and return the child to the home. During FY 2016, 1,194 children exited foster care. Of this number, 862 or 72 percent were reunified with their parents. Other reasons for children leaving foster care include: adoption by a non-relative; adoption by a relative; placement in another jurisdiction such as the custody of the Department of Juvenile Corrections; aging out of foster care after turning 18; guardianship with a non-relative; or guardianship with a relative.

Ms. Unsworth explained the Department's goal is to limit the distress experienced by the child when he or she is removed from the home, and placement in a relative's home is prioritized. When a child is placed in foster care, the Department immediately begins searching for relatives and fictive kin replacement options. "Fictive kin" means someone who doesn't meet the statutory definition of a relative but who has a significant relationship with the child, such as a close family friend. Another priority is to keep siblings together. The Department must obtain information about relatives from the birth parents and the child, immediately contact relatives, and assess those relatives to determine if they are a viable placement option. This can be completed the same day a child is placed in foster care or later in the case. If there are no local relative or fictive kin placement options, a child is typically placed with a non-relative foster parent unless the child has significant mental health or behavioral health issues which may require group home or residential care.

Ms. Unsworth advised the Department tries to match the child with an appropriate foster family with the skill, knowledge, and expertise to meet the child's needs in the same community the child was living in. Due to the ongoing decline in licensed foster homes, this can be challenging. The Department has seen a decline of approximately 130 licensed foster homes over the past four years. The decline is likely related to a number of factors, including an increase in relative and fictive kin families who often close their foster care licenses after permanency for the child is achieved; families closing their licenses after adopting other children; changes in life circumstances; and families' frustrations over interactions with the Department or the overall system.

Ms. Unsworth further informed the Committee the Department's emphasis is on placement stability and limiting the number of moves for children in foster care. During the 2016 legislative session, changes were made to the CPA to improve communication with foster parents. In FY 2017 the Department began sending written notification to foster parents regarding placement changes. The Program is focused on preventing unannounced moves unless there are safety concerns. Changes were also made last year to institute judicial approval in contested placement decisions. Of the 1,398 children who were in foster care on June 30, 2016, approximately 42 percent were placed in non-relative foster homes; 9 percent were placed in treatment foster homes, group homes, and residential treatment centers or hospital and detention settings; 6.6 percent were placed with fictive kin; 4.5 percent were placed in non-relative pre-adoptive settings; and 12 percent were placed in their own homes with court oversight.

Ms. Unsworth mentioned the Department improved its information systems, and next year the Department hopes to have more specific information regarding the reasons for placement changes. Over 88 percent of children have fewer than two placement changes, and 65 percent only experience one placement setting.

Ms. Unsworth advised once a child is placed in foster care, social workers monitor progress in achieving the family service plan and regularly assess the safety, permanency, and wellbeing of the child. If a child is still in foster care at 12 months after the date of removal, the court conducts a permanency hearing, and the Department presents its recommendations to the court. Options include reunification, legal guardianship with a relative or non-relative, adoption by a relative or non-relative, or another permanent planned living arrangement for youth 16 years and older, commonly referred to as long-term foster care. This means the child will likely remain in foster care until aging out upon his or her 18th birthday.

Ms. Unsworth reported the Department has made a number of modifications to existing practice standards, and its focus has been on improving internal and external communication. Next month, the Department will undergo a comprehensive federal child and family services review. Idaho has been through two prior reviews and has successfully completed its program improvement plans during each of the reviews. The Program will begin working with its partners and stakeholders to develop a program improvement plan to address areas for improvement identified in the review.

Ms. Unsworth said the Program's goals for improvement are included in the Department's Strategic Plan and the Program-specific Child and Family Services (CFS) Plan. The Strategic Plan sets a prioritized timeline for meeting measurable objectives and attained goals to better serve the people of Idaho. Within that plan is a specific initiative to transform child welfare systems to improve outcomes for children. The CFS Plan is a five-year plan which is submitted to the Department's federal partner, and it also sets forth vision and goals to strengthen Idaho's overall child welfare system. The work of the interim foster care study committee, pending Office of Performance Evaluation study, and federal review process will inform Program improvement efforts. The Department is excited about its initiative to transform child welfare systems and have a dedicated multidisciplinary committee to help guide that initiative.

Ms. Unsworth explained the Department's goals are to: 1.) develop a robust, sustainable, and effective foster care program; 2.) retain a highly-skilled work force and ensure that work force has the resources and support necessary to meet the needs of the families served; 3.) ensure children are only placed in foster care when they are unsafe and a sufficient safety plan cannot be managed in the home; 4.) return children home as soon as a sufficient safety plan can be maintained in the home; 5.) have a functional and sustainable continuous quality improvement system; 6.) give the Department party status in child protective act cases; 7.) have legal representation in all CPA cases; and 7.) modernize the Department's information system to better support the delivery of services.

Senator Martin inquired why the total number of children served in foster care has remained relatively constant even though the number of referrals has increased. **Ms. Unsworth** answered the Department has refined its safety assessment practices to ensure children are coming into care only when absolutely necessary and a safety plan cannot be managed in the home. The Department is providing more in-home services than in the past to maintain children in their homes. The number of safety assessments has increased, but the number of removals has remained level and has even gone done over the last ten years. The Department is paying close attention to the data because there is a spike this fiscal year due to opioid use, and an upward trend is expected. **Senator Martin** asked for numbers over the last ten years and for 2017 so far. **Ms. Unsworth** replied the Department served about 3,500 children in FY 2006. Through targeted efforts, the numbers have gone down since then. **Ms. Unsworth** stated she did not have the FY 2017 numbers but could provide them to the Committee.

Senator Lee asked what led the Department to bring a proposal to increase foster parent payments, and inquired whether the Department believes it will attract more foster families. **Ms. Unsworth** answered she knows of no foster family providing care to make money. Idaho is far behind other states in reimbursement rates, and the cost of care is increasing. **Ms. Unsworth** said she did not expect to see an increased number of foster families as a result, nor did she think it would affect retention rates very much.

Vice Chairman Souza inquired if the Department has a plan to help foster families feel more appreciated and valued in non-monetary ways. **Ms. Unsworth** responded the most important component is relational. When there is a crisis, sometimes the Department starts treating foster families like they are employees. The Department wants to identify ways to provide concrete support to the foster families, such as additional training and a program of resource "para-mentors" who are foster parents who mentor current foster parents. The Department is also considering a pilot program to create a foster care liaison to provide customer service to foster parents, rather than relying on the social workers.

Senator Lee inquired if the Department has any information on the effect of last year's legislation requiring a judge to ask about psychotropic drugs at each of the hearings, given that Idaho is ahead in having children in foster care on psychotropic drugs. **Ms. Unsworth** stated it is too soon to know the effect, and the Department has no data. The standardized court reports have been modified to ensure that information is included, and the judges are making inquiry about those medications. A team is working with Division of Medicaid and the Drug Utilization Review Board to track and monitor the data and is also conducting some case review of high profile users to see what can be done to address the issue.

Chairman Heider asked if most foster families have their own children, and if so what are their ages. **Ms. Unsworth** replied most foster families are parents and with children still in the home, but some have never parented and some are empty nesters.

Chairman Heider asked what happens to foster children who turn 18 and leave the foster family environment and whether there is anyone to watch out for them. **Ms. Unsworth** responded the Department has some support for those young people. Any 18-year-old going out into the world needs a lot of support, and some foster children have experienced significant trauma so it can be more difficult for them. The Department has an independent living program, and children can receive case management services to the age of 21. There is some financial support available to help with job readiness and limited help with room and board. In addition, there are education and training vouchers available up to $5,000 a year for post-secondary education up to the age of 23. Some colleges and universities have a guardian scholars program. Boise State University has a unique program with a social worker on campus who meets with these young people every week to be a point of contact on campus and connect them with other young people on campus who aged out of foster care.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:05 p.m.

Senator Heider
Chair

Jeanne Jackson-Heim
Secretary

Section 59-509 – Idaho State Legislature

legislature.idaho.gov/statutesrules/idstat/Title59/T59CH5/SECT59-509/

Idaho Statutes

TITLE 59
PUBLIC OFFICERS IN GENERAL
CHAPTER 5
SALARIES OF OFFICERS
59-509. Honorariums or compensation for members of boards, commissions and councils. The members of part-time boards, commissions or councils shall receive for each day spent in the actual performance of duties, an honorarium, compensation, or expenses, as provided in the following schedule:
(a) Members shall serve without honorarium, compensation, or expense reimbursement of any kind.
(b) Members shall serve without honorarium or compensation of any kind, but shall be reimbursed for actual and necessary expenses, subject to the limits provided in section 67-2008, Idaho Code.
(c) Members shall serve without honorarium or compensation of any kind, but shall be reimbursed for actual and necessary expenses, without being subject to the limits provided in section 67-2008, Idaho Code.
(d) Members shall receive the sum of fifteen dollars ($15.00) per day, and shall be reimbursed for actual and necessary expenses, subject to the limits provided in section 67-2008, Idaho Code.
(e) Members shall receive the sum of twenty dollars ($20.00) per day, and shall be reimbursed for actual and necessary expenses, subject to the limits provided in section 67-2008, Idaho Code.
(f) Members shall receive the sum of twenty-five dollars ($25.00) per day, and shall be reimbursed for actual and necessary expenses, subject to the limits provided in section 67-2008, Idaho Code.
(g) Members shall receive the sum of thirty-five dollars ($35.00) per day, and shall be reimbursed for actual and necessary expenses, subject to the limits provided in section 67-2008, Idaho Code.
(h) Members shall receive the sum of fifty dollars ($50.00) per day, and shall be reimbursed for actual and necessary expenses, subject to the limits provided in section 67-2008, Idaho Code.
(i) Members shall receive the sum of seventy-five dollars ($75.00) per day, and shall be reimbursed for actual and necessary expenses, subject to the limits provided in section 67-2008, Idaho Code.
(j) Members shall receive an honorarium in the sum of fifteen dollars ($15.00) per day, and shall be reimbursed for actual and necessary expenses, subject to the limits provided in section 67-2008, Idaho Code, unless otherwise provided by statute. Payment of an honorarium as provided in this subsection shall not be considered salary as defined in section 59-1302(31), Idaho Code.
(k) Members shall receive an honorarium in the sum of twenty dollars ($20.00) per day, and shall be reimbursed for actual and necessary expenses, subject to the limits provided in section 67-2008, Idaho Code. Payment of an honorarium as provided in this subsection shall not be considered salary as defined in section 59-1302(31), Idaho Code.
(l) Members shall receive an honorarium in the sum of twenty-five dollars ($25.00) per day, and shall be reimbursed for actual and necessary expenses, subject to the limits provided in section 67-2008, Idaho

Code. Payment of an honorarium as provided in this subsection shall not be considered salary as defined in section 59-1302(31), Idaho Code.
(m) Members shall receive an honorarium in the sum of thirty-five dollars ($35.00) per day, and shall be reimbursed for actual and necessary expenses, subject to the limits provided in section 67-2008, Idaho Code. Payment of an honorarium as provided in this subsection shall not be considered salary as defined in section 59-1302(31), Idaho Code.
(n) Members shall receive an honorarium in the sum of fifty dollars ($50.00) per day, and shall be reimbursed for actual and necessary expenses, subject to the limits provided in section 67-2008, Idaho Code. Payment of an honorarium as provided in this subsection shall not be considered salary as defined in section 59-1302(31), Idaho Code.
(o) Members shall receive an honorarium in the sum of seventy-five dollars ($75.00) per day, and shall be reimbursed for actual and necessary expenses, subject to the limits provided in section 67-2008, Idaho Code. Payment of an honorarium as provided in this subsection shall not be considered salary as defined in section 59-1302(31), Idaho Code.
(p) Members shall receive an honorarium in the sum of one hundred dollars ($100) per day, and shall be reimbursed for actual and necessary expenses, subject to the limits provided in section 67-2008, Idaho Code. Payment of an honorarium as provided in this subsection shall not be considered salary as defined in section 59-1302(31), Idaho Code.
(q) Members shall receive the sum of one hundred dollars ($100) per day, and shall be reimbursed for actual and necessary expenses, subject to the limits provided in section 67-2008, Idaho Code.
I listory:
[59-509, added 1980, ch. 247, sec. 1, p. 583; am. 1996, ch. 66, sec. 1, p. 199; am. 1997, ch. 320, sec. 2, p. 946; am. 2006, ch. 269, sec. 1, p. 838; am. 2008, ch. 80, sec. 2, p. 208.]

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

State of Idaho
Department of Health and Welfare
Division of Family and Community Services
Child and Family Services Program

First Annual Legislative Foster Care Report for SFY 2016

A copy of this report is posted at

http://www.healthandwelfare.idaho.gov/Children/AbuseNeglect/tabid/74/Default.aspx

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Idaho will develop a robust, sustainable, and effective foster care program. 19
Goal 2 19
The child welfare program will retain a highly skilled workforce that has the training, resources, and support to address the safety, permanency and well-being of the families served. 19
Goal 3 20
Children will only be placed in foster care when they are unsafe and a sufficient safety plan cannot be managed in the home; children will return home after a removal as soon as a sufficient safety plan can be maintained in the home. 20
Goal 4 20
The child welfare program will have a functional, sustainable, and inclusive feedback loop for our Continuous Quality Improvement system that values stakeholder and family engagement. 20

Goal 5 21

The Department will be given party status in Child Protective Act (CPA) cases and the Department will have legal representation in all CPA cases. 21

Goal 6 21

The program will modernize the child welfare information system - this effort will serve to improve the program's technology platform and related software applications to support the delivery of child welfare services in the most cost effective and time sensitive manner. 21

Appendix A: Summary of Required Court Hearings 22

Appendix B: Child Welfare Process Flow Chart 23

Background

The 2016 Annual Foster Care Report published by the Idaho Department of Health and Welfare Child and Family Services (CFS) program is intended to provide the Idaho Legislature with information regarding the state's foster care system, as well as the current functioning of the system.

This report is provided by the Child and Family Services program pursuant to Idaho Code, Title 16, Chapter 16, Section 1646, which states:

> The state department of health and welfare shall submit an annual report regarding the foster care program to the germane standing committees of the legislature no later than ten (10) days following the start of each regular session. On or before February 15 of each year, the state department of health and welfare shall appear before the germane standing committees to present the report. Such report shall include, but need not be limited to, the number of children that are in the department's legal custody pursuant to this chapter, the number of such children who have been placed in foster care, how many times such children have been moved to different foster care homes and the reasons for such moves, best practices in foster care, goals to improve the foster care system in Idaho to ensure best practices are adhered to, a description of progress made with regard to the previous year's goals to improve the foster care system and any other information relating to foster care that the legislature requests. If a member of the legislature requests additional information between the time the report is received by the legislature and the time the department appears to present the report, then the department shall supplement its report to include such additional information.

Overview of the Child and Family Services Program

Child and Family Services' primary commitment and responsibility is the safety, well-being, and permanency of children who are victims of child abuse, neglect, or abandonment. As an agency, we believe that the best approach to support and protect children is to strengthen families so they can safely parent their children and meet the child's needs for permanency and well-being.

Efforts are specifically directed at ensuring families participate in identifying and implementing appropriate solutions to identified concerns, and at addressing family needs, using their ethnic and linguistic background, and unique values and strengths. Some children in out-of-home placements are not able to return home safely, so concurrent planning from the time of removal promotes timely permanence for children and youth. Concurrent planning involves a plan to reunify, as well as an alternate plan should reunification not be possible.

This family-centered approach is reflected in our daily work with families and is supported by federal law, state law, and public policies that place a high priority on family unity, involvement, and privacy.

Child and Family Services program responsibilities fall into four broad areas:

- Receiving reports of abuse or neglect
- Assessing allegations of abuse and neglect

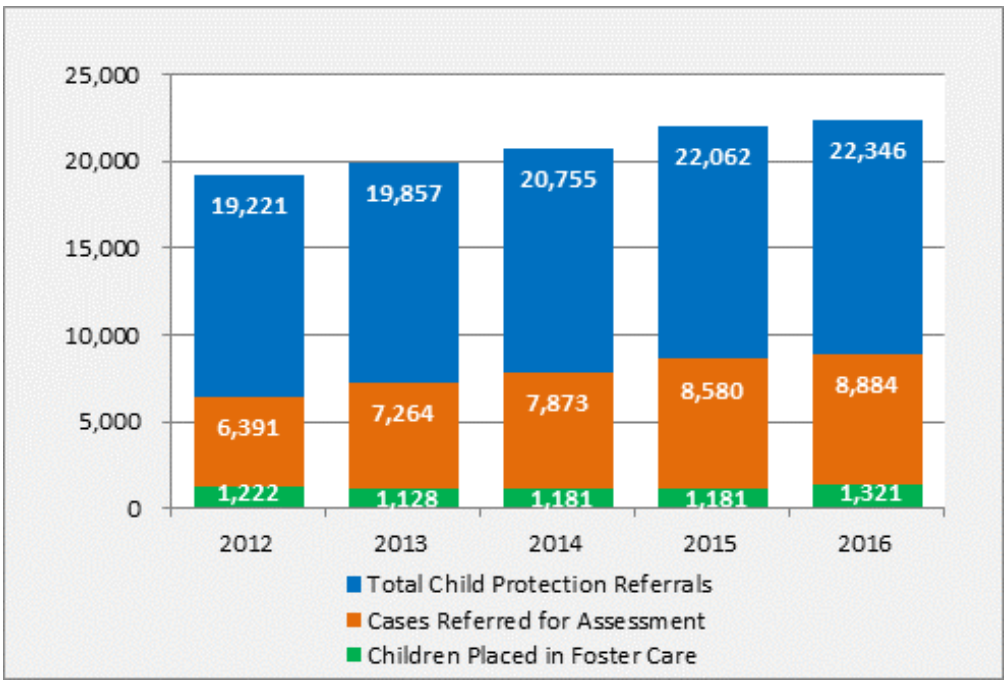
- Providing ongoing case management services to children; either in their own homes or in out of home placements
- Assuring that children have safety and permanency in their own homes or other permanent homes

Receiving Reports of Abuse or Neglect

The Child and Family Services program has a Centralized Intake Unit in Boise to which all reports of child abuse or neglect throughout the state are directed. Each report is assessed to determine whether the allegations fall under the statutory definitions of abuse, abandonment, or neglect. Once that determination is made, the report is prioritized for a response. Referrals involving a life-threatening and/or emergency situation require an immediate response. Other reports receive a priority which requires a response within either 24 or 72 hours. On all reports requiring an immediate response, CFS coordinates the response with local law enforcement. The ability to take and respond to child abuse and neglect reports operates 24/7 across the state.

Table 1 (below) contains a breakdown of the referrals received, assessments assigned, and number of children placed in foster care as a result of a removal, and are organized by state fiscal year for the last five years. The table shows 2012-2016 trends in the number of maltreatment reports assessed each year in the state. For the last five years, the number of assessments completed by CFS has increased, as has the number of referrals received each year.

Table 1: Referrals, Assessments, and Children Placed in Foster Care by SFY



During state fiscal year 2016, CFS received a total of 22,346 referrals regarding concerns of abuse, neglect, or abandonment. Of these, 8,884 were assigned for a safety assessment, and 1,321 children were placed into foster care.

Table 2: Referrals by Maltreatment Types

Referrals by Type and SFY					
Referral Type	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**SFY 2016**
Information & Referral	12474	12368	12750	13069	13413
Neglect	4031	4757	5393	6333	6255
Physical Abuse	1859	1995	2084	2209	2080
Sexual Abuse	441	611	518	431	545
Other	416	126	10	21	53
Total	**19,221**	**19,857**	**20,755**	**22,063**	**22,346**

Table 2 illustrates neglect accounts for the majority of referrals to CFS that meet priority guidelines, and is the most frequent reason children are removed from their homes. Information and Referral is the designation given to referrals containing concerns regarding the welfare of a child that are screened out because they do not meet the definition of abuse, neglect, or abandonment. These referrals may be referred to other entities or agencies.

Cases of neglect may include inadequate supervision, or situations in which the physical environment poses health or safety hazards that directly affect the health and safety of a child, and often involve a parent's unmet mental health or substance use issues.

Table 3: Sources of Maltreatment Referrals

Referrals by Source and SFY										
	2012		**2013**		**2014**		**2015**		**2016**	
Referral Source	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
School Personnel	3278	17.1%	3133	15.8%	3205	15.4%	3484	15.8%	3726	16.7%
Parent/Substitute	2769	14.4%	2807	14.1%	2921	14.1%	3182	14.4%	2839	12.7%
Relative	1777	9.2%	1964	9.9%	2157	10.4%	2180	9.9%	2477	11.1%
Private Agency	1708	8.9%	2291	11.5%	2429	11.7%	2506	11.4%	2337	10.5%
Law Enforcement	2167	11.3%	1945	9.8%	2114	10.2%	2321	10.5%	2294	10.3%
Friend/Neighbor	1488	7.7%	1811	9.1%	1789	8.6%	1669	7.6%	1670	7.5%
Hospital	911	4.7%	1066	5.4%	1126	5.4%	1155	5.2%	1322	5.9%
Child Protection	564	2.9%	886	4.5%	927	4.5%	981	4.4%	946	4.2%
Medical	646	3.4%	548	2.8%	695	3.3%	695	3.2%	860	3.8%
Anonymous	1020	5.3%	1003	5.1%	979	4.7%	1108	5.0%	859	3.8%
Other	2893	15.1%	2403	12.1%	2413	11.6%	2781	12.6%	3016	13.5%
Total	**19221**		**19857**		**20755**		**22062**		**22346**	

Table 3 identifies the sources of all maltreatment reports received by the Centralized Intake Unit during the past five state fiscal years. School personnel and parents are the primary reporting sources for maltreatment reports.

Idaho Code, Title 16, Chapter 16, Section 1605(1) provides direction regarding mandatory reporting in the state of Idaho for physicians, hospital staff, coroners, schools, daycares, and any

other persons having reason to believe a child has been subjected to maltreatment must report to law enforcement or the department. An exception is made for "duly ordained minister of religion." Failure to report as required in this section of Idaho Code is a misdemeanor.

Assessing Child Safety

A Comprehensive Safety Assessment is completed for all child protection referrals that meet Child and Family Services Priority Response Guidelines for assessment. The primary purpose of the assessment is to assure the child's safety and determine whether the child and family are in need of services to address identified safety threats. The Comprehensive Safety Assessment includes a robust information collection process, and includes a face to face contact and interview with the child. Information is also collected by the social worker through interviews with the parents/caregivers and relevant collateral contacts such as extended family members, law enforcement, school staff, medical professionals, and service providers. The assessment includes application of standardized criteria, along with social worker's critical analysis of the information and conclusion regarding the child's safety.

Upon completion of a Comprehensive Safety Assessment, the agency must determine whether maltreatment has occurred and whether the child is safe or unsafe. Whenever a child is determined to be unsafe the case remains open for services. If the child is determined to be safe the case is closed with no additional intervention.

Whenever possible, efforts are made to safely maintain children in their homes. However when a safety threat exists, a safety plan must be put into place to manage the child's safety. Actions in a safety plan must address the safety threat to the child and are specific to the family's circumstances. Safety actions might include respite care, supervision and monitoring, resource acquisition, and homemaker services. If the child is assessed to be in immediate danger, law enforcement is charged with the decision for removal. When a child is removed, Child and Family Services makes placement arrangements for the child.

Removal from the Home

Efforts are made to minimize the trauma of removing a child from the home by an immediate search for any relatives who could serve as a placement resource for the child or children. The Idaho Child Protective Act requires that the Department first considers, consistent with the best interests and special needs of the child, placement with a fit and willing relative. If a suitable relative cannot be found, the child is placed in a fictive kin (individuals with a significant relationship with the child) or a non-relative foster care placement.

There are only a few methods in which a child can be removed from his/her home in Idaho. The first is when law enforcement makes the determination a child is in a dangerous situation and therefore they declare the child to be in imminent danger. Circumstances which justify a declaration of imminent danger may include: when the home environment poses a significant health and safety hazard to the child; when the child has serious physical injuries as the result of maltreatment; or when there is no caregiver in the home to care for the child.

The second way for a child to be removed from his/her home is through a petition to the court from the department indicating it is unsafe for the child to remain in their home. A judge determines whether or not to enter an Order of Removal. An example of when the department may submit a petition to a judge is when caregivers are not providing adequate supervision to a child due to the caregiver's mental health or substance use issues, and a safety plan cannot adequately address the child's safety needs while in the home.

Another method of removal is through a Rule 16 Expansion Order. In Idaho, juvenile offenses are governed by the Juvenile Corrections Act and the Idaho Juvenile Rules. Rule 16 of the Idaho Juvenile Rules allows for the court to expand a Juvenile Corrections Act proceeding into a Child Protective Act proceeding when the court has reasonable cause to believe that the juvenile living within the state comes within the jurisdiction of the Child Protective Act.

Cases involving the removal of children from their home enter the court system. The Idaho Child Protective Act gives the court responsibility for determining whether the removal of the child is warranted and for making other key decisions as those cases move through the court process. The first court hearing is the shelter care hearing, and must be held within 48 hours of the child's removal, excluding weekends and holidays. At the shelter care hearing, the court determines if the child should be returned to their home or placed in the temporary custody of the department pending an adjudicatory hearing. Adjudicatory hearings are required to be held within thirty (30) days of the child's entering foster care. At the hearing, the judge makes a determination as to whether the evidence indicates abuse, neglect, abandonment, or an unstable home environment has occurred, and determines whether the child should remain in foster care or return home.

If a child is under the age of twelve (12) years, the court will appoint a guardian ad litem for the child. For children twelve (12) years and older, the court appoints counsel to represent the child(ren), and in certain circumstances, may also appoint a guardian ad litem for the child(ren).

As shown in Table 1, there were 1,321 children in 2016 that entered foster care as a result of maltreatment or an unstable home environment. Table 4 below indicates the number of children in foster care on the last day of each state fiscal year for the last five years. The point-in-time number of children in foster care in Idaho has ranged from 1,289 to 1,395.

Table 4: Children in Foster Care by SFY

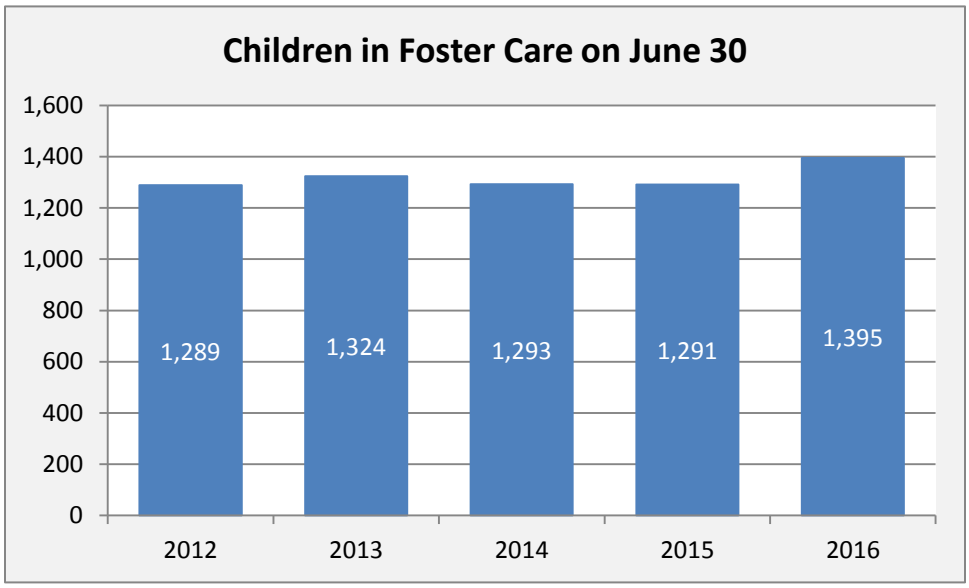


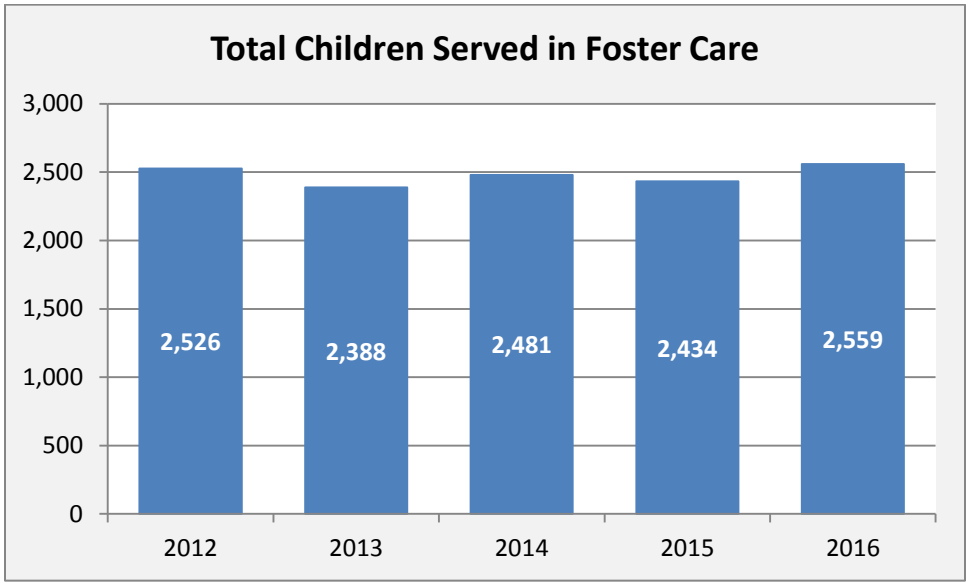
Table 5 includes a breakdown of the removal reasons for children who entered foster care during the last five state fiscal years.

Table 5: Removal Reasons by SFY

Removal Reason Breakdown by SFY										
	2012		2013		2014		2015		2016	
Removal Reasons	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Neglect	956	78.2%	921	81.6%	960	81.3%	947	80.2%	1084	82.1%
Physical Abuse	145	11.9%	101	9.0%	102	8.6%	163	13.8%	146	11.1%
Sexual Abuse	46	3.8%	41	3.6%	48	4.1%	19	1.6%	37	2.8%
Abandonment	28	2.3%	37	3.3%	43	3.6%	31	2.6%	28	2.1%
Homeless	28	2.3%	18	1.6%	26	2.2%	19	1.6%	22	1.7%
Voluntary Placement	19	1.6%	10	0.9%	2	0.2%	2	0.2%	4	0.3%
Total	**1222**		**1128**		**1181**		**1181**		**1321**	

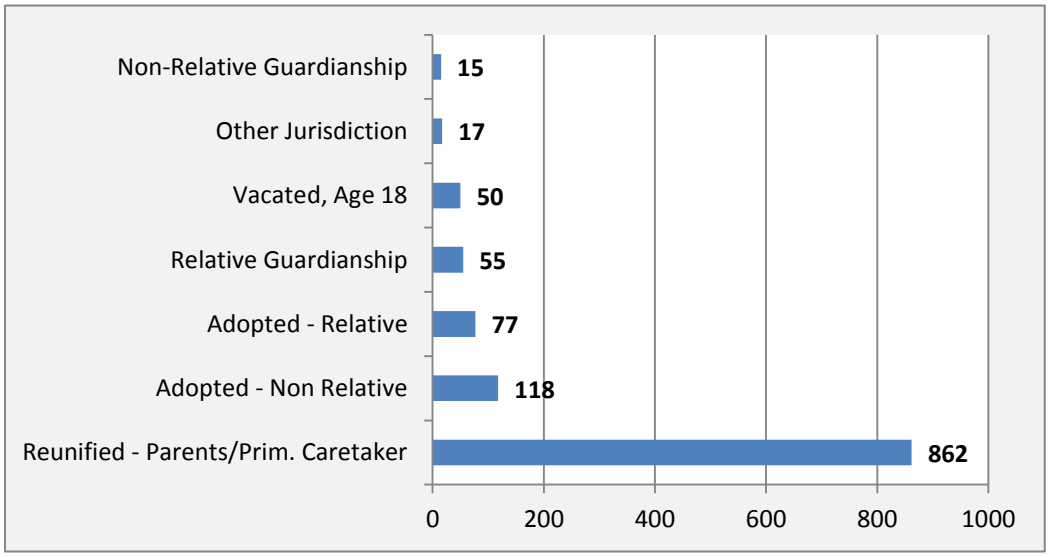
The data shown in Table 6 illustrates the total number of children served through the foster care program during the last five state fiscal years. The number of children served in foster care over the past five years has remained steady at an average of 2,477 children per year.

Table 6: Children Served in Foster Care by SFY



During the state fiscal year 2016, 1,194 children exited foster care. Of these children, 862 (72%) were reunified with their parents/caregiver. As shown in Table 7, "Other Jurisdiction" could include children placed in the custody of the Department of Juvenile Corrections or another agency/jurisdiction, or tribe transfer.

Table 7: Children Exiting Foster Care in SFY 2016



Placements in Foster Care

Managing the removal and determining the placement of the child is a responsibility that is taken very seriously. The department's goal is to limit the distress and damage a child experiences, and reduce the potential to permanently impact the child. Placement in relative homes is prioritized. When a child enters foster care, CFS immediately begins to search for relative/ fictive kin placement options capable of keeping siblings together. Child and Family Services workers obtain relative information from the birth parents and child, immediately contacting and assessing the relatives to determine if they are a viable placement option. This process can be completed the same day a child is placed in foster care or can occur later in the case.

The Child and Family Services program strives to place siblings together. The sibling bond is important and is separate from the bond between parents and their children. When children are placed in foster care they experience many losses. They often are able to understand why they cannot be with their parents, but do not understand why they cannot be with their siblings. Adult adoptees and foster care alumni both describe the loss of sibling contact as the most devastating loss they experienced.

The most common reason siblings are not placed together when they first enter foster care is due to a lack of foster homes that can accommodate all of the siblings. When this happens, CFS looks for opportunities to reunite the siblings in one home, while maintaining contact through sibling visits. Child and Family Services' practice related to sibling placement is evaluated on an ongoing basis through internal Case Record Reviews and federal Child and Family Services Reviews. In order to meet sibling placement expectations, CFS must demonstrate concerted efforts have been made to place siblings together, or if they are not placed together, they have regular contact. Compelling reasons for sibling separation in placements must be documented.

If there are no local relative/fictive kin placement options, a child is typically placed with a non-relative foster parent, unless the child has significant mental health, behavioral and/or developmental needs requiring group home or residential care. Ideally, CFS matches the child with an appropriate foster family that has the skill, knowledge, and expertise in meeting needs similar to the child's and is in the same community in an effort to maintain the child's connections. Due to a decline in foster homes and limited placement resources, this can be challenging.

The child's best interests are the primary consideration in all placements. Child and Family Services developed a definition based on a review of laws and policies in states where the term was already defined. Factors identified as important to consider in placement determinations by experts in attachment, permanency, and adoption were also considered.

Child and Family Services defines "best interest" as eight factors which, when combined, identify the current and potential individual needs of a child. The factors are the child's:

1) Emotional/behavioral needs.
2) Medical/physical needs.
3) Educational/developmental needs.
4) Cultural/religious needs.

5) Trauma history and past experiences.
6) Relationships with parents, relatives, siblings, and current caretakers.
7) Interests and community connections.
8) Family placement preferences.

Child and Family Services workers are mindful of the importance of maintaining relative and sibling connections, and the impact of placement changes on a child's attachment and overall development when making placement recommendations and policy decisions. Therefore, no single best interest factor is considered more or less important than the others. The weight placed on any one factor is highly dependent on the identified needs of a particular child or sibling group.

Placement Changes in Foster Care

Child and Family Services practice emphasizes placement stability and limiting the number of moves for children in foster care. When children experience placement changes, they can develop distress, loss, and an absence of belonging, all of which can result in feelings of distrust and a fear of forming healthy relationships and attachments with others. A planned placement change is the foreseen placement of a child with a relative, fictive kin, non-relative foster parent, or group home or residential care. The social worker and provider(s) have made advanced arrangements for the placement of a child, which includes transitional planning. Reasons for planned placement changes include:

- Placement with siblings
- Placement with a relative/fictive kin
- Placement with a non-relative foster family
- Child's treatment needs
- Permanency placement
    - Pre-adoptive placement
    - Guardianship

Planned moves include a transition plan to assist the child with the move. The child's current relationship with the new caregiver, the child's emotional and developmental needs, the proximity of the new placement to the birth family, and the willingness and ability of the two families to engage in the transition can impact the transition plan. Planned transitions typically include visitation with the new placement including overnight visits. The new caregiver may also be asked to participate in treatment with the child. Time frames for transition vary based on each child's age, needs, and case circumstances.

An unplanned placement change is an unexpected disruption in the child's placement. The following are examples of unplanned placement changes:

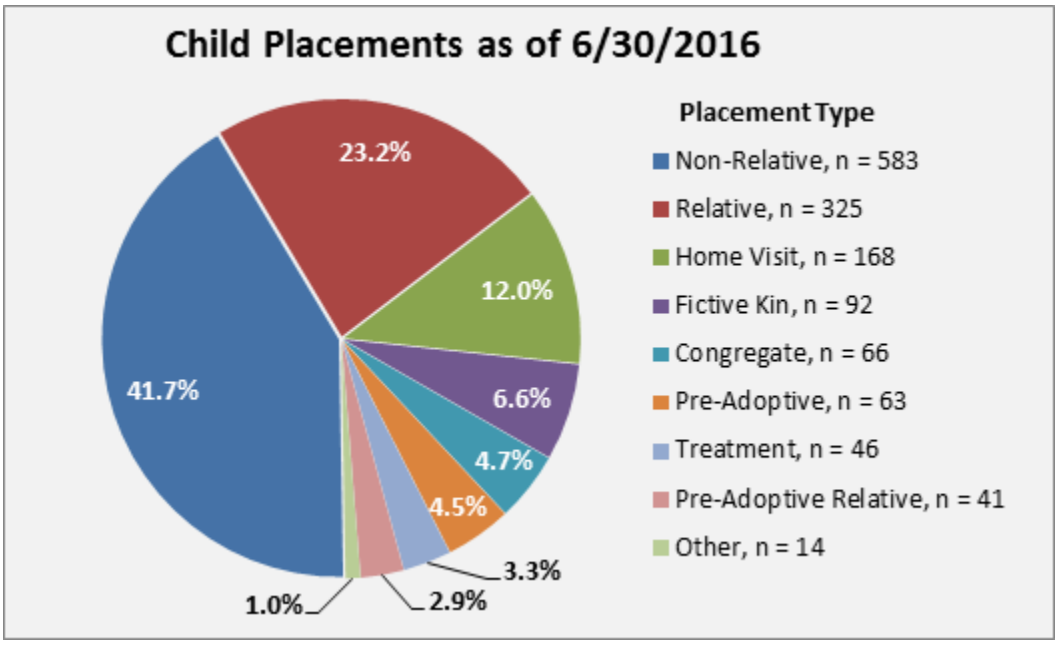
- Foster family's request
- A safety issue in the foster home (allegations of abuse or neglect)
- Child's treatment needs requiring a higher level of care
- Hospitalizations
- Detention

To reduce foster parent requests for placement changes, CFS makes efforts to provide supportive services or other resources to assist foster families to care for children and avoid placement disruptions. In some instances, foster families may be unable to meet a child's needs due to significant behavioral issues and request that the child be moved.

During the 2016 legislative session changes were made to the Child Protective Act regarding notification of placement changes. In SFY17, CFS began sending written notification to foster parents regarding placement changes. Child and Family Services is committed to preventing unannounced moves, unless there are safety concerns and to ensuring clear communications and expectations with foster parents regarding placement changes.

Table 8 (below) contains information regarding the 1,398 children who were in foster care on June 30, 2016 and where they were placed. The majority of those children were in non-relative foster care placements.

Table 8: Child Placements on June 30, 2016



The number of placements for children who were served in foster care during SFY16 is depicted in Table 9 below. As highlighted in the data, over 88% of children had fewer than two (2) placement changes. Of these children more than 65% had only one (1) placement setting therefore experiencing no placement changes while in foster care.

Table 9: Number of Placement Changes for Children in SFY16

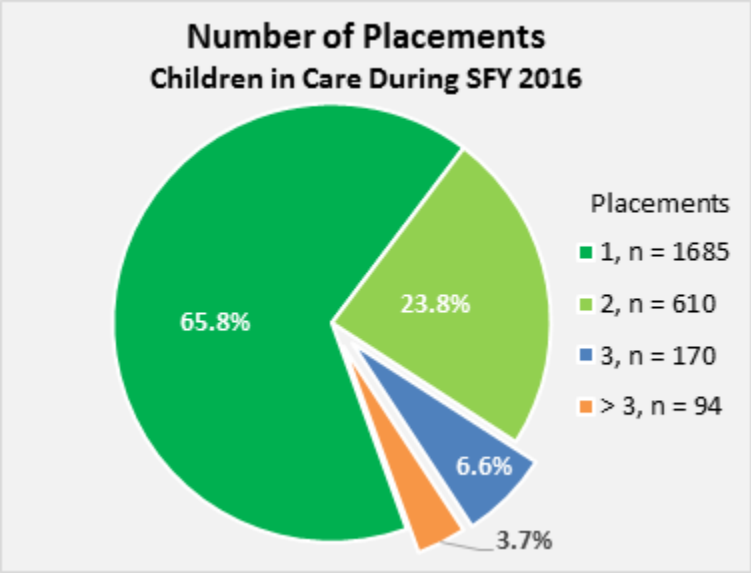


Table 10 provides information regarding placement change reasons for children served in foster care during the 2016 state fiscal year. As identified in the table, more than 50% of the reasons for placement changes where documented as "placement change." In an effort to better identify reasons children experience moves, changes were made to the database system to improve tracking in SFY17.

Table 10: SFY16 Placement Changes Reasons

Placement End Reasons	#	%
Placement Change	739	56.5%
Placed With Relative	142	10.9%
Foster Parent Request	134	10.2%
Move to Relative Placement	81	6.2%
Level Change	51	3.9%
Child's Behavior	34	2.6%
Pre-Adoptive Placement	28	2.1%
Change in Foster Family's Circumstance	27	2.1%
Licensing Issue	21	1.6%
Runaway	18	1.4%
Allegations of Abuse in Foster Home	17	1.3%
Placed in DJC Shared Custody	9	0.7%
Sibling Move	4	0.3%
Child's Parent Request	2	0.2%
Case Transfer	1	0.1%
Total	1308	100%

Provision of Ongoing Case Management Services

Once a child has been placed in foster care, social workers monitor the family's progress in achieving the objectives spelled out in the service plan, and regularly assess the safety, permanency, and well-being of the child. Case management responsibilities include:

- Making monthly contact with children, parents, and foster families.
- Communicating with service providers to ensure family members are receiving services.
- Transporting or making transportation arrangements for children and their families.
- Arranging and supervising visits between children and parents, and between children and their siblings.
- Working on the alternative plan, which includes ongoing contacts with relatives, and home studies of relatives residing in-state and out-of-state.
- Conducting specialized recruitment to locate an adoptive family for children unable to remain with the foster parents.
- Preparing required court reports and testifying in court hearings.
- Documenting casework activities into CFS's child welfare information system (iCARE).

Periodic Court Hearings

Federal and state law require a court hearing to review the case progress must be held no later than six months from the date of removal. Hearings may be held more frequently at the discretion of the court.

At 12 months from the date of removal, a permanency hearing must be held. At that time, CFS presents its recommendation for permanency. The permanency options include:

- Reunification
- Legal guardianship with a relative or non-relative
- Adoption by a relative or non-relative
- Another planned permanent living arrangement (this is only a permanency option for youth age sixteen (16) years and older)

For every child who has been in out-of-home care for at least 15 of the child's last 22 months, the state is obligated by state and federal law to file a petition to terminate parental rights. If compelling reasons exist for not terminating the parents' rights, those reasons must be approved by the court; otherwise the court will order the filing of a petition for termination of parental rights. Parents may choose to voluntarily terminate their parental rights, or their rights may be removed through an involuntary court process.

Permanency Decision Making

The Child and Family Services program is responsible for placing a child in foster care in a safe environment until such time reunification can occur. As shown in table 7 most children in foster care are eventually reunified with their families. Efforts are also made from the time of removal to make sure the child is living in an environment which has the potential for permanency in the event they cannot be reunified. The permanency potential of the child's placement is evaluated at each court hearing and by placement selection committees within CFS. Permanency placement recommendations, by CFS standard, are not made by a single individual. They are

made by placement selection committees, with the court being ultimately responsible for finalizing all adoptions and guardianships. The placement selection process is a model which incorporates various steps, depending on the specific case circumstances.

The process involves an assessment of the child's needs and consideration of best interest factors, including: emotional/behavioral needs; medical/physical needs; educational/developmental needs; cultural and religious needs; trauma history and past experiences; relationships with parents, relatives, siblings, and current caregivers; the child's interests and community connections; and child and family placement preference. The goal is to make a recommendation that is in the child's best interests.

Determinations relating to where and with whom children are placed are subject to judicial review by the court, and when contested by any party, judicial approval. The court also finalizes all adoptions and guardianships.

Best Practices in Child Welfare

The Child and Family Services program is dedicated to employing best practices in child welfare service delivery and policy development. Child and Family Services routinely uses research and guidance on best practices, promising practices, and evidenced-based practices during leadership meetings to inform and guide statewide policy and practice related decisions. In SFY 2016, there were nine (9) Program Manager meetings, ten (10) Child Welfare Subcommittee meetings, and six (6) Supervisor Workgroup meetings. These statewide leadership team meetings resulted in several revisions and additions to Idaho child welfare policy and practice over the last year.

Revisions to the Standard for Comprehensive Safety, Ongoing, and Reassessment were made regarding assessing the safety of children who are the subject of a report of child abuse or neglect and who reside in or visit homes outside of Idaho during the safety assessment process.

Revisions to the Concurrent Planning Standard and Permanent Placement Selection are in the process of being completed. These revisions will incorporate changes made during the 2016 Idaho legislative session including placement priorities for children in foster care and youth involvement in permanency planning.

Revisions to the Infant Toddler Standard were made regarding updates to the referral process for children ages birth to three for Infant Toddler Program services, as well as the process for appointing a surrogate parent.

Revisions to the Well-Being Standard are in the process of being completed. These revisions will incorporate the implementation of the Every Student Succeeds Act, as well as consistency with federal expectations of timeframes around well-being requirements.

Revisions to the written materials provided to parents who have a child placed into foster care are in the process of being updated. Specifically, information regarding parental rights and responsibilities and a basic overview of what a parent can expect when working with CFS will be included in these materials. These materials will be consistent statewide and a process for ongoing revision will be put in place.

Quarterly statewide all-staff video conferences, known as "fireside chats," were implemented to facilitate ongoing communication and ensure feedback loops regarding important issues related to CFS practice planning and implementation, and questions are delivered at all levels of the program.

A Child Welfare Executive Steering Committee was developed to help ensure the completion of the department's strategic plan initiative to transform the child welfare system to improve outcomes for children. Committee members include: department and division leadership; representatives from the Governor's Office, the Attorney General's Office, and the judiciary; legislators; a foster parent; a CASA Director; a Keeping Children Safe Panel member; and the Executive Director of the Idaho Children's Trust Fund.

A survey of adoptive parents receiving Idaho adoption assistance benefits was completed. The results are being compiled and will be used to identify program and policy needs for ensuring quality customer service and support to families willing to provide permanency for children in foster care.

Court report templates were revised to include legislative changes made during the last legislative session, as well as assure consistency with the comprehensive safety assessment and reassessment of safety.

The Child and Family Services program has been conducting internal case record reviews since 2004 to evaluate practices in the program. This rigorous internal case record review process assesses statewide performance in the areas of safety, permanency, and well-being. Over SFY 2016, 136 cases statewide were reviewed using the On-Site Review Instrument. In addition to the internal review, CFS also started a federal Child and Family Services Review, which looks at these same areas with federal oversight and measures.

The output of the federal Child and Family Services Review will highlight areas needing improvement within the Idaho child welfare system. Beginning in the second half of SFY 2017, CFS will develop a Program Improvement Plan aimed at identifying themes, trends, strengths, and will target areas for improvement. The plan will include goals, interventions, key activities, baselines, timeframes, performance measures, and reporting periods. The plan will be developed in collaboration with internal and external partners, including social workers, supervisors, managers, courts, tribes, law enforcement, guardians ad litem, youth, parents, foster parents, contractors, and community service providers.

Plan for Improvement

Improvement efforts for the Child and Family Services program are captured in two plans: the Strategic Plan for the Idaho Department of Health and Welfare and the program-specific Child and Family Services Plan. These plans are aligned to meet the need for improvement by both the department and the child welfare system.

The Strategic Plan lays the foundation for the department to address state and community issues with a vision that is coordinated with internal and external partners. The plan sets a prioritized timeline for meeting measurable objectives to attain goals that better serve the people of Idaho.

The Child and Family Services Plan (CFSP) is a five-year plan which sets forth the vision and the goals to be accomplished to strengthen Idaho's overall child welfare system. The plan's goals and objectives rest within the framework of the Child and Family Services Review outcomes and systemic factors established by the Adoption and Safe Families Act of 1997. The CFSP covers the full array of child welfare services from prevention and protection through permanency and well-being. As required by federal regulations (45 CFR 1357.16), CFS engages agencies, organizations, and individuals in the ongoing CFSP-related consultation and coordination process (e.g. Court Improvement Program, tribes, youth, families, foster parents, law enforcement, educators, and community behavioral health providers).

Data used to establish and measure progress on the CFSP goals include qualitative and quantitative findings from:

- Federal case record reviews
- State-conducted case record reviews
- Independent Living case record reviews and National Youth in Transition (NYTD) results
- Indian Child Welfare Act case record reviews
- Feedback from internal and external stakeholders

Federal, state-conducted, Independent Living, and Indian Child Welfare Act case record reviews consist of in-depth reviews of case documentation and court documents, in addition to case-related interviews with children, parents, foster parents, social workers and supervisors for the purpose of evaluating safety, permanency and well-being outcomes for children and families, as well as state compliance with federal guidelines.

Additional quantitative data used to monitor performance include a state profile provided by the Children's Bureau of the U.S. Department of Health and Human Services. The November 2015 profile indicates Idaho's child welfare system met all of the federal performance indicators for permanency, re-entry into foster care, placement stability, maltreatment in foster care, and recurrence of maltreatment.

In the past year, CFS has made a number of policy and practice improvements. The goals and progress made in each area are highlighted below.

Goal 1

Idaho will develop a robust, sustainable, and effective foster care program.

Progress on Goal 1

- Revised foster parent application and licensing forms.
- Enhanced collaboration with Eastern Washington University to collect and use data to drive foster parent recruitment strategies.
- Expanded the Resource Peer Mentor Program to provide additional mentoring and coaching to foster families.
- Provided foster parents additional training in the following topics: human trafficking, grief & loss, and caring for children who have experienced trauma, normalcy for children in foster care, and trust-based relational intervention strategies.
- Revised the Child Welfare Foster Care Academy for all new workers.
- Provided Foster Parent Recruitment and Retention statewide training.
- Improvements were made to foster parent recruitment messaging.

Goal 2

The child welfare program will retain a highly skilled workforce that has the training, resources, and support to address the safety, permanency and well-being of the families served.

Progress on Goal 2

- Continued partnership with Idaho State University (ISU) to provide training to child welfare social workers, supervisors, leadership, and community stakeholders.
- Continued evaluation of workforce development efforts through pre- and post-training evaluations, staff discussions, surveys, and ISU performance reports.
- Established the Workforce Recruitment and Retention panel with several universities and colleges in Idaho to promote higher education in social work, improve child welfare recruitment, and promote the availability of college-level courses relating to child welfare and child trauma.
- Developed a new curriculum for new supervisors which covers topics such as Strength-Based Supervision, Family Centered Practice, as well as the department required Supervisor Training and Resource Program.

Goal 3

Children will only be placed in foster care when they are unsafe and a sufficient safety plan cannot be managed in the home; children will return home after a removal as soon as a sufficient safety plan can be maintained in the home.

Progress on Goal 3

- Drafted statewide guidelines to support child welfare social workers to apply the Comprehensive Safety Assessment with fidelity and consistency throughout the state.
- Developed a quality assurance tool for conducting reviews on the fidelity of the application of the Comprehensive Safety Assessment. Use of the tool is expected to begin during the first calendar quarter of 2017.
- The program is currently collecting information on safety-related services needed to support families who are able to keep their children safe in their home with the support of family preservation services.

Goal 4

The child welfare program will have a functional, sustainable, and inclusive feedback loop for our Continuous Quality Improvement system that values stakeholder and family engagement.

Progress on Goal 4

- In November 2015, CFS hosted a statewide stakeholder meeting in Boise at which CFS staff presented information and data regarding new and updated practice standards, proposed legislative changes, implementation of practice initiatives, as well as an update on progress on established goals from the previous stakeholder meeting held in October 2014. Participants had an opportunity to work in groups to provide feedback regarding their assessment of strengths, challenges, and opportunities for the stakeholder group to work with CFS to make progress toward the strategic plan goals. A notable suggestion from this group was the need for local stakeholder meetings as opposed to the larger statewide meeting approach. As a result, the agency will focus on developing representative stakeholder groups in each of the three hub-based areas of the state to inform the statewide functioning of the child welfare system.
- In June 2015, CFS launched a statewide expansion on the use of Family Group Decision Making (FGDM) meetings which are designed to increase family participation in case planning. Family Group Decision Making meetings were implemented to address the protection and care needs of children by involving both family members and professionals in the service plan development process. Through the FGDM process, the family group is positioned to lead decision making, and CFS staff support family group plans which address the concerns of the department. Family Group Decision Making meetings recently began being prioritized for case planning purposes for children ages 0-6, and are additionally utilized for safety and permanency planning purposes. The 0-6 age range is being targeted because 40% of the department's substantiated cases are for

children ages 0-5, and internal data reflects that the 4-6 age group shows a longer reunification time.

Goal 5

The Department will be given party status in Child Protective Act (CPA) cases and the Department will have legal representation in all CPA cases.

Progress on Goal 5

- At this time the Department continues to collaborate with legislators regarding the need to amend the Child Protective Act to make the Department a party to all CPA actions.

Goal 6

The program will modernize the child welfare information system - this effort will serve to improve the program's technology platform and related software applications to support the delivery of child welfare services in the most cost effective and time sensitive manner.

Progress on Goal 6

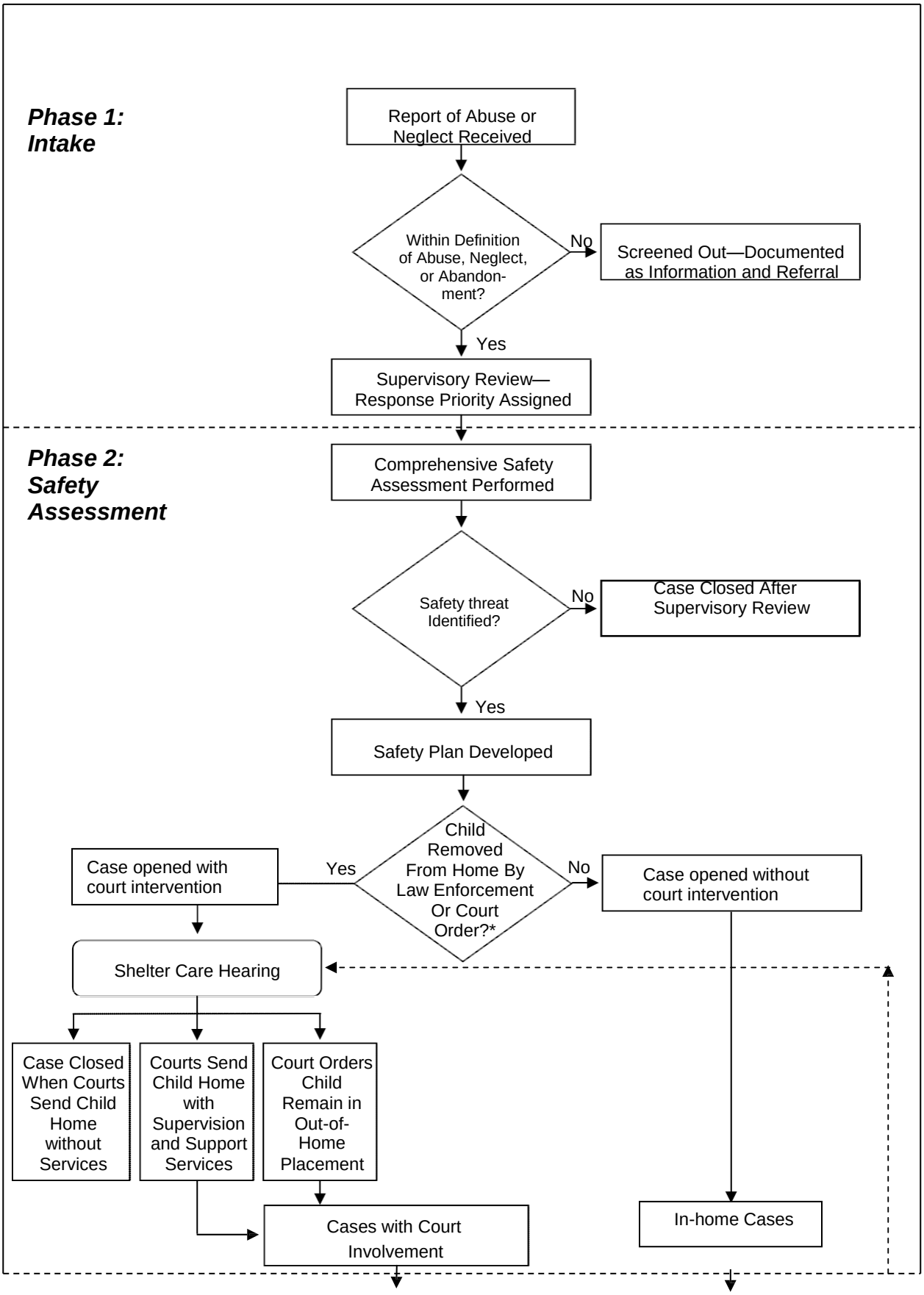
- The Data Quality Improvement Initiative (DQI), established in April 2015, continued its work in SFY 2016 by providing training and reports to child welfare managers and supervisors, promoting the importance of reliable data in making program decisions. From July 2015 to June 2016, all seven regions showed improvement in the timeliness of data entry into the child welfare information system (iCARE). Further improvements in timeliness of data entry are anticipated and further refinements of DQI tools are underway.
- In January 2016 a portal was opened to allow the Criminal History Unit (CHU) direct access to data elements within the iCARE database. This tool has been used by CHU for 15,000 searches allowing rapid access to time sensitive data to assist in conducting background checks.
- In January 2016 automated financial reports were brought online to allow regional staff to easily and accurately monitor expenditures for budget tracking.
- Currently in development is a portal to allow automated referrals of secure information to law enforcement jurisdictions throughout the state.

Appendix A: Summary of Required Court Hearings

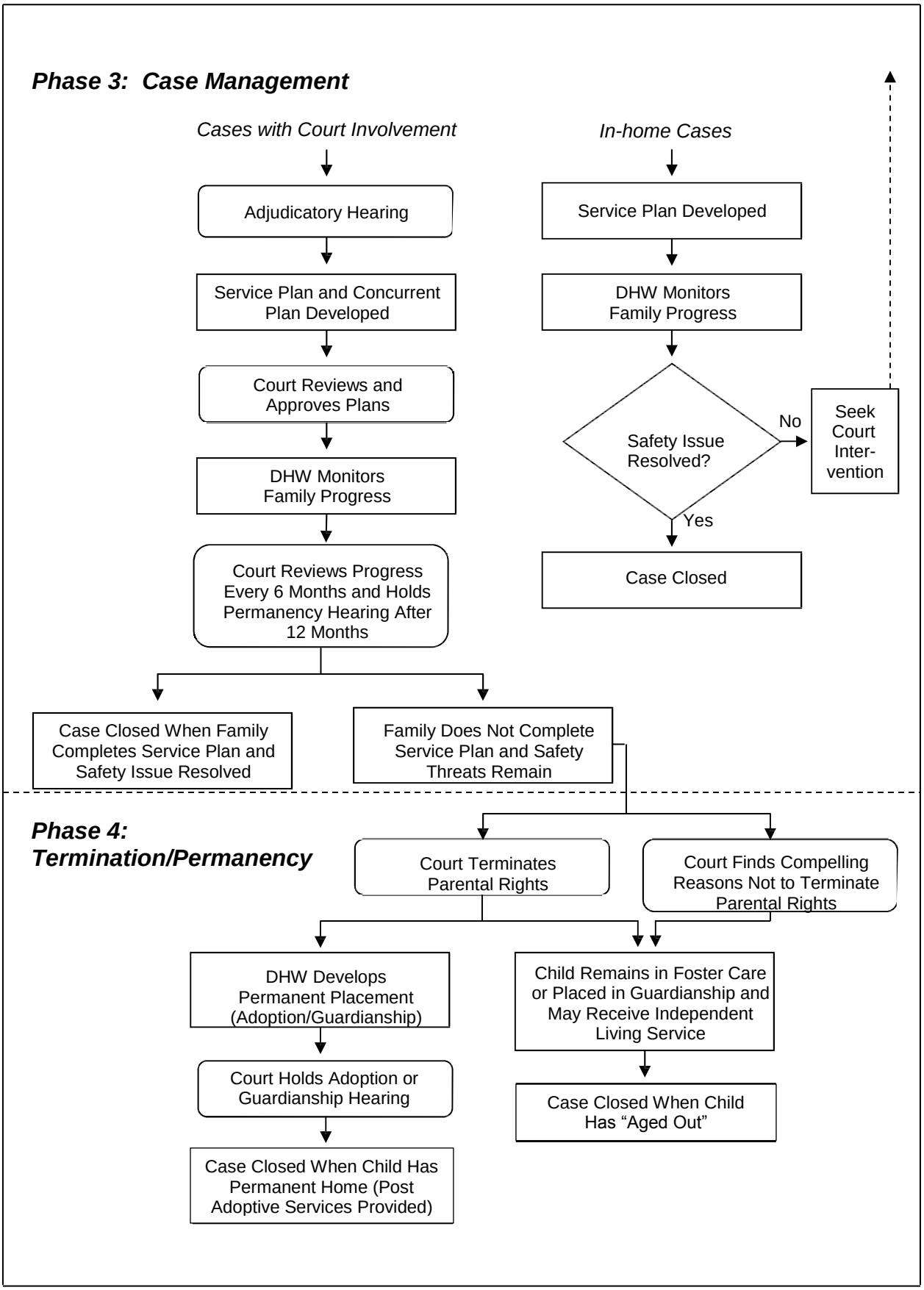
Hearing	Purpose	Time Requirement
Shelter Care Hearing	To determine if the removal of a child from his/her home is warranted. The court must find that it is contrary to the welfare of the child to remain in his/her home. The court must also determine that reasonable efforts have been made to prevent removal unless there are aggravating circumstances, such as the parent abandoning the child, committing murder, or committing felony assault against a child.	Within 48 hours of removal.
Adjudicatory Hearing	Following investigation of referrals, to determine whether the evidence indicates abuse or neglect has occurred and to determine whether the child should remain in foster care.	Within 30 days of the petition requesting removal.
Plan Review	To review the service plan developed by the Department. The court can approve, reject, or modify the plan.	Within 60 days of removal or 30 days of the court order taking custody of the child, whichever comes first.
Review Hearings	To review child protection cases while the child remains in the Department's legal custody.	Held at six (6) month intervals.
Permanency Hearing	To review the permanency plan developed by the Department, which contains its final recommendation regarding reunification and permanent placement of the child.	Twelve (12) months after removal or the court accepts jurisdiction for a case, whichever comes first.
Guardianship Hearing	To appoint a guardian for the child if the child's permanency plan is guardianship.	Thirteen (13) months after removal, unless an extension is approved by the court.
Termination Hearing	To determine if termination of parental rights is in the child's best interests. The court must find that reasonable efforts to achieve reunification have been made, but these efforts have failed.	To be initiated when a child has been in out-of-home care more than 15 of the last 22 months.
Adoption Finalization	To approve the adoption of a child. The child remains in Department custody and review hearings continue until the adoption is finalized.	Within 24 months of removal.

*The hearings listed above are those which are required to be held by state and federal law. Additional hearings are often held at the discretion of the court to assess case status and progress.

Appendix B: Child Welfare Process Flow Chart



** The majority of children enter foster care via a declaration of imminent danger by law enforcement. Less frequently, the Department may file a petition with the court requesting removal. In this circumstance, a judge makes a determination to sign an order for removal.*


Phase 3: Case Management
Cases with Court Involvement
Adjudicatory Hearing
Service Plan and Concurrent Plan Developed
Court Reviews and Approves Plans
DHW Monitors Family Progress
Court Reviews Progress Every 6 Months and Holds Permanency Hearing After 12 Months
Case Closed When Family Completes Service Plan and Safety Issue Resolved
Family Does Not Complete Service Plan and Safety Threats Remain
In-home Cases
Service Plan Developed
DHW Monitors Family Progress
Safety Issue Resolved?
No
Seek Court Inter-vention
Yes
Case Closed
Phase 4: Termination/Permanency
Court Terminates Parental Rights
Court Finds Compelling Reasons Not to Terminate Parental Rights
DHW Develops Permanent Placement (Adoption/Guardianship)
Court Holds Adoption or Guardianship Hearing
Case Closed When Child Has Permanent Home (Post Adoptive Services Provided)
Child Remains in Foster Care or Placed in Guardianship and May Receive Independent Living Service
Case Closed When Child Has "Aged Out"

AMENDED AGENDA #1

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Tuesday, January 31, 2017

SUBJECT	DESCRIPTION	PRESENTER
Approval of Minutes	Minutes of the January 23, 2017 Meeting	Senator Anthon
Gubernatorial Appointment	Vote on the Gubernatorial Appointment of Sue Walker to the Idaho Commission for the Blind & Visually Impaired	
Docket No. 24-0301-1601	Rules of the State Board of Chiropractic Physicians	Mitch Toryanski Idaho Bureau of Occupational Licenses
Docket No. 24-1001-1601	Rules of the State Board of Optometry	Mitch Toryanski
Docket No. 24-1201-1601	Rules of the Idaho State Board of Psychologist Examiners	Mitch Toryanski
Docket No. 24-2301-1601	Rules of the Speech and Hearing Services Licensure Board	Mitch Toryanski

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
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MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Tuesday, January 31, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.
GUBERNATORIAL APPOINTMENT:	**Consideration of Gubernatorial Appointment of Sue Walker to the Idaho Commission for the Blind and Visually Impaired. Senator Martin** moved to send the Gubernatorial appointment of Sue Walker to the Idaho Commission for the Blind and Visually Impaired to the floor with recommendation that she be confirmed by the Senate. **Senator Lee** seconded the motion. The motion carried by **voice vote.**
APPROVAL OF MINUTES:	**Senator Anthon** moved to approve the Minutes of the January 23, 2017 Committee meeting. **Senator Harris** seconded the motion. The motion carried by **voice vote.**
PASSED THE GAVEL:	Chairman Heider passed the gavel to Vice Chairman Souza to conduct the rules review.
DOCKET NO. 24-1001-1601	**Rules of the State Board of Optometry. Mitch Toryanski** introduced himself to the Committee as Legal Counsel to the Idaho Bureau of Occupational Licenses (Bureau), representing the Board of Optometry. **Mr. Toryanski** explained H 333 (2016) aligned the Board of Optometry's renewal and reinstatement statute with the Bureau's new renewal and reinstatement statute at Idaho Code § 67-2614. This year the Board of Optometry rules must be amended to align with the new statute. The rule decreases the reinstatement fee from $150 to $35, consistent with the statute. Based on past reinstatement numbers, the Board of Optometry estimates nine optometrists will likely fail to renew their licenses and be required to pay the reinstatement fee. The fee decrease will result in a negative impact of $1,035 to the Board of Optometry's dedicated fund, and there is no impact to the General Fund. **Mr. Toryanski** informed the Committee the docket also increases the number of continuing education hours optometrists can earn online from six to nine annually. **Mr. Toryanski** advised the changes in this pending fee rule were approved by the Board of Optometry in an open meeting that was noticed to the public. A postcard was sent to 461 licensed optometrists, and no comments were received.

Vice Chairman Souza asked the amount of the reinstatement fee if someone fails to renew in a timely manner. **Mr. Toryanski** replied today it would cost $150. If the docket is approved, the cost would be $35. The reinstatement fee is set in the Bureau's statute.

MOTION: **Senator Foreman** moved to approve **Docket No. 24-1001-1601. Senator Harris** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 24-0301-1601 **Rules of the State Board of Chiropractic Physicians. Mr. Toryanski** introduced himself to the Committee on behalf of the State Board of Chiropractic Physicians (BCP) and also introduced Dr. Mary Jo White, Chair of the BCP, from Post Falls. **Mr. Toryanski** explained the 2013 balance in the BCP account was $136,539. Today the balance is negative $84,825. The steep decline over those four years was caused by increased complaints, investigations, prosecutions, and a negotiated rulemaking hearing held last year. The BCP requests a fee increase estimated to increase revenue by $36,150 per year. No special assessment is made when the balance goes in the red; instead, the BCP proposes a fee increase and hopes to recover lost ground over three or four years.

Mr. Toryanski stated the docket also contains changes to speed up and streamline the peer review process. It establishes that the recommendation of the Peer Reviewer Panel is not subject to appeal, and if peer reviewers determine a chiropractor has violated any laws or rules, the original request for peer review will be referred to the BCP for investigation so the Peer Reviewer Panel's findings do not taint the process if disciplinary action is required. A patient, chiropractor, or third party can ask for peer review, which does not establish a precedent nor is it controlling authority. It is merely an opinion by learned chiropractors that perhaps can resolve a conflict or dispute without having to go to litigation.

Mr. Toryanski advised the changes were approved by the BCP in a meeting noticed to the public. A postcard was mailed to 722 licensed chiropractors, and no comments were received.

Senator Harris asked if the problems that caused the fund deficit have been fixed. **Mr. Toryanski** said the fee increase will fix the problem. There were some very expensive cases. One local case involved a chiropractor who vigorously disputed every charge the BCP made at every level. When the proceeding concluded, the hearing officer found for the BCP, and the chiropractor appealed the decision to the district court. Before the case was heard on the merits, the chiropractor passed away. In disciplinary actions, if the professional prevails, he can get attorney's costs and fees from the BCP. When the BCP prevails, it can recover its costs and fees. With the death of the chiropractor, the BCP settled for a small amount of the approximately $130,000 that it took to prosecute the case.

MOTION: **Chairman Heider** moved to approve **Docket No. 24-0301-1601. Senator Foreman** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 24-1201-1601

Rules of the Idaho State Board of Psychologist Examiners. Mr. Toryanski introduced himself on behalf of the Board of Psychologist Examiners (BPE). **Mr. Toryanski** also introduced Dr. Helen Holly, Psychologist and BPE Member. **Mr. Toryanski** advised the rule docket: 1.) specifies licensees may receive continuing education credit from classes taught on-line from the same organizations from which they can get credit for in-person attendance; 2.) establishes that service extenders can provide service only after their supervisory plan is approved by the Board; 3.) creates a new category of service extender for those who provide psychometrician services only; and 4.) establishes rules to complement the Idaho Telehealth Access Act based on questions received after the Idaho Telehealth Access Act was passed.

Mr. Toryanski explained Section 601 is a new section pertaining to Telepsychology. The rule defines "emergency," "information technology," "telehealth provider," and "telepsychology services" and provides general guidance to psychologists providing services through electronic means. The rule also provides procedures for getting informed consent from patients, security and confidentiality, conducting assessments, and practicing telepsychology across state lines.

Mr. Toryanski informed the Committee the pending rule was approved by the BPE in an open meeting that was noticed to the public. Postcards were mailed to 347 licensees informing them of the change and inviting their comments. The BPE received one comment during the comment period from a psychologist who wanted to know if he was practicing telepsychology if he simply stored clinical information on the hard drive of the computer in his office. The BPE assured him that he was not. After the comment period, the BPE was contacted by an insurance company that was very supportive of the telepsychology rules but had concerns about the Board's interpretation of one of the definitions and one of the security requirements. The BPE agreed to monitor these two issues to determine if any refinement of the rules is needed. The BPE was also contacted by the local American Association of Retired Persons (AARP) representative regarding the need to obtain written, informed consent upon a psychologist's subsequent contact with a telepsychology patient. The BPE agreed with AARP's comment and assured AARP it would not interpret the rule to require psychologists to get a written informed consent every time a service is provided. The BPE will work with AARP over the next year to see if the rule needs more clarity.

Senator Martin stated he heard a judge has ruled parts of the Telehealth Access Act unconstitutional. **Mr. Toryanski** answered he is not aware of any legal action having to do with the Telehealth Access Act. Outside of the constitutionality issue, a number of boards have looked at the law because they also provide services by electronic means. The Telehealth Access Act is so succinct and clear, many boards have decided it is unnecessary to promulgate rules to implement it.

Chairman Heider inquired how long telepsychology has been used, and if psychologists and patients feel it is as effective as meeting with the patient in person. **Mr. Toryanski** responded psychologists have likely been providing telepsychology services since the phone was invented. **Mr. Toryanski** stated Dr. Holly would be a good resource for more information. **Dr. Helen Holly** introduced herself as a clinical psychologist at Saint Alphonsus Pain and Spine Clinic and a new member to the BPE. The experience of telepsychology is important in Idaho because of the rural nature of the State. This service will allow more services to people who are now unable to access them. It has already been used in the military setting for many years, such as with people on ships who are deployed. Navy psychologists are stationed on aircraft carriers, so smaller ships will often conduct telepsychology between the aircraft carrier

and the smaller vessel through a Skype-type mechanism. It seems everyone almost prefers electronic to in-person communication. The level of disclosure is often higher because there is a sense of safety for the patient when in his or her own surroundings and not a foreign environment.

MOTION: **Senator Martin** moved to approve **Docket No. 24-1201-1601. Senator Foreman** seconded the motion. The motion carried by **voice vote.**

DOCKET NO. 24-2301-1601 **Rules of the Speech and Hearing Services Licensure Board. Mr. Toryanski** introduced himself to the Committee on behalf of the Speech and Hearing Services Licensure (SHSL) Board and also introduced Dr. Gail Chaney, a licensed audiologist and SHSL Board member. **Mr. Toryanski** explained the SHSL Board regulates the practice of audiology, speech-language pathology, and hearing aid dealing and fitting services. This docket: 1.) lowers the original license fee by 30 percent and license renewal fee by 20 percent; 2.) establishes rules to define the role of audiology support personnel; and 3.) establishes qualifications for the audiologists and hearing aid dealers and fitters who supervise provisional permit holders.

Mr. Toryanski informed the Committee the SHSL Board's balance has been steadily increasing over the past six years and is now three times its annual budget of $85,000 per year. Boards are typically advised to maintain a balance of 100 to 150 percent of their annual budgets. The SHSL Board feels its fund balance is high and wants to collect less from its licensees. The SHSL Board proposes to lower the original license fee from $100 to $70 and the license renewal fee from $125 to $100.

Mr. Toryanski stated the second change involves rules for audiology support personnel as provided for in the Speech and Hearing Services Act at Idaho Code § 54-2907. Support personnel are helpers trained under the direction of audiologists who perform designated tasks under the supervision of an audiologist. This docket sets forth a supervisor's responsibilities, the tasks support personnel can perform, and training guidance.

Mr. Toryanski advised the SHSL Board felt it was important to establish some minimum qualifications for audiologists and hearing aid dealer and fitters who supervise hearing aid provisional permit holders. A provisional permit holder is a person who holds a permit to practice hearing aid dealing and fitting under supervision. A supervisor must be approved in advance by the SHSL Board and hold either a hearing aid dealing and fitting license or an audiology license that is current and in good standing. The licensee cannot have had any disciplinary action in the two years immediately before becoming a supervisor. If the supervisor is a hearing aid dealer and fitter, the license holder must hold either a current board certificate in hearing instrument sciences for the National Board for Certification in Hearing Sciences or have actively practiced for three years immediately preceding appointment as a supervisor. If the supervisor is an audiologist, the licensee must have actively practiced as a licensed professional for one year before becoming a supervisor.

Mr. Toryanski explained the changes in this pending fee rule were approved by the SHSL Board in an open meeting that was noticed to the public. A postcard describing the changes and requesting comments was sent to all 1,116 licensees. Three responses were received expressing concern that the audiology support personnel section would affect the newborn hearing screening performed by a number of hospitals. The SHSL Board contacted the Idaho Hospital Association and met with a Health and Welfare Program Coordinator for newborn hearing screening along with a number of interested parties who perform this service. Consensus was reached that the proposed rules would not affect the newborn hearing screening. The SHSL Board agreed to examine some language in the coming year to make this clearer. The SHSL Board knows of no opposition to the docket.

MOTION: **Senator Harris** moved to approve **Docket No. 24-2301-1601. Senator Agenbroad** seconded the motion. The motion carried by **voice vote.**

PASSED THE GAVEL: Vice Chairman Souza passed the gavel back to Chairman Heider.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 3:34 p.m.

Senator Heider
Chair

Jeanne Jackson-Heim
Secretary

AMENDED AGENDA #1

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Wednesday, February 01, 2017

SUBJECT	DESCRIPTION	PRESENTER
Approval of Minutes	Minutes of the January 19, 2017 Meeting	Senator Harris
Presentation	Community Care Advisory Council Annual Report	Christine Pisani, Vice Chair Community Care Advisory Council
H 0002	Relating to Pharmacists	Alex Adams, Executive Director Idaho State Board of Pharmacy
H 0003	Relating to Pharmacists	Alex Adams
H 0004	Relating to Pharmacists	Alex Adams
H 0005	Relating to Controlled Substances	Alex Adams

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, February 01, 2017

TIME: 3:00 p.m.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:20 p.m.

APPROVAL OF MINUTES: **Senator Harris** moved to approve the minutes of the January 19, 2017 meeting. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**

PRESENTATION: **Community Care Advisory Council Annual Report. Christine Pisani,** Executive Director of the Idaho Council on Developmental Disabilities, introduced herself to the Committee, appearing as Vice Chair of the Community Care Advisory Council (Council) to present the Council's annual report (see Attachment 1). **Ms. Pisani** explained the Council was created by statute in 2005 and is a forum for stakeholders in residential care/assisted living facilities and certified family homes. The Council meets quarterly and its purpose is to: 1.) make policy recommendations regarding the coordination of licensing and enforcement standards in residential care/assisted living facilities and certified family homes, as well as provision of services; 2.) advise the agency during development and revision of rules; 3.) review and comment upon any proposed rules pertaining to residential care/assisted living facilities or certified family homes; and 4.) submit an annual report to the Legislature stating opinions and recommendations that would further the State's capability in addressing residential care/assisted living facility and certified family home issues.

Ms. Pisani informed the Committee the Council is comprised of assisted living and certified family home providers; advocates for elderly individuals and people with developmental disabilities and mental health issues; and residents or family members of assisted living facilities and certified family homes. The Director of the Department of Health and Welfare (Department) or his designee also serves on the Council, and at this time the designee is Tamara Prisock. Last year, the Council elected to add a non-voting member, a resident/family member of a residential assisted living facility, to provide valuable insight.

Ms. Pisani stated pages 6 through 9 of the annual report contain survey information and trends regarding assisted living facilities and certified family homes. The Department has done extensive work on its website to provide useful information to the public regarding assisted living facilities, including survey results and information about complaints.

Ms. Pisani advised the Council has identified several issues over the past year. The first involves funding. Providers continue to express concern that negotiations with the Department's Division of Medicaid regarding outdated rates for Medicaid reimbursement have not resulted in an increase in rates. Reimbursement rates for services provided in certified family homes are almost 15 years old. Personal care service rates in residential/assisted living facilities are lower than what they were in 2009. As time has gone by, numerous supports for clients have been curtailed or eliminated, and new burdens on providers have evolved. The Council recommends a fresh look at the current operating environment to ensure funding is adequate to safely care for residents according to established regulations and recent interpretations of those regulations.

Ms. Pisani explained the second issue is the assessment of residents in assisted living facilities. In 2014, the Council began work on ways to improve the assessment of residents admitted to assisted living facilities or certified family homes to ensure there is a good match between the resident and the services provided. When residents have needs beyond the facility's ability to provide required care, some residents are involuntarily discharged and admitted to another residential setting that may be more appropriate for their needs. Moving is stressful and disruptive for the resident. In cases in which a facility chooses to maintain a resident but cannot provide the required care, the facility is in violation of the requirements of its statewide certification. Many assisted living facilities and certified family homes use the Uniform Assessment Instrument, a tool used by the Department's Division of Medicaid to determine Medicaid reimbursement. The Council has requested the Department explore other options for assessment tools. Changes in how residents are assessed will likely require updates to Idaho law and rules.

Ms. Pisani stated the third growing issue in Idaho is the difficulty of finding appropriate residential placement for individuals who exhibit difficult behaviors. Assisted living facilities and certified family homes are required not to admit or keep individuals who attempt to harm themselves or others. Most of the individuals are on Medicaid, and providers feel they do not receive sufficient Medicaid reimbursement to implement supervision and services needed to effectively manage difficult behaviors. There is also a lack of training to provide the needed support. This situation requires a provider to either run the risk of losing its license if the resident harms himself or others, or to discharge the resident, even when the resident has nowhere else to go. Last year, the Council recommended the Department work with stakeholders to find a solution to this problem. The Department responded by making the issue a high priority and launching an initiative to examine the problem and explore solutions.

Ms. Pisani advised the last two issues involve implementation of residential care/assisted living rule changes that were negotiated in 2014 and implemented in 2015. To date, the only concerns expressed to the Department and the Council have come from a few small assisted living facilities which have become organized to become the Idaho Small Providers Association. One of the rules that has caused financial stress to small providers is having the staff up and awake and available 24 hours a day, 7 days a week. The Department's Division of Medicaid has met with providers to ensure they are billing accurately to maximize Medicaid reimbursement and alleviate some of the financial strain regarding that rule change. The Council has also identified the need to update the rules pertaining certified family home and will be working this year to provide recommendations to the Department.

Ms. Pisani commented the Council is collaborative and solutions oriented. Tamara Prisock provides excellent support to the Council with accurate details of the programs and a sense of urgency in addressing any concerns the Council brings to her attention.

Vice Chairman Souza mentioned the table of core deficiencies on page 5 of the report that shows the abuse category has jumped up and asked how the Council deals with that type of increasing problem. **Ms. Pisani** responded the table reflects individual incidents that are not necessarily brought to the Council. They are incidents reported to the Department and the Department conducts its own investigation. Tamara Prisock likely has additional information.

Senator Jordan expressed concern that the reimbursement rates have not been raised for almost 15 years and asked for data that shows the commensurate increase in cost of service provision over that same period of time. **Ms. Pisani** advised Ms. Prisock would have that data and would be pleased to provide it. **Senator Jordan** asked for the definition of a small service provider. **Ms. Pisani** asked to defer that question to Tamara Prisock.

Senator Lee has heard from a number of providers in her district who struggle with the dilemma of individuals with challenging behaviors and asked what measures are being taken to address this issue. **Ms. Pisani** replied that Ross Edmunds, Administrator of Behavioral Health with the Department, plans to present some legislation and an appropriation request for a "heart home" model, which is the ability to support people with challenging behaviors with a different reimbursement rate. The State has no response to the current level of need in this area and no place for individuals to be served. The "heart home" model will not resolve the entire issue but will be a good first step to implement.

H 0002

Relating to Pharmacists. Alex Adams, Executive Director of the Idaho State Board of Pharmacy (BOP), introduced himself to the Committee to present the bill. **H 0002** amends the BOP qualifications for licensure by reciprocity, meaning how pharmacists who are licensed in other states can transfer their licenses to practice in Idaho. A strict interpretation of today's statute would mean an individual who had a minor infraction in another state would never be eligible to transfer the license into the State of Idaho. The bill updates language to conform with the intent of the model act of the National Association of Boards of Pharmacy (NABP). NABP processes license transfer requests across all 50 states and the District of Columbia, and the BOP worked closely with NABP to update language to ensure what is proposed conforms to the model act. Specifically, the bill clarifies that pharmacists are not eligible to transfer a license into Idaho if the license is currently revoked, suspended, or restricted in a manner that prevents him or her from practicing pharmacy in the home state. Minor infractions can be taken up on a case-by-case basis.

Senator Martin asked if the law change would allow the BOP to look at any violations a pharmacist had in the past. **Mr. Adams** responded NABP has a way to flag individuals with past discipline when processing the license reciprocity request. The BOP delegates certain authority to BOP staff to process applications. If there are criminal issues or previous suspensions or revocations, those applications are held until a BOP meeting. The BOP hears the merits of the specific case, and the individual can present to the BOP. The BOP can judge based on the severity of the violation whether the individual should be permitted to practice in the State of Idaho.

Senator Jordan asked if there are appeal opportunities contained in the rules or elsewhere for someone who is denied a license. **Mr. Adams** answered the BOP follows the State's Administrative Procedures Act, which specifies the process for both hearings and appeals and rights of the individual. The BOP is also advised by a Deputy Attorney General in all areas.

MOTION:

Vice Chairman Souza moved to send **H 0002** to the floor with a **do pass** recommendation. **Senator Jordan** seconded the motion. The motion carried by **voice vote. Senator Jordan** offered to sponsor the bill.

H 0003 **Relating to Pharmacists.** **Mr. Adams** stated **H 0003** would allow pharmacists to prescribe and administer tuberculosis (TB) skin tests in pharmacy settings. This has become a common and routine practice in pharmacies in other states. Most commonly, TB skin tests are often required as a condition of employment or for college students. In a TB skin test, a health professional performs an intradermal injection, and the patient has to return within three days for the test to be interpreted. Having this service available in a pharmacy provides substantial convenience to the consumer. Several studies have been published. One demonstrated a 93 percent completion rate for the test across 600 patients, while the comeback rate for other healthcare settings was only 40 to 50 percent.

Mr. Adams explained the bill contains safeguards requiring pharmacists to: 1.) complete special training on appropriate technique, with free training options available; 2.) follow clinical guidelines for testing; 3.) document the results of tests provided; and 4.) coordinate a timely referral to the patient's primary care provider or a local clinic in the rare instances when a patient tests positive for TB. In the study of other states where the test was performed in pharmacies, the referral rate to the primary care provider was only two to three percent.

Chairman Heider asked if this test is the TB tine test, or is it an actual inoculation. **Mr. Adams** answered this test is an actual injection under the skin. He is not familiar with previous testing procedures. **Vice Chairman Souza** asked if the pharmacy would be required to report test results to the primary care physician. **Mr. Adams** stated only a positive result must be reported to the local health district or the Department in accordance with Idaho reportable diseases rules.

MOTION: **Senator Lee** moved to send **H 0003** to the floor with a **do pass** recommendation. **Senator Harris** seconded the motion. The motion carried by **voice vote.**

H 0004 **Relating to Pharmacists.** **Mr. Adams** stated the goal of **H 0004** is to make it as easy to quit smoking as possible. The Federal Drug Administration (FDA) has approved seven smoking cessation medications. Three of them are already available over the counter: patches; gum; and lozenges. Four are prescription only: nasal spray; inhalers; Chantix; and Zyban. When someone makes the decision to quit smoking, often it is a spontaneous decision. If the person has to wait weeks to get into the primary care provider, the will to quit might bend or break in the meantime. Having these products conveniently accessible at the pharmacy might help consumers make that quick decision.

Mr. Adams informed the Committee **H 0004** would allow a pharmacist to prescribe any of the seven tobacco-cessation medications. Some of the prescription products are more effective than over-the-counter products. In clinical trials, Chantix has the highest effectiveness rate. Also, some of the prescription products can be used in combination with the over-the-counter products. There might be some clinical use cases where a person would need a nasal spray or inhaler. Pharmacists would be required to obtain advanced training, document the services provided, and notify the patient's primary care provider. This would create harmony with other State programs like the Idaho Quitline.

Mr. Adams stated there are often questions about the safety of smoking-cessation products. The BOP noted the focus of negative comments on this proposal was almost entirely on the risks without considering the benefits. The FDA reviewed the evidence of the largest clinical trial ever conducted on these products and issued a report in December 2016 stating the benefits of the products outweigh the risks. According to the FDA, the most common side effects of Chantix are short-term nausea and short-term constipation. By contrast, smoking can cause death. The FDA said the most common side effects of Zyban are short-term dry mouth and short-term insomnia. By contrast, smoking can cause lung cancer. One of the rare risks of Chantix was suicidal ideation. However, the FDA recently removed the "black box" warning from Chantix related to neuropsychiatric events. It is the first time in U.S. history that the FDA has ever removed a "black box" warning from a drug. Pharmacists have been allowed to prescribe smoking cessation products in New Mexico, California, and nine Canadian provinces for 50 cumulative years. The BOP contacted its counterparts in those jurisdictions and asked how many complaints were received alleging harm. There were zero complaints, zero civil lawsuits. The BOP also asked the largest liability insurer in the U.S. regarding pharmacist insurance rates in New Mexico pre- and post-implementation of the policy. The answer was there was no change because it did not increase risk and was found to be safe and effective in other jurisdictions.

Mr. Adams advised the BOP found 11 peer-reviewed studies showing good results from the use of community pharmacists for tobacco-cessation programs. Overall, pharmacy-based interventions were found to be more cost effective than other health care settings. The largest of these studies was in New Mexico with 1,437 patients. Pharmacists achieved quitting rates similar to other health professionals. In late 2016, the results of a randomized control trial in Alberta, Canada showed pharmacists achieved a 20 percent greater relative reduction in smoking compared to the control group of usual physician care. Medicaid within the last few weeks has provided advice on how to facilitate easier access to medically necessary and time sensitive drugs, including tobacco-cessation productions, and specifically highlighted the New Mexico and California examples.

Senator Martin asked if the bill would allow pharmacists to prescribe only the seven products mentioned or would the bill allow prescribing of any new products that might be identified in the future. **Mr. Adams** answered the bill provides a pharmacist may prescribe any smoking cessation product approved by the FDA. Pharmacists would be able to prescribe those mentioned today as well as any approved by the FDA in the future. Naming the specific drugs in the legislation would require a law change each time a new drug is approved.

Senator Martin asked whether it is a good step to move from the current model of obtaining a prescription from the doctor and going to the pharmacy to have the prescription filled. **Mr. Adams** responded the statute currently includes a list of products that can be prescribed by a pharmacist such as dietary, fluoride supplements, immunizations, opioid antagonists, and epinephrine auto-injectors. The root of every one of those products is public health need where access to the products can help achieve public health goals. For example, one in four Americans has gone to a pharmacy in the last 12 months to obtain an immunization. Data from TriCare and Harvard Medical School show this is the most cost-effective venue to get an immunization. Other states are far ahead of Idaho in this regard and allow other products such as flu medications, contraceptives, strep throat medications, and travel medications to be prescribed by a pharmacist.

Senator Jordan inquired whether the pharmacist has a choice whether or not to prescribe the medications. **Mr. Adams** answered yes. No pharmacist is compelled to prescribe the products and must obtain additional training to provide the service. It is unlikely all pharmacists will offer the service. **Senator Jordan** asked if this is the same type of training as with the TB test where it is available online and relatively inexpensive. **Mr. Adams** replied the TB test training is only a 29-minute video but for this service, the pharmacists would be required to choose a training accredited by the American College of Physicians. There are several free programs, and there is a curriculum used in other states called "Rx for Change," from the University of California - San Francisco, including a variety of programs focusing on the pharmacological treatment of nicotine dependence. There is a time cost associated with the training but no direct cost outlay.

Vice Chairman Souza asked if pharmacists in other states have to take advanced training to prescribe contraceptives and the other products mentioned. **Mr. Adams** said it depends on the state. He thinks every state requires some kind of training but he is not aware of the specifics. Some states conditioned the approval to administer flu medication on the pharmacist administering an FDA-approved Clinical Laboratory Improvement Amendment (CLIA) waived test that will determine the individual actually has flu prior to prescribing. There was also concern that if pharmacists prescribe the medications, it could increase antimicrobial resistance. However, studies found the service actually decreased prescribing of antimicrobials 40 to 60 percent. **Vice Chairman Souza** asked if the BOP is planning to bring forward a list of products for pharmacists to prescribe, or will they be presented one at a time. **Mr. Adams** answered these are tough things to work out and he would hope not to have to come back every year with a new product.

TESTIMONY: **Pam Eaton** introduced herself as President and CEO of the Idaho Retailers Association, which includes the Idaho Retail Pharmacy Council and the Idaho State Pharmacy Association, in support of **H 0004. Ms. Eaton** informed the Committee Mr. Adams already covered many of the points she wanted to make. She has heard questions about what happens if there are adverse effects, and the doctor would know about it where the pharmacist might not. Side effects to these medications are minor, and if one occurs, it will occur outside the physician's office or pharmacy. No one knows there is an adverse effect unless the patient calls. The pharmacist would review the adverse effects with the patient, just like a physician would, and direct the patient to pick up the phone and call if something happens.

Ms. Eaton addressed another concern that a patient might feel more reluctant to talk to the pharmacist about health risks. In her experience, many patients feel more comfortable talking to the pharmacist because the physician might be more judgmental. **Ms. Eaton** advised that pharmacists are repeatedly voted at the top for trustworthiness. Most people, especially if they have health issues, have a better relationship with their pharmacists than they do with their physicians, usually because they see their pharmacists more often. For these products, it truly doesn't matter where people get their prescriptions.

TESTIMONY: **Billy Gallagher** introduced himself to the Committee as a second-year family medicine resident to speak in opposition to **H 0004**. **Dr. Gallagher** said his job is to see patients every day and make sure the "what ifs" of bad outcomes are accounted for. He prescribes tobacco cessation medications on a regular basis, but not always for smoking cessation. For example, Wellbutrin is also an anti-depressant. It is true Chantix had the "black box" warning removed, but Wellbutrin still has one. Both Chantix and Wellbutrin have recommendations for laboratory monitoring before starting the medication. Chantix has side effects affecting nearly every organ system, including promoting heart arrhythmias. Wellbutrin can lower the threshold for seizures and is Class D in pregnancy, cautioned in the elderly and for patients with liver disease. It can cause glaucoma, which if left untreated could cause blindness.

Dr. Gallagher commented that pharmacists cannot order lab work. A doctor will have the patient's full medical record. Other monitoring for blood pressure and the patient's past medical history is also indicated to make sure there is no history of depression or other mental health diseases, due to the warning that the drug can increase the risk of suicidal behavior or thoughts. Sometimes patients skip around to pharmacists based on where they are at that moment, but usually there is only one primary care doctor. The patient physician relationship is one of the strongest and the 20 to 30 minute appointments sitting face to face with patients is better than having a conversation in a busy Walgreen's. The medicines have serious implications, and he is not sure sufficient monitoring can take place at a pharmacy. It can work if a pharmacist is just down the hall from the doctor. The Idaho Medical Association chose not to support this bill based on their experience.

Chairman Heider asked Dr. Gallagher if he opposed all pharmacist prescribing privileges or just this particular type of drug. **Dr. Gallagher** answered he did not oppose all pharmacist prescribing privileges. A lot of what they do is helpful and provides access to busy people who cannot make it to a doctor's office during the day. The smoking-cessation medications have significant implications, and the list will keep growing. Next will be lipid lowering medicines, anti-depressants, and high blood pressure medications. These are best delivered from the doctor where the patient will call when there is a problem.

Senator Jordan inquired if Dr. Gallagher was familiar with the New Mexico program and if he has seen other adverse impacts from this type of program that might not have risen to the level of a complaint. **Dr. Gallagher** replied he is not familiar with the New Mexico program and would like to look into it further.

Senator Foreman asked about Dr. Gallagher's experience prescribing these drugs and what side effects he has seen to cause him concern. **Dr. Gallagher** responded there are pros and cons to taking drugs, and the black box warnings are cause for concern. He has prescribed medicines in a similar class that can cause a person to be very anxious and provide them with a lot of internal energy and anguish. This is stronger in people with a history of anxiety or depression or bi-polar disorder and can drive people to the emergency room or damage their relationships and ability to function at work. When he prescribes a new medication, he asks the patient to return in two weeks so he can check in and make sure the drug is overall improving their function. This is very similar to the approach for tobacco-cessation products. When he has seen bad side effects, he is quick to take them off the medication. **Senator Foreman** stated it is convenient to go to the pharmacy and it is cheaper, and from the consumer point of view, it sounds good. **Senator Foreman** asked how one would explain to the consumer that the risk outweighs the convenience. **Dr. Gallagher** answered he would counter that monitoring of blood pressure, kidney and liver function, pregnancy status, and so forth is important. Perhaps a patient has smoked for 40 years and has untreated illnesses and giving a prescription

could exacerbate those problems and provoke a heart attack or stroke. He would want to make sure someone is thoroughly screened before prescribing.

TESTIMONY: **Andrea Winterswyk** introduced herself to the Committee as an Idaho pharmacist to speak in support of **H 0004**. Pharmacy school is four years long and a very intensive program. Pharmacists learn about diseases as well as medications. **Dr. Winterswyk** teaches a three-hour lab for pharmacy students on smoking cessation and focuses on behavior modification. Pharmacists are the medication experts and have a doctorate in pharmatherapy. With a condition like tobacco dependence that has such serious implications, having the proper resources to be able to quit is crucial. Increased access to drugs is a benefit, and all pharmacists are trained to prescribe these products. The risk of the medication and the liability are carried on the person who prescribes it no matter who that is. Pharmacists provide close follow-up and patients are more likely to succeed in quitting smoking.

Dr. Winterswyk said she has personal experience with patients identifying pre-existing conditions. Patients tell her right away if they are pregnant and are very willing to discuss their psychiatric maladies because they don't want to harm themselves. The clinical trial mentioned by Mr. Adams found no significant difference in neuropsychiatric adverse effects between Chantix, Zyban, nicotine replacement, and placebo. The trial included patients with pre-existing illnesses so it is a realistic picture and even within that cohort, there was no statistical difference.

Dr. Winterswyk stated pharmacists screen patients for tobacco use and provide behavioral modification, and pharmatherapy is the most beneficial service they can provide today. Pharmacists are more than capable of providing this service and monitoring the patient, as they are more accessible and would not do anything the doctor wouldn't do.

Senator Foreman asked whether pharmacists will be able to provide the same one-on-one consultation at a busy drug store as in the doctor's office. **Dr. Winterswyk** replied any health care setting is very busy. One of the most beautiful things about a pharmacy is it has a private consultation room and the pharmacist can administer a health questionnaire. It is totally feasible and is done with immunizations even with the busy workload in a retail setting. A pharmacist can prescribe 400 immunizations every few days and still find time to sit a minute or two to make sure the person is okay and answer questions. It is not only feasible, it is enjoyable. Pharmacists are trained to have connection with the patient and not just put pills in a bottle.

Mr. Adams advised the Committee he did not hear any evidence of harm in the 12 years New Mexico has approved this program, nor in California, nor in Canada. The same arguments were made in 2011 against allowing pharmacists to prescribe immunizations. The studies have not been refuted and show good results.

MOTION: **Senator Martin** moved to send **H 0004** to the floor with a **do pass** recommendation. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**

DISCUSSION: **Senator Jordan** will support the motion because it addresses the concerns about accessibility and does not preclude a physician from offering advice and counsel to a patient. It will be interesting to get some data as this goes forward to see how it works.

Senator Martin advised he sits on the Millennium Fund and Idaho spends millions each year to get Idahoans to stop using tobacco products. He supports this and other measures to assist in smoking cessation.

Senator Foreman stated he will support this bill but is close to reaching a maximum of what he wants to put on the backs of pharmacists. He has the highest respect for the profession and they do good work to bridge the gap between the patient and physician, but perhaps the pharmacists are being asked to do too much. Based on the studies and presentations, he intends to support the bill.

Vice Chairman Souza said she also supports the motion because it is a help to have the professions work together to provide primary care when Idaho is so short of primary care providers, and doctor visits are often five to seven minutes. Primary care physicians are overworked as is, and pharmacists who want to be involved can. It provides more options for consumers.

Chairman Heider called for the vote, and the motion carried by **voice vote.**

H 0005 **Relating to Controlled Substances. Mr. Adams** stated **H 0005** relates to the Idaho Prescription Monitoring Program (PMP). The bill sets a record retention deadline for PMP data at five years. Currently, data is kept in perpetuity. The five-year period was chosen to synchronize with the statute of limitations for felony cases.

Mr. Adams explained legislation was passed in 2014 to require all prescribers to register for access to the PMP except veterinarians. Pharmacists were not part of that legislation, and this bill would require pharmacists to register for access the PMP similar to the requirement for prescribers. At the beginning of 2016, only 60 percent of pharmacists were registered, and as of two weeks ago the rate has gone up to 89 percent after the BOP conducted outreach efforts. Registration is free and takes three to five minutes.

Mr. Adams informed the Committee the bill would expand the definition of "delegates" of a supervising practitioner. Currently, a nurse or other office personnel can search the PMP on behalf of a prescriber. A pharmacy technician can search on behalf of a pharmacist. Delegate access to the PMP has increased use of the database 28 percent. The definition of delegate would be expanded to included medical and pharmacy students on behalf of the supervising prescriber or pharmacist in the usual course of care. Idaho State University brought this idea to the BOP because early practice exposure while going through the curriculum can help engender long-term participation and increased use of the database.

MOTION: **Senator Harris** moved to send **H 0005** to the floor with a **do pass** recommendation. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**

ADJOURNMENT: There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:45 p.m.

Senator Heider
Chair

Jeanne Jackson-Heim
Secretary

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Monday, February 06, 2017

SUBJECT	DESCRIPTION	PRESENTER
Approval of Minutes	Minutes of the January 17, 2017 Meeting Minutes of the January 25, 2017 Meeting	Senator Foreman Senator Jordan
Presentation	Catastrophic Health Care Cost Program FY 2016 Annual Report	Kathryn Mooney, Program Director Catastrophic Health Care Cost Program
RS25031	Relating to Immunizations	Sarah Clendenon and Miste Karfeldt Health Freedom Idaho
RS25153	Relating to Persons with Disabilities	Richelle Vannoy

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, February 06, 2017

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Souza, Senators Martin, Anthon, Agenbroad, Foreman, and Jordan

ABSENT/ EXCUSED: Senators Lee and Harris

NOTE: The sign-in sheet, testimonies, and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:09 p.m.

APPROVAL OF MINUTES: **Senator Foreman** moved to approve the Minutes of the January 17, 2017 meeting. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**

Senator Jordan moved to approve the Minutes of the January 25, 2017 meeting. **Senator Martin** seconded the motion. The motion carried by **voice vote.**

PRESENTATION: **Catastrophic Health Care Cost Program FY 2016 Annual Report. Kathryn Mooney,** Program Director for the Catastrophic Health Care Cost Program (CAT Fund), presented its annual report (see Attachments 1 and 2). **Ms. Mooney** informed the Committee the CAT Fund has been in existence for many years and began when Idaho counties pooled their money to assist in recovering costs of medical claims within the county hospitals. When that process became too cumbersome, the Legislature created the CAT Fund in 1991. The CAT Fund is funded by the State and administered by a board of directors (CAT Board). In 2010, the CAT Board contracted with the Idaho Association of Counties to serve as program administrator. S1158 (2011) recodified the CAT Fund and added the Director of the Department of Health and Welfare (Department) and four legislators to the CAT Board.

Ms. Mooney advised the CAT Fund process starts when providers submit applications to the Department. In FY 2010 there were approximately 6,700 applications, and the number has declined to 5,000 applications in FY 2016. Formerly, the counties received all applications to determine eligibility, but submitting all applications to the Department has streamlined the process and provides the Department with information on the volume and type of claims. Approximately ten percent of applications are determined by the Department to be Medicaid eligible before consideration by the CAT Fund.

Ms. Mooney said the biggest year for the CAT Fund was FY 2011 with $38 million in expenditures. The CAT Fund is the payer of last resort, and the counties go through every other possible payment program for a person before the CAT Fund pays a claim. The cost per case has remained steady.

Ms. Mooney stated diagnosis data is used to determine how many of the applicants are residents, whether documented or undocumented, and the type of care provided. The largest categories of expenditures are for mental health issues or ongoing treatment for medical issues such as cancer and heart problems. In FY 2016, combined county and CAT Fund payments totaled $33 million. Of that amount, mental health expenditures are borne about 99 percent by the counties.

Ms. Mooney commented legal and administrative costs total approximately $7 million statewide. The CAT fund spends about $380,000 for administration. By the time indigent care is considered by the CAT Fund, it is strictly for determining eligibility for payment. The CAT Fund has three employees who pay bills, receive reimbursements and revenues, provide training, act as liaison with case attorneys, and support the counties.

Ms. Mooney said the county case load has shown a small increase in FY 2016. For the first time, the counties are now spending more on indigent care than the CAT fund because many cases involving ongoing follow-ups and cancer care are being handled by other resources such as the Health Insurance Exchange (Exchange). The counties have been diligent in ensuring those who qualify for the Exchange are enrolled.

Ms. Mooney informed the Committee in 2010, the CAT Fund began a review process and hired a company to review all emergent cases totaling $75,000 or more and all pre-authorizations to determine medical necessity. The review process has dramatically lowered costs and the legislative appropriation request from year to year.

Vice Chairman Souza inquired about the total administrative costs of the CAT Fund. **Ms. Mooney** answered at the State level, administration costs between $360-380,000, of which a good portion is attributable to the contract with the Idaho Association of Counties. The total administrative costs for the counties is $6.9 million.

Senator Jordan expressed her understanding that the cost of ongoing care is decreasing because pre-existing conditions can no longer be denied. **Ms. Mooney** replied that is partially correct. The Affordable Care Act (ACA) has cut ongoing care costs because the hospitals are getting patients signed up for insurance coverage. There was a program prior to the ACA that also saved the CAT Fund a significant amount of money. Based on research the CAT Fund has done, the CAT Fund is now only servicing 100 percent of poverty level.

Vice Chairman Souza asked how costs are recouped and whether there is an attempt made to collect repayment from someone utilizing the CAT Fund. **Ms. Mooney** responded a lien is placed on every case on behalf of the county and the CAT Fund. About $2.5 to $3 million is consistently recovered each year. **Vice Chairman Souza** mentioned she is aware Kootenai County has been working diligently to collect money to return back to the CAT Fund and inquired whether different counties are using different techniques and successfully sharing those methods with others. **Ms. Mooney** answered there is an annual training conference where the counties have an opportunity to share with each other. Collections is frustrating for the counties. For a number of years, Kootenai County hired a collection agency but ultimately determined they could handle collections in-house. Ada County has gone back and forth on collection methods but is currently handling collections in-house. **Ms. Mooney** recognized Kootenai County for returning nearly $1 million to the CAT Fund of the nearly $3 million expended in FY 2016.

RS 25031

Relating to Immunizations. **Sarah Clendenon** and **Miste Karlfeldt** introduced themselves to the Committee on behalf of Health Freedom Idaho to present **RS 25031**, the purpose of which is to clarify Idaho Code § 39-4802(2). **Ms. Clendenon** stated the law allows an Idaho parent or guardian to submit a signed statement to school officials in order to exempt a child from State-prescribed vaccinations for public school enrollment. The Department has since created an exemption form and mandates its use. The form contains unnecessary and possibly incriminating language that is far outside the scope of the law. Additionally, participation in the immunization registry is voluntary, and a parent is not required to disclose vaccination status to the State. By mandating the current form, which lists individual vaccines and demands confidential medical information, parents are unable to exercise their right to privacy and exemption without facing enrollment denial by schools.

Ms. Clendenon informed the Committee the draft legislation would modify Idaho Code § 39-4802(2) to add language stating the signed exemption statement does not have to be made on a required form. This clarifies the parent has a right to enroll their children in Idaho schools while maintaining privacy, the right to medical confidentiality, and the right to opt out of providing vaccination information to the registry.

Ms. Clendenon advised Health Freedom Idaho has attempted to work with the Department on this issue and the Department has been unsympathetic to the concerns expressed. The Department has refused to modify either the rule or the form (see Attachment 3).

Senator Foreman asked if there are any objections to the Department supplying a form as long as it doesn't have the statements on page 1 of the form. **Ms. Karlfeldt** answered she does not have a problem if the form aligns with the statute and asks for only name, date, and signature. She understands the need for a form to simplify making the statement, but it needs to be only a signed statement.

Vice Chairman Souza inquired what part of the form could be incriminating to a parent. **Ms. Karlfeldt** responded the first page of the form asks the parent to agree the parent is knowingly putting the child at risk by not getting vaccinations. **Vice Chairman Souza** asked whether it was true that the form instead says the parent is putting the child at risk of contracting the disease. **Ms. Clendenon** replied it is something to that effect. **Vice Chairman Souza** said she understands the concern, but the Department is trying to ensure parents are informed about individual communicable diseases if children are exposed and not protected by an immunization. There are pros and cons to all health care choices. If a parent does not understand the risk, the decision may or may not be a good one if the parent is not fully informed. **Vice Chairman Souza** stated she has spoken to several people who have a fear they are incriminating themselves or admitting they are less than an adequate parent, or that there might be some legal action taken against them in the future if anything happened. She asked for an explanation of where that fear is coming from based on the form. **Ms. Clendenon** responded she has done 11 years of vaccine research. The wording of the statements does not line up with her personal research. The form is only the Department's opinion.

Vice Chairman Souza suggested a parent could write a disclaimer in the philosophical exemption section that the parent did not agree with the Department's opinion and is still going to opt the child out of the vaccination. **Ms. Karlfeldt** answered she believes she would be putting her child at risk more by administering the vaccine than by opting out of it, and that choice is not addressed on the form. She would be fine with Vice Chairman Souza's suggestion, but many schools and day cares will not accept the form if any changes have been made on it. **Chairman Heider** commented the bill would eliminate the need for the form and it is not a discussion about whether or not a parent can get an exemption.

Senator Jordan asked what happens if a parent has not done as much research as Ms. Clendenon and Ms. Karlfeldt and the parent exempts the child from immunizations, and the child suffers ramifications from exposure. What would the Department say to the parent who asks why he or she wasn't informed about the dangers to the child. The form still offers the choice to parents and there is information given. **Ms. Karlfeldt** answered it would be between the doctor and the parent of the child. Parents get a lot of education from the doctor about the vaccines and the statute does not indicate it is the Department's responsibility to provide that information.

TESTIMONY: **Ingri Cassel** provided written testimony to the Committee (see Attachment 4).

MOTION: **Senator Anthon** moved to send **RS 25031** to print. **Senator Foreman** seconded the motion.

DISCUSSION: **Senator Martin** said he will support the motion and is not debating whether or not to immunize. Any procedure has positives and negatives. The language of the statute is very clear. **Senator Martin** has received responses from various school districts about the form. One response said the school does not accept handwritten forms. Another district stated the official Department form must be used, and the law does not allow parents or guardians to claim an exemption.

Senator Foreman stated Idaho Code is simple and clear. He applauds the Department for its concern, and the Department can fulfill its mandate to protect the public health by putting the disclaimer information on a separate sheet and handing it to parents when they turn in a signed exemption statement.

Vice Chairman Souza agreed that offering the information as education rather than a mandate leaves the decision in the hands of the parent.

The motion carried by **voice vote. Senator Jordan** requested she be recorded as voting nay.

RS 25153 **Relating to Persons with Disabilities. Richelle Vannoy** introduced herself to the Committee as the parent of a 13-year-old son with Asperger's Syndrome and Attention Deficit Hyperactivity Disorder (ADHD) to request a change to Idaho's implementation of the Americans with Disabilities Act. Her son has started to walk away from school since fifth grade, and middle school has been challenging. She recently took him out of school after the School Resource Officer handcuffed him and held him to the ground because he tried to walk home. Her son gets upset in school because of crowds, changes in assigned seating, or schedule changes. The school has created an Individualized Education Plan specifically for his needs that states he cannot be touched and if he starts to walk away from school, he needs to be followed and his mother contacted immediately so she can go to the school.

Ms. Vannoy said the ADA only allows dogs and miniature horses to be considered service animals. Some people can't handle dogs and she can't accommodate a miniature horse. Adding the possibility of a Savannah cat as a service animal would be another option. Savannah cats can be trained like dogs. There is a trainer in Denver, Colorado who breeds these cats specifically as therapy cats. The cats can be trained to stay on leashes and go in showers. Her son doesn't like water and it would help him to have a cat go in the shower with him to soothe him. Cats can be trained for car rides and detect meltdowns, and they can go in shopping carts. The ADA states service animals should be able to detect the onset of psychiatric episodes and lessen their side effects, and therapy cats can be trained to do this. Service animals should be able to provide safety checks or room searches, turn on or off lights as needed, keep individuals from self harm or harmful situations, and prevent possible meltdowns in the handler.

Ms. Vannoy has written to the trainer in Colorado and described her son's needs, and the trainer has guaranteed personalized training for the cat. There are stages for cats, ranging from F1 to F6, where F1 is like a wild animal and F6 is like a housecat. They were matched with an F5 cat for her son.

DISCUSSION: **Senator Martin** asked the age of Ms. Vannoy's son. **Ms. Vannoy** answered he is 13. **Senator Martin** stated he has two grandsons with Asperger's Syndrome who are in their teens and doing extremely well. He expressed his best wishes for Ms. Vannoy.

Senator Foreman commented the infrastructure to support this change is already in place. The transportation companies are used to dealing with service animals. **Senator Foreman** asked if there are other animals besides cats this would apply to. **Ms. Vannoy** said she has heard some people rely on house cats, birds, and a few other animals. She is interested in the Savannah cat because it has the personality of a dog.

Senator Agenbroad asked whether there is a list of support animals that would be included. **Chairman Heider** said the legislation includes all kinds of support animals.

Senator Jordan mentioned there is a lot of new research being done with PTSD and Asperger's Syndrome. The language of the bill provides opportunities to make provisions for different needs and would still require licensing of service animals.

Vice Chairman Souza asked how a service animal is licensed or certified and what determines a service animal. **Ms. Vannoy** responded it is done through a federal government website under the ADA section. There are a number of websites where a person can simply order a service animal vest but that's not what she's trying to do.

Vice Chairman Souza commented she appreciates many people have needs that can be helped by true service animals. She is concerned about animals of all sorts being called service animals when they are not, and she has personally had that experience. She is highly allergic to dogs and cats, and there are a lot of people who bring an animal into a situation that would not normally be appropriate. They are not really service animals, the owners just want to bring them along. **Vice Chairman Souza** asked how society can help people who need service animals while still protecting the rest of the public from inappropriate behavior. **Ms. Vannoy** answered it is up to the people who have a service animal to get them properly registered and licensed through the right company. Anybody can go through a random fake website, but it is up to the restaurant or other place to ask for the proper documentation. It's the same problem with no smoking and there are smokers standing right by a building. There is not really a right and wrong, and she hopes people are respectful.

Vice Chairman Souza is looking for some notification or requirement in the RS that says the animal shall be a certified service animal through the ADA and any owner of public place such as a café or restaurant may ask to see the certification of that animal before allowing the animal into the establishment. She was told it is against the law in Washington State to ask for any proof an animal is a service animal. **Vice Chairman Souza** commented she is not quite sure the balance is right and asked if there is a requirement to carry or have on the animal some sort of notification it is a service animal. **Ms. Vannoy** said she believes there are requirements for service animals but does not know whether a public place is allowed to ask for documentation. Her sister has a service dog for epilepsy and was asked by a hotel in Idaho to show paperwork for her dog.

Senator Foreman said the bill allows people to ask for documentation and the documentation has to be signed by a licensed health care provider. Where he sees it being a problem is with air transport carriers who may have separate regulations.

MOTION: **Senator Martin** moved to send **RS 25153** to print. **Senator Foreman** seconded the motion. The motion carried by **voice vote.**

ADJOURNED: **Chairman Heider** adjourned the meeting at 4:09 p.m.

Senator Heider
Chair

Jeanne Jackson-Heim
Secretary

Catastrophic Health Care Cost Program

Idaho State Legislature Health & Welfare Committee

Kathryn Mooney

Director

Catastrophic Health Care Cost Program
Board Members

Roger Christensen	Chairman	IAC Region 6	Bonneville County
Paul Christensen	Vice Chairman	IAC Region 4	Cassia County
Richard Armstrong	Secretary	Director	Dept. H&W
Walt Kirby		IAC Region 1	Boundary County
Greg Johnson		IAC Region 2	Lewis County
Dave Case		IAC Region 3	Ada County
Bill Lasley		IAC Region 5	Power County
David High		Governor’s Appointee	Boise
Senator Jim Guthrie		Leg. District 28	McCammon
Senator Maryanne Jordan		Leg. District 17	Boise
Rep. Tom Loertscher		Leg. District 32	Bone

NEW CAT Cases Approved for FISCAL 2016

County	Cases	Amount		County	Cases	Amount
ADA	185	$4,748,568		GOODING	12	$355,345
ADAMS	5	$103,623		IDAHO	6	$83,448
BANNOCK	45	$1,843,805		JEFFERSON	2	$88,900
BEAR LAKE	6	$170,420		JEROME	16	$372,830
BENEWAH	1	$12,605		KOOTENAI	52	$1,557,145
BINGHAM	9	$219,802		LATAH	5	$249,845
BLAINE	15	$270,782		LEMHI	5	$75,794
BOISE	4	$95,896		LEWIS	2	$29,929
BONNER	3	$86,069		LINCOLN	3	$79,823
BONNEVILLE	11	$375,629		MADISON	6	$157,998
BOUNDARY	3	$38,221		MINIDOKA	13	$238,070
BUTTE	0	$0		NEZ PERCE	15	$168,308
CAMAS	1	$7,086		ONEIDA	0	$0
CANYON	45	$1,152,326		OWYHEE	10	$297,906
CARIBOU	1	$1,060		PAYETTE	8	$241,344
CASSIA	14	$323,559		POWER	2	$7,499
CLARK	0	$0		SHOSHONE	11	$172,125
CLEARWATER	5	$86,953		TETON	0	$0
CUSTER	3	$142,725		TWIN FALLS	69	$1,490,021
ELMORE	19	$575,292		VALLEY	4	$182,441
FRANKLIN	6	$218,520		WASHINGTON	4	$89,089
FREMONT	1	$19,171				
GEM	7	$158,769		**TOTAL**	**634**	**$16,588,741**

Medicaid Determinations

(Combined Application Unit) est. Session 2009

	FY 2013	FY 2014	FY 2015	FY 2016
Total Applications Received	6767	6425	5683	4997
Applications Approved	688	706	767	455
Approval Percentage	10%	10%	14%	10%
Applications Denied	6090	6136	4952	4576
Applications Pending	259	154	86	86

Catastrophic Health Care Cost Program

History of Claims Paid
By the State

	2012	2013	2014	2015	2016
No. of cases Approved	1292	1150	1109	721	634
Provider Payments	$32,745,334	$30,718,074	$28,977,540	$18,615,111	$16,582,239
Average Amount per Case	$25,345	$26,711	$26,129	$25,818	$26,155

COMBINED STATE & COUNTY CASES & DOLLARS
Fiscal Year 2016

DIAGNOSTIC CODE	AGE							GENDER		RESIDENT		HOUSEHOLD SIZE						AMOUNT PAID
	0 TO 10	11 TO 20	21 TO 30	31 TO 40	41 TO 50	51 TO 64	65+	M	FEM	YES	NO	1	2	3	4	5	6+	TOTAL
01 Accident-Vehicle	0	5	17	12	9	10	0	41	12	49	4	21	9	8	6	5	1	$1,568,057
10 Accident-General	0	6	33	31	40	61	2	114	59	165	8	89	45	13	14	7	5	$2,466,250
20 Coronary	0	0	17	30	67	166	8	175	113	280	8	142	89	28	17	7	5	$6,014,157
30 Birth	0	1	2	2	0	0	0	1	4	5	0	1	2	1	1	0	0	$37,931
40 Cancer	0	0	8	20	17	76	3	55	67	119	3	60	45	7	1	3	6	$1,704,658
50 Respiratory	0	2	6	17	21	39	3	37	50	87	0	43	20	20	1	1	2	$1,911,662
60 Mental Health	3	123	567	563	363	293	41	1161	860	1990	31	1610	121	31	21	16	9	$6,553,461
70 General	1	18	130	135	166	257	64	444	337	751	29	451	157	59	51	27	28	$6,089,866
80 Chronic Disease	0	6	15	24	32	47	3	90	37	125	2	63	39	14	8	1	2	$1,761,554
90 Infectious Disease	0	0	3	4	6	6	0	11	8	17	2	8	5	4	1	0	1	$180,861
100 Neurology	0	1	0	4	4	7	0	8	8	16	0	5	7	1	1	1	1	$369,475
200 Digestive System	2	8	82	81	85	147	5	155	233	370	17	169	103	51	28	18	18	$5,291,704
TOTALS	6	170	880	923	810	1109	129	2292	1788	3974	104	2662	642	237	150	86	78	$33,949,636

Indigent Trends

County Case Load

Fiscal Yr.	2012	2013	2014	2015	2016
New Case Load	6,491	5,308	4,864	3,795	4,080
County Provider Payments	$28,150,125	$21,952,052	$22,552,726	$17,714,102	$17,367,397
CAT Provider Payments	$27,122,266	$30,718,074	$28,976,000	$18,615,111	$16,582,239
Combined State County $ $ to Providers	$55,272,391	$52,670,052	$51,528,726	$36,329,213	$33,949,636

Medical Reviews FY 2013 - 2016

	Fiscal 2013	Fiscal 2014	Fiscal 2015	Fiscal 2016	Fiscal 17 1st 1/2
TOTAL	**1243**	**1494**	**1543**	**1528**	**715**

QUESTIONS

CATASTROPHIC HEALTH CARE COST PROGRAM

ANNUAL REPORT
FISCAL YEAR 2016

TO
MEMBERS OF HEALTH AND WELFARE COMMITTEES
IDAHO STATE LEGISLATURE
JANUARY 2017

CATASTROPHIC HEALTH CARE COST PROGRAM
BOARD OF DIRECTORS
700 W. WASHINGTON ST.
BOISE, ID 83702
(208) 345-1366

ROGER S. CHRISTENSEN
CHAIRMAN OF THE BOARD

ANNUAL REPORT OF

THE CATASTROPHIC HEALTH CARE COST PROGRAM
January 2017

Pursuant to Idaho Code §31-3517, the following is the report of the Catastrophic Health Care Cost Program.

TO: All Members of the Health & Welfare Committees,

FROM: Administrative Board of the Catastrophic Health Care Cost Program

The state catastrophic health care cost program was established by the Idaho Legislature in 1991 and commenced operations on October 1, 1991. The state-funded catastrophic health care cost program (CAT fund) is a continuation of the previously county-funded indigent program. The legislature assumed funding responsibility for the program effective October 1, 1991, as a means of providing property tax relief to Idaho residents.

In fiscal year 2016 the catastrophic program was administered by a board of directors consisting of six county commissioners, one from each region, one member appointed by the director of the department of health and welfare, four legislators, and one member appointed by the governor as follows: Region 1, Walt Kirby, Boundary County; Region 2, Greg Johnson, Lewis County; Region 3, Rick Yzaguirre, Ada County; Region 4, Paul Christensen, Cassia County; Region 5, Steve Hadley, Bannock County; Region 6, Roger Christensen, Bonneville County; H&W Director Richard Armstrong, Senator Jim Guthrie, Rep. John Rusche, Rep. Tom Loertscher and the Governor's appointee, David High. The administrative board governs all activities of the CAT fund and meets approximately every eight weeks to consider pending claims and provide oversight for program management.

Beginning in fiscal 2010, the administrative board has contracted with the Idaho Association of Counties to serve as program administrator and it handles the day-to-day affairs of the CAT program, through a program director. Currently, the IAC is employed on an annual contract currently running through September 2017.

From July 1, 2015 to June 30, 2016, the CAT board approved the payment of 634 cases spent $16,588,741 on medical claims for those new cases as well as ongoing claims from previously approved cases. (See Exhibit "A") From July 1, 2016, to December 31, 2016 (FYTD17) the CAT board approved 293 new cases, as well as continuing to pay ongoing claims for cases previously approved and has paid providers during this time period, in the amount of $5,440,159. (See Exhibit "B")

The contract between the association and the CAT fund has proven to be an effective cost mitigating tool for both the CAT fund and the counties. The program director, through the association provides training for county social services directors and staff in the use of the procedures and processes implemented to standardize case submission to the CAT program, including use of a secure data warehouse. As required, the board provides the state controller's office with annual audits, which have consistently shown responsible management of the program in an efficient manner with minimal administrative costs. (Exhibit "C")

In an effort to provide both entities involved in indigent payments with as much information as possible in their decision making, and for the board's continued effort toward responsible accountability, a program was implemented in fiscal 2011 to provide medical reviews for the county commissioners to use during their determination process. The IAC continues their contract with a medical professional on behalf of and with full support from all 44 counties, to provide case medical reviews. This year, the policy was expanded to allow for reviews on any services that require pre authorization.

Traditionally, those indigents who benefit from the program are individuals who were ineligible for Medicaid or other government assistance programs. They are faced with a catastrophic illness or injury and do not qualify through the health exchange in Idaho for health insurance. All of these indigents are required to reimburse both the county and the state of Idaho. This year's reimbursement report shows those payments received by the state.

The counties shoulder all of the collection and administration in seeking reimbursements from those who are able to make payments. From July 1, 2015 through June 30, 2016, the fund received reimbursement payments of $3,009,431 (See Exhibit "D".) In the first six months of fiscal year 2017, the CAT fund has received reimbursement payments approximately $1,265,750 (See Exhibit "E".)

Beginning in FY 2004, the Catastrophic Health Care Cost Program began receiving from the counties $5.00 for every seat belt fine collected from violations imposed under Idaho Code §49-673. The fund received $98,578 for the fiscal year 2016.

Pursuant to Idaho Code §31-3505A(3) the CAT board has requested from hospitals, information to report to the legislature. This request for information was sent to forty four (42) hospitals across the state of Idaho. Thirty-two (32) hospitals responded this year with the required information. (See Exhibit "F".) As there is no penalty to the providers for failing to respond, cooperation is tenuous at best. The hospitals that respond make every effort to provide accurate information.

The catastrophic board takes very seriously their responsibility to be accountable for the funds provided by the state. The administrator reviews each case to ensure statutory compliance by the counties. The cases are then presented to the board for review. Additionally, they monitor administrative costs closely. The financial burden of administering the program statewide is borne predominantly by the counties with a reported $7.8 m. In contrast, the CAT program has made every effort to curb operating expenses, this year, including medical reviews paid, is approximately $366,600.

The board for the catastrophic health care cost program annually requests information from the 44 counties of the state of Idaho to report to the legislature as required by Idaho Code §31-3505A(3). All counties reported information as requested. The totals are broken out into 2 separate formats. BOTH reports are the same information. One shows data by county and on the last page, titled "Recapitulation" all dollars spent for indigent medical care is shown by diagnosis category. *Both* reports show county ***and*** state funds added together in these final 2 reports. (See Exhibit "G".)

Should you have any further questions concerning the catastrophic health care cost program, please feel free to contact any member of the catastrophic program administrative board, or the program director, Kathryn Mooney at 208-345-1366

EXHIBIT A
NEW CAT CASES
Fiscal Year 2016

COUNTY	No of cases	PROVIDER PAYMENTS		COUNTY	No of cases	PROVIDER PAYMENTS
ADA	185	$4,748,568		GOODING	12	$355,345
ADAMS	5	$103,623		IDAHO	6	$83,448
BANNOCK	45	$1,843,805		JEFFERSON	2	$88,900
BEAR LAKE	6	$170,420		JEROME	16	$372,830
BENEWAH	1	$12,605		KOOTENAI	52	$1,557,145
BINGHAM	9	$219,802		LATAH	5	$249,845
BLAINE	15	$270,782		LEMHI	5	$75,794
BOISE	4	$95,896		LEWIS	2	$29,929
BONNER	3	$86,069		LINCOLN	3	$79,823
BONNEVILLE	11	$375,629		MADISON	6	$157,998
BOUNDARY	3	$38,221		MINIDOKA	13	$238,070
BUTTE	0	$0		NEZ PERCE	15	$168,308
CAMAS	1	$7,086		ONEIDA	0	$0
CANYON	45	$1,152,326		OWYHEE	10	$297,906
CARIBOU	1	$1,060		PAYETTE	8	$241,344
CASSIA	14	$323,559		POWER	2	$7,499
CLARK	0	$0		SHOSHONE	11	$172,125
CLEARWATER	5	$86,953		TETON	0	$0
CUSTER	3	$142,725		TWIN FALLS	69	$1,490,021
ELMORE	19	$575,292		VALLEY	4	$182,441
FRANKLIN	6	$218,520		WASHINGTON	4	$89,089
FREMONT	1	$19,171				
GEM	7	$158,769		TOTAL	634	$16,588,741

EXHIBIT B

PROVIDER PAYMENTS FYTD2017

July 2016 - December 2016

	Payments			Payments
ADA	$2,253,869		GOODING	$259,548
ADAMS	$36,512		IDAHO	$27,431
BANNOCK	$350,419		JEFFERSON	$38,493
BEAR LAKE	$3,655		JEROME	$12,856
BENEWAH	$5,704		KOOTENAI	$209,450
BINGHAM	$284,150		LATAH	$48,665
BLAINE	$65,067		LEMHI	$53,222
BOISE	$13,314		LEWIS	$59,744
BONNER	$39,577		LINCOLN	$0
BONNEVILLE	$93,167		MADISON	$260,767
BOUNDARY	$0		MINIDOKA	$967
BUTTE	$0		NEZ PERCE	$106,815
CAMAS	$0		ONEIDA	$0
CANYON	$38,190		OWYHEE	$61,905
CARIBOU	$127,938		PAYETTE	$33,260
CASSIA	$127,938		POWER	$0
CLARK	$0		SHOSHONE	$78,132
CLEARWATER	$279		TETON	$0
CUSTER	$47,879		TWIN FALLS	$296,943
ELMORE	$194,815		VALLEY	$21,880
FRANKLIN	$5,411		WASHINGTON	$97,716
FREMONT	$0			
GEM	$84,482		TOTAL	$5,440,159

EXHIBIT "C"

STATE OF IDAHO – STATE FUNDED CATASTROPHIC HEALTH CARE COST PROGRAM

BASIC FINANCIAL STATEMENTS

with

INDEPENDENT AUDITOR'S REPORT

For the Fiscal Year Ended June 30, 2016

STATE OF IDAHO – STATE FUNDED
CATASTROPHIC HEALTH CARE COST PROGRAM
For the Year Ended June 30, 2016

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Searle Hart & Associates, PLLC
CERTIFIED PUBLIC ACCOUNTANTS

Gerald W. Searle, CPA
Steven J. Hart, CPA
Farrell J. Steiner, CPA
Dana Eric Izatt, CPA
Joshua R. Searle, CPA

INDEPENDENT AUDITOR'S REPORT

Administrative Board
Catastrophic Health Care Cost Program
Boise, Idaho

Report on the Financial Statements

We have audited the accompanying financial statements of the governmental activities of the Catastrophic Health Care Cost Program, an agency of the state of Idaho, as of and for the year ended June 30, 2016, and the related notes to the financial statements, which collectively comprise the program's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the governmental activities of the Catastrophic Health Care Cost Program, an agency of the state of Idaho, as of June 30, 2016, and the respective changes in financial position for the year then ended in conformity with accounting principles generally accepted in the United States of America.

3395 South Holmes • Idaho Falls, Idaho 83404 • 208-524-3880 • FAX 208-524-3883

Idaho Falls • Rexburg

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require supplementary information, such as management's discussion and analysis and budgetary comparison information to be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's response to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Management has omitted management's discussion and analysis that accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements. Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of the financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. Our opinion on the basic financial statements is not affected by this missing information.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have issued our report dated September 26, 2016, on our consideration of the Catastrophic Health Care Cost Program's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of the audit performed in accordance with *Government Auditing Standards* in considering the Catastrophic Health Care Cost Program's internal control over financial reporting and compliance.

Searle Hart + Associates, PLLC

Idaho Falls, Idaho
September 26, 2016

BASIC FINANCIAL STATEMENTS

STATE OF IDAHO - STATE FUNDED
CATASTROPHIC HEALTH CARE COST PROGRAM
GOVERNMENTAL FUNDS BALANCE SHEET AND
STATEMENT OF NET POSITION
June 30, 2016

	General	Totals	Adjustments
ASSETS			
Cash and investments	$ 7,445,078	$ 7,445,078	$ -
Refunds and reimbursements receivable	-	-	-
TOTAL ASSETS	7,445,078	7,445,078	-
DEFERRED OUTFLOWS	-	-	-
TOTAL ASSETS AND DEFERRED OUTFLOWS	$ 7,445,078	$ 7,445,078	-
LIABILITIES AND FUND BALANCES			
LIABILITIES			
Benefits payable	$ -	$ -	-
TOTAL LIABILITIES	-	-	-
DEFERRED INFLOWS	-	-	-
FUND BALANCES			
Restricted	7,445,078	7,445,078	(7,445,078)
TOTAL FUND BALANCES	7,445,078	7,445,078	(7,445,078)
TOTAL LIABILITIES, DEFERRED INFLOWS AND FUND BALANCES	$ 7,445,078	$ 7,445,078	(7,445,078)
NET POSITION			
Restricted			$ 7,445,078

The notes to the financial statements are an integral part of this statement.

	Statement of Net Position
$	7,445,078
	-
	7,445,078
	-
	7,445,078
	-
	-
	-
	-
	-
	-
$	7,445,078

STATE OF IDAHO - STATE FUNDED
CATASTROPHIC HEALTH CARE COST PROGRAM
GOVERNMENTAL STATEMENT OF REVENUES, EXPENDITURES, AND CHANGES IN FUND BALANCE AND STATEMENT OF ACTIVITIES
For the Year Ended June 30, 2016

	General Fund	Totals	Adjustments
EXPENDITURES/EXPENSES:			
Health and sanitation:			
Contract administration	$ 341,238	$ 341,238	$ -
Other professional services	14,630	14,630	-
Board travel	-	-	-
Indemnity payments	-	-	-
Health care payments	-	-	-
Miscellaneous - overhead allocation	10,714	10,714	-
Trustee/benefit payments	16,310,660	16,310,660	-
TOTAL EXPENDITURES/EXPENSES	16,677,242	16,677,242	-
PROGRAM REVENUES:			
Charges for services	-	-	-
Operating grants and contributions	-	-	27,000,000
Capital grants and contributions	-	-	-
TOTAL PROGRAM REVENUES	-	-	27,000,000
NET PROGRAM REVENUE (EXPENSE)			
GENERAL REVENUES:			
Interest on investments	179,308	179,308	-
Gain (loss) on investments	-	-	-
Other revenues			
Seat belt income	98,578	98,578	-
Refunds and reimbursements	3,006,344	3,006,344	-
Other sources (uses)			
Intergovernmental appropriation	27,000,000	27,000,000	(27,000,000)
Intergovernmental appropriation reversion	(28,892,700)	(28,892,700)	-
TOTAL GENERAL REVENUES OTHER SOURCES (USES)	1,391,530	1,391,530	(27,000,000)
EXCESS OF REVENUES OVER (UNDER) EXPENDITURES AND OTHER FINANCIAL SOURCES (USES)	(15,285,712)	(15,285,712)	15,285,712
CHANGES IN NET POSITION	-	-	(15,285,712)
RESTRICTED FUND BALANCE/NET POSITION - July 1, 2015	22,730,790	22,730,790	-
RESTRICTED FUND BALANCE/NET POSITION - June 30, 2016	$ 7,445,078	$ 7,445,078	$ -

The notes to the financial statements are an integral part of this statement.

	Statement of Activities
$	341,238
	14,630
	-
	-
	-
	10,714
	16,310,660
	16,677,242
	-
	27,000,000
	-
	27,000,000
	10,322,758
	179,308
	-
	98,578
	3,006,344
	-
	(28,892,700)
	(25,608,470)
	-
	(15,285,712)
	22,730,790
$	7,445,078

STATE OF IDAHO – STATE FUNDED
CATASTROPHIC HEALTH CARE COST PROGRAM
NOTES TO THE FINANCIAL STATEMENTS
For the Year Ended June 30, 2016

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The basic financial statements of the Catastrophic Health Care Cost Program have been prepared in conformity with accounting principles generally accepted in the United States of America (U.S. GAAP), as applied to government units.

The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. The more significant part of the Catastrophic Health Care Cost Program's accounting policies are described below.

A. Reporting Entity

For financial reporting purposes, the Catastrophic Health Care Cost Program contains a General Fund. The management of the Catastrophic Health Care Cost Program does not have oversight responsibility or governing authority to significantly influence operations of any component units. The Catastrophic Health Care Cost Program is considered an agency of the state of Idaho.

B. Significant Accounting Policies

It is the Board's policy to use the state's accounting system to maintain its books and records. The state's accounting system will allow the state to report on a modified accrual basis of accounting.

Much of the accounting is done on a statewide centralized accounting system. As the constitutional officer responsible for the state's accounting, the state controller pre-audits payment vouchers initiated by departments before paying claims. Transactions for receipts are initiated by departments and recorded in state records by the state controller and the state treasurer. A monthly, summary-level reconciliation of all receipts and expenditures must be approved by the departments and returned to the state controller. Certain other functions – including purchasing, insurance, telephone and communications, and public works – are centralized in the Department of Administration. Agencies are billed their proportionate share of these costs.

Idaho Code, Section 67-3521, allows agencies and departments to encumber appropriations for a specific product or service due and payable prior to or as of the end of the current year. There were no encumbrances outstanding at the beginning of the year. There were no encumbrances at the end of the current fiscal year for invoices from pre-authorized cases dated and received through June 30, 2016.

C. Basis of Presentation

Government-Wide Statements – The Statement of Net Position and the Statement of Activities display information about the Catastrophic Health Care Cost Program of the state of Idaho. All funds reported are considered governmental type activities as opposed to business type activities. These funds are financed through state appropriations, safety restraint citations, interest earnings and refunds and reimbursements.

Fund Financial Statements – The fund financial statements provide information about the Catastrophic Health Care Cost Program's funds. The Catastrophic Health Care Cost Program consists of a General Fund.

NOTES TO THE FINANCIAL STATEMENTS

2. CASH AND INVESTMENTS (Continued)

The state is limited to the following general types of investments:

1. Certain revenue bonds, general obligation bonds, local improvement district bonds, tax and revenue anticipation notes and registered warrants of state and local governmental entities.

2. Time deposit accounts.

3. Bonds, treasury bills, interest-bearing notes, debentures, or other similar obligations of the United States Government and the Farm Credit System and its agencies and instrumentalities.

4. Repurchase agreements.

5. Banker's acceptance and prime commercial paper.

Deposits and investments are included in the state of Idaho Investment Pool Funds, an unrated fund, and are under the direction of the state treasurer. These investments are included in the state of Idaho's Comprehensive Annual Financial Report which is available through the state controller's office.

3. REFUNDS AND REIMBURSEMENTS RECEIVABLE

There were no material refunds or reimbursement checks dated through June 30, 2016 that were received by the Catastrophic Health Care Cost Program in the 2017 fiscal year.

4. BENEFITS PAYABLE

Benefits are accrued on a modified accrual basis of accounting for the fund financial statements and on a full accrual basis on the government-wide financial statements. Invoices for pre-authorized cases dated through June 30, 2016 which will be paid in the 2017 fiscal year, if any, are reflected as benefits payable.

5. RELATED PARTY TRANSACTIONS

The Catastrophic Health Care Cost Program has not been involved in related party transactions that would violate the Idaho Code or federal regulations.

6. SUBSEQUENT EVENTS

Subsequent events have been considered through the report date of September 26, 2016.

7. SEAT BELT INCOME

Idaho Code 49-673 allows for a citation of $10 for violation of safety restraint use laws of which $5 of each citation is apportioned to the Catastrophic Health Care Cost Fund. For the fiscal year ended June 30, 2016, $98,578 was apportioned as set forth in this code section.

8. CAPITAL ASSETS

There are no capital assets to be accounted for in this program.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Fund Accounting - The Catastrophic Health Care Cost Program uses funds to report on its financial position and the results of its operations. Fund accounting is designed to demonstrate legal compliance and to aid financial management by segregating transactions related to certain government functions or activities.

Governmental Funds

General Fund – The General Fund is the general operating fund of the Catastrophic Health Care Cost Program. It is used to account for all financial resources except those required to be accounted for in another fund.

Special Revenue Fund – The Special Revenue Fund is established to account for the proceeds of specific revenue sources other than assessments, expendable trusts, or major capital projects that are legally restricted to expenditures for specified purposes. There were no special revenue funds as of June 30, 2016.

D. Basis of Accounting

Government-Wide Financial Statements – The government-wide financial statements are reported using the economic resources measurement focus and the accrual basis of accounting. Revenues, expenses, gains, losses, assets, deferred outflows of resources, liabilities, and deferred inflows of resources are recognized when earned or at the time when the liabilities are incurred, regardless of when the related cash flows take place.

Fund Financial Statements - The modified accrual basis of accounting is used by all governmental fund types. Under the modified accrual basis of accounting, revenues, expenditures, transfers, assets, deferred outflows of resources, liabilities and deferred inflows of resources are recognized when susceptible to accrual (i.e., when they become both measurable and available or payable.) "Measurable" means the amount of the transaction can be determined and "available" means collectible within the current period or soon enough thereafter to be used to pay liabilities out of the current appropriation. "Payable" indicates whether and to what extent the liability has matured, independent of the method and timing of resource accumulation.

E. Budgets

Budgets are adopted on a basis consistent with generally accepted accounting principles. An annual appropriated budget is adopted for the General Fund.

2. CASH AND INVESTMENTS

All cash balances shown on the basic financial statements are held and invested by the Idaho state treasurer. All interest earned and reported on this financial statement is deposited to the Catastrophic Health Care Cost Program account and is the property of the board.

Idaho Code provides authorization for the investment of funds as well as specific direction as to what constitutes an allowable investment.

STATE OF IDAHO - STATE FUNDED
CATASTROPHIC HEALTH CARE COST PROGRAM
STATEMENT OF REVENUES, EXPENDITURES AND CHANGES IN FUND BALANCE
BUDGET AND ACTUAL (WITH BUDGET TO GAAP DIFFERENCES) - GENERAL FUND
For the Year Ended June 30, 2016

	GENERAL FUND		
	Original Budget	Final Budget	Actual
REVENUES			
Interest on investments	$ -	$ -	$ 179,308
Gain (loss) on investments	-	-	-
Other			
Seat belt income	-	-	98,578
Refunds and reimbursements	-	-	3,006,344
TOTAL REVENUES	-	-	3,284,230
EXPENDITURES			
Health and sanitation:			
Contract administration	359,583	359,583	341,238
Other professional services	13,624	13,624	14,630
Board travel	-	-	-
Indemnity payments	-	-	-
Health care payments	-	-	-
Miscellaneous	10,093	10,093	10,714
Trustee/benefit payments	29,116,700	29,116,700	16,310,660
TOTAL EXPENDITURES	29,500,000	29,500,000	16,677,242
EXCESS OF REVENUES OVER (UNDER) EXPENDITURES	(29,500,000)	(29,500,000)	(13,393,012)
OTHER FINANCIAL SOURCES (USES)			
Intergovernmental appropriations	29,500,000	29,500,000	27,000,000
Intergovermental appropriation reversion	-	-	(28,892,700)
TOTAL OTHER FINANCIAL SOURCES (USES)	29,500,000	29,500,000	(1,892,700)
EXCESS OF REVENUES OVER (UNDER) EXPENDITURES AFTER OTHER FINANCIAL SOURCES (USES	$ -	$ -	(15,285,712)
ADJUSTMENTS			
Net (increase) decrease in expenditure accruals			-
Net increase (decrease) in revenue accruals			-
EXCESS OF REVENUES OVER (UNDER) EXPENDITURES-MODIFIED ACCRUAL BASIS			(15,285,712)
RESTRICTED FUND BALANCE/NET POSITION - July 1, 2015			22,730,790
RESTRICTED FUND BALANCE/NET POSITION - June 30, 2016			$ 7,445,078

9. RESTRICTED FUND BALANCE/NET POSITION

The fund balance/net position should be reported as restricted when constraints placed on the use of resources are either externally imposed by creditors, grantors, contributors, or laws or regulations of other governments or are imposed by law through constitutional provisions or enabling legislation. Constraints have been placed on the use of the resources of the Catastrophic Health Care Cost Fund by enabling legislation. Therefore, the entire fund balance/net position has been reported as restricted. If the fund had both restricted and unrestricted fund balance/net position available, the restricted fund balance/net position would be spent first.

10. RISK MANAGEMENT

The Catastrophic Health Care Cost Program is exposed to various risks related to torts, theft of assets, and errors and omissions. The fund's risk management program encompasses various means of protecting the fund against loss including liability coverage through commercial insurance carriers through the state of Idaho.

11. STATE APPROPRIATIONS

During the 2016 fiscal year, the state of Idaho appropriated $27,000,000 for the Catastrophic Health Care Cost Program's use. During 2016 fiscal year, cash was transferred in the amount of $28,892,700 back to the state.

REQUIRED SUPPLEMENTARY INFORMATION

STATE OF IDAHO - STATE FUNDED
CATASTROPHIC HEALTH CARE COST PROGRAM
STATEMENT OF REVENUES, EXPENDITURES AND CHANGES IN FUND BALANCE
BUDGET AND ACTUAL (WITH BUDGET TO GAAP DIFFERENCES) - GENERAL FUND
For the Year Ended June 30, 2016

	GENERAL FUND		
	Original Budget	Final Budget	Actual
REVENUES			
Interest on investments	$ -	$ -	$ 179,308
Gain (loss) on investments	-	-	-
Other			
Seat belt income	-	-	98,578
Refunds and reimbursements	-	-	3,006,344
TOTAL REVENUES	-	-	3,284,230
EXPENDITURES			
Health and sanitation:			
Contract administration	359,583	359,583	341,238
Other professional services	13,624	13,624	14,630
Board travel	-	-	-
Indemnity payments	-	-	-
Health care payments	-	-	-
Miscellaneous	10,093	10,093	10,714
Trustee/benefit payments	29,116,700	29,116,700	16,310,660
TOTAL EXPENDITURES	29,500,000	29,500,000	16,677,242
EXCESS OF REVENUES OVER (UNDER) EXPENDITURES	(29,500,000)	(29,500,000)	(13,393,012)
OTHER FINANCIAL SOURCES (USES)			
Intergovernmental appropriations	29,500,000	29,500,000	27,000,000
Intergovermental appropriation reversion	-	-	(28,892,700)
TOTAL OTHER FINANCIAL SOURCES (USES)	29,500,000	29,500,000	(1,892,700)
EXCESS OF REVENUES OVER (UNDER) EXPENDITURES AFTER OTHER FINANCIAL SOURCES (USES	$ -	$ -	(15,285,712)
ADJUSTMENTS			
Net (increase) decrease in expenditure accruals			-
Net increase (decrease) in revenue accruals			-
EXCESS OF REVENUES OVER (UNDER) EXPENDITURES-MODIFIED ACCRUAL BASIS			(15,285,712)
RESTRICTED FUND BALANCE/NET POSITION - July 1, 2015			22,730,790
RESTRICTED FUND BALANCE/NET POSITION - June 30, 2016			$ 7,445,078

GAAP Differences	GAAP Basis
$ -	$ 179,308
-	-
-	98,578
-	3,006,344
-	3,284,230
-	341,238
-	14,630
-	-
-	-
-	-
-	10,714
-	16,310,660
-	16,677,242
-	(13,393,012)
-	27,000,000
-	(28,892,700)
-	(1,892,700)
-	(15,285,712)
-	-
-	-
-	(15,285,712)
-	22,730,790
$ -	$ 7,445,078

Notes to the Required Supplementary Information

1. The Catastrophic Health Care Cost Program budgets on a modified accrual basis.

Searle Hart & Associates, PLLC
CERTIFIED PUBLIC ACCOUNTANTS

Gerald W. Searle, CPA
Steven J. Hart, CPA
Farrell J. Steiner, CPA
Dana Eric Izatt, CPA
Joshua R. Searle, CPA

Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With Government Auditing Standards

INDEPENDENT AUDITOR'S REPORT

Administrative Board
Catastrophic Health Care Cost Program
Boise, Idaho

We have audited, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the governmental activities of the Catastrophic Health Care Cost Program, an agency of the state of Idaho, as of and for the year ended June 30, 2016, and the related notes to the financial statements, which collectively comprise the program's basic financial statements, and have issued our report thereon dated September 26, 2016.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered Catastrophic Health Care Cost Program's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Catastrophic Health Care Cost Program's internal control. Accordingly, we do not express an opinion on the effectiveness of the Catastrophic Health Care Cost Program's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over financial reporting that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit we did not identify any deficiencies in internal control, as defined above, that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Catastrophic Health Care Cost Program's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a

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direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the result of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Searle Hart + Associates, PLLC

Idaho Falls, Idaho
September 26, 2016

EXHIBIT D

Reimbursements Received
Fiscal Year 2016

	Reimbursements			Reimbursements
Ada	$572,000		Gooding	$38,693
Adams	$36,571		Idaho	$42,026
Bannock	$146,578		Jefferson	$62,802
Bear Lake	$11,872		Jerome	$37,279
Benewah	$26,111		Kootenai	$534,796
Bingham	$63,401		Latah	$30,111
Blaine	$20,734		Lemhi	$17,090
Boise	$7,416		Lewis	$11,804
Bonner	$58,976		Lincoln	$16,039
Bonneville	$88,591		Madison	$32,434
Boundary	$44,365		Minidoka	$32,705
Butte	$1,046		Nez Perce	$52,436
Camas	$0		Oneida	$0
Canyon	$127,693		Owyhee	$30,865
Caribou	$7,704		Payette	$53,542
Cassia	$35,143		Power	$13,312
Clark	$4,098		Shoshone	$15,402
Clearwater	$14,999		Teton	$59,965
Custer	$4,715		Twin Falls	$376,263
Elmore	$65,236		Valley	$36,610
Franklin	$2,658		Washington	$41,683
Fremont	$11,842			
Gem	$121,828		Total	$3,009,431

EXHIBIT E				
Reimbursements and Refunds FYT2017				
July 1, 2016 - December 31, 2016				
	Reimbursements			Reimbursements
Ada	$228,381		Gooding	$62,899
Adams	$1,606		Idaho	$5,047
Bannock	$42,834		Jefferson	$11,874
Bear Lake	$1,286		Jerome	$14,535
Benewah	$4,602		Kootenai	$157,020
Bingham	$19,919		Latah	$13,924
Blaine	$9,099		Lemhi	$9,667
Boise	$2,341		Lewis	$5,851
Bonner	$95,346		Lincoln	$4,264
Bonneville	$61,969		Madison	$5,614
Boundary	$32,683		Minidoka	$21,776
Butte	$0		Nez Perce	$7,890
Camas	$0		Oneida	$0
Canyon	$117,698		Owyhee	$13,182
Caribou	$16,947		Payette	$6,165
Cassia	$16,097		Power	$10,161
Clark	$4,098		Shoshone	$24,128
Clearwater	$3,059		Teton	$1,063
Custer	$7,325		Twin Falls	$122,660
Elmore	$27,253		Valley	$23,909
Franklin	$4,084		Washington	$12,117
Fremont	$5,684			
Gem	$29,695		TOTAL	$1,265,750

EXHIBIT F

Fiscal 2016			
Providers	No. Patients	Total Amt of Billed Charges	Amount Received
Bear Lake Memorial Hospital	11	$220,141	$72,291
Benewah Community Hospital	26	$89,898	$42,105
Bingham Memorial Hospital	53	$810,646	$110,608
Bonner General Hospital	14	$140,485	$62,687
Boundary Community Hospital	3	$25,766	$15,188
Caribou Memorial Hospital	58	$49,964	$27,601
Cascade Medical Center	1	$2,794	$536
Cassia Regional Medical Center	65	$1,724,024	$669,615
Clearwater Valley Hospital	20	$188,745	$84,696
Eastern Idaho RMC	64	$6,761,771	$1,511,112
Franklin County Medical Center	5	$84,083	$36,333
Gritman Medical Center			
Kootenai Medical Center	400		$3,281,837
Madison Memorial Hopsital	84	$637,108	$228,137
Minidoka Memorial Hospital	5	$56,528	$18,669
Mountain View Hospital	11	$11,518	$4,651
North Canyon Med Ctr			
Oneida County Hospital	1	$3,011	$1,824
Portneuf Medical Ctr	293	$8,416,741	$2,664,764
Center	194	$15,354,713	$4,547,383
St. Alphonsus Ontario	10	$253,138	$96,395
St. Alphonsus Nampa	35	$1,228,348	$447,621
St. Josephs Regional Medical Center	98	$2,590,900	$812,703
St. Lukes Regional Medical Center	516	$24,690,963	$8,037,277
(St. Lukes) Elmore Medical Center	35	$301,193	$108,503
St. Lukes Magic Valley	385	$11,350,932	$3,348,394
St. Mary's Hospital	12	$126,506	$59,050
Steele Memorial Medical Center	5	$109,386	$64,117
Syringa General Hospital	8	$60,012	$30,543
Valley Medical Center	3	$4,923	$1,638
Walter Knox Memorial Hospital	4	$24,423	$10,333
Weiser Memorial Hospital	9	$41,946	$23,693
West Shoshone Hospital	16	$40,958	$14,862
West Valley Medical Center	171	$2,975,232	$741,483
TOTALS	2615	$78,376,795	$27,176,651

EXHIBIT G

TOTALS FOR COMBINED STATE & COUNTY
Fiscal Year 2016

COUNTY	NO. OF CASES	PROVIDER PAYMENTS		COUNTY	NO. OF CASES	PROVIDER PAYMENTS
ADA	1209	$10,651,083		GOODING	57	$733,884
ADAMS	9	$172,517		IDAHO	21	$205,743
BANNOCK	207	$3,038,224		JEFFERSON	9	$111,556
BEAR LAKE	11	$199,784		JEROME	151	$622,891
BENEWAH	19	$66,381		KOOTENAI	294	$2,911,899
BINGHAM	59	$459,746		LATAH	36	$384,269
BLAINE	28	$409,272		LEMHI	16	$202,358
BOISE	15	$177,560		LEWIS	13	$84,381
BONNER	38	$177,265		LINCOLN	23	$105,008
BONNEVILLE	74	$633,300		MADISON	18	$309,041
BOUNDARY	12	$96,794		MINIDOKA	66	$419,184
BUTTE	1	$5,298		NEZ PERCE	47	$433,325
CAMAS	4	$3,872		ONEIDA	30	$16,002
CANYON	818	$3,346,119		OWYHEE	29	$491,421
CARIBOU	7	$54,118		PAYETTE	79	$528,320
CASSIA	66	$581,737		POWER	7	$22,305
CLARK	2	$1,917		SHOSHONE	29	$313,662
CLEARWATER	30	$231,879		TETON	1	$7,500
CUSTER	3	$175,725		TWIN FALLS	380	$3,337,816
ELMORE	53	$1,042,344		VALLEY	15	$282,113
FRANKLIN	13	$245,282		WASHINGTON	26	$212,123
FREMONT	5	$49,845				
GEM	50	$394,772		TOTAL	4080	$33,949,636

2016 RECAPITULATION

	AGE							GENDER		RESIDENT		HOUSEHOLD SIZE						AMOUNT PAID
DIAGNOSTIC CODE	0 TO 10	11 TO 20	21 TO 30	31 TO 40	41 TO 50	51 TO 64	65+	MALE	FEMALE	YES	NO	1	2	3	4	5	6+	TOTAL
01 Accident-Vehicle	0	5	17	12	9	10	0	41	12	49	4	21	9	8	6	5	1	$1,568,057
10 Accident-General	0	6	33	31	40	61	2	114	59	165	8	89	45	13	14	7	5	$2,466,250
20 Coronary	0	0	17	30	67	166	8	175	113	280	8	142	89	28	17	7	5	$6,014,157
30 Birth	0	1	2	2	0	0	0	1	4	5	0	1	2	1	1	0	0	$37,931
40 Cancer	0	0	8	20	17	76	3	55	67	119	3	60	45	7	1	3	6	$1,704,658
50 Respiratory	0	2	6	17	21	39	3	37	50	87	0	43	20	20	1	1	2	$1,911,662
60 Mental Health	3	123	567	563	363	293	41	1161	860	1990	31	1610	121	31	21	16	9	$6,553,461
70 General	1	18	130	135	166	257	64	444	337	751	29	451	157	59	51	27	28	$6,089,866
80 Chronic Disease	0	6	15	24	32	47	3	90	37	125	2	63	39	14	8	1	2	$1,761,554
90 Infectious Disease	0	0	3	4	6	6	0	11	8	17	2	8	5	4	1	0	1	$180,861
100 Neurology	0	1	0	4	4	7	0	8	8	16	0	5	7	1	1	1	1	$369,475
200 Digestive System	2	8	82	81	85	147	5	155	233	370	17	169	103	51	28	18	18	$5,291,704
TOTALS	6	170	880	923	810	1109	129	2292	1788	3974	104	2662	642	237	150	86	78	$33,949,636

Operating Costs Paid	$5,132,282
INdigent Legal Costs Paid	$1,360,017
County Medical Review Cost	$410,793

Child's Name: _____

IDAHO CERTIFICATE OF IMMUNIZATION EXEMPTION

School Immunization Requirement

The Idaho Department of Health and Welfare strongly supports immunization as one of the easiest and most effective tools in preventing serious infectious diseases. These vaccine-preventable diseases can cause serious illness and even death. The Idaho Department of Health and Welfare also recognizes that individuals have the right to make the decision whether or not to vaccinate their children. If you have any questions about the benefits and risks of immunization, please contact your healthcare provider or local health department.

SECTION 1: ***Please read the following statements, check the box(es), and date each statement regarding vaccine-preventable diseases for which an exemption is claimed. Sections 1 and 2 must be completed for this exemption to be valid.***

☐ **Diphtheria (DTaP, DT, Tdap, Td):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing diphtheria if exposed to this disease. Serious symptoms and effects of this disease include: heart failure, paralysis (can't move parts of the body), breathing problems, coma, and death. _____ Date

☐ **Tetanus (DTaP, DT, Tdap, Td):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing tetanus if exposed to this disease. Serious symptoms and effects of this disease include: "locking" of the jaw, difficulty in swallowing and breathing, seizures (jerking and staring), painful tightening of muscles in the head and neck, and death. _____ Date

☐ **Pertussis (Whooping Cough) (DTaP, Tdap):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing pertussis (whooping cough) if exposed to this disease. Serious symptoms and effects of this disease include: severe coughing fits that can cause vomiting and exhaustion, pneumonia, seizures (jerking and staring), brain damage, and death. _____ Date

☐ **Polio:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing polio if exposed to this disease. Serious symptoms and effects of this disease include: paralysis (can't move parts of the body), meningitis (infection of the brain and spinal cord covering), permanent disability, and death. _____ Date

☐ **Measles, Mumps, Rubella (MMR):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing measles, mumps, and/or rubella if exposed to these diseases. Serious symptoms and effects of measles include: pneumonia, seizures (jerking and staring), brain damage, and death. Serious symptoms and effects of mumps include: meningitis (infection of the brain and spinal cord covering), painful swelling of the testicles or ovaries, sterility, deafness, and death. Serious symptoms and effects of rubella include: rash, arthritis, and muscle or joint pain. If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects such as deafness, heart problems, and mental retardation. _____ Date

☐ **Hepatitis B:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing hepatitis B if exposed to this disease. Serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), life-long liver problems, such as scarring and liver cancer, and death. _____ Date

☐ **Varicella (Chickenpox):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing varicella (chickenpox) if exposed to this disease. Serious symptoms and effects of this disease include: severe skin infections, pneumonia, brain damage, and death. A person who has had chickenpox can get a painful rash called shingles years later. _____ Date

☐ **Varicella Disease History:** I believe that my child has had chickenpox, but was not diagnosed by a licensed health care professional. _____ Date

☐ **Hepatitis A:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing hepatitis A if exposed to this disease. Serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), "flu-like" illness, hospitalization, and death. _____ Date

☐ **Meningococcal:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing meningococcal disease if exposed to this disease. Serious symptoms and effects of this disease include: meningitis (infection of the covering of the brain and spinal cord), blood infections, loss of arms or legs, problems with nervous system, deafness, mental retardation, seizures (jerking and staring), strokes, and death. _____ Date

Please continue to complete Section 2

SECTION 2: ***Please select ONE of the following exemption types (medical, religious, philosophical) for vaccines checked in Section 1.***

☐ MEDICAL EXEMPTION (This exemption requires the signature of a licensed physician)

As the child's physician, I certify that the physical condition of this child is such that the immunization(s) checked in Section 1 would endanger the health of the child.

- ☐ This medical exemption is permanent.
- ☐ This medical exemption is temporary. Duration of temporary exemption: _____/_____/_____

I hereby request that this child be exempted from the Immunization Requirements for Idaho School Children (IDAPA 16.02.15) due to a medical condition for which immunizations are contraindicated.

Name of Physician (PRINT) | Signature of Physician | Medical License # | Date

As the child's parent/guardian, I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak, both for his/her own protection and for the protection of others. I acknowledge that I have read this document in its entirety.

Name of Parent/Guardian (PRINT) | Signature of Parent/Guardian | Date

Full Name of Exempted Child (PRINT) | Child's Date of Birth (Month, Day, Year)

☐ RELIGIOUS EXEMPTION

As the child's parent/guardian, I certify that I am a member of a recognized religious organization which has doctrine that opposes immunizations for the following reason(s):

_____

_____

_____

_____

_____

_____

I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak, both for his/her own protection and for the protection of others. I acknowledge that I have read this document in its entirety.

Name of Parent/Guardian (PRINT) | Signature of Parent/Guardian | Date

Full Name of Exempted Child (PRINT) | Child's Date of Birth (Month, Day, Year)

☐ PHILOSOPHICAL EXEMPTION

As the child's parent/guardian, I am opposed to having my child receive the immunization(s) checked in Section 1 of this form for the following reason(s):

_____

_____

_____

_____

_____

_____

I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak, both for his/her own protection and for the protection of others. I acknowledge that I have read this document in its entirety.

Name of Parent/Guardian (PRINT) | Signature of Parent/Guardian | Date

Full Name of Exempted Child (PRINT) | Child's Date of Birth (Month, Day, Year)

Jeanne Jackson-Heim

From: enforceidaholaw@use.startmail.com
Sent: Saturday, February 04, 2017 2:52 PM
To: Jeanne Jackson-Heim
Subject: RS 25031 documents

Dear Senate H&W Secretary Jeanne Jackson-Heim,

The following is what I sent to the senators on this committee. It is important that they have in front of them the following documents prior to them voting on RS 25031:
Idaho Attorney General opinion relating to RS 25031 http://www.vaclib.org/legal/10-14-2015-IdahoAGResponse.pdf
IDHW's immunization exemption form
http://healthandwelfare.idaho.gov/Portals/0/Health/Immunizations/IIP/School_Exemption_Form_English.pdf

Please make copies of these for their folders for Monday's meeting. Thank you!

+++++++++

Since 2010, the IDHW has used their rulemaking authority to create an exemption form required by licensed daycares and schools for children whose parents have decided for one reason or another not to follow Idaho's immunization mandates.
I have personally contacted multiple legislators on the illegality of their form since it is not in harmony with state statute and, furthermore, compels the parent to sign a form with statements that they do not agree with. At first, we recommended that parents simply put an X across the entire document and affix it to their notarized affidavit, submitting this to the school/daycare. Unfortunately, the governor's office told us that this was not acceptable, that the form could be adjusted with add ons and cross outs but that parents HAD to use this form to be allowed into a licensed daycare or school in Idaho. Furthermore, the Idaho AG told us that the only thing we could do was have the situation corrected by the legislature -- that is YOU. So while it is generally understood that state statutes trump agency's admin. rules, certainly, this is not what is being practised in the state of Idaho. Please note #3 and #4 in the Idaho AG's opinion here http://www.vaclib.org/legal/10-14-2015-IdahoAGResponse.pdf
Maybe this is one of the reasons Idaho received a D- in 'integrity investigation'. See
https://www.publicintegrity.org/2015/11/09/18377/idaho-gets-d-grade-2015-state-integrity-investigation

Please remember that RS 25031 has NOTHING to do with being pro-vaccine or anti-vaccine. This proposed bill is about forcing IDHW to follow state law. I have heard countless stories from around the state. Many health departments told parents they were not allowed to alter the document in any way. Why? The reason they were told is that it was a LEGAL document. Precisely my point. You cannot force someone to affix their signature to a form that has statements that are not true and violate a parents rights. Any time you affix your signature to ANYTHING, you are agreeing to the information above your signature. For documentation, see the email correspondence between Mitch Scoggin, manager of Idaho's Immunization Program, and myself at the following link
http://www.vaclib.org/legal/emailcorrespondence.pdf

Also for reference, here are links to IDHW's forms:
For schools http://healthandwelfare.idaho.gov/Portals/0/Health/Immunizations/IIP/School_Exemption_Form_English.pdf
For daycares http://healthandwelfare.idaho.gov/Portals/0/Health/Immunizations/IIP/Childcare_Exemption_Form_English.pdf

Why this has taken so long and had to rise to the level of hundreds of impacted families is beyond my comprehension. Do you value your job as a legislator? Seriously, what is the point of you passing so many laws when state agencies can violate them through their rulemaking authority? Please think long and hard about your function as a senator and vote YES to pass RS 25031 out of your committee on Monday, February 6, 2017.

In the Spirit of Truth,

Ingri Cassel, District 1 (mad as hell that I was disenfranchised based upon gossip)
P.O. Box 457
Spirit Lake, Idaho 83869
(208) 255-2307

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Tuesday, February 07, 2017

SUBJECT	DESCRIPTION	PRESENTER
Gubernatorial Appointments	Reappointment of Beth Elroy to the Board of Environmental Quality	Beth Elroy
	Reappointment of Carol Mascarenas to the Board of Environmental Quality	Carol Mascarenas
Presentation	Department of Health & Welfare FY 2018 Budget Review	Richard Armstrong, Director
RS25093C1	Relating to Health Care	Rebekah Hall

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Tuesday, February 07, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:11 p.m.
GUBERNATORIAL APPOINTMENT:	**Reappointment of Beth Elroy to the Board of Environmental Quality.** **Beth Elroy** introduced herself to the Committee and provided her educational background. She completed an internship at the Idaho National Engineering and Environmental Laboratory (INEEL) and went to work for Monsanto, where she was responsible for environmental compliance for several facilities in Wyoming and Eastern Idaho. After ten years at Monsanto, she worked briefly for Ashgrove Cement and next joined Micron Technology as an environmental engineer responsible for air programs. After several promotions, she is now the site manager responsible for all Micron facilities, including construction, operations, maintenance, environmental safety, health, workforce development, and snow removal. **Ms. Elroy** informed the Committee she has been married for 23 years and has two teenage sons, and her family enjoys skiing and outdoor sports. It is important to focus on protecting the environment so all can continue to enjoy Idaho's quality of life, while being mindful of businesses and giving them the opportunity to thrive. **Vice Chairman Souza** inquired what Ms. Elroy appreciates most about the Board of Environmental Quality (Board) and the most important part of the Board's function. **Ms. Elroy** responded it is ensuring the Department of Environmental Quality maintains a well-trained staff, including both technical and management skills necessary to sustain the environmental programs. **Senator Martin** asked Ms. Elroy to identify an issue in which the Board has been involved that has been beneficial to the State. **Ms. Elroy** answered there are two issues: 1.) a contested case proceeding regarding a Blackfoot facility, where she learned about the professionalism of the staff and how they were able to maintain detailed technical records that withstood scrutiny; and 2.) recent rulemaking where the staff collected technical data from the State of Idaho and did not just rely on guidance from other U.S. jurisdictions. **Chairman Heider** thanked Ms. Elroy and advised the Committee would vote on her reappointment at the following day's meeting.

GUBERNATORIAL APPOINTMENT: **Reappointment of Carol Mascarenas to the Board of Environmental Quality. Carol Mascarenas** introduced herself to the Committee. **Ms. Mascarenas** was first appointed to the Board 12 years ago. She is originally from Southern California and obtained a civil engineering degree with an environmental emphasis in 1986. **Ms. Mascarenas** informed the Committee she worked two years for a California regulatory board and this experience led to her interest in reports and investigations rather than just conducting oversight. She worked for a private consultant for three years and met her husband, who is from Soda Springs, Idaho. She has worked at INEEL for the last 26 years with increasing levels of responsibility and has been project engineer on several clean-up areas. In 2005, she moved to the research division of INEEL and is currently the Environmental Safety, Health, and Quality Director.

Ms. Mascarenas said her tenure on the Board has afforded her a balanced perspective as a regulator, industry member, and government representative.

Senator Martin asked about Ms. Mascarenas's length of service and accomplishments with the Board. **Ms. Mascarenas** answered her original appointment was 12 years ago, and she pointed out three items of significance. After her initial appointment, she was immediately required to learn the process for handling disputes and overseeing Department of Environmental Quality decisions. At her first meeting, she received three three-inch binders of materials relating to a dispute from Idaho Falls, and the Board came to a balanced decision. **Ms. Mascarenas** mentioned the issue of handling mercury was quite controversial, especially with the pollutants coming from other areas not within the State of Idaho. **Ms. Mascarenas** also identified the Board's challenge of an Environmental Protection Agency (EPA) fish consumption value. The Board and EPA had a good dialog even though the Board did not agree with EPA, and the Board came to a good decision.

Chairman Heider thanked Ms. Mascarenas for her service and advised that the Committee would vote on her reappointment at the following day's meeting.

PRESENTATION: **Department of Health and Welfare FY 2018 Budget Review. Richard Armstrong,** Director of the Department of Health and Welfare (Department), introduced himself to the Committee to provide an overview of the Department's FY 2018 budget request (see Attachment 1).

Director Armstrong informed the Committee the Department's FY 2018 budget request of $2.88 billion is comprised of 61 percent federal dollars, 25 percent General Fund, 12 percent receipts, and 2 percent dedicated funds. The request represents an increase of three and one-half percent, while the General Fund increase is six percent, or approximately $44 million. The increase is fueled largely by an increase in Medicaid participants and for strategic investments in behavioral health services. Receipts are an important part of the budget, with drug rebates in the Medicaid program contributing the most, and the request includes an additional $10 million in spending authority to utilize receipt dollars first.

Director Armstrong mentioned approximately 85 percent of the Department's appropriation, or $2.5 billion, is paid to private service providers. The Department is always looking for administrative efficiencies to keep operating costs low while balancing equitable provider payments. The budget request includes an increase of 34 full-time positions (FTPs). More than one-half of the new FTPs are the result of the Jeff D settlement agreement. The Department's 2,910 FTP count is still below the 3,137 FTPs prior to 2009. Behavioral health services would increase from 3.5 percent to 3.8 percent of the total budget, mostly due to mental health innovations proposed by the Department.

Director Armstrong informed the Committee Medicaid is the largest appropriation, and the Department has worked hard to improve health care quality while controlling costs. The monthly cost per participant has decreased by nine percent over the last five years. A good part of this decrease is attributed to the concept of patient-centered medical homes (PCMHs) to oversee patient care. Medicaid enrollees in primary care facilities have experienced reduced hospitalizations, emergency visits, and total cost of care as a result. The Department is working to expand the PCMH concept to hospitals and other providers to develop coordinated care efforts. Based on the experience of other states, the Department expects to see better care for participants while maintaining lower costs. The State Medicaid program is also working to improve the care for individuals with special health care needs and expand mental health services for Idaho children, and to improve its system of care for individuals with developmental disabilities.

Director Armstrong provided information on the use of public assistance by region, including food stamps, Medicaid, cash assistance, and subsidized child care. On June 30, 2016, there were 252,000 citizens, or 21 percent of the State's population, participating in at least one public assistance program. The highest use is in Southwest Region 3, which includes Canyon County, at 28 percent. Region 4 is the lowest, and that includes Boise, at 16 percent. In June 2008 before the recession, 14 percent of Idaho citizens received public assistance. Eligibility criteria for the programs has not changed, and the State is at full employment at 3.8 percent, suggesting the economic recovery has not been uniform across all income levels. People are working but their incomes are low enough that too many still qualify for public assistance.

Director Armstrong informed the Committee of the Department's seven budget priorities. Three of the priorities involve efforts to improve and coordinate behavioral health services. The top priority is a redesign of the children's mental health program to expand services to more Idaho children through Medicaid. General Fund dollars can be used to leverage federal funds to reach more children who have trouble functioning in their day-to-day lives. This priority is the result of the Jeff D lawsuit, which took 35 years to reach agreement. The lawsuit is disappointing because millions of dollars have been spent on legal fees rather than in providing services to children and families. **Director Armstrong** provided examples of benefits to the State of improving children's mental health treatment: 1.) improved school performance; 2.) fewer children getting in trouble with the law; 3.) fewer children entering foster care; 4.) fewer children who take up criminal behavior as adults; and 5.) fewer children transitioning to adulthood with unmet mental health needs. The Department's FY 2018 budget request includes an increase in foster care stipends and $11 million for mental health services for high risk probationers.

Director Armstrong reported the Office of Performance Evaluations very recently released a study on the State's child welfare system. The report is detailed and includes several themes germane to the budget request. The study found a need to better support foster families, both from a monetary and resource standpoint, and improve communication and interaction with them. The FY 2018 budget request includes a 20 percent increase in the foster care stipend. Second, the study found a shortage of social workers and a need to better manage their workload. The Department's budget request includes two line items for year two of the modernization of the welfare information system to reduce documentation demands on social workers, and the addition of six support staff to help schedule and transport children to visitations with their families to free up social worker time currently spent handling these duties.

Director Armstrong explained there are more than 160,000 open child support cases at this time, and it is important to be successful in collecting child support. Otherwise, families are often forced to rely on public assistance to meet their basic needs. About two-thirds of child support cases involve self-reliance programs. Unlike many states, Idaho requires single parents applying for public assistance to open a child support case. The 160,000 open cases represent more than 411,000 parents and children, and the Department collects and distributes more than $211 million in child support payments each year. The child support system modernization project is a three-year project, and the FY 2018 budget request is for year two of the project. Year two involves a redesign of State interfaces, better case management tools for staff, a new business work tool management engine, improved security and privacy safeguards, and a better online tool for families to receive information about their cases. The goal of the modernization project is to reduce risk and minimize cost by avoiding building a brand new system. Average cost of a new system in other states is between $80 to $100 million. The modernization project has a 66 percent federal match to help reduce the cost to the State.

Director Armstrong stated last year, the Department presented a multi-year funding road map for the Idaho Child Care Program to accomplish four goals: 1.) move the ICCP off the mainframe and into the current eligibility system called Idaho Benefits Eligibility System (IBES); 2.) increase market rates to ICCP providers which have not been adjusted since 2001; 3.) implement federal changes in the Child Care Reauthorization Act; and 4.) address case load increases as more families return to work. In December 2016, ICCP was moved from the mainframe to IBES. For FY 2018, the Department requests planning costs to cover the multi-year road map with just under $1 million in General Funds while using a 71 percent federal match.

Director Armstrong advised the Division of Behavioral Health has a growing need for a facility to house and treat people who have been charged with a crime but are deemed incompetent to stand trial due to mental illness. The courts commit these people to State hospitals, but the State hospitals are not designed, equipped, or staffed for high risk mentally ill and very violent patients. The number of court-ordered commitments to restore competency has more than tripled in the last five years. The number of significant events including assaults on staff or other patients, property damage, or self harm has increased 50 percent in the last three years. To alleviate the facility need, the Department plans to repurpose a building currently being used to hospitalize adolescents in Blackfoot. The building will be upgraded to handle high risk mentally ill patients and will be accomplished in three phases. First, the FY 2018 budget includes a request for $300,000 to allow the Department of Corrections to expand its mental health bed capacity from three beds to nine beds. Second, the Department will build a 16-bed adolescent unit in the Treasure Valley to replace the beds in Blackfoot. Since more than two-thirds of the youths who are patients in the Blackfoot facility are from the Treasure Valley, it makes sense to locate the new facility in the Treasure Valley. Phase three will retrofit the Blackfoot facility to accommodate the high risk patients.

Director Armstrong reported the Department is working on another initiative for the developmentally disabled population that is still in its infancy. The Department intends to build another facility for the developmentally disabled, separate from the psychiatric facility.

Director Armstrong informed the Committee that the Idaho Department of Corrections estimated 35 percent of all felony offenders will return to prison within three years of release. In 2015, the State hired the Western Interstate Commission on Higher Education (WICHE) to evaluate the behavioral health needs of the felony prison population. The analysis is required annually by the Legislature as a result of the Justice Reinvestment Initiative (JRI). The evaluation identified a total of 7,388 felony offenders with a moderate to high risk of recidivism. The JRI recommends resources be focused on these offenders. Offenders usually lose access to behavioral health services when they leave prison, and many struggle with mental illness and substance use disorders. Under Idaho Code § 19-2524, the Department is responsible for providing services to this population, and the budget request is necessary for the Department to meet its statutory obligation. The Department proposes to contract with a behavioral health provider so parolees have access to services to help them stabilize in their communities and become productive and self-sufficient. At the current annual cost in corrections of $20,000 per inmate per year, intervention services would need to be successful with only 560 or eight percent of those 7,388 offenders to justify the expense. The Department is requesting $11.2 million in General Funds to cover this obligation. If the request goes unfunded, the population will continue to be underserved, which may result in their return to prison.

Director Armstrong stated the Department's employee turnover of 12 percent in 2016 was a decrease from 15 percent in 2015. Last year's three percent change in employee compensation was helpful in trimming the turnover rate. The Department still has two areas of concern: licensed practical nurses and facility supervisors, which are currently at 27 percent turnover. The Department wants to move their pay closer to current market rate. The 2015 targeted increases for child welfare social workers was quite successful in retaining those employees. State worker pay lags the private section by over 20 percent, although the benefit package is comprehensive and helps close that gap. With the current low unemployment rate, wages are increasing, and the State needs to attract and retain a talented work force.

Senator Lee asked for an update on the Southwest Idaho Treatment Center (SWITC) and if there has been any consideration for using that property for the secure mental health facility. **Director Armstrong** responded the plan is confusing. The new 16-bed facility for adolescents could be built on the SWITC property. The secure facility will be in Blackfoot and will house only adults. The local facility for adolescents will not be a secure facility. It would be nice to knock down the abandoned structures existing on the SWITC property and save the real estate costs for the facility. The old hospital there is terribly inefficient and could not be used.

Senator Martin asked what percent of the Department's budget is federal money, and if there are large reductions in federal programs, what effect will that have on the Department and the State. **Director Armstrong** replied on average, 61 percent of the Department's budget is federally funded. Within the Department, some programs have higher percentages of federal money and some lower. With a new U.S. President and Administration, the Department always considers what might happen if a program goes away and determines whether the program would be continued in a lesser form or simply eliminated. **Director Armstrong** said he is not convinced there will be any dramatic changes at this time. It is always difficult to reduce or eliminate programs when participants are used to receiving benefits.

Vice Chairman Souza asked for an overview of the Jeff D lawsuit and its impact. **Director Armstrong** replied the lawsuit started in 1980 because State Hospital South commingled adolescents with adults. The suit also involved the question of why so many children were institutionalized, and if there were community-based services, some children might have remained at home. The settlement agreement provides a plan for the State to provide services within a community for children with serious mental illness. Services must be available without regard to income. The plan involves Medicaid because the State does not have enough resources to implement the plan on its own. Not all children will be eligible for Medicaid, but enough will be eligible to leverage matching federal money. The State must prove to the court over the next four years that it has complied with the settlement. After four years, the State will be released from court oversight. The settlement is not a one-time event but a substantial transformation for Idaho children.

Senator Agenbroad asked for some bright moments from Director Armstrong's tenure at the Department. **Director Armstrong** responded there are many.

The insurance exchange reduced the cost of indigent care by one-half in a short period of time. More than 100,000 Idahoans processed through the most recent open enrollment period, and Idaho's enrollment will likely be number one in the nation. Operating costs for the exchange are 1.9 percent, one-half of the next closest state.

Idaho has been able to create a single eligibility system that few states have been able to replicate. Every program managed by the Department comes through a single source of eligibility processing, and it is extremely effective.

In 2006 or 2007, the costs for processing food stamps was about $54 per case per month. Now, it's close to $20, while some states are still at $54 or higher.

Department staff has been brilliant at figuring out how to do things better with an eye toward delivering services online in real time. It used to take more than 20 days to deliver food stamp benefits. Now, 85 percent are processed at the point of application, and there is no backlog.

The federal government allows seven days to process emergency applications, and the Department processes them immediately. Idaho has been number one in the U.S. for timeliness for five years in a row.

The Department has re-engineered every process throughout the agency, and each one is an immense success because more can be done with fewer people and lower cost while providing better customer service.

Chairman Heider asked why there is such a rise in mental health issues compared to the past. **Director Armstrong** answered illegal drug use and the new types of drugs are the primary problem. Today's marijuana is dramatically more potent than the marijuana of the 1970's. Heroin use is on the rise, and opiate addiction is an epidemic. Prescription drug opiate use is unprecedented and creates a dependency that often leads to heroin use. Methamphetamine was not very well known 10 to 15 years ago. Methamphetamine alters the brain permanently and destroys the frontal cortex, leading to more violent behavior. This violent behavior by patients in facilities has always been controlled by staff, but at one facility 40 percent of the staff have had workers compensation claims in the last few years due to patient assaults. There is no way to adjudicate these assaults, and there is no place to put the patients.

RS 25093C1

Relating to Health Care. Rebekah Hall introduced herself to the Committee as a member of the Idaho CMV Advocacy Project to present **RS 25093C1** relating to education on cytomegalovirus (CMV). **Ms. Hall** informed the Committee her four-year-old daughter Keira was born with congenital CMV. Most people have been infected with CMV by the age of 40 but have never heard of it. CMV is typically a harmless virus, and if a healthy person has any symptoms, it is similar to a common cold. CMV is one of the few viruses that can cross the placental barrier if contracted by a pregnant woman. A baby infected with CMV is at risk for microcephaly and other brain damage, hearing loss, vision problems, cerebral palsy, and death. The Center for Disease Control reports one in 150 babies is born with CMV, and of those, one in five will have permanent disabilities. CMV is more prevalent than Down's Syndrome, spina bifida, human immunodeficiency virus or acquired immunodeficiency syndrome, and Zika virus.

Ms. Hall stated pregnant women need to be aware of and informed about CMV just like most know to avoid eating certain types of fish, cheese, and lunch meat and to avoid the cat litter box. CMV is preventable and understanding how it can be prevented is critical information for pregnant women to make informed decisions on whether or not to engage in behaviors that put them at higher risk for contracting CMV. **Ms. Hall** commented she had two children prior to Keira, read many books about pre-natal development, and obtained regular pre-natal care. However, she had never heard of CMV until it was too late for Keira. **Ms. Hall** explained she most likely caught CMV from her then-toddler by kissing him on the mouth or finishing his macaroni and cheese or wiping his runny nose and failing to wash her hands afterwards. Keira has cerebral palsy, vision impairment, and failure to thrive; she will never walk or talk and struggles to hold up her own head. Keira receives all her nutrition entirely by a feeding tube, and it is unlikely she will outlive her parents or her brothers. Nevertheless, Keira is a fighter. **Ms. Hall** said she hoped to bring her daughter to the meeting, but Keira is currently in the hospital with breathing problems.

Ms. Hall informed the Committee the bill would provide for an Idaho education and awareness program so pregnant women can understand how to prevent CMV and why it is important. The effective distribution of this information will save the State millions of dollars in the care and treatment of various disabilities associated with CMV infection. In four years, Keira has had 14 surgeries and spent over 100 days in the hospital. Keira is followed by 16 medical specialists and seven types of therapists, takes seven medications, and averages six appointments a week not including school. To date, Medicaid has paid almost $300,000 on Keira's behalf. The education endeavor is anticipated to cost $60,000 in the first year. If even one infection is prevented, it will be cost effective.

Ms. Hall advised Idaho would be the seventh state to pass legislation regarding CMV. This bill is modeled after one passed by Utah in 2013.

Senator Foreman asked why the medical community has not stepped up to address the CMV issue if it is so common and preventable. **Ms. Hall** answered it is a complicated issue. Doctors know about it but are not as well informed as they should be. Most infants born with CMV do not come out looking as sick as Keira. Many are completely asymptomatic but may go on to develop problems as they grow. CMV is the number one cause of hearing loss in children outside of genetic predisposition. Because the hearing loss is progressive, it is not identified at birth. If a child starts losing hearing at age two, it's more difficult to connect it back to congenital CMV. Another reason physicians do not talk about preventative measures is they believe the methods of prevention are unrealistic. Telling parents not to kiss their children may be like telling people not to breathe air, but if people know the specifics about CMV, it might change their minds. **Ms. Hall** further explained some medical practitioners believe nothing can be done about infection except termination of pregnancy. This is no longer true, but the information is difficult to find, and the options are not fully reflected in the standards of care for doctors in the U.S. **Senator Foreman** inquired if the primary preventative step is lack of contact. **Ms. Hall** replied the easiest way to contract CMV is from wet bodily fluids to wet bodily fluids. CMV is most commonly contracted by pregnant women through their smaller children or by child care workers who have contact with runny noses and slobbery faces. The most helpful preventative measures are to avoid sloppy kisses with kids, avoid sharing eating utensils or food, and wash hands very carefully after wiping noses or changing diapers.

Senator Souza asked if there is a test for CMV, and if there is a part of the gestational period of the pregnancy that the mother is more vulnerable. **Ms. Hall** referred the question to Erica Jensen.

Ms. Jensen introduced herself to the Committee as a registered nurse who has worked as a labor and delivery nurse and in pediatric clinics. **Ms. Jensen** said she was diagnosed with CMV during the first trimester of her pregnancy with twins. She finally learned of the CMV diagnosis through a blood test. Because it was her first trimester and her initial infection, the risk to the babies was much higher and the doctor recommended she terminate the pregnancy. **Ms. Jensen** did not want to terminate the pregnancy and after much searching, she was able to identify a treatment in Europe that was successful. Even being involved in health care, she was not familiar with CMV, and she was angry she didn't know more. Having information about simple hand hygiene and where to kiss her two-year-old would have been helpful.

Senator Souza inquired about the treatment used in Europe and whether it is accepted or legal in the U.S. **Ms. Jensen** responded she believes it is still considered experimental in the U.S. The treatment consisted of immunoglobulin infusions at 17 weeks and 19 weeks with donated plasma from people with high CMV antibodies. The cost was $25,000 per infusion, but the treatments were ultimately covered by insurance. It was cost effective compared to treating her children for CMV issues.

MOTION: **Senator Martin** moved to send **RS 25093C1** to print. **Senator Harris** seconded the motion.

Senator Jordan thanked the presenters for bring the issue forward and making the Committee aware of the problem.

The motion carried by **voice vote.**

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:27 p.m.

Senator Heider
Chair

Jeanne Jackson-Heim
Secretary

IDAHO Department of Health and Welfare

Idaho Department of Health & Welfare

Senate Health & Welfare Committee

Richard Armstrong
Director

February 7, 2017

IDAHO DEPARTMENT OF HEALTH & WELFARE

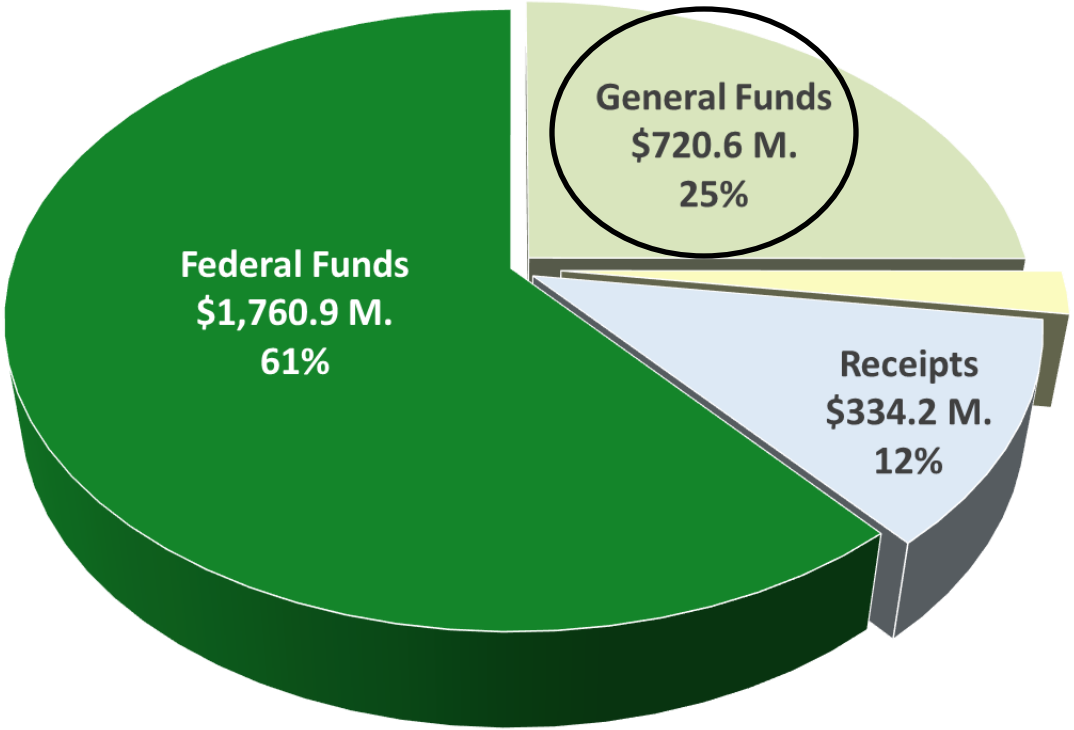
Today's Presentation

1. DHW budget overview
2. Medicaid cost containment/improvements
3. Public assistance use by region
4. Budget priorities

IDAHO Department of Health and Welfare

DHW SFY 2018 Recommendation by Fund Source

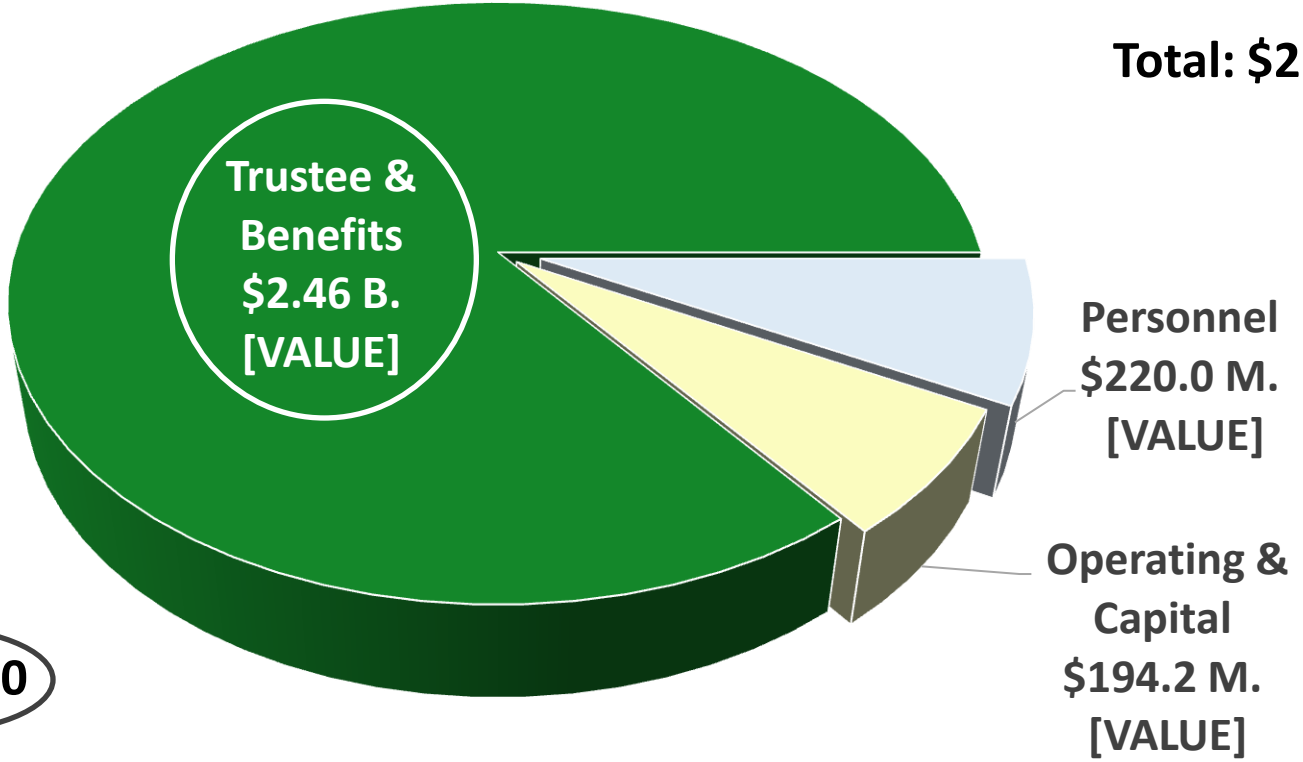
Total: $2.88 B.



Increase from SFY 2017	
General	6.0%
Dedicated	-6.5%
Receipts	7.5%
Federal	2.1%
Total	3.5%

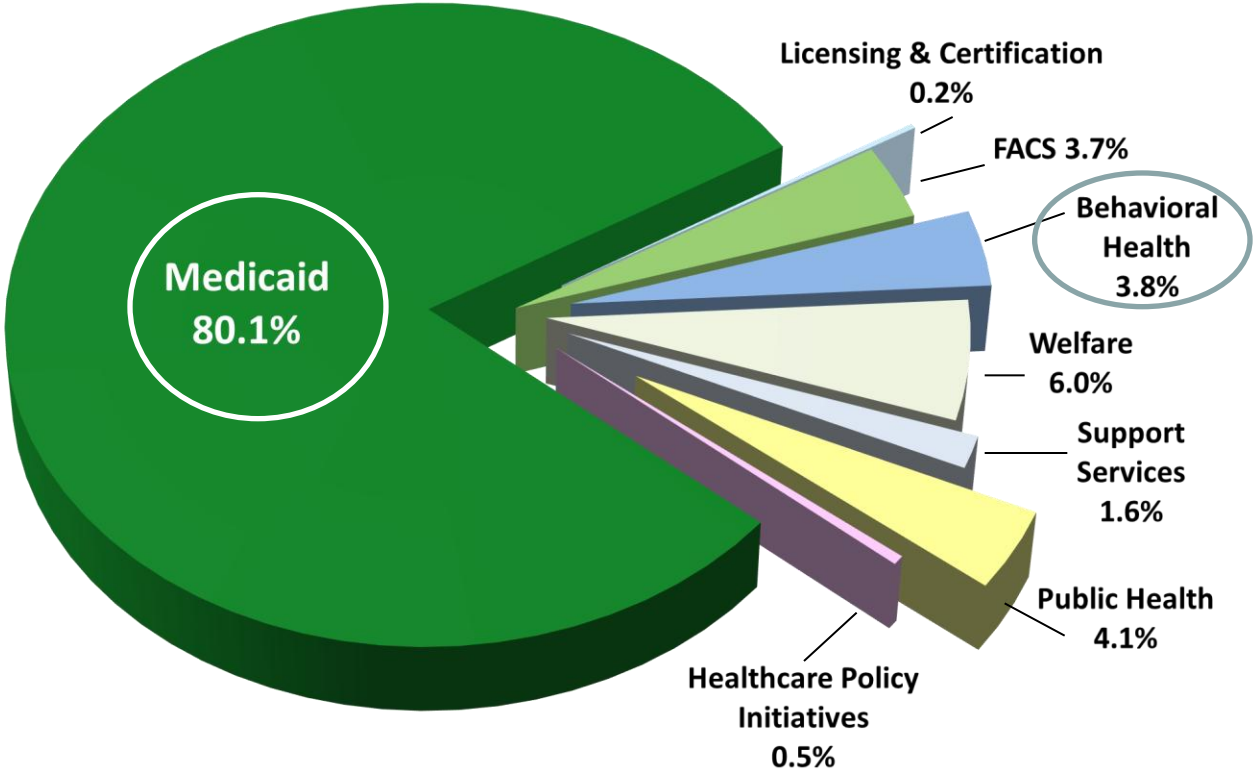
DHW SFY 2018 Recommendation by Category

Total: $2.88 B.

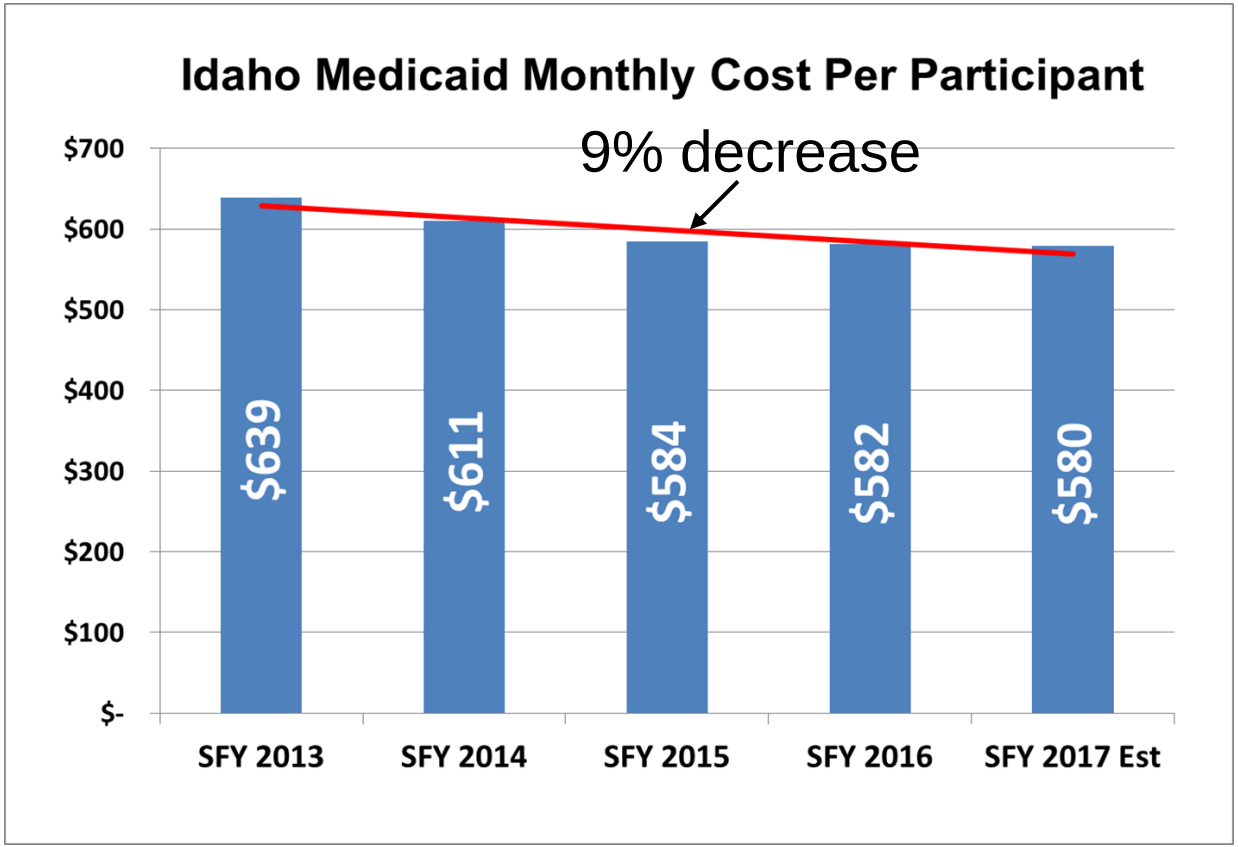


FTP: 2,910

DHW SFY 2018 Recommendation by Program

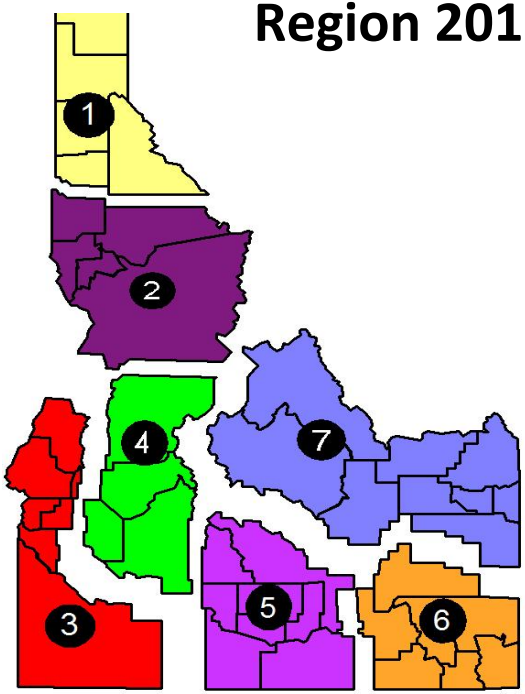


Total: $2.88 B.



- **Medicaid cost per participant has dropped over last 5 years**
- **PCMH enrollees: Reductions in ER, hospitalizations and total cost of care**
- **Expanding PCMH concept to hospitals and other providers through coordinated care networks**

Public Assistance by Region 2016



Region	Estimated Population	Receiving Cash Payments	Child Care Assistance	Food Stamps	Medicaid	Totals
1	225,007 13.6%	3,185 1.4%	1,007 0.4%	24,894 11.1%	40,670 18.1%	47,276 21.0%
2	107,383 6.5%	1,489 1.4%	269 0.3%	8,693 8.1%	15,463 14.4%	17,597 16.4%
3	272,363 16.5%	4,427 1.6%	1,528 0.6%	42,017 15.4%	66,858 24.5%	76,956 28.3%
4	477,248 28.8%	5,040 1.1%	1,778 0.4%	40,401 8.5%	64,473 13.5%	75,580 15.8%
5	192,395 11.6%	1,989 1.0%	878 0.5%	20,893 10.9%	40,863 21.2%	45,584 23.7%
6	166,429 10.1%	2,278 1.4%	756 0.5%	20,520 12.3%	33,932 20.4%	39,084 23.5%
7	214,105 12.9%	1,833 0.9%	1,069 0.5%	23,927 11.2%	44,169 20.6%	50,089 23.4%
Totals	1,654,930 100.0%	20,241 1.2%	7,285 0.4%	181,345 11.0%	306,428 18.5%	352,166 21.3%

**Data is from June 2016. Totals are an unduplicated count of unique individuals.*

FY 2018 Budget Priorities

1. Children's Mental Health
2. Child Welfare
3. Child Support System
4. Child Care Funding
5. Psychiatric Facilities Plan
6. Felony probationer treatment
7. Employee CEC

Children's Mental Health: Youth Empowerment Services

- Settlement agreement of 35-year Jeff D. lawsuit to improve and expand access to children's mental health services

- Utilizes $1.2 M. GF currently used for treatment to leverage federal funds of an additional $3 M. = $4.2 M.
- $1.2 M. → $4.2 M. can improve treatment and expand access for more children
- Includes 7 field staff in regional offices and 11 staff for data analytics, quality improvement, mental health assessments and oversight

Downstream Impact of Children's Mental Health Treatment

1. Improved school performance
2. Fewer children getting in trouble with the law.
3. Fewer children entering foster care
4. Fewer children who take up criminal behavior as adults
5. Fewer children transitioning to adulthood with unmet mental health needs.

Child Welfare Addresses Key Issues in FY18 Recommendation

1. Improve support for foster families.
   - Retain foster families
   - Increase foster care stipend by 20%
   - Improve communication

Child Welfare 2018 Recommendations			
	GF	FF	Total
Foster Care Stipend	$347,800	$491,300	$839,100
Information System	$297,000	$729,000	$1,026,700
6 Visitation Staff	$82,300	$182,300	$264,600

2. Improve workload management.
   - Upgrade technology to reduce time-laden, administrative burden
   - 6 Foster care visitation support staff to supervise arranging, transporting and supervising visitation
   - Review and improve processes to create efficiencies, capacity, and increased effectiveness

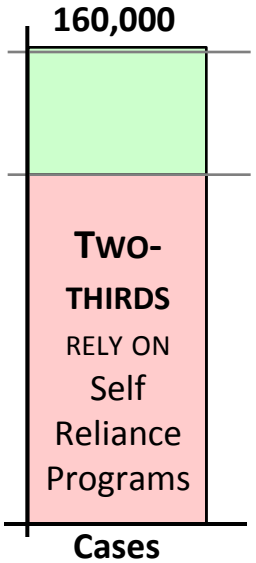
IDAHO Department of Health and Welfare

Year 2: Child Support System Modernization

FFY 2016

$ 211M Collections

411,000 Parents & Children



Year 2: SFY2018		
General Funds	Federal Funds (66%)	Total
$2.7 M.	$5.3 M.	$8.0 M.

Year 1

Migrate Mainframe Code & Update Code

Year 2

Modernize:
Interfaces
Case Management
Workflow manager
Security & Privacy
Self Service

Year 3

Modernize:
Financial Transactions
Notifications
Rules Engine
Ongoing Security

Idaho Child Care Program (ICCP) Funding

SFY2018		
General Funds	Federal Funds (71%)	Total
$1.0 M.	$2.4 M.	$3.4 M.

Move ICCP off the mainframe and into IBES

I.B.E.S.

Provider Reimbursement

2016 Legislature approved
Market rate adjustment
Not updated since 2001

Child Care Federal Reauthorization

New rules by congress to help parents get back to work or attend college

ICCP Caseload (Child Care Subsidies)

Parent Pays + **ICCP Subsidy Pays** = Child Care

Psychiatric Facilities Plan

Increase of Commitments to Restore Competency				
FY12	FY13	FY14	FY15	FY16
52	109	104	132	170

Increase of 326%

- Idaho mental health hospitals are not designed, equipped or staffed for dangerously mentally ill patients
- During last three years, significant events that include assaults, property damage and self-harm increased 50% at Idaho's two state hospitals, reaching 625 incidents in FY16

IDAHO Department of Health and Welfare

Psychiatric Facilities Plan

Three phase plan:

1. July 2017: Temporary increase of Dept. of Corrections secure mental health beds from current 3 beds to 9; estimated cost $300,000.

	Current	2019
Secure beds	3	9
High Risk Beds	0	20
Adolescent Beds	16	16

2. Fall 2018: Build 16 bed adolescent mental health facility in Treasure Valley; more than 2/3rds of patients are from Treasure Valley. Estimated cost: $10.3 M. from Permanent Building Fund.

3. Summer 2019: Retrofit current adolescent unit in Blackfoot to 20 high-risk, adult beds to protect staff, other patients and reduce elopements.

Treatment for felony probationers and parolees

- Dept. of Corrections estimates 35% of all felony offenders return to prison within 3 years of release

Felony Probationer Treatment		
GF	FF	Total
$11.2 M.	0	$11.2 M.

- 7,388 moderate to high risk probationers and parolees identified to be eligible for behavioral health services
- With annual cost of $20K per inmate, program would need to be successful with just 560 (8%) of 7,400 to justify expense

Change in Employee Compensation (CEC)

- DHW turnover is down from 15% in 2015 to 12% in 2016
- 3% CEC increase this year helped, but areas of high turnover remain

Strategic Pay Increases for FY18			
	GF	FF	Total
Surveyors	$61,300	$135,000	$196,300

- Pay currently lags private sector by over 20%, although benefit package is comprehensive and helps
- With unemployment at less than 4%, wages are increasing as employers seek the best and brightest.
- The state cannot afford to lose any more ground – we need to be able to attract and retain a talented workforce.

IDAHO Department of Health and Welfare

Idaho Department of Health & Welfare

Senate Health & Welfare Committee

Richard Armstrong
Director

February 7, 2016

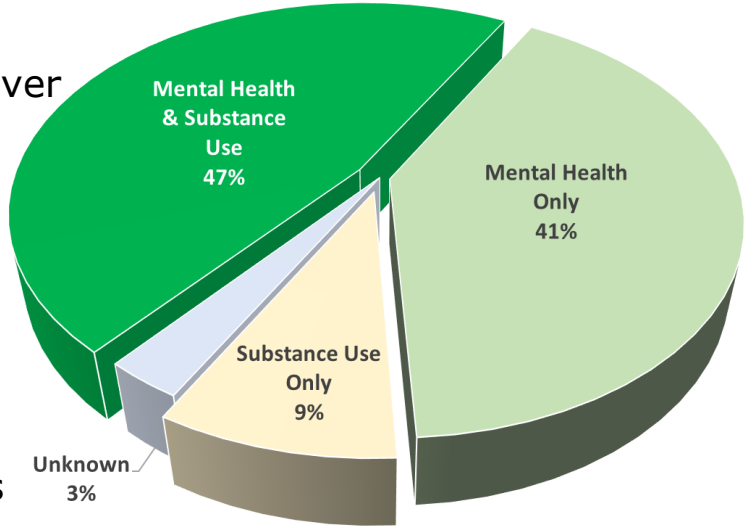
IDAHO DEPARTMENT OF HEALTH & WELFARE

IDAHO Department of Health and Welfare

Community Crisis Centers Update for 2016

Eastern Idaho Crisis Center (opened 12/2014) :

- Provided 3,414 episodes of care in 2016, averaging over 9 patients per day, avg. stay of 16 hours
- 253 Law enforcement referrals = $35,420 savings
- 314 Hospital referrals=$660,000 estimated savings
- Total savings for first 2 years = $1.2 M.



Northern Idaho Crisis Center (opened 12/2015):

- 1,114 episodes of care in 2016, avg. stay of 18 hours
- 25% presented with depression/anxiety, another 21% with suicidal thoughts
- 265 Law enforcement referrals and 157 from hospitals

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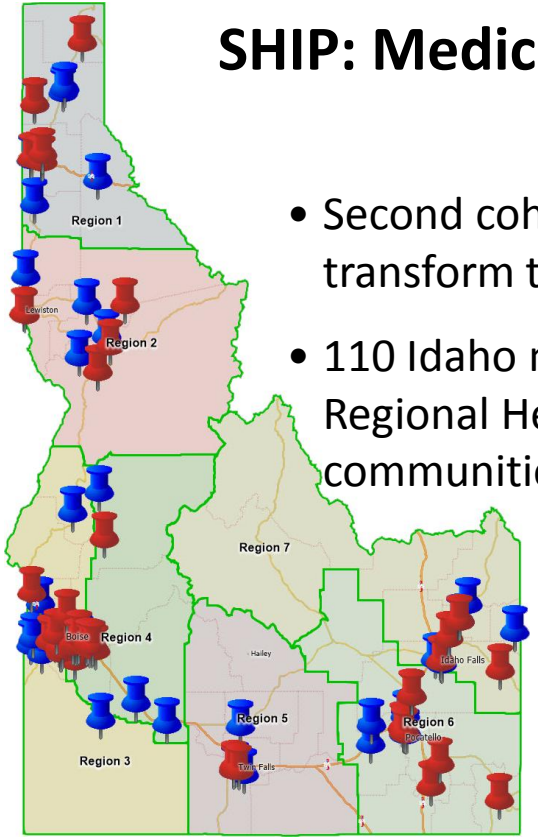
SHIP: Medical Community Continues to Embrace Patient Centered Medical Home Model



- Second cohort of 55 practices selected and began training Feb. 1 to transform to Patient Centered Medical Homes
- 110 Idaho medical practices are now training from across all 7 Regional Health Districts and include urban, rural and frontier communities:
  - Private Practices
  - Community Health Clinics
  - Rural Health Clinics
  - Federally Qualified Health Centers
  - Hospital/Health System owned Clinics
  - Indian Health Service Clinics

AMENDED AGENDA #1

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Wednesday, February 08, 2017

SUBJECT	DESCRIPTION	PRESENTER
Approval of Minutes	Minutes of the January 26, 2017 Meeting	Senator Agenbroad
Gubernatorial Appointment	Vote on the Reappointment of Beth Elroy to the Board of Environmental Quality	
	Vote on the Reappointment of Carol Mascarenas to the Board of Environmental Quality	
Presentation	Epidiolex Expanded Access Program	Dr. Kris Hahn, State Epidemiologist Dr. Robert Wechsler, Idaho Comprehensive Epilepsy Center
S 1037	Relating to Dentists	Susan Miller, Board of Dentistry
S 1038	Relating to Dentists	Susan Miller

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Wednesday, February 08, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:18 p.m.
APPROVAL OF MINUTES:	**Senator Agenbroad** moved to approve the Minutes of the January 26, 2017 meeting. **Senator Harris** seconded the motion. The motion carried by **voice vote.**
GUBERNATORIAL APPOINTMENT:	**Consideration of Gubernatorial Appointment of Beth Elroy to the Board of Environmental Quality. Vice Chairman Souza** moved to send the Gubernatorial Appointment of Beth Elroy to the Board of Environmental Quality to the floor with recommendation that she be confirmed by the Senate. **Senator Jordan** seconded the motion. The motion carried by **voice vote.**
GUBERNATORIAL APPOINTMENT:	**Consideration of Gubernatorial Appointment of Carol Mascarenas to the Board of Environmental Quality. Senator Harris** moved to send the Gubernatorial Appointment of Carol Mascarenas to the Board of Environmental Quality to the floor with recommendation that she be confirmed by the Senate. **Senator Martin** seconded the motion. The motion carried by **voice vote.**
PRESENTATION:	**Epidiolex Expanded Access Program. Dr. Christine Hahn,** State Epidemiologist with the Department of Health and Welfare (Department), introduced herself to the Committee. **Dr. Hahn** provided background information to the Committee on the clinical trial of Epidiolex, an experimental drug derived from cannabidiol (CBD). The Department was instructed by the Governor in 2015 to administer the clinical trial to provide Epidiolex to children with severe epilepsy. Epidiolex is not yet approved by the Federal Drug Administration (FDA) for use in the U.S. but it was available through an Expanded Access Program (Program). The medication is derived from the cannabis plant, but all the Tetrahydrocannabinol (THC) has been removed. CBD oil is administered as drops under the tongue. **Dr. Hahn** stated the Idaho Program was initially approved for 25 children, and this year approval was given to enroll an additional 15 children. The children must be Idaho residents aged 18 or under and must have severe epilepsy not controlled by medications. The clinical trials around the country have been promising enough that the drug may be approved within the next year.

Chairman Heider welcomed Dr. Robert Wechsler to the Committee and thanked him for his work with the children on this clinical trial. **Dr. Wechsler** introduced himself to the Committee as a researcher in many clinical trials and an investigator for GW Pharmaceuticals (GW) in other trials of Epidiolex. GW recommended Dr. Wechsler as a researcher for the Idaho Program because of his experience. The Idaho Program was originally approved for 25 places, and there was a question whether that number would be sufficient to accommodate the need. The Idaho Program requires children to be referred by a pediatric neurologist who has reviewed the child's chart and can attest that all reasonable appropriate therapies have otherwise been exhausted.

Dr. Wechsler informed the Committee out of the original 25 places, one child could not stay in the Idaho Program because he could not tolerate having blood draws. The first 24 patients are all still involved, and **Dr. Wechsler** said he presented the data on those patients to the American Epilepsy Society meeting in abstract and poster form in December 2016. Per FDA guidance and GW policies, the clinical trial is run as an "open label" research study, meaning there is no placebo and all participants receive the actual medication. With an open label research study, there is not much motivation for participants to exit the program, even if they are not seeing a real benefit. About two-thirds of participants receive a genuine benefit. Only about 20 percent of participants have experienced a significant reduction in the number of seizures, but he has heard from some families that the intensity and duration of their children's seizures has decreased. **Dr. Wechsler** mentioned he takes these reports with a grain of salt because there is no empirical evidence to support the claims.

Dr. Wechsler advised there were a few cases on the waiting list last year, so he approached GW about expanding the Program. Idaho's Program was one of the few in the U.S. that was allowed to expand to add 15 places. The Program has done well in meeting the need, and there is not a big waiting list at this time. By being thoughtful about the criteria to include participants at the outset of the trial, the demand has tapered off quite a bit. For example, **Dr. Wechsler** said he was contacted in late 2016 by the neurologist of the child who could not tolerate the blood draws. The neurologist asked if the child could be readmitted to the Program. **Dr. Wechsler** informed the neurologist he hated to lose a second place if it turned out the child still could not tolerate the blood draws, and the parents assured him the child would be fine with blood draws at this time. At this time there are 38 participants in the Program with one place left, and they intend to add this child for the last place.

Dr. Wechsler stated some patients have benefited quite a bit from the use of Epidiolex, but he believes there is a healthy dose of wishful thinking mixed in for others. Overall, the successes are on par with other clinical trials of the drug. There is a strong likelihood the drug will be approved once it is submitted to the FDA. The approval process takes several months, but it is very possible the drug will be available commercially in early 2018. At that point, the Program will no longer be necessary.

Chairman Heider asked if prolonged use of the drug will continue to make an improvement in the patient's status. **Dr. Wechsler** answered his gut feeling is that this product will be on par with any other product approved for epilepsy. It will not be dramatically better than other drugs, but there will be individuals for whom it is better than anything else they tried. However, that is true of many of the patients he treats with a variety of drugs. His best guess is that some will have sustained success, and some will have success for a while and the benefits will taper off. Every time a new drug comes along, there are a few people for whom it turns out to be the miracle they were waiting for. Others do well only for a while, and these are often the patients who end up in future clinical trials of other drugs.

Chairman Heider inquired how long it will be until the FDA approves the drug and it is available to every Idaho child with this condition. **Dr. Wechsler** responded GW has fast-track status. GW's data is presently being looked at by its statisticians, and he believes GW will submit for FDA approval in the first half of 2017. It will likely take eight to twelve months for FDA approval after submission.

Senator Jordan asked if Dr. Wechsler noticed any unusual or adverse effects from the drug during the study. **Dr. Wechsler** responded adverse effects are the main reason to conduct this type of study. The benefit of this kind of study is to collect information on safety and tolerability. The tolerability of the drug has been surprisingly good. The most common side effect encountered has been sedation or sleepiness, particularly in patients who are taking one or more other epilepsy medications. There is a significant interaction between CBD and two other commonly-used epilepsy drugs that causes the sedation side effect. **Dr. Wechsler** said he primarily deals with adult patients and it is important for the child's pediatric neurologist to stay involved. When he sees side effects, he sends the child back to the referring provider to adjust the child's medications as appropriate. Out of the 24 initial patients, seven had significant drowsiness as a consequence of adding CBD oil. Most of the seven were taking both of the other two common medications, and the side effect was reduced with the reduction or elimination of one or both of those two drugs.

Senator Harris asked what is the anticipated market cost of the drug after it is approved. **Dr. Wechsler** replied he has no idea. However, the data shows Epidiolex does not achieve dramatically better results than any other approved epilepsy drug. He feels GW will be obliged to price the product competitively with every other approved drug. There has been excitement surrounding this topic, but that must be tempered by competition from artisanal dispensaries in the 22 states that have approved medical or recreational marijuana. He knows some of the people leading this project at GW and they are very smart, good people. He does not think they would price things ridiculously high.

Senator Souza commented this is an important topic and there was a lot of emotion surrounding it at the Legislature last year. She asked if Dr. Wechsler knows of Idaho children with severe epilepsy who might benefit from the drug but who did not qualify for the clinical trial because they didn't meet the criteria. **Dr. Wechsler** answered the main criteria for the Program was that at least four conventional approved therapies for the patient's epilepsy type must have been tried and failed, including one combination of two medications. The criteria were set loosely, and while there are many children who would technically meet the criteria, their referring neurologists recognized there were more things to be tried first. When a product is FDA approved and shown to be effective and safe, it gets broader use than in the clinical trials because the trials carry an element of risk and it is unknown whether there will be long-term health risks. Children are not included in clinical trials unless all other reasonable options have been exhausted. **Dr. Wechsler** commented he thinks the demand will be fairly significant when the drug is approved and it will have a successful launch. He thinks there might a little bit of disappointment six to 12 months after approval because he does not think the drug will live up to the hype. Sometimes there is hesitancy to prescribe a new drug right after it is approved, but he does not think that will be the case with this particular drug due to the political environment around it.

Senator Souza inquired whether Epidiolex is currently available in other countries. **Dr. Wechsler** answered it is not currently available for epilepsy in other countries.

Senator Souza further inquired whether the drug will likely be prescribed for adults for reasons other than epilepsy. **Dr. Wechlser** responded it is hard to predict what prescribers will do, and he suspects there will be some effort to prescribe it for all kinds of things, whether it has been shown to work for those things or not. Once GW has approval, he thinks the drug will be tested in other areas to see if it has any benefit. He thinks it will definitely have a role for adults with epilepsy. The FDA approval sought is for two different syndromes: Lennox-Gastaut Syndrome (LGS) and Gervais Syndrome (GS). There is a misperception in the medical community that these are only childhood diseases. In the clinical trial of another epilepsy drug, 80 percent of participants with LGS were children. Unfortunately, children with LGS do not suddenly become normal at age 18; they become adults with the same condition. Many patients with LGS live to their 50's and 60's; he has a 70-year-old patient with LGS in a Boise group home. Of all patients with LGS, the adults dramatically outnumber the children, but there is more complacency about the diagnosis and the seizures in adult patients. **Dr. Wechsler** explained he has participated in a number of LGS studies, and most participants were adults with LGS. He feels Epidiolex will have a role in the care of adult patients. Many of these adults end up in State facilities or group homes, and they will potentially benefit greatly.

Senator Lee commented there was significant debate about this issue in 2016 and asked if there is something different about this particular drug versus other CBD oil that can be purchased online or in other states. **Dr. Wechsler** answered the biggest difference is that Epidiolex will have a regulated content of CBD oil. The problem with artisanal preparations is the content is not regulated. As an example, the FDA pulled random samples of 18 products from six different manufacturers available on the Internet. Sixteen of the 18 products had zero percent CBD. The other two had less than two percent CBD. Epidiolex contains 100 milligrams (mg) of CBD per milliliter (ml). The "Cadillac" version of CBD oil is called "Charlotte's Web" and has about 50 mg of CBD per ml, but it is not regulated by any kind of authority. Dr. Wechsler has a patient who buys Charlotte's Web online from Colorado, and the company selling it has told the patient the correct dose is 7 ml, or about 350 mg. In the Epidiolex studies, doses are commonly as high as 25 mg per kilogram of body weight. For an average size person, the dose might be as high as 2,000 mg. Another patient who is buying a highly purified CBD oil received instructions to place three drops under her tongue for one week, then increase to nine drops under the tongue. It is not chemically possible to have enough CBD in nine drops of oil to get a meaningful dose. It is unfortunate that people have such strong belief in CBD oil that they stop their mainline therapies. His colleagues in the pediatric epilepsy world in Colorado reported the number of children showing up in emergency rooms with seizure emergencies has dramatically risen since the marijuana dispensaries opened. Families are putting their children on CBD oil and taking them off their medications without physician approval.

S 1037

Relating to Dentists. Susan Miller, Executive Director of the Idaho State Board of Dentistry (Board), introduced herself to the Committee to present **S 1037**. The bill revises Idaho Code § 54-920 and addresses three issues.

Ms. Miller informed the Committee that licensees who choose retirement status currently have no option to return to active status other than to apply as a first applicant. The Board explains this issue to licensees in their renewal materials, but some don't read the fine print. Some licensees inadvertently made a poor choice and wanted to reactivate the licenses later, but the statute expressly prohibits the Board from converting a retirement license to an active status license.

Ms. Miller explained the current definition of active status allows licensees to absent their practice for up to two years for only the reasons specified in the statute. There are other reasons a licensee may wish to absent the practice, and in some cases, it may be for longer than a two-year period.

Ms. Miller said the third issue has to do with converting an inactive status license to active status. The current statute requires evidence of 1,000 hours of clinical practice within the two years immediately prior to making the request to activate a license. Requiring continuing education instead of clinical practice hours would be consistent with the requirement for an active status practitioner who may or may not actually be practicing.

Ms. Miller reviewed the proposed changes to the statute. The bill would:

- eliminate the retirement status fee;
- revise the definition of active status to allow absence from practice for any reason;
- eliminate the retirement status definition;
- delete the requirement for license applicants to show intent to engage in practice within two years;
- allow licensees to go on inactive status for any reason;
- remove the clinical practice requirement for converting a license from inactive to active status and replace it with a continuing education requirement; and
- revise the statute to eliminate conflicting language and clarify what must be done to qualify for an active status license.

Ms. Miller reported the Board has heard no opposition to the bill. The Idaho State Dental Association and the Idaho Dental Hygiene Association are both in support of the legislation. **Ms. Miller** stated the Board's public member, Tina Wilson, and Board counsel Michael Kane are both present and available to answer questions.

Senator Lee asked if a licensee goes on inactive status for ten years and wishes to reactivate, would the licensee be required to complete the same hours of continuing education as if the licensee had been on active status during that period. **Ms. Miller** answered that is correct.

Senator Foreman asked if there is a way to ensure a licensee is not required to complete outdated or unavailable courses. **Ms. Miller** replied the Board rules do not specify particular areas of continuing education. The courses must be oral health or health related. **Senator Foreman** commented his concern is that the courses are current and relevant rather than going back to complete courses that might have been required in the past and are now outdated. **Ms. Miller** responded if a licensee had been inactive for ten years, it is true the licensee could have completed the education nine years ago and it would not be current. That issue was not contemplated in this legislation, but if the Board begins to see this type of problem, it will be addressed in future legislation.

Senator Martin stated he perceives the intention is to make it easier for dentists to reinstate licenses but asked why the language was stricken to remove the Board's discretion. **Ms. Miller** answered the Board felt there was an inconsistency between the language setting forth the requirements and the section pertaining to Board discretion.

TESTIMONY: **Elizabeth Criner** introduced herself on behalf of the Idaho State Dental Association (ISDA). **Ms. Criner** stated the ISDA supports the bill and appreciated the opportunity to work with the Board on the legislation.

Senator Martin asked Ms. Criner her opinion of the effect of the bill. **Ms. Criner** replied the bill provides an opportunity for dentists who decide on early retirement to maintain licensure and have an opportunity to return to practice. The bill provides flexibility and appropriate oversight, and education requirements are a good way to move forward with that option.

MOTION: **Vice Chairman Souza** moved to send **S 1037** to the floor with a **do pass** recommendation. **Senator Anthon** seconded the motion. The motion carried by **voice vote.**

S 1038 **Relating to Dentists. Michael Kane** introduced himself to the Committee as General Counsel for the Board. **Mr. Kane** explained **S 1038** would give the Board specific authority to engage in emergency proceedings when there is an immediate danger to public health. **Mr. Kane** informed the Committee about a situation involving a dentist who allowed untrained dental assistants to administer intravenous anesthetics, write prescriptions for controlled substances on pre-signed prescription pads, and sedate a patient and drill and fill a tooth. When the Board learned of this situation, it began an emergency proceeding and asked the Attorney General's (AG's) Office for assistance. The day of the proceeding, the AG's Office advised the Board it did not have authority to conduct the emergency proceeding. **Mr. Kane** pointed out the Administrative Procedures Act (APA) provision that allows regulatory boards to conduct emergency proceedings, and the AG's Office said that section of the APA was inapplicable to the Board's emergency authority.

Mr. Kane said the AG's Office provided a lengthy opinion in support of its position (see Attachment 1). The legislation would authorize the Board to conduct an emergency proceeding in the same manner as the other medical boards and the Board of Veterinary Medicine. The proposed language is identical to that authorized by the Legislature for the Board of Veterinary Medicine. Although the Board is unlikely to encounter a similar situation for many years, it will allow the Board to issue a sort of temporary restraining order to hold things in place until a full hearing on the merits can be conducted.

Mr. Kane stated the fiscal note has been revised in accordance with Senate rules and there is no impact to the General Fund.

Senator Lee asked if this issue could be addressed across all boards and further inquired if there were any other sanctions that could be imposed on the dentist to stop the behavior. **Mr. Kane** responded this was the only sanction available to the Board. There are criminal sanctions available but the Board has no jurisdiction, and criminal proceedings can go on for a year or longer.

Senator Anthon said the AG's Office is not always correct, and he inquired what is authorized in subsection 6(b) of the bill that could not be done in subsection 6(a). **Mr. Kane** replied he was a former Deputy Attorney General and occasionally wrote opinions, and they are just opinions. In this situation, the AG's Office was also counseling the Board as to what they could and couldn't do. The Board's own attorney was telling the Board it couldn't conduct the emergency proceeding. Subsection 6(a) describes the Board's standard process of investigation, filing a complaint, pretrial fillings, and a hearing. This process can go on for one year or more, even to come to a stipulated resolution. It is very rare to try a case involving a dentist; 99 percent of the time the Board reaches an agreed-upon resolution such as a reprimand up to and including revocation of a license. The bill allows the Board to act on a temporary, emergency basis and conduct a quick hearing where the hearing officer will determine whether there is potential risk of immediate danger to the public health. The licensee can do almost anything to continue practicing but the Board can dictate certain

conditions of practice while the matter is fully adjudicated. Some cases go all the way to the Supreme Court and the regular process can be lengthy.

Senator Anthon stated he is still confused and reviewed the section of the Board's enabling legislation that says proceedings will be conducted in accordance with the APA, which specifically authorizes emergency proceedings. In his opinion, the bill adds language which further narrows the conditions under which an emergency proceeding can be conducted. **Mr. Kane** replied he agrees with the interpretation, and the Board has no desire to speed up the process for handling typical violations. The Board is stuck with the AG's interpretation of the APA.

Senator Anthon asked why there is no reference to judicial review in subsection 6(b) when subsection 6(a) provides for judicial review of actions taken under that subsection. **Mr. Kane** responded judicial review would apply under the APA. An emergency proceeding would allow the Board to tell a licensee to stop certain actions, and the Board would then conduct a full proceeding under subsection 6(a). As a matter of law under the APA, the licensee is always entitled to judicial review any time a licensee's substantive right is affected. There could be judicial review even while the slower proceeding is underway.

MOTION: **Senator Martin** moved to send **S 1038** to the floor with a **do pass** recommendation. **Senator Jordan** seconded the motion.

DISCUSSION: **Senator Anthon** commented Mr. Kane has done an excellent job and the Board has been restricted. The bill is not very well drafted and is unnecessary. **Senator Anthon** said he will not support the motion.

Senator Foreman stated he agrees with Senator Anthon. Mr. Kane has done a good job but the bill is a complete redundancy, and the Board already has the authority to do what it needs to do. **Senator Foreman** said he does not like to see new laws that repeat existing law.

Senator Lee mentioned she agrees letters of advice should not direct legislation. However, there is a precedent that has hampered the Board's ability to act on an egregious situation. The substance and spirit is to allow the Board to immediately sanction a licensee when necessary. It may not be perfect, but she will support the motion in the interest of public safety.

SUBSTITUTE MOTION 1: **Vice Chairman Souza** said she agrees with Senator Anthon's concern about the lack of judicial review in the new language. **Vice Chairman Souza** made a substitute motion that **S 1038** be held subject to the call of the Chair. **Senator Anthon** seconded the motion.

SUBSTITUTE MOTION 2: **Senator Lee** made an alternate substitute motion to send **S 1038** to the 14th Order for possible amendment. **Senator Jordan** seconded the motion.

Chairman Heider called for a vote on substitute motion 2 to send **S 1038** to the 14th Order for possible amendment. The motion failed by **voice vote.**

Senator Jordan stated she appreciates the intent of the substitute motion but her primary concern is the Board would be left without an option to fix the problem for quite a while. Other Board statutes address similar situations in the same way to protect public safety. **Chairman Heider** commented current law remains in place if there is no action taken. **Senator Jordan** said the existing statute does not accommodate this particular circumstance. **Chairman Heider** mentioned the current statute includes hearing provisions in subsection 6.

Senator Foreman said existing law does protect the public and the Committee should stand on existing law. He does not support the substitute motion.

Senator Lee mentioned there is precedent in other board statutes. The fact other boards have this language creates a vulnerability for the actions the Board was trying to take. The new language would give the Board the contemplated authority. Holding the bill in committee would create a lack of parity with other boards and might result in revisiting the issue next year.

Chairman Heider called for a roll call vote on substitute motion 1 to hold **S 1038** subject to the call of the Chair. **Vice Chairman Souza, Senators Harris and Anthon, and Chairman Heider** voted aye. **Senators Martin, Lee, Foreman, and Jordan** voted nay. The substitute motion failed on a tie vote.

Chairman Heider called for discussion on the original motion.

Vice Chairman Souza said the bill is well intended and her only concern is the lack of judicial review in the added language. Although Mr. Kane assured that would be covered and she understands the concerns about duplicating language, she will support the original motion.

SUBSTITUTE MOTION 3:

Senator Anthon commented the legislation would make it harder for the Board to exercise its emergency powers and asked if the Chair would entertain another substitute motion to send the bill to the amending order. **Senator Anthon** moved to send **R 1038** to the 14th Order for possible amendment. **Senator Harris** seconded the motion.

Senator Anthon said he was originally in favor of holding the bill but he understands the wishes of the Committee and thinks the next best option is the 14th Order.

Chairman Heider called for a roll call vote on substitute motion 3 to send **S 1038** to the 14th Order for possible amendment. **Vice Chairman Souza, Senators Lee, Harris, Anthon, Jordan, and Chairman Heider** voted aye. **Senators Martin and Foreman** voted nay. The substitute motion carried. No vote was taken on the original motion.

ADJOURNED:

There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:40 p.m.

Senator Heider
Chair

Jeanne Jackson-Heim
Secretary

RECEIVED SEP 19 2016

COPY

STATE OF IDAHO

OFFICE OF THE ATTORNEY GENERAL

LAWRENCE G. WASDEN

September 15, 2016

Susan Miller, Executive Director
Idaho Board of Dentistry
STATEHOUSE MAIL

Re: Authority of the Idaho Board of Dentistry to Issue Emergency Suspension Orders

Dear Ms. Miller:

The Board of Dentistry ("Board") asks whether Idaho Code section 67-5247, standing alone, constitutes a sufficient grant of legislative authority to allow it to conduct emergency suspension proceedings against a dentist licensed and regulated by the Board. Based on our review of this matter, it appears that the provisions of section 67-5247, standing alone, are procedural in nature and do not constitute a specific delegation of legislative authority to take summary action against the dentist. While we realize that the Board's disciplinary authority includes suspension of licenses, suspension orders entered in emergency or summary proceedings are, as explained below, a different issue and require a specific legislative delegation of authority to the individual board.

In arriving at this conclusion, we have reviewed the statutory language, as well as the Board's specific powers and duties, Idaho case law, and supporting authorities. A review of the powers and duties of other boards and agencies lends support for the position that when the legislature intends to grant the power to conduct emergency proceedings, it does so specifically, within the statute of the agency. Our conclusion that the APA does not constitute a grant of authority to conduct emergency proceedings is also supported by the rules of the Board itself, which specifically recognize that the board has the ability to conduct emergency proceedings in matters involving anesthesia licensing.

P.O. Box 83720, Boise, Idaho 83720-0010
Telephone: (208) 334-2400, FAX: (208) 854-8071
Located at 700 W. Jefferson Street, Suite 210

I.
EMERGENCY SUSPENSION OF PROFESSIONAL LICENSES

A. Idaho Code Section 67-5247

Codified with the Administrative Procedures Act, section 67-5247 reads as follows:

> 67-5247. Emergency proceedings. – (1) An agency may act through an emergency proceeding in a situation involving an immediate danger to the public health, safety, or welfare requiring immediate agency action. The agency shall take only such actions as are necessary to prevent or avoid the immediate danger that justifies the use of emergency contested cases.
>
> (2) The agency shall issue an order, including a brief, reasoned statement to justify both the decision that an immediate danger exists and the decision to take the specific action. When appropriate, the order shall include findings of fact and conclusions of law.
>
> (3) The agency shall give such notice as is reasonable to persons who are required to comply with the order. The order is effective when issued.
>
> (4) After issuing an order pursuant to this section, the agency shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.
>
> (5) Unless otherwise required by a provision of law, the agency record need not constitute the exclusive basis for agency action in emergency contested cases or for judicial review thereof.

Despite what might appear, this provision does not constitute a legislative delegation of authority intended to empower a board or agency to conduct emergency proceedings. On the contrary, this provision delineates the due process prerequisites which a duly authorized or empowered board or agency must include as part of its emergency proceedings. It details the procedural steps which must be taken to protect property rights of an individual against whom emergency action will be taken: it does not act as a separate authorization of power by which to take emergency actions.

B. Public Policy and Procedure Reflected in the APA

Idaho Code section 67-5247 is a statute found within the Idaho Administrative Procedures Act (APA). The APA is codified at title 67, chapter 52, Idaho Code. The APA is a comprehensive compilation of statutes enacted and amended by the Idaho Legislature in 1992 and 1993, respectively, to provide a uniform set of procedural laws, incorporating essential concepts of due process and fair play found in the federal and state constitutions and case law, to govern and guide the administrative decision-making

processes applicable to most state agency interaction with licensees, involved stakeholders, the general public and others.

In enacting the APA, one of the legislative goals was to strike an appropriate balance between the competing interests of public protection and rights or privileges granted individuals who have been issued professional licensees by state agencies. To that end, approximately half of the APA contains provisions regarding contested case proceedings and judicial review thereof. As used in the APA, "A proceeding by an agency, other than the public utilities commission or the industrial commission, that may result in the issuance of an order is a contested case and is governed by the provisions of [the APA], except as provided by other provisions of law."[1] As you know, the provisions of the APA and the Idaho Rules of Administrative Procedure of the

Attorney General ("IRAP"), apply to contested case disciplinary proceedings conducted by the Board.[2]

While due process may be a somewhat flexible principle mandating different requirements depending on the unique circumstances of a particular case, at the very essence or heart of due process are the concepts of notice and opportunity to be heard. In an ordinary or "typical" contested case proceeding against a licensee, the subject of the proceeding is entitled to receive clear notice of (1) the charges, (2) the authority of the agency to commence and prosecute the action, (3) the date and place of an evidentiary hearing on the violations, (4) the right to legal representation, and (5) other essential rights.[3] In addition, and significantly, Idaho Code section 67-5254 states that "an agency shall not revoke, suspend, modify, annul, withdraw or amend a license, or refuse to renew a license of a continuing nature . . ., unless the agency first gives notice and opportunity for an appropriate contested case in accordance with the provisions [of the APA] or other statue."[4] In other words, notice and opportunity for hearing is the norm or general rule and must ordinarily precede agency adverse action against a license.

The reason for these protections is obvious. Absent notice and pre-deprivation opportunity to be heard, the licensee is deprived of a substantial right or privilege without any process. Without an opportunity to contest the allegations and put on evidence refuting the need for an emergency suspension, the livelihood of the licensee will be taken away; as well as the livelihood of employees or others whose paycheck directly depends on the continued viability of the licensee's ability to practice his or her profession. The risk of irreparable harm to the licensee's reputation and financial interest is simply too great to warrant departure from the norm except in the most extreme of cases.

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[1] Idaho Code § 67-5240. Cf. definition of "contested case" found at Idaho Code § 67-5201(6).
[2] Idaho Code § 54-912(6) and (7); IDAPA 19.01.01.003 (Board of Dentistry administrative rules).
[3] *See generally*, Idaho Code § 67-5242.
[4] Idaho Code § 67-5254(1).

While pre-suspension notice and hearing is the general rule, section 67-5254 continues by saying: "This section does not preclude any agency from: (a) taking immediate action to protect the public interest in accordance with section 67-5247, Idaho Code . . . ."[5] Thus, the APA recognizes the need for deviation from the normal procedure requiring pre-deprivation notice when the test for emergency action is met. But these provisions don't necessarily answer the question of authority raised in your correspondence.

C. Idaho Case Law Discussing Emergency Suspensions

Because emergency action is so unusual and is reserved for the rarest of cases where public health, safety or welfare is in imminent danger and ordinary due process protections are insufficient to prevent the immediate injury, there is a dearth of reported Idaho case law on the subject. Indeed, only two reported cases were located in the author's research.

In Van Orden v. State Dep't of Health & Welfare, 102 Idaho 663, 637 P.2d 1159 (1981), the Department of Health and Welfare ("Department") had issued a provisional license to the Van Ordens authorizing them to operate a shelter home, pending review of the Van Ordens' application for a full license. When concerns arose regarding the Van Ordens' qualifications for a full license, the Department first notified the Van Ordens that the provisional license would be extended through the completion of a hearing on the allegations, but then on October 12, 1977 and prior to the scheduled hearing, notified the Van Ordens that the provisional license was suspended effective October 17 and that a post suspension hearing was scheduled for October 21.[6] Following a November 1997 hearing, the Department adopted the hearing officer's written opinion that, among other things, the summary suspension of the provisional license was based upon an emergency endangering the safety of residents of the facility and that under these circumstances the prehearing suspension satisfied due process requirements. On appeal, the district court reversed the Department's order.[7] Upon further appeal, the Idaho Supreme Court reversed the district court and reinstated the Department's order.

In ruling for the Department, the Supreme Court commented:

> Following an abortive judicial proceeding, the provisional license was in effect revived since the parties stipulated that the center would continue to operate pending a hearing on a suspension of the provisional license and action on the full license.

* * *

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[5] Idaho Code § 67-5254(3)(a).
[6] 102 Idaho at 664, 637 P.2d at 1160.
[7] *Id.* at 665, 637 P.2d at 1161.

> The interest involved here is the pursuit of a business enterprise dependent upon state licensure and the stability of that business would obviously be harmed if the facility were closed pending a review. In the case at bar, however, there could be no such effect since the provisional license was extended through the date set for the application hearing. Thus, there was no actual deprivation on September 14 and thus, no value in additional or substitute safeguards.[8]

These comments from the Court indicate that no actual emergency suspension had taken place; therefore it was not directly at issue. Notwithstanding this fact, the Court went on to say that assuming for argument's sake that there had been an actual emergency suspension there would be no constitutional violation given the substantial health and safety factors at issue. In so ruling, the Court cited the summary suspension provisions of the APA and the following language found in Section 2-4003-12, a Department administrative rule applicable to shelter homes:

> Emergency Action by Director. In the event of an emergency endangering the life or safety of a resident, the Director may summarily suspend or revoke any shelter home license. As soon thereafter as practicable, the Director shall provide an opportunity for a hearing.[9]

Because there had been no actual emergency suspension in effect in Van Orden and because the Department of Health and Welfare had a separate rule authorizing it to take summary action against a license, the Van Orden case is of little if any help in resolving the question of whether Idaho Code section 67-5247, standing alone, grants an administrative agency the authority to initiate an emergency suspension proceeding.

Turning then to the second and final Idaho reported case discussing section 67-5247, in Kuna Boxing Club, Inc. v. Idaho Lottery Com'n, 149 Idaho 94, 233 P.2d 25 (2009), the Idaho Lottery Commission ("Commission") did indeed summarily suspend Kuna Boxing's bingo license without a hearing pursuant to the emergency provisions of section 67-5247.

In reviewing the suspension, the Idaho Supreme Court stated: "Idaho Code § 67-5247(1) governs an agency's power to act through an emergency proceeding . . . ." While it might be argued that this judicial comment might be dispositive of the issue presented, a careful review of the case reveals that whether or not section 67-5247 granted an agency authority to enter an emergency suspension order was not at issue and was not raised by Kuna Boxing. As to the emergency suspension, Kuna Boxing raised only two issues on appeal: "(1) whether the Commission complied with statutory requirements under the APA when it suspended Kuna Boxing's bingo license; and (2) whether the Commission violated Kuna Boxing's right to procedural due process when it

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[8] 102 Idaho at 665-666; 637 P.2d at 1161-1162.
[9] *Id.* at 666, 627 P.2d at 1162.

suspended Kuna Boxing's bingo license."[10] Kuna Boxing argued that there was no danger to the public health, safety or welfare justifying an emergency suspension and that the Commission failed to follow statutory procedures following the suspension. Kuna Boxing did not challenge the Commission's authority to take emergency action under section 67-5247 and, lacking a direct challenge to the statute, the Idaho Supreme Court merely assumed, without deciding, that the statute "governs an agency's power to act through an emergency proceeding." In effect, this was dicta by the Court.

Unfortunately, neither Kuna Boxing nor Van Orden answer the question presented in your letter.

D. Comments from Recognized Experts in Administrative Law and Procedure

As mentioned earlier, the APA was enacted effective July 1, 1993. Two of the main participants on the Attorney General's task force that prepared a draft of the APA for use by the legislative interim committee and the full legislature were Professor Dale D. Goble of the University of Idaho College of Law and Deputy Attorney General Michael S. Gilmore. It is fair
to say that Professor Goble and DAG Gilmore are recognized and respected experts in administrative law and procedure and were in no small part instrumental in the enactment of the APA and the interpretation and application of its various provisions.

Professor Goble and DAG Gilmore jointly authored an article entitled "The Idaho Administrative Procedure Act: A Primer For The Practitioner" that was published at 30 Idaho L. Rev. 273 (1993/1994, Idaho Administrative Procedure Act Special Edition). In their introductory remarks to this comprehensive work, the authors set the stage for the proper interpretation and application of the APA by noting:

> While an administrative procedure act functions like a constitution in limiting agency discretion, it differs from a constitution because it confers no substantive authority. The new Idaho Administrative Procedure Act (APA) merely prescribes limits on the exercise of authority delegated to an agency by another statute.[11]

Later in their work Professor Goble and DAG Gilmore make specific comments regarding the emergency action provisions codified at Idaho Code section 67-5247. The authors stated:

> [T]he APA specifies procedures to be employed in emergency proceedings when the agency may issue an order to address a "situation involving an immediate danger to the public health, safety, or welfare requiring immediate agency action."

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[10] 149 Idaho at 98, 233 P.2d at 29.
[11] 30 Idaho L. Rev. at 277.

* * *

> It has long been recognized that the government possesses the power to act summarily when there is an immediate danger to the public health, safety, or welfare. For example, the director of the Department of Water Resources is empowered to issue an order requiring a cessation of activities that "involve an unreasonable risk of...damage to life or property or subsurface, surface, or atmospheric resources" from the construction or operation of a geothermal or injection well. Quarantines and seizures of adulterated foods are other common examples of this power. The APA provides the procedures that an agency is to employ when it exercises emergency powers over an individual or an individual's property.

* * *

> The protections accorded licensees are subject to two explicit limitations. First an agency may take immediate action against a licensee if the agency is authorized to exercise emergency powers...."[12]

These remarks by Professor Goble and DAG Gilmore make it clear that the APA merely provides the procedure for agency action. The APA "confers no substantive authority." The substantive authority must be found in other provisions of law, such as specific agency statutes or rules. This includes authority to involve emergency suspension proceedings. To emphasize the point, the authors state: "[A]n agency may take immediate action against a licensee <u>if the agency is authorized to exercise emergency powers</u>." (Emphasis added.) Obviously, if the APA itself granted or authorized the power for emergency suspensions, there would be no need for this qualifying statement. The only purpose for the statement must be to emphasize that the authority must come from another source.

Finally, to assist deputy attorney generals, and by extension clients, in interpreting and applying the newly enacted APA and the "Idaho Attorney General's Model Rules of Practice and Procedure," codified at IDAPA 04.11.01., then Attorney General Larry Echohawk commissioned the publication of a booklet containing the APA and rule provisions, along with accompanying comments.[13] The comments regarding the APA statutes were written by Professor Goble. In discussing the emergency proceedings provisions of the APA, Professor Goble wrote:

> The Administrative Procedure Act does not authorize an agency to exercise emergency powers; the power to take such actions must be based

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[12] *Id.* at 331-332. Footnotes by Professor Goble and DAG Gilmore that include citations to Idaho Code have been omitted here.

[13] Printed by The Caxton Printers, Ltd., Caldwell, Idaho (effective July 1, 1993).

> upon another statute....Section 67-5248 [now 67-5247] merely specifies the procedures that an agency must follow to exercise such power.[14]

Taken together, these comments from recognized experts in Idaho administrative law and procedure leave little doubt that state agencies, including the Board of Dentistry, cannot rely solely upon the APA as the source of authority for issuing emergency suspension orders. The source must come from Board statutes or rules. A review of some state agencies that have enacted just such authority is instructive.

E. Examples of Idaho Professional Licensing Board Statutes and Rules Expressly Authorizing Emergency Proceedings[15]

Clearly not all Idaho state agencies even have the need to issue emergency proceedings. Most agencies, even most licensing agencies, would not encounter a situation where imminent danger to the public exists necessitating immediate agency action to avoid or mitigate the danger.

The Board of Dentistry is clearly within anyone's list of agencies that should have the authority to commence emergency proceedings. Several other agencies on the list have apparently recognized that the APA is not the source of such authority, and, therefore, have seen fit to have legislation or rules enacted to expressly grant them authority to commence such proceedings. A cursory review of Idaho statutory and regulatory law yields the following:

--Board of Pharmacy: "The board may suspend, without an order to show cause, any [controlled substances] registration simultaneously with the institution of proceedings under section 37-2718, Idaho Code, or where renewal of registration is refused, if it finds that there is an imminent danger to the public health or safety which warrants this action."[16]

--Board of Veterinary Medicine: "Whenever it appears that grounds for discipline exist under this chapter and the board finds that there is an immediate danger to the public health, safety or welfare, the board is authorized to commence emergency proceedings for revocation or other action. Such proceedings shall be promptly instituted and processed under the applicable provisions of chapter 52, title 67, Idaho Code."[17]

--Board of Nursing: "If the Board finds that public health, safety, and welfare requires emergency action and incorporates a finding to that effect in its order, summary suspension of a license may be ordered pending proceedings for revocation or other

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[14] Booklet, p. 32.
[15] The examples given do not purport to be an exhaustive list. There may be other state agencies with particular statutes or rules regarding emergency proceedings.
[16] Idaho Code § 37-2719(b).
[17] Idaho Code § 54-2105(8)(c).

action. Such proceedings shall be promptly instituted and determined as authorized in Title 67, Chapter 52, Idaho Code."[18]

--Department of Environmental Quality: "If the Director finds the public health, safety or welfare requires emergency action, the Director shall incorporate findings in support of such action in a written notice of emergency revocation issued to the permittee. Emergency revocation shall be effective upon receipt by the permittee . . . ."[19]

--Department of Health and Welfare (Home Health Agencies): "If the Department finds the public health, safety, or welfare imperatively requires emergency action, a license may be summarily suspended pending proceedings for revocation or other action."[20]

--Department of Health and Welfare (Residential Habitation Agencies): "When the Department finds the public health, safety, or welfare imperatively requires emergency action, a certificate may be summarily suspending pending proceedings for revocation or other action."[21]

--Department of Health and Welfare (Radiation Control Rules): "If the Radiation Control Program Director finds the public health, safety or welfare requires emergency action, the Director will incorporate findings in support of such action in a written notice of emergency revocation issued to the licensee . . . ."[22]

Of perhaps most particular interest and applicability to the Board of Dentistry and thus the question being analyzed is one of the Board's own rules codified at IDAPA 19.01.01.064. This rule states:

> The Board may, at any time and for just cause, institute proceedings to revoke, suspend, or otherwise restrict an anesthesia a [sic] permit issued pursuant to Sections 060 and 061 of these rules. If the Board determines that emergency action is necessary to protect the public, summary suspension may be ordered pending further proceedings . . . .

While I can only speculate as to the reason the Board enacted this emergency suspension authorization for anesthesia permits but did not do likewise for general licenses, the rule supports the conclusion that the Board recognizes that something more than Idaho Code section 67-5247 is needed to authorize emergency suspension proceedings.

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[18] IDAPA 23.01.01.134.
[19] IDAPA 58.01.17.920.03.
[20] IDAPA 16.03.07.003.06.e.
[21] IDAPA 16.04.17.100.04.g.
[22] IDAPA 16.02.27.053.08.

II.
INTERPRETATION AND CONCLUSION

The provisions of the Idaho Administrative Procedures Act are applicable to the Board of Dentistry. The APA establishes the general procedural framework within which contested case proceedings must be conducted. This framework specifies that agency action must ordinarily be preceded by notice and an opportunity to be heard. Under Idaho Code section 67-5247 there is, however, a very narrow exception to this general rule when the statutory test for emergency proceedings is met and the agency has been granted specific emergency action authority under its Practice Act or administrative rules.

Although the Board has seen fit to promulgate a rule authorizing it to take emergency action against an anesthesia permit, it has not done so as to licenses in general. Interpreting and applying the pertinent APA provisions in light of the authorities discussed in this letter leads to the conclusion that section 67-5247, standing alone, is insufficient for the Board to summarily suspend a dentist's license. Since the Board's statutes and rules do not independently provide that authority, the conclusion must be that the authority does not currently exist and the Board is not empowered to enter an emergency suspension order against a dentist's license.

Thank you for contacting the Attorney General's Office with this important issue. If you have any further questions or concerns that you wish to discuss, please do not hesitate to contact me at 334-4111.

Sincerely,

BRIAN KANE
Assistant Chief Deputy

BPK/tjn

AMENDED AGENDA #1

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Thursday, February 09, 2017

SUBJECT	DESCRIPTION	PRESENTER
Docket No. 16-0202-1601	Rules of the Idaho Emergency Medical Services (EMS) Physician Commission	Dr. Curtis Sandy, Commission Chair
RS24921	Relating to the Immunization Assessment Board	Senator Martin
RS25106	Relating to Tobacco	Senator Martin
RS25180	Relating to Health Care	Senator Thayn
H 10	Relating to Chiropractors	Mitch Toryanski, Idaho Bureau of Occupational Licenses

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, February 09, 2017

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Agenbroad, Foreman, and Jordan

ABSENT/ EXCUSED: Senator Anthon

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.

RS 25180 **Relating to Health Care. Senator Thayn** was recognized to present **RS 25180. Senator Thayne** informed the Committee the Health Care Alternatives for Citizens Below 100 Percent of Poverty Level Task Force (Task Force) met last year and recommended a State-funded program with a primary care component. The Task Force suggested using the Millennium Fund as a funding source. The legislation would provide funding for up to $600 per year in primary health care costs for people in the coverage gap by establishing a Community Primary Care Program (CPCP), including a life coaching component to move people out of poverty as soon as possible.

Senator Thayn explained the new program would be under the auspices of the Catastrophic Health Care Cost Program (CAT Fund). The bill sets forth qualifications for the CPCP as well as the application process, the requirement for orientation, and a definition for "direct primary care." The bill also provides for additional compensation for working with a participant on a personal improvement plan (PIP) to assist participants with other kinds of needs in addition to health needs. A participant would be required to reapply every year with a three-year lifetime limit for participation and could stay in the CPCP if income increases up to 250 percent of the federal poverty limit. Criteria are established in the bill for terminating and enrolling participants, and funding. The bill establishes powers and duties for administration of the CPCP by the CAT Fund Board and contains a sunset clause.

Senator Jordan stated she is a member of the CAT Fund Board and the CAT Fund has a very small staff. She questioned what the CAT Fund Board would need to administer the new program and how it would work. **Senator Thayn** answered the CAT Fund would need more staff, and he estimated an additional $600,000 for administrative costs in the fiscal note. **Senator Jordan** inquired whether the CAT Fund is aware of the proposal and if the CAT Fund has given input on this proposal. **Senator Thayn** replied he has spoken to the counties and Kathryn Mooney at the CAT Fund. Ms. Mooney has been providing ideas how the plan could work if the legislation passes.

Vice Chairman Souza asked if the $600 per year limit would be limited to $150 per quarter, or if the entire amount could be expended in the first quarter if a patient had a serious need. **Senator Thayn** answered the limit was $150 per quarter.

Vice Chairman Souza referred to page 5, line 41 of the bill that provides a patient can remain in the CPCP for one year unless the participant refuses to adhere to prescribed or recommended treatment and asked who would make that determination. **Senator Thayn** confirmed it would be the primary care provider.

Senator Agenbroad inquired whether the use of the word "same" in the last line of the fiscal note was intentional as it could make a difference. **Senator Thayn** responded it was a typographical error and should be "some."

Senator Martin asked if Senator Thayn has been in contact with the co-chairs of the Millennium Fund about the legislation. **Senator Thayn** replied he has not specifically contacted the co-chairs but he has proceeded based on the recommendation of the Task Force. He believes the funding is available.

MOTION: **Senator Harris** moved to send **RS 25180** to print. **Senator Martin** seconded the motion.

DISCUSSION: **Senator Lee** commented all options to address expanded health care should be looked at, and she looks forward to reviewing this innovative proposal and any others that might come forward.

There being no more discussion, **Chairman Heider** called for the vote. The motion carried by **voice vote.**

PASSED THE GAVEL: Chairman Heider passed the gavel to Vice Chairman Souza to conduct the rules review.

DOCKET NO. 16-0202-1601 **Rules of the Idaho Emergency Medical Services (EMS) Physician Commission.** **Dr. Curtis Sandy,** introduced himself as an emergency medicine physician at Portneuf Medical Center in Pocatello, and he serves as the Commission Chair. **Dr. Sandy** informed the Committee the EMS Physician Commission (Commission) was formed by the passage of H 858 (2006). The Commission is composed of 11 voting members appointed by the Governor, representing a variety of stakeholder groups and geographic areas. The purpose of the Commission is to establish standards for the scope of practice and medical supervision for licensed EMS personnel and organizations.

Dr. Sandy pointed out the rule's "incorporation by reference" section updates the version of the Standards Manual, maintained by the Commission. The Standards Manual describes the skills, treatments, and procedures that licensed EMS personnel may perform, and the Commission refines the Standards Manual to reflect current best practices in EMS. Dr. Sandy provided a summary of the changes made to the 2017-1 Standards Manual (see Attachment 1). Most of the changes are merely housekeeping issues, but the Commission also added language regarding airway management practices, including mandatory use of continuous end tidal carbon dioxide monitors and a quality review by the agency medical director. The Commission added appendices for ventilator management and critical care transport guidelines. Other changes were made to align the Commission's Standards Manual with the EMS Bureau's rules.

Vice Chairman Souza remarked she did not see anything significant on the list of changes and inquired whether the change was on the order of an equipment list. **Dr. Sandy** responded the Commission has requirements for things like airway management and requires specific equipment to be used. The end tidal carbon dioxide monitor is now mandatory for all patients who are intubated in the pre-hospital environment. **Vice Chairman Souza** asked for confirmation that the list includes the most significant changes and there were no policy changes in the updates to the Standards Manual. **Dr. Sandy** confirmed that is the case.

MOTION: **Senator Foreman** moved to approve **Docket 16-0202-1601**. **Chairman Heider** seconded the motion. The motion carried by **voice vote.**

PASSED THE GAVEL: Vice Chairman Souza passed the gavel back to Chairman Heider.

RS 24921 **Relating to the Immunization Assessment Board. Senator Martin** introduced himself to present **RS 24921**. **Senator Martin** explained the legislation changes the sunset date of the Idaho Immunization Assessment Program from 2017 to 2019. **Senator Martin** said he is a member of the Idaho Immunization Assessment Board (Board), and the legislation is co-sponsored by Representative Thompson, who also serves on the Board. The Board was established by H 432 (2010) and became effective February 1, 2010 to decrease the cost, availability, and maintenance of prescriptive items. The Board's immunization program is administered by the Idaho Department of Health and Welfare (Department), and the Department purchases childhood vaccines from the Centers for Disease Control and Prevention at a significant discount. The vaccines are then made available to Idaho professional caregivers through the Department. In the past, vaccines had to be purchased from multiple sources. Health care providers had to keep track of what source a vaccine was bought from and maintain different inventory controls for various items. Costs of vaccines are passed on to the insurers who in turn pass on the costs to insurance providers and then to Idaho citizens. The immunization program has reduced costs.

Senator Foreman moved to send **RS 24921** to print. **Senator Lee** seconded the motion. The motion carried by **voice vote.**

RS 25106 **Relating to Tobacco.**

MOTION: **Senator Martin** asked for unanimous consent to return **RS 25106** to the sponsor. There were no objections.

H 10 **Relating to Chiropractors. Mitch Toryanski** introduced himself to the Committee as legal counsel to the Idaho Board of Occupational Licenses on behalf of the State Board of Chiropractic Physicians (BCP). **Mr. Toryanski** introduced Dr. Herbert Oliver, a chiropractor and BCP member who was also present, and mentioned the BCP public member is former Senator Chuck Coiner from Hansen. **Mr. Toryanski** explained **H 10** is a clean-up bill to consolidate fee provisions into one section. The bill also raises fee caps and modernizes language governing the deposit and expenditure of fees. The legislation clarifies the process for granting and reactivating inactive licenses and deletes archaic language concerning the review of license applications and personal interviews. There is no impact to the General Fund or the BCP dedicated fund.

Mr. Toryanski informed the Committee the changes contained in the bill were approved by the BCP in an open meeting noticed to the public. The BCP mailed 722 notices to licensed chiropractors and received no comments.

Senator Foreman asked how much the fee caps were raised on average. **Mr. Toryanski** answered the caps are currently set at $150. The fees will be bumping up against the caps and without the increase in the caps, the BCP would be required to undertake a two-step process to request a future fee increase.

Senator Martin referred to page 2 of the bill and stated he was confused about the strike-outs through the fee amounts when there is subsequent language stating the applicant must submit a fee set by board rules. Similar language appears for another license type. **Senator Martin** asked whether the bill would authorize the BCP to set fees of its choice. **Mr. Toryanski** explained the fee amounts are set in rule. The fee caps were reorganized in the bill to be consolidated in Idaho Code § 54-707(a). The fee caps would be stricken from page 2 and moved to page 1. In addition, the fee caps would be raised from $150 to $250.

Senator Lee referred to page 2, line 35, where language is proposed to be deleted, and inquired whether there is some other provision for notification to let an applicant know of a license denial and the reason. **Mr. Toryanski** answered the BCP typically provides notices by U.S. Mail. This change will allow the BCP to save money by eliminating the requirement for certified mail. Almost none of the boards use certified mail any longer, and the bill brings the chiropractors in line with the other boards. **Senator Lee** further inquired why the paragraph was not simply changed to say regular mail and commented she would like the legislation to provide for notice to an applicant about a license denial. **Mr. Toryanski** responded that he is unaware of language requiring any of the boards to notify the applicant in a specific manner. He assured Senator Lee notice of denial is given by the BCP.

Senator Lee asked about the appeal process for an applicant who was denied a license and who feels the action was arbitrary and capricious. **Mr. Toryanski** replied the BCP's actions are controlled by the Administrative Procedures Act (APA), which affords anyone who is the subject of a negative action the right to appeal that action first to the BCP and then to district court.

Senator Martin commented it appears all fees have been raised and asked when the fees were originally set and how long it has been since they have been changed. **Mr. Toryanski** answered most of the fees were last raised in 1993 and many of the caps were raised in 2003.

Vice Chairman Souza asked for clarification about the dates as they relate to Mr. Toryanski's earlier statement that fees were pushing up against the fee caps. She inquired how the fees could be pushing up against the caps if the caps were just raised in 2003. **Mr. Toryanski** replied the BCP presented a rule change this year to increase fees, and the fees will be raised at the conclusion of the legislative session. That forthcoming increase will put the fees up against the current caps.

MOTION: **Senator Lee** moved to send **H 10** to the floor with a **do pass** recommendation. **Senator Jordan** seconded the motion. The motion carried by **voice vote.**

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 3:33 p.m.

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Senator Heider
Chair

_____

Jeanne Jackson-Heim
Secretary

Summary of Changes
EMS Physician Commission Standards Manual
2016-1 to 2017-1

Updated IDAPA reference (pages 4-5)

III. EMS PERSONNEL AUTHORITY TO ACT

Licensed EMS personnel who are representing an Idaho EMS agency and who possess a valid credential issued by that agency's EMS medical director may act and provide services in the out-of-hospital setting under the following conditions:

1. When participating in a planned deployment or agency sanctioned standby of personnel resources approved by the EMS medical director; or

Licensed EMS personnel who are representing a hospital or medical clinic and who possess a valid credential issued by the hospital or medical clinic supervising physician may act and provide services in the hospital and medical clinic setting under the following conditions:

1. When participating in a planned deployment or agency sanctioned standby of personnel resources approved by the hospital or medical clinic supervising physician; or

Effective date of new standards manual and scope of practice (page 14): July 1, 2017

Appendix A Changes:

- Item numbering updated
- EMR/FR95
  - Scope of practice removed
- EMR – 2011
- EMT/EMTB94
  - Scope of practice removed
- EMT - 2011
  - Aerosolized (MDI) added to scope of practice (line 88)
  - Nebulized (SVN) added to scope of practice (line 104)
  - Inhaled Beta Agonist changed from X** to X**2, OM (line 138)
  - Inhaled Beta Agonist (SVN) X** to X**2, OM (line 139)

Appendix B Changes:

- "Video Laryngoscopes" added under available options for Laryngoscope blades
- "must use quantitative or wave form for continuous end tidal" added under Requirements for Tube Placement
- "All intubations, including RSI, must be reviewed by the Medical Director." Added under PCR Documentation

Appendix C Changes:

- "Video Laryngoscopes" added under available options for Laryngoscope blades
- "must use quantitative or wave form for continuous end tidal" added under Requirements for Tube Placement
- "All intubations, including RSI, must be reviewed by the Medical Director." Added under PCR Documentation

Appendix C Changes:

- "Cuffed sizes = 3.5mm – 8.0mm" and "Uncuffed Size = 2.5mm" added under available options for Selection of tube size (page 38)

New Appendices:

- EMSPC Ventilator Standards "Appendix E"
- EMSPC Critical Care Transport Guidelines "Appendix D"

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Tuesday, February 14, 2017

SUBJECT	DESCRIPTION	PRESENTER
Approval of Minutes	Minutes of the January 27, 2017 Meeting Minutes of the January 30, 2017 Meeting Minutes of the January 31, 2017 Meeting Minutes of the February 1, 2017 Meeting Minutes of the February 6, 2017 Meeting Minutes of the February 7, 2017 Meeting	Senator Lee Senator Souza Senator Foreman Senator Martin Senator Anthon Senator Harris
Presentation	Idaho Council on Suicide Prevention	Dr. Linda Hatzenbuehler, Chair
	Department of Health & Welfare Suicide Prevention Program	Elke Shaw-Tulloch, Administrator, Division of Public Health Kim Kane, Program Manager
	Idaho Suicide Prevention Coalition	Nate Fisher, Executive Director

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, February 14, 2017

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Agenbroad, Foreman, and Jordan

ABSENT/ EXCUSED: Senator Anthon

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.

APPROVAL OF MINUTES: **Vice Chairman Souza** moved to approve the Minutes of January 30, 2017. **Senator Foreman** seconded the motion. The motion carried by **voice vote.**

Senator Foreman moved to approve the Minutes of January 31, 2017. **Senator Martin** seconded the motion. The motion carried by **voice vote.**

Senator Martin moved to approve the Minutes of February 1, 2017. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**

Senator Harris moved to approve the Minutes of February 7, 2017. **Senator Jordan** seconded the motion. The motion carried by **voice vote.**

Chairman Heider noted the Minutes of January 27, 2017 and February 6, 2017 will be held until the following day.

PRESENTATION: **Idaho Council on Suicide Prevention. Dr. Linda Hatzenbuehler** introduced herself to the Committee as a psychologist from Pocatello and Chair of the Idaho Council on Suicide Prevention (Council). **Dr. Hatzenbuehler** provided background on the establishment of the Council in 2006. The three tasks of the Council are to: 1.) oversee the implementation of the Idaho Suicide Prevention Plan (SPP); 2.) ensure the continued relevance of the SPP; and 3.) report annually to the Governor and the Legislature (see Attachment 1).

Dr. Hatzenbuehler stated 2015 was a landmark year for suicide prevention. Approximately one person per day died by suicide in Idaho in 2015. For the period 2011 to 2015, there were 102 school-aged deaths by suicide, and 24 deaths for the age group 14 and under. In 2016, a report was published covering 50 years of research on the risk factors associated with the prevention of death by suicide. The study revealed psychologists know the risk factors for suicide and can intervene but there is no way to predict the actual act of suicide. Thus, prevention is of paramount importance.

Dr. Hatzenbuehler informed the Committee many Idaho organizations are interested in working on this public health issue. The Council is directly under the Governor's office, and Council membership is comprised of parts of other organizations to bring the groups together. Many of the organizations are advocacy groups whose specific mission is to work toward preventing death by suicide, and the groups include members whose lives have been touched by suicide.

Dr. Hatzenbuehler reported the key factors associated with prevention of death by suicide are articulated in the SPP. She said Idaho is making progress and moving in the right direction. Having a hotline available is one of the key components to prevention. The suicide hotline is now available 24 hours a day, seven days a week and has additional capabilities. Another key component is having an organized State program responsible for suicide prevention activities. In 2015, the Legislature charged the Health Quality Planning Commission (HQPC) with developing an implementation plan to move Idaho further along in suicide prevention. The HQPC made recommendations, and as a result the Legislature appropriated nearly $1 million dollars in 2016 toward prevention of death by suicide.

Dr. Hatzenbuehler thanked the Committee for its support of the appropriation. She recognized Elke Shaw-Tulloch and Kim Kane for their fine work to establish and staff the program very quickly after the appropriated funds were available on July 1, 2016 and asked Ms. Shaw-Tulloch to continue the presentation.

PRESENTATION: **Elke Shaw-Tulloch** introduced herself to the Committee as the Administrator of the Division of Public Health for the Department of Health and Welfare (Department). In 2016, the Department received an ongoing appropriation for approximately $971,000 toward suicide prevention efforts. **Ms. Shaw-Tulloch** thanked the HQPC and the Idaho Suicide Prevention Coalition (Coalition) for their support and assistance.

Ms. Shaw-Tulloch reported the number of deaths by suicide showed a 15 percent increase in 2015 from the previous year. The Suicide Prevention Program (Program) mission is to develop, implement, and support statewide programs to prevent suicide in Idaho in alignment with the SPP. The Program has four full-time equivalent positions and has been working at full speed to get up and running to promote best practices and coordinate a collaborative approach with its partners.

Kim Kane introduced herself as Program Director for the Suicide Prevention Program. **Ms. Kane** provided information on the risk factors for suicide and presented a model from Dr. Thomas Joiner, who is an expert in suicide. Dr. Joiner runs a clinic for the highly suicidal at Florida State University. His theory is becoming the gold standard for understanding the suicidal mind, and the theory has been vetted by almost 50 studies. Dr. Joiner's model only applies to people who actually die by suicide, and suicide is statistically rare. As an example, data on Idaho high school students shows one in ten students reports making a suicide attempt in a one-year period. However, only one in every 6,000 to 7,000 students are actually lost to suicide in one year.

Ms. Kane explained Dr. Joiner's theory provides three things that must be in place for those who actually die by suicide. People who are at a high level of suicidality are not in a rational state of mind. A person must desire to commit suicide, and the person must be capable of going through with the act. First, a person considering suicide perceives himself as a burden to those around him. The word "perceived" is important because the people around the suicidal person do not consider the person to be a burden. Those who die by suicide believe wrongly their death is worth more than their life. The suicidal brain is a very dark and narrow-thinking brain. Thus, it is a myth to consider suicide as a selfish act because the person thinks he is doing others a favor.

Ms. Kane stated the second condition that must be present is called "thwarted belongingness." The person has come to feel disconnected from others, even though the person appears to be surrounded by supportive friends and family. In the person's irrational thinking, he feels people don't truly understand him and begins to isolate himself. When a person feels himself to be a burden and disconnected from others and feels those situations won't change, that condition is hopelessness which can lead to the desire for suicide. Not everyone who feels hopeless is lost to suicide, because the third component must also exist.

Ms. Kane advised the third component is capability. A person is not born with the ability to harm himself, but a person must become used to the idea of self harm. Those who die by suicide have gotten used to the idea of physical pain, injury, and death, and have developed a fearlessness about physical pain, injury, and death. Certain groups of people have higher rates of suicide, including: law enforcement; doctors; military; prostitutes; veterinarians; and dentists. One habituates to the idea of physical pain by either experiencing or witnessing physical pain, injury, and death.

Ms. Kane informed the Committee that only when these three factors overlap is there a death by suicide. Other risk factors like drug or alcohol abuse, hopelessness, family history, and so forth are called "distal factors" by researchers. Risk factors are only important when warning signs for suicide appear, like self-isolating, giving away prized possessions, and talking about or threatening suicide. Even someone with many risk factors will have protective factors and resilience. The opposite of thwarted belonging is feeling connected; and the opposite of perceived burdensomeness is feeling capable, effective, and productive as a person.

Ms. Kane commented the Program was funded to maintain the suicide hotline and support upstream youth suicide prevention efforts. Suicide prevention experts recently reviewed gatekeeper training, which trains people to look for warning signs and how to help people. Gatekeeper training has not resulted in a decrease in youth suicide because programs need to work to prevent young people from becoming suicidal to begin with, instead of waiting until there are warning signs. For example, Sources of Strength is a program to foster hope, health, strength, and resiliency in young people instead of telling at-risk youth they are at risk.

Ms. Kane advised some of the Program's accomplishments include setting up and staffing the entire Program and providing money for the suicide hotline (see Attachment 2). The hotline has added a "208" number to allow people to text the hotline between the hours of 3:00 p.m. to midnight. The "800" number is available 24 hours a day, seven days a week. The Program also provided funding for youth training in the schools and researched ideas for a public awareness campaign. Program staff is currently reviewing the marketing plan for the public awareness campaign and hopes to launch it in late spring. The Program also provided support to the Council, including helping compile and print the annual Program report and interim update to the SPP.

Ms. Kane said the Program convened stakeholder meetings focusing on a "zero suicide" initiative which has been proven to reduce suicide rates. In October 2016, a young man planned to jump from a downtown parking garage and then decided not to jump. The Program began an informal investigation of downtown Boise parking structures to find if they were an actual destination for death by suicide. One building was the site of more health checks and more calls than any other structure. The Program made recommendations to the organization in charge of the structure, and four recommendations are currently being implemented. Representative Caroline Troy put together a new task force to look at lethal means.

Senator Martin asked if there was any work being done to get a three- or four-digit number for the hotline. **Kim Kane** answered this issue has been researched by several national associations. There is no evidence anyone has any trouble using the current "800" number. Tapping into the "N-1-1" system is an arduous task and most of the numbers are already taken. Some marketing companies will allow the us of "#" and a three-digit number plus a code word. That approach is possible but expensive and there is no funding to support it at this time.

John Reusser, Director of the Idaho Suicide Prevention Hotline, introduced himself to the Committee and explained the three-digit number approach costs about $50,000 per year. Call volume has been increasing steadily over the last few months, and people are using the "208" number. It appears people are able to reach the hotline. **Chairman Heider** asked how young people can know the suicide hotline number. **Mr. Reusser** answered there were press releases last fall when the hotline was launched. In addition, it was announced on the Program's Facebook page and there were several radio spots. The Program mails hotline materials almost daily to middle schools and high schools throughout the State. The number will be included in the television spots being developed by Ms. Kane.

Vice Chairman Souza commented she is surprised to see the majority of suicides fall into the age group of 85 years and over (see Attachment 3). She inquired whether those people are defined as suicides in the same fashion as other age groups, or are they simply infirm people who are in pain and don't want to live any more because their bodies are giving out. **Dr. Hatzenbuehler** replied the suicide data includes anyone who does something to assist his own death. People in that specific age range have a high incidence of suicide. The visual image might be of someone hanging on to a rope coming from the ceiling, and a person hangs on as long as possible and then just doesn't have the strength to do it any more. **Vice Chairman Souza** again referred to the chart (see Attachment 3) and asked how Idaho compares nationally in the 15 to 34 age group. **Dr. Hatzenbuehler** responded Idaho ranks second in the nation for suicides in that group.

Vice Chairman Souza asked what role medications play in death by suicide, and if there is a nexus between changes in medication and an incidence of someone completing a suicide. **Dr. Hatzenbuehler** answered it is known that the use of certain anti-depressant medications in teenagers creates risk of suicide. In her field, medication is helpful to people who suffer from mood disorders because the medications can help the person spark some energy needed to make changes in his or her life. Research shows medication is only half the answer for depression; cognitive behavior therapy is also needed to help change thinking patterns. There is a clear relationship between mood disorders and death by suicide.

Vice Chairman Souza inquired how someone can be helped who doesn't want to help himself. **Dr. Hatzenbuehler** replied it is necessary to do the best you can to be vigilant and protect the person from himself. It's important to take safety precautions, such as locking up medication or other lethal means, and provide supervision while attempting to reach out to the person with various mental health resources. Mood disorders are cyclical and suicidal thoughts lift over time, so one tries to wait until the lift occurs to provide treatment at that time.

Senator Lee stated this is a timely topic because her district recently experienced a death by suicide. She suggested it would be helpful to set expectations for when death by suicide will decrease. **Dr. Hatzenbuehler** answered there will be no quick turnaround. In addition, as population numbers increase, absolute numbers of suicide will increase. It will take cultural changes to see a difference. For example, the notion of a designated driver to avoid driving drunk has been a successful cultural change over the last years. Public awareness is important that suicide is not an acceptable way to die, just as it's not acceptable to throw trash out the window or put a child in the car without a restraint.

PRESENTATION: Idaho Suicide Prevention Coalition. Nate Fisher introduced himself to the Committee as the Executive Director of the Idaho Suicide Prevention Coalition (Coalition). **Mr. Fisher** stated the Coalition was formed less than two years ago because of great concern about suicide and the need for education (see Attachment 4). **Mr. Fisher** recognized the Coalition President, Stuart Wilder, who is also the President of the Live Wilder Foundation, as present at the meeting along with other advocates for suicide prevention. February 15th is Suicide Prevention Advocacy Day, and advocates from all over Idaho will be present at the Statehouse to learn how to talk about suicide.

Mr. Fisher provided the names of other organizations that form the Coalition, which is a public-private partnership. People who see the trauma of suicide, such as nurses, paramedics, and police, began approaching the Coalition about joining, and the list of members continues to grow. The Coalition is a non-profit organized under Section 501(c)(3)(h) of the Internal Revenue Code, which allows for limited advocacy on all aspects of suicide prevention, training, and advocacy. **Mr. Fisher** thanked Chairman Heider for the Committee's support of last year's funding request.

Mr. Fisher reported the Coalition does not solely rely on the State to achieve success. The Coalition has many partners. For example, the hotline was underfunded, and the Coalition provided 60 percent of the funding. The J. A. and Katherine Albertson's Foundation provided $300,000 for infrastructure and grants for the hotline. Century Link helped facilitate the hotline's ability to receive text messages.

Mr. Fisher presented the Coalition's priorities, including coroner reporting, school prevention program access, and safe storage. One of the challenges is timely reporting of suicides, particularly in school age children. There are too many unfortunate stories about the delay in reporting and the "postvention" response. When a suicide has occurred, there is trauma to the school and the community. It is important to have timely reporting of suicide in order to provide counseling and support for the students. Feelings of isolation, loneliness, and empathy can spread and be copied throughout schools and it is necessary to react quickly to prevent contagion. The Coalition requests the coroners work with the Department and the Department of Education for a voluntary 48-hour turnaround time on suicide reporting.

Mr. Fisher stated there are two paradigms to be discussed. One involves behavioral health professionals whose mandate is to do no harm. The other is the judicial system that requires due process. The two systems don't necessarily work together. If a mentally ill person is brought in on a criminal charge and left in a jail cell for two weeks, that is doing harm. The person might have been adjudicated but there is no improvement in mental health. The majority of the cases responded by law enforcement have a mental illness or substance abuse component. This issue is worthy of a larger discussion.

Mr. Fisher said safe storage is being careful with firearms and pharmaceuticals. The Coalition has been working with various groups and the firearms dealerships to raise awareness about safe storage and handling of lethal means. If there is a person having mental health challenges or is agitated, it is important for others to prevent access to routes of self harm and harm to others. The Coalition wants to get information to the dealerships to help them recognize how to deal with someone who comes in who is distraught. This would be a voluntary approach and it means putting time and distance between a suicidal person and the lethal means.

Mr. Fisher described a recent public service announcement developed by the Coalition and shown on television where a person at the shooting range looks at the camera and says he wasn't feeling himself about a year ago and his friends asked if they could keep his firearms until he felt better. The person went on to say his friends saved his life, and then he continues shooting.

Chairman Heider thanked Mr. Fisher for his efforts to save lives.

TESTIMONY: **Bonnie Burlage** introduced herself to the Committee as a Coroner to present concerns about the 48-hour turnaround for notification. It's not always possible to know whether a death is suicide. Lab work can take several weeks to get results.

Chairman Heider asked if the coroners use the Idaho State Police (ISP) laboratory. **Ms. Burlage** replied that they do not, and ISP uses the lab the coroners use. The coroners provide their lab reports to ISP.

Ms. Burlage further commented the coroners have concerns about the Health Insurance Portability and Accountability Act (HIPAA). She inquired where the information about the cause of death would be transmitted, and what kind of information the Coalition wants. The current regulations do not allow for reporting this type of information to a private association.

Senator Lee stated she understands there is often a period of time that the cause of death but sometimes the cause is obviously suicide. The intent of reporting this information is to prevent contagion. **Senator Lee** asked if Ms. Burlage would be comfortable reporting apparent suicides if the HIPAA issue could be resolved. **Ms. Burlage** answered the coroners would rather report to the Department. She also does not know what information the Coalition wants reported.

Chairman Heider suggested there might be a way to work together on the reporting issue to ensure notification is happening in a more timely manner to benefit everyone involved.

Gene Turley introduced himself to the Committee as the Twin Falls County Coroner. In Twin Falls County last year, there were five suicides in seven days. A couple of weeks ago, there were three suicides in five days. The majority of suicides are committed on the Perrine Bridge, and it is surprising how many suicides are elderly people. **Mr. Turley** agreed education is important. Idaho is usually in the top five in the U.S. for suicides because it is rural, there is better access to weapons, it might be a "macho" thing, and there is insufficient mental health care.

Mr. Turley commented only 18 percent of suicides leave a note, and when there is a note at a death scene, it helps tremendously. He appreciates what the Coalition is attempting to do, but he is very protective of his constituents and does not support giving a private association demographic information. It also takes time to conduct a thorough investigation. Blood and urine lab results could take eight weeks. **Mr. Turley** said he is board certified in forensic examinations and conducts what he calls a "psychological autopsy". He talks to employers, past employers, friends, families, and first responders about a suspected suicide. He is very careful before listing a cause of death as suicide because it is traumatic to the family to have that information in the permanent official records.

Stewart Wilder introduced himself as the President of the Coalition and President of the LiveWilder Foundation. He appreciates hearing from the coroners who testified and said this type of discussion is needed. The Coalition's position is not that the coroners should report to the Coalition, but the information needs to go to Ms. Kane's office so she has the most current data to measure the success of the Program. The 48-hour reporting requirement to schools for known suicides is the most important issue due to the effect of contagion. Current state law allows five days to report and the Coalition wants to shorten that period. **Mr. Wilder** commented when his son committed suicide, his other son could have learned of the death through social media before the death was officially reported as a suicide, and that would have been unfortunate.

Senator Jordan thanked Mr. Wilder for the clarification and asked if there would be value in promptly reporting a death to the school without designating it a suicide right away. **Mr. Wilder** answered that getting any available data would be helpful, but reporting suicides is especially important because of the downstream effects on other students and families. For every suicide, there are six individuals who are deeply impacted by the suicide, and contagion is a real issue.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:25 p.m.

Senator Heider
Chair

Jeanne Jackson-Heim
Secretary

REACHING NEW HEIGHTS

Idaho Council on Suicide Prevention

Linda Hatzenbuehler, Chair

What is the Idaho Council on Suicide Prevention?

- Established under Executive Order No. 2006-35

  (most recently No. 2014-08)

- Purpose
  1. Oversee the implementation of the Idaho Suicide Prevention Plan
  2. Ensure the continued relevance of the Plan
  3. Report annually to the Governor and the Legislature

Why do we need a Council on Suicide Prevention in Idaho?

362

Total deaths by suicide in Idaho in 2015

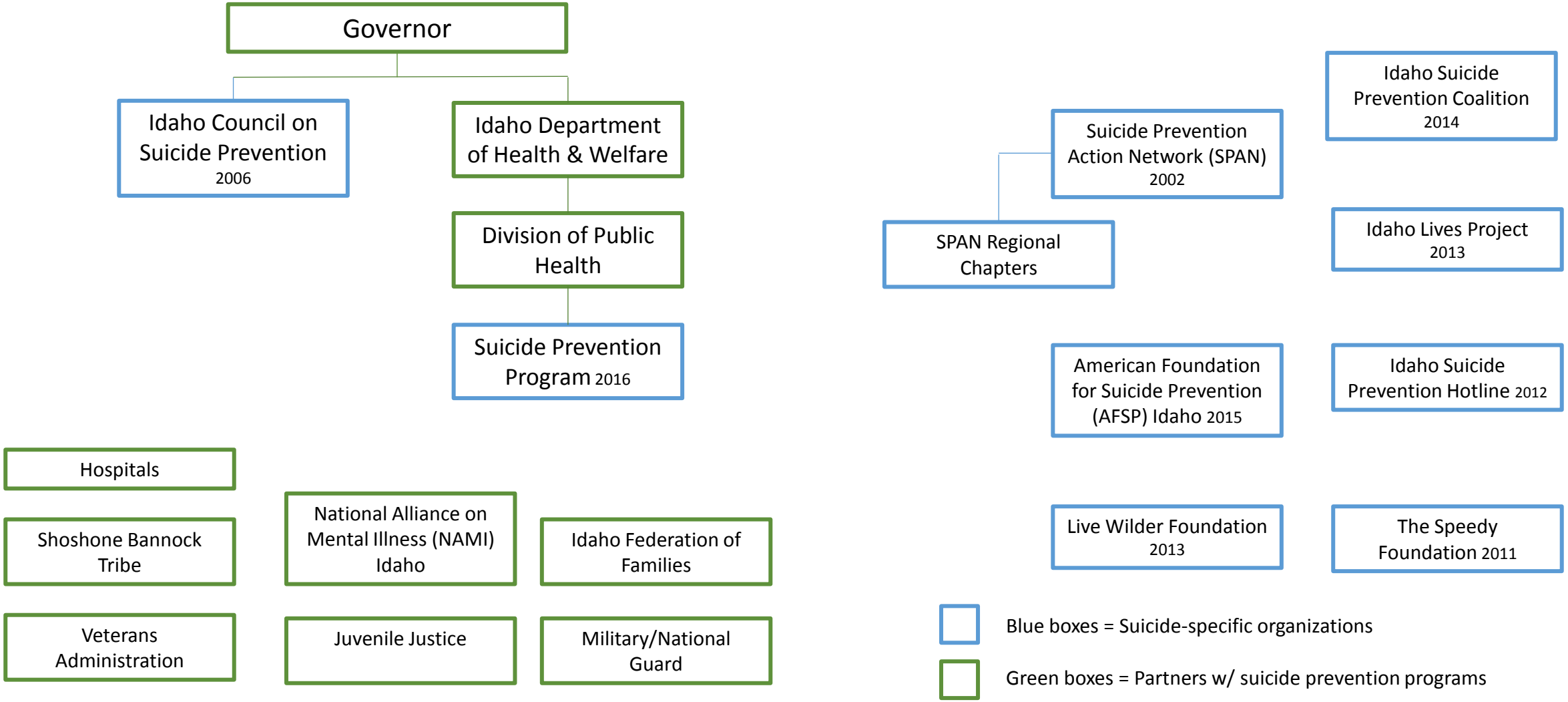
102

School-aged death to suicide in Idaho from 2011-2015

24

Children age 14 and under lost to suicide in Idaho from 2011-2015

Suicide Prevention Organizations in Idaho



Idaho Suicide Prevention Program

IDAHO DEPARTMENT OF HEALTH & WELFARE

DIVISION OF PUBLIC HEALTH

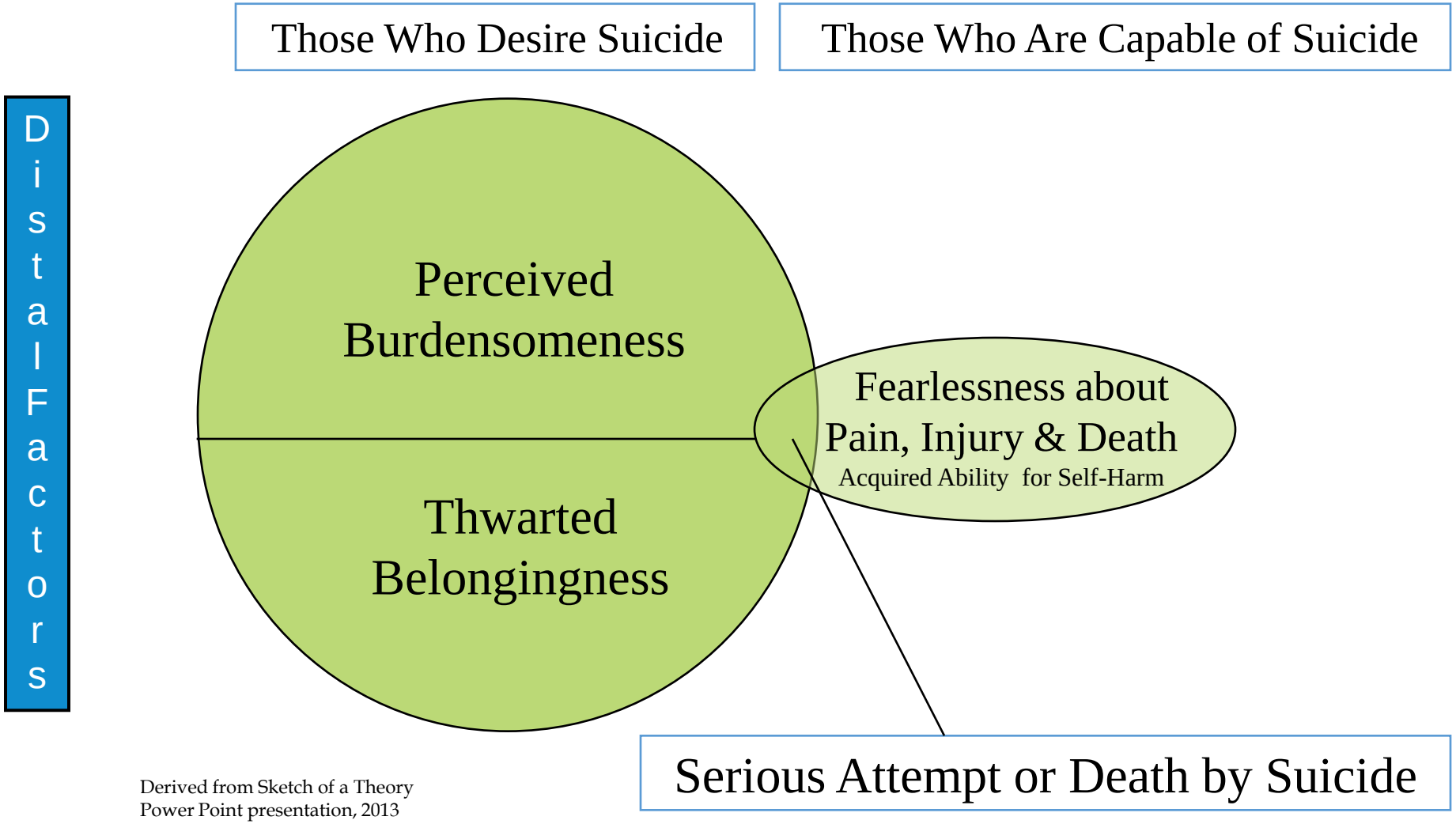
Public Health Suicide Prevention Program Beginnings

- The 2016 Idaho Legislature allocated funds to established the Suicide Prevention Program (SPP)
- The SPP develops, implements and supports statewide programs to prevent suicide in Idaho in alignment with the statewide Idaho Suicide Prevention Plan
- The SPP employs four full-time staff

Interpersonal-Psychological Theory of Suicide

Thomas Joiner, PhD

Why People Die by Suicide



Derived from Sketch of a Theory Power Point presentation, 2013
Thomas Joiner, PhD

SPP Primary Initiatives 2016/2017

- Provide funding to the Idaho Suicide Prevention Hotline
- Provide funding for upstream youth suicide prevention education
- Research and conduct a public awareness campaign
- Provide funding and administrative support to the Idaho Suicide Prevention Council
- Establish and convene suicide prevention stakeholder group to improve coordination of efforts
- Pursue additional suicide prevention strategies and respond to suicide related requests

DHW/SPP Accomplishments 7/2016 – 1/2017

- Hired and trained staff, and created infrastructure for SPP within the Division of Public Health
- Provided funding to the Idaho Suicide Prevention Hotline
  - 1-800-273-TALK (8255) or 1-208-398-HELP (4357)
- Provided funding to the Idaho Lives Project for training Idaho youth in strength, hope and resilience
- Conducted research and drafted marketing plan for statewide suicide prevention public awareness campaign
- Provided support to the Idaho Suicide Prevention Council
  - Coordinated meetings
  - Updating the 2011 Idaho Suicide Prevention Plan
  - Compiled and printed the annual Governor's Report

DHW/SPP Accomplishments 7/2016 – 1/2017

- Convened two SPP stakeholder group meetings and increased collaboration
- Conducted research and began education and capacity-building for the Zero Suicide Initiative which targets health systems and is proven to reduce suicide rates
- Conducted informal investigation of downtown Boise parking garages to identify and make recommendations to increase safety levels at a potential "destination" garage. Recommendations are being adopted.
- Helped establish a Lethal Means Task Force in partnership with Rep. Caroline Troy, the Idaho Firearms Alliance and other partners
- Responded to numerous requests for information and consultation from a wide variety of citizens, stakeholders, service providers and the media

Contact US

Linda Hatzenbuehler, Chair
Idaho Council on Suicide Prevention
208-221-6306
hatzlind@isu.edu

Kim Kane, Program Manger
Suicide Prevention Program
Division of Public Health
Idaho Department of Health & Welfare
208-334-4938
Kim.Kane@dhw.idaho.gov

Idaho Suicide Prevention Hotline

by JANNUS

1-800-273-TALK (8255)

New Call or Text Number
208-398-HELP (4357)

ISPH has voice enabled our crisis text number so calls from Idahoans with out of state cell phones ring directly into our center 24/7. Crisis text response hours to this same number are currently M-F 3 pm to Midnight.

Suicide in Idaho

Idaho is consistently among the states with the highest suicide rates. In 2015 (the most recent year available) Idaho had the 5th highest suicide rate, 57% higher than the national average.

- In 2015, 362 people completed suicide in Idaho; one suicide death every day.
- Between 2011 and 2015, 102 Idaho school children (age 18 and under) died by suicide. Twenty four of these were age 14 and under.

Staffing Information

- In 2016, volunteers contributed a total of 13,483 hours to ISPH-staffing the phones, conducting outreach, and helping train new volunteers, for an approximate in-kin value of $258,873.
- Current staff consists of one full time Project Director, a full time Volunteer Coordinator, full time Program Assistant, 2 full time Phone Room Supervisors, 9 part time Phone Room supervisors, 3 interns and an Americorps Volunteer (7.88 FTE).

Program Goals

- Complete infrastructure/ capacity upgrades.
- Continue Marketing Crisis Text Response Statewide.
- Add Crisis Chat response.
- Collaborate with state prevention program.
- Continue sustainable funding strategies.

Caller Issues

2016	4th Quarter	YTD 2016
Suicide	37%	43%
Self-Reported Mental Health Issues	33%	36%
Interpersonal	28%	31%
Financial	13%	13%
Self-Reported Addiction	9%	10%
Physical Health	9%	9%

Call Statistics

2016

	4th Quarter	2016
Total Contacts	1,730	5,973
Total Calls Received	1,682	5,906
(SMS Texting Interventions)	48	67
First time (non-repeat) Callers	70%	69%
Military Member / Families	272	952
Rescue Calls	27	107
Follow Up Actions Completed	146	551
Percentage of Calls W/ follow up Actions	8%	9%
Caller Age:		
10 - 14	32	136
15 - 19	137	511
20 - 24	114	468
25 - 34	104	489
35 - 44	117	458
45 - 54	211	674
55 - 64	204	770
65 - 74	59	200
75 - 84	0	11
85 +	3	3
Did not collect	749	2,253

Contacts by County

2016

	3rd Q	4th Q	2016
Ada	305	366	1325
Adams	1	0	7
Bannock	63	85	274
Bear Lake	0	0	2
Benewah	1	5	11
Bingham	15	13	56
Blaine	9	5	49
Boise	3	0	8
Bonner	30	19	105
Bonneville	33	78	194
Boundary	0	3	7
Butte	0	0	10
Camas	0	0	1
Canyon	125	167	575
Caribou	0	0	1
Cassia	4	13	28
Clark	0	0	2
Clearwater	0	1	3
Custer	1	0	5
Elmore	14	8	37
Franklin	3	0	12
Fremont	16	4	60
Gem	10	6	33

	3rd Q	4th Q	2016
Gooding	14	13	35
Idaho	1	1	8
Jefferson	4	1	10
Jerome	14	21	42
Kootenai	34	94	241
Latah	60	30	144
Lemhi	1	3	7
Lewis	3	2	6
Lincoln	2	0	3
Madison	5	6	24
Minidoka	5	1	20
Nez Perce	40	24	135
Oneida	0	0	1
Owyhee	0	0	9
Payette	6	8	20
Power	0	6	9
Shoshone	5	3	25
Teton	1	1	5
Twin Falls	54	45	197
Washington	0	2	13
Caller Refused unable to Collect	426	559	1,834
Other*	81	61	359
YTD Totals	1389	1730	5973

"So many lives are touched by suicide, including mine. But I have long believed that we are given adversity as a teacher, as a path toward empathy, and as a tool. So I didn't hesitate to sign up as a volunteer for the new Idaho Suicide Prevention Hotline. It was a huge relief to learn that we would be properly trained; that we would have professional supervisors to guide us as needed; that there would be support on the hotline calls and their after-effects. And none of this went undone. I feel cradled by my peers and especially by the Hotline staff." — ISPH Volunteer

1607 W. Jefferson St., Boise, ID 83702 • Office 208-258-6990 • jreusser@jannus.org
idahosuicideprevention.org • jannus.org • 1-800-273-TALK (8255)

SUICIDE PREVENTION LIFELINE

CONTACT usa

Suicide in Idaho: Fact Sheet

January 2017

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

- Idaho is consistently among the states with the highest suicide rates. In 2015, Idaho had the 5th highest suicide rate, 57% higher than the national average.
- Suicide is the 2nd leading cause of death for Idahoans age 15-34 and for males age 10-14.
- Between 2011-2015, 102 Idaho school children (age 18 and under) died by suicide. Twenty-four of these were age 14 and under.
- There are 836,000 emergency department visits for self-inflicted injury each year in the United States.
- In 2015, there were 44,193 deaths by suicide in the United States, an average of 1 person every 12 minutes.

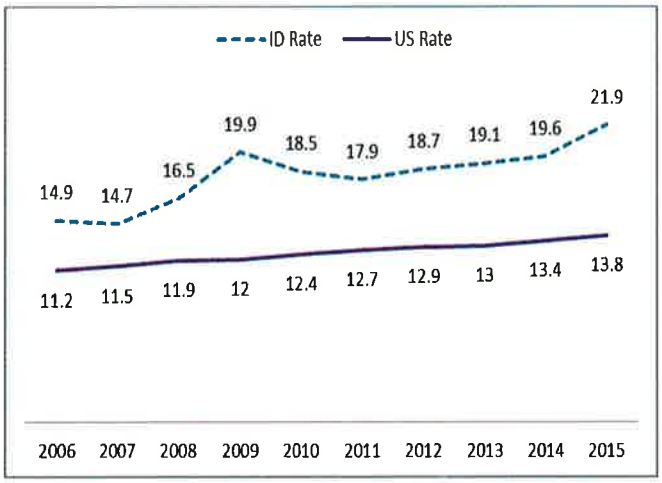
Idaho Resident Suicides By Region: 2015

*Rate per 100,000 population

Region	Anchor City	Suicides 2015	Rate (per 100,000)	Population	Suicides 2011-2015	5-Year Average Rate
1	Coeur D'Alene	63	28.0*	225,007	245	22.4
2	Lewiston	20	18.6-	107.383	120	22.5
3	Nampa	53	19.5*	272.363	238	18.0
4	Boise	86	18.0-	477,248	394	17.1
5	Twin Falls	44	22.9*	192,395	193	20.4
6	Pocatello	46	27.6*	166,429	188	22.6
7	Idaho Falls	50	23.4*	214,105	195	18.5

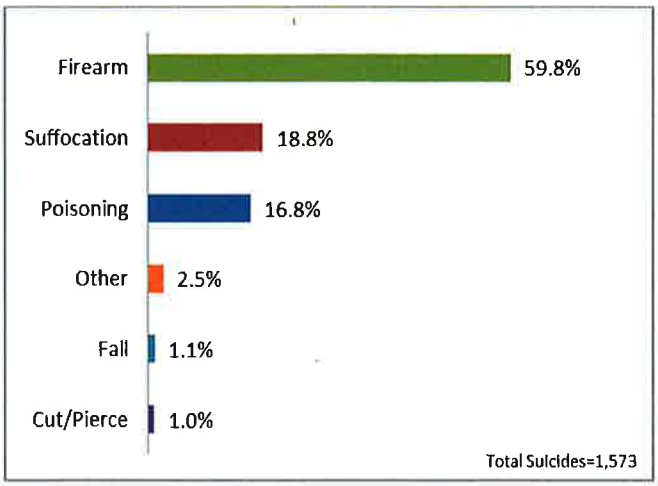
* Increase from 2014, - Decrease from 2014

Idaho & US Rates by Year: 2006-2015



*Rate per 100,000 population

Idaho Method: 2011-2015 (All Ages)



Suicide in Idaho: Fact Sheet

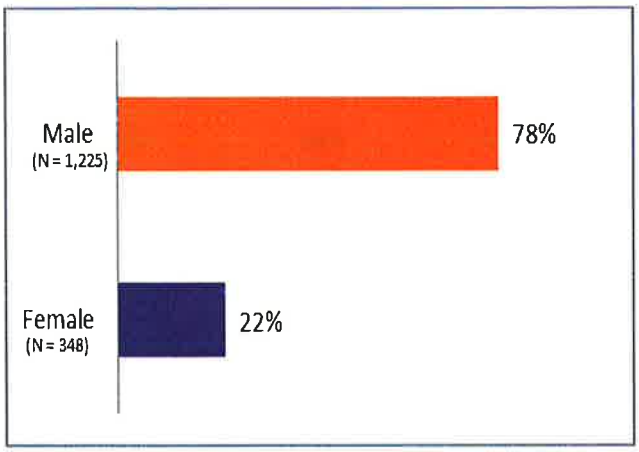
January 2017

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Idaho Youth Risk Behavior Survey 2015 –Public and Charter High School Students

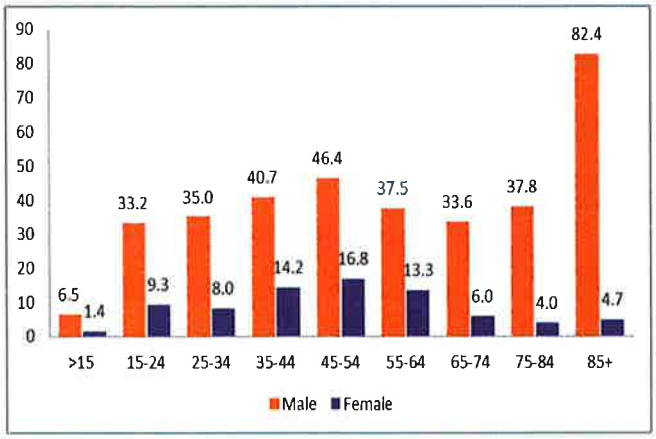
Grade	Sad or Hopeless (%)	Suicidal (%)	Plan (%)	Attempt (%)	Medical care for attempt (%)
9th	29.7	19.3	16.4	10.8	5.0
10th	29.7	17.9	15.1	10.1	2.2
11th	35.3	23.6	21.4	10.3	3.2
12th	32.3	18.6	14.8	7.6	1.7
Idaho Overall	31.6	19.8	17.0	9.8	1.9

Idaho Suicide Deaths by Gender: 2011 - 2015



Idaho Suicide Rates by Age and Gender: 2011-2015 Combined

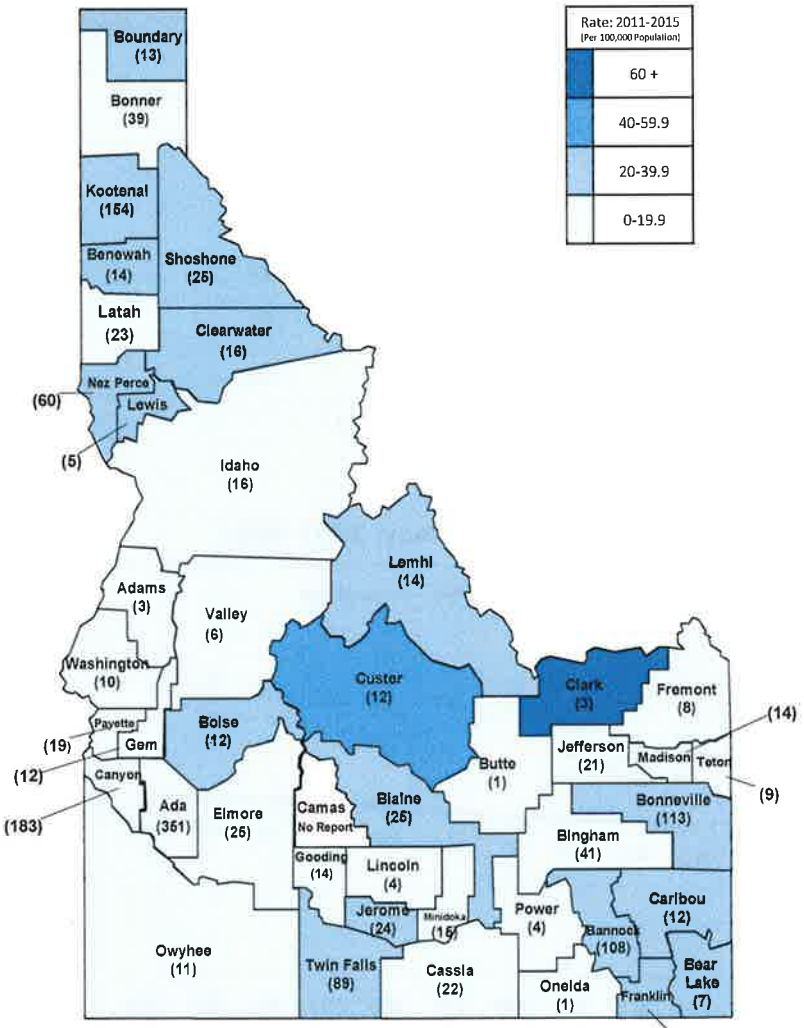
(*Rate per 100,000 population)



Idaho Suicide Rates by County: 2011-2015

*Rate per 100,000 population

**Number of deaths is shown below county name.



*Note: Rates for many counties are based on fewer that 20 deaths. Caution is advised when interpreting rates based on small numbers.

Sources: Idaho Bureau of Vital Records and Health Statistics, Idaho Department of Health & Welfare, Centers for Disease Control and Prevention, State Department of Education

Special Thanks to Martijn Van Beek, Research Analyst Senior and Pam Harder, Research Analyst Supervisor, Idaho Bureau of Vital Records and Health Statistics

- **Idaho Suicide Prevention Coalition**

LEGISLATIVE UPDATE 2017

idaho Suicide Prevention Coalition

i The semicolon is symbolic, denoting a pause in life, and not the end

ISPC Organized in 2015 with 501(c)(3) H designation approved 2016

Mission:
Create a statewide coalition "The Idaho Suicide Prevention Coalition" in order to have a concerted representation of public and private supporters on suicide prevention, training, education and policy.

Objective 2015:
Support the Idaho Health Quality Planning Commission's (HQPC) and the Idaho Council on Suicide Prevention recommendations for strategic legislative needs and funding.

Advocacy Successes and Opportunities:

- Statute change: Mission of H&W to include suicide prevention
  - Instrumental in the success of legislation and funding 2016

- Hotline Funding
  - State Legislative Funding Lobby – 60% operations
  - $300k infrastructure grant – J.A. and Kathryn Albertson Foundation
  - $44.9k texting program grant – Public Utilities Commission

- Opportunities:
  - Coroner System and Reporting Improvements
  - School Prevention Program Access and Funding
  - Safe Storage Awareness for Lethal Means

The Coalition's stance is legislation is <u>last</u> recourse!

Coroner Reporting

Led efforts to put coroner reporting on the table with H&W and Coroner Assn:

- 5 day statute to immediate reporting
  - School Reporting for Postvention practices to reduce contagion and improve supports.

- Accountability of coroners to who?
  - No state agency (Medical Examiner's Office)
    - Coroner's Association
    - Voluntary system (voter accountability)
    - Accurate and timely data to support the SPP efforts

- Coroner credentialing is not required.

Status of efforts with SPP, H&W and Coroner Assn:

- 48 hr reporting initiative is in place with voluntary participation
- Coroner report updates through H&W
- Education and training initiative a focus of the Assn.

Coroner:

The death of a student has a profound impact on a school community; this is compounded when the death is the result of suicide. Timely action by a school in the aftermath of a suicide is critical to support students, staff and parents.

Timely Reporting

What is needed:

- Timely Action – support students, staff and parents
  - Coroners – first point of contact to determine suicidal death
    - State Dept of Education notification essential for consultation, resources, supports, etc
    - Name of school is the only information needed for SDE

- Schools invoke Evidence Based Postvention practices – prevent contagion

Law and Behavior Health
An Uneasy Alliance

- Same Person Different Name
  - **Offenders** (Law)
  - **Patients/Clients** (Behavior Health)
- Public Perception
- Professional Perception

Law and Behavioral Health Paradigm Conflicts

Avoid the Collision - Professional Responsibility

Behavioral Health Professionals

- Don’t exaggerate the state of knowledge of the profession
- Don’t ignore the problem of translating the behavior science language into legal findings

Lawyers and Judges

- Don’t ignore the value of behavior science
- Don’t give up fact finding in favor of science

SAFE STORAGE OF LETHAL MEANS

Firearms and Pharmaceuticals

Means in Order of Completion of Suicide:

- firearm
- poisoning
- hanging
- jumping from high place
- downing
- cutting (sharp object)

ISPC COLLABORATION ON SAFE STORAGE EDUCATION

- Idaho Suicide Prevention Program
- Idaho Firearms Alliance
- American Foundation for Suicide Prevention
- NRA
- National Shooting Sports Foundation
- SPAN Idaho
- The Speedy Foundation
- State of UT: successes and resource sharing

…And other stakeholders to *jointly* raise awareness around safe storage and handling of lethal means.

Idaho Vital Statistics Report:

- 60% of suicide deaths between 2010 and 2014 involved a firearm

- Poisoning is the leading cause of death among females in Idaho.
  - Medication overdose is the primary means
  - Physician's have the highest rates – access and education

Sadly, Idaho dropped from 9th to 5th in the US in 2015 for suicide rates (American Association of Suicidology Report Dec 2016)

ISPC is in place to direct change for a reversal in the statistics; together we can do this!

Strategies
Partnering and Outreach

Firearm-owning community:
- shooting range owners
- hunting organizations
- firearm instructors and others

Healthcare and Pharmaceutical community
- Clinicians
- Hospitals
- Pharmacists and others

Goal:
Increase involvement in suicide prevention education and safety

Education and Awareness

Importance of Lethal Means Education:

- Healthcare Professionals and Firearm Communities
  - secure medications and firearms away until the individual stabilizes

- Supporting Voluntary Safe Storage
  - Education Initiatives
  - Public Awareness Campaigns
  - Access to Educational Materials, Resources, Gun Locks, Medication Lockboxes, etc

Putting time and distance between a suicidal person and lethal means can help save lives.

Awareness Campaign :
Is Your Safety On?

The National Shooting Sports Foundation and the American Foundation for Suicide Prevention used the 2017 SHOT Show to scale up their campaign to stop 10,000 deaths over the next decade.

AMENDED AGENDA #1

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Wednesday, February 15, 2017

SUBJECT	DESCRIPTION	PRESENTER
Approval of Minutes	Minutes of the January 27, 2017 Meeting Minutes of the February 6, 2017 Meeting	Senator Lee Senator Anthon
RS25272	Unanimous Consent for Referral to Senate Judiciary & Rule for Printing	Senator Foreman
S 1081	Relating to the Immunization Assessment Board	Senator Martin
H 11	Relating to Optometrists	Mitch Toryanski, Idaho Bureau of Occupational Licenses
	REMINDER: Committee Photo - Thursday, February 16 - 1:20 p.m. - Senate Chambers	

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Wednesday, February 15, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:02 p.m.
APPROVAL OF MINUTES:	**Senator Lee** moved to approve the Minutes of the January 27, 2017 meeting. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**
	Chairman Heider stated the Minutes of the February 6, 2017 meeting will be held for a future agenda.
RS 25275	**Unanimous Consent for Referral to Senate Judiciary & Rules for Printing. Senator Foreman** informed the Committee **RS 25275** is a concurrent resolution to focus public and government attention on Post-Traumatic Stress Injury (PTSI). The resolution designates the June 2017 as PTSI Awareness Month and June 27, 2017 as PTSI Awareness Day.
UC REQUEST:	**Senator Foreman** asked for unanimous consent to send **RS 25275** to the Judiciary and Rules Committee for printing. There were no objections.
UC REQUEST:	**Senator Martin** asked for unanimous consent to hear **H 11** before **S 1081** to allow time for another presenter to arrive. There were no objections.
H 11	**Relating to Optometrists. Mitch Toryanski**, Legal Counsel for the Idaho Bureau of Occupational Licenses (Bureau), introduced himself to the Committee on behalf of the State Board of Optometry (Board). The Board is comprised of five members, and **Mr. Toryanski** recognized three Board members present: Dr. Wayne Ellenbecker, Chairman from Coeur d'Alene; Dr. Joy Johnson, Vice Chair from Nampa; and newly-appointed public member Bill Von Tagen from Boise. Also present is former Board Chair Dr. Jack Zarybnisky from Burley.
	Mr. Toryanski explained **H 11** removes archaic language regarding the issuance of licenses as well as the requirement for optometrists to display the license in a conspicuous part of the office. The bill also requires all licensed optometrists to be qualified to use pharmaceutical agents to both diagnose and treat conditions of the eye by January 1, 2019. Ninety-seven percent of optometrists are trained and qualified to dilate pupils, diagnose disease, and prescribe eye drops, but three percent are not qualified. For the past 10 to 15 years, the Board has encouraged the optometrists without this training to obtain it to be fully qualified, but the optometry statute does not require it, so a handful have not done so. The Board believes all optometrists in Idaho should be trained to the same standard, and the fact some are not presents a public safety issue. **Mr. Toryanski** stated the Board President will further explain to the Committee.

Mr. Toryanski said the bill does not impact the General Fund or the Bureau's dedicated fund, since it does not create a new program, and license applications will continue to be considered by the Board at regularly-scheduled meetings.

Senator Martin referred to line 32 of the bill and asked why an optometrist should not be required to display the license. **Mr. Toryanski** answered the statute currently requires all licensees to display their licenses in every office, and some have multiple offices. Often the licensee will display the diploma from optometry school, but the license is about the same size as a driver's license. The Board does not feel an optometrist should be disciplined for not displaying the license conspicuously in every office location.

Senator Jordan mentioned she has received several emails on this topic from optometrists who are fairly close to retirement, and they are concerned about being stopped in their careers. **Senator Jordan** asked whether the Board considered grandfathering these remaining optometrists and requiring a statement that they do not provide the services instead of precluding them from practicing. **Mr. Toryanski** replied the Board's intent is not to put anyone out of business, and grandfathering was discussed. However, the Board felt it was important to not have any optometrists practicing who did not have qualification to use pharmaceutical agents. The bill allows nearly two years for the optometrists to obtain the hours and the refresher cardiopulmonary resuscitation class necessary for certification.

Senator Jordan asked if there are recorded cases of complaints or situations that occurred as a result of this requirement not being in place. **Mr. Toryanski** responded he reviewed the discipline taken against optometrist licenses since 1995, and the records show no optometrist without the certification to use pharmaceutical agents has been disciplined for missing something. One was disciplined for failure to provide a contact lens prescription to a patient after he took the money, but that is not relevant to this discussion. There have been 10 optometrists disciplined in the last 22 years, not a high number compared to some other boards.

Senator Lee commented she is unclear on why the bill was brought forward. It appears to be an attempt to raise the standards and knowledge for provider competency versus actually addressing a safety concern. **Senator Lee** asked why some optometrists couldn't simply choose to be certified and others make the choice not to be certified. **Mr. Toryanski** replied he cannot provide a firsthand account; however, Dr. Ellenbecker and other professionals can address that more directly.

TESTIMONY: **Dr. Wayne Ellenbecker** introduced himself to the Committee. He is an optometrist from Coeur d'Alene and the current Board chairman. **Dr. Ellenbecker** explained the Board's rationale in requesting the law change. The Board is charged with protecting the public, and the public expects to receive the same level of care no matter what optometrist they are seeing. Having different levels of licensure does not fulfill the accepted standard of care that all practicing optometrists have the ability to use both diagnostic pharmaceutical agents (DPA) and therapeutic pharmaceutical agents (TPA). Failure to either diagnose and/or treat conditions could be visually or physically harmful to the patient. It is a threat to public safety if all optometrists cannot practice to an accepted standard of care. If a practitioner can prescribe a contact lens for a patient, he should also be able to manage the complications arising from that action, such as infections, ulcers, and keratitis which are all treated with topical medications. A practitioner should also be able to dilate the eye and check for evidence of ocular and systemic conditions in the retina. Even cataract evaluation is helped with dilation. Diabetic retinopathy, hypertensive retinopathy, and tumors are examples of conditions that can only be seen by dilation.

Dr. Ellenbecker advised in 1993 the Legislature added a provision for therapeutic licensing. Over 95 percent of licensed Idaho optometrists either become TPA certified since that time or are TPA certified through the current licensing and graduation requirements. There are only six doctors who do not have the DPA certification to dilate, and two are active in Idaho. Currently 11 doctors do not have the TPA licensing component and five are active in Idaho. There are 550 doctors with both DPA and TPA certification. Since 2001, the Board has discussed this issue numerous times. In October 2012, the Board mailed a letter to all non-TPA certified doctors, asking them to become TPA certified, but none did. Over the years, the Board has attempted multiple times to contact the affected practitioners and asked them to gain TPA licensure.

Dr. Ellenbecker advised there is one remaining course that meets the Board's requirements in Florida. The course is a ten-day course that costs $6,500. The therapeutic management and ocular disease exam is also offered once a year and can be taken by computer through a Pearson VUE test center at a cost of $450. The Board has given significant warning and plenty of time to obtain therapeutic licensure, but a few have chosen not to do so. The issue was discussed at several Board meetings, and the affected licensees were invited to attend. The Board also sent a postcard to all licensees regarding the proposed legislation. One optometrist attended in person and two participated by conference call. The Board considered the opinions of these participants and voted to move forward with legislation to protect the public. The effective date of January 1, 2019 allows everyone the time to become compliant. The profession is currently held to an unacceptable standard of care, and other states will not allow license by reciprocity due to this specific issue. All professions, medical or otherwise, are forced to change as accepted practice patterns change.

Senator Foreman commented it is admirable the Board wants to modernize health care, but there does not seem to be a realized threat to health care because there are no violations or incidents. The affected practitioners have a great deal of institutional knowledge and patients who rely on them. The providers recognize they are not operating with all the pharmaceutical abilities as their newer counterparts, and the providers refer patients when necessary. **Senator Foreman** asked whether it wouldn't be better to grandfather these providers rather than lose years of knowledge. **Dr. Ellenbecker** replied any consumer doesn't always know or realize there is an avenue to report a bad experience. In many cases, the problem is simply taken care of and the consumer moves on without knowing the provider was in error. If a patient doesn't know dilation is a standard of care, how will the patient know if something was done correctly or whether there was an undiagnosed problem. These practitioners have already been grandfathered. Therapeutic licensing has been available in Idaho since 1993, and anyone licensed at that time had to go through the training process. Students coming out of school now receive the training automatically.

Senator Foreman asked what it would cost to go to Florida to get training. **Dr. Ellenbecker** repeated the available course costs $6,500 and takes ten days. There is a follow-up test that costs $450. There would be additional travel and lodging expenses. There are costs involved in keeping up to date in private practice. Some new equipment and systems cost $25,000 and up.

Vice Chairman Souza mentioned Dr. Ellenbecker is from her area and she took all four of her children to his office when they were young. **Vice Chairman Souza** stated there is a hesitation to create any situation that will put people out of business who have been successfully practicing for many years, and she asked for more information on the reciprocity issue. **Dr. Ellenbecker** replied licenses can be recognized from state to state, but the licenses have to be equal. The Idaho license is not equal to other states' licenses because there are three different tiers. An Idaho licensee with a lower tier license would not be able to be licensed by reciprocity in another state. **Vice Chairman Souza** confirmed it would be a burden for an Idaho optometrist to get reciprocity in another state because the level of practice requirements are unequal and asked if someone with a lower tier Idaho went to another state, would the person have to take additional training or pass a qualifying test in order to practice in that other state. **Dr. Ellenbecker** responded every state is different. When someone comes to Idaho through reciprocity, as long as the person meetings the highest level license, reciprocity applies.

Senator Anthon inquired of Dr. Ellenbecker whether an optometrist who does not have this certification or training is committing malpractice. **Dr. Ellenbecker** replied it might be a legal question, but in his opinion, the answer is yes. Certain insurance plans require dilation in some cases, and the inability to offer that service would fail to meet the accepted standard of care.

Senator Foreman asked if most of the patients who see this handful of optometrists are told to see another doctor to get additional services, or are the patients uninformed. **Dr. Ellenbecker** replied a patient assumes all optometrists are licensed the same and are not informed certain services cannot be performed. Patients assume they are getting the highest level of care available.

TESTIMONY: **Art Osterberg** introduced himself to the Committee as an optometrist from Orofino to speak in opposition to **H 11. Dr. Osterberg** informed the Committee there are only four doctors to whom this law would apply (see Attachment 1). The four remaining doctors are not leaving Idaho and don't have to worry about getting a license somewhere else. He is not opposed to the first part of **H 11** but the second part is unacceptable because in his opinion it is wrong, unfair, discriminatory, unconscionable, and probably unconstitutional. If passed, the law would be a form of genocide to the senior doctors. They have the most experience and wouldn't be here if they didn't get good results. The bill allows 22 months to practice until a license would be pulled and they would have to go work at Walmart or Home Depot.

Dr. Osterberg asked what is wrong with his license and why can't he keep the license he got in 1966. His record is unblemished and has practiced over 50 years, including military optometry. He is a master refractionist who only works with certified opticians in Lewiston and taught at Pacific University teaching doctors how to make glasses. His current practice is a "second opinion" practice. People come to him saying they can't see well, and he helps them see 20/20 without paying $800 for glasses. He sees patients with undiagnosed cataracts and he refers them to Pacific Cataract and Laser Institute (PCLI) in Lewiston. His patients are always pleased.

Dr. Osterberg commented he knew a doctor in Lewiston in the 1970s who was an eye, ear, nose and throat medical doctor. The medical field was no longer training doctors with that specialty but he was a good physician and the medical board allowed him to continue practicing. If **H 11** is passed into law, everybody loses. He doesn't charge his patients $800 for glasses nor does he charge to remake glasses if something is wrong. His income will be affected, as well as his ability to sell the practice.

Dr. Osterberg said he talked to the Board and was dissatisfied with the results of those discussions. He feels the Board does not care what he says, and he just wants to keep his license. He does not want to be grandfathered into their therapeutic license because he wouldn't use it. He knows another optometrist in Idaho Falls, Dr. King, who has a unique practice working with reading disabilities, cross eyes, and stroke victims. Dr. King doesn't use therapeutic drugs and doesn't want to use the drug. As far as Dr. King's practice, no one in the Lewiston area does functional optometry or vision training.

Dr. Osterberg said Dr. King graduated from Pacific University in 1968. He read a quote from Dr. King about the type of optometry services she wants to provide. The Board has proposed legislation to protect the public but Dr. King does not believe anyone is harmed if she does not provide pharmaceutical treatment, and appropriate referral is more important. Dr. King will probably be forced to retire if the legislation passes, and the public will be denied her care.

Dr. Osterberg advised he wrote the Board in 2014 and urged the Board not to press the tiered licensure issue. All senior optometrists will be eliminated in due time and do not need to be stressed by possible litigation, proposed legislation, unfavorable media, and loss of income. The former Board chair told him people don't know who they are going to if there are three tiers of license. **Dr. Osterberg** said people don't care as long as the doctor can help them see. He just wants to be left alone to take care of his patients.

Senator Martin asked if being able to dilate eyes has value to Dr. Osterberg's patients. **Dr. Osterberg** said if his patients ask him if he dilates, he tells them no. When he asks the patients if they still want him to look around in their eyes, they tell him yes because they heard he's the best. He can still look inside the eye. Dilation only makes a bigger window.

Senator Foreman commented he hears Dr. Osterberg saying his practice is limited by not being licensed to use drugs, and his practice is highly specialized and fits into a well-defined role that benefits his patients. **Senator Foreman** asked how Dr. Osterberg handles his referrals to other doctors. **Dr. Osterberg** replied when there is a problem he tells them and gives them a choice of two doctors to see. He generally refers to PCLI or there are some others in Lewiston and Spokane.

TESTIMONY: **Dr. Jack Zarybnisky** introduced himself as an optometrist from Burley to speak in favor of **H 11**. The bill should pass because reciprocity is a big factor. If he wanted to move to a warmer climate, because Idaho has the three tiers of license, he could not be licensed by reciprocity in another state. The bill must pass so all optometrists function at the same level and the general public can be assured the optometrist is able to detect all eye diseases and prescribe the needed medications. Some of the newer instruments cannot be used if the eye is not dilated, and some conditions such as retinal tears, peripheral cysts, and cancer cannot be seen with just an ophthalmoscope. Patients don't ask if a doctor can do this or that, they just assume the doctor can do whatever is needed to take care of the situation.

Dr. Zarybnisky said Idaho needs to keep up with educational standards, and Idaho is falling behind without this bill. Since he graduated, all schools require this training of their students, and all health care professions need to keep going to school. Financially, the training is not that big a burden. The other day, his own office spent $45,000 on a piece of equipment to allow them to look into the very far periphery of the eye to detect certain conditions. Medicaid, Medicare, and VSP Vision Care patients are required to see a doctor who can dilate the eye. There are other options for a doctor who does not want to obtain the training to still make a living.

TESTIMONY: **Dr. Philip Rainey**, a Boise optometrist, introduced himself to the Committee to speak in favor of **H 11**. As the standard of care progresses in all medical fields, it is wise to stay on top of as much information as possible. Much of what was learned in school is obsolete or surpassed in only five to ten years. In order to stay at the top tier of licensing, an optometrist must complete 18 hours of continuing education a year, but at other tiers the requirement is only 12 hours per year. The lower-tier optometrists are behind the current standards of care and are getting farther behind because they have to complete fewer education hours per year.

Dr. Rainey reported there used to be other programs closer to Idaho that offered this training, but most of the other optometrists have already completed the training. There is only one school left and that is in Florida. The expense is not onerous and it is a cost of doing business like upgrading a piece of equipment. The training will make optometrists more capable.

TESTIMONY: **Dr. Joy Johnson**, Board member, introduced herself to the Committee. **Dr. Johnson** informed the Committee of a 1970s court case where an ophthalmologist did not check the pressure of a young woman's eye. The patient was only in her 30s and checking pressure in someone under 40 was not the standard of care. However, the woman developed glaucoma and vision damage, and the doctor lost the case. The lawsuit caused the optometrists to change their practice to do more than the basic standard.

Dr. Johnson said she graduated in 1986 and has always been able to dilate eyes, but it is not a routine practice. Dilation changes her description of the optic nerve and helps her watch the optic nerve over time. She has a patient with a nevus or mole in the eye. A nevus can develop into melanoma. Dr. Johnson always dilates the patient's eye because otherwise she cannot follow him appropriately for changes. If she didn't know the nevus was there, she could easily miss it. It is not always convenient for her to dilate and she can't charge extra, but it's the right thing to do for her patients. She has purchased $2-3,000 worth of medical equipment she can't be reimbursed for, but it gives her patients better care and lets her sleep at night.

Dr. Johnson stated an optometrist from another state recently requested a lower tier license and the Board was told it would be required to grant that license. An applicant has to pass an exam but can still obtain a license without therapeutics or diagnostics because the option exists in the law.

Vice Chairman Souza asked why an outside doctor could to request a license without the diagnostic and therapeutic portion, and whether it is preferable to offer choices or have a uniform license at the same standard. **Dr. Johnson** answered because the law still includes the tiered license, the option exists to practice without diagnostics and therapeutics. She can't imagine anyone wanting to practice without at least the diagnostic portion. The Board's counsel advised the Board the applicant had to be granted the license if requested. Ultimately, the applicant was advised of the Board's plan to eliminate the tiered license option and the applicant withdrew the request.

Mr. Toryanski closed by informing the Committee the Board thinks this bill needs to pass for public safety reasons.

Vice Chairman Souza asked for an explanation of how someone coming to Idaho could get a license without including therapeutics and diagnostics in the practice. It appears that the statute supports the way Dr. Osterberg wants to practice, without offering therapeutics and diagnostics. **Mr. Toryanski** replied the Board rules require someone transferring a license to the State to have therapeutic qualifications. However, if it is a new license and the applicant has the training and passes the exam, the applicant is not required to get a license that allows them to use pharmaceuticals. It is something of a loophole, and the purpose of the bill is to close that loophole. **Vice Chairman Souza** asked where the law states therapeutics must be used in an optometry practice, or that an optometrist can't practice without offering therapeutics and diagnostics. **Mr. Toryanski** referred to the sentence added to Idaho Code § 54-1522 in the bill requiring every applicant to be certified as of January 1, 2019. He would be happy to provide the additional statutes for review. **Vice Chairman Souza** stated she understands the law would require certification, but it doesn't require an optometrist to offer the services or use them. **Mr. Toryanski** confirmed that understanding.

Senator Harris asked for clarification on the reciprocity issue and whether it applies only to individual doctors or Statewide recognition of doctors. **Mr. Toryanski** answered the states all have their own laws and standards. Generally, reciprocity is given if the state where the optometrist is coming from has substantially equivalent licensure as the state coming to. The Bureau oversees many professional licenses, and if a professional from another state was trying to be licensed, the relevant regulatory board would review the other state's requirements. If it was substantially the same as Idaho's, the professional would be granted the license. If the other state has a lower standard to be licensed, then Idaho would not allow the license.

MOTION: **Senator Jordan** moved that **H 11** be held subject to the call of the Chair. **Senator Martin** seconded the motion.

DISCUSSION: **Senator Foreman** said he would like to see a grandfather clause added to the bill. There are only 11 people who fall into the area of concern, and they have been practicing a long time with a lot of expertise. In short order, this will become a moot point due to retirements.

Vice Chairman Souza stated some leeway should be given. There is a requirement for certification but not a requirement to use the practice. There does not seem to be any practical difference between how the senior optometrists practice and a new optometrist who is certified but chooses not to use the pharmaceuticals. **Vice Chairman Souza** commented the standard of care needs to be improved and a multiple-tiered system is not desirable. She would like to see some amendment to allow the senior optometrists to continue, perhaps with some sort of disclosure form for the patients to sign so the public is aware that optometrist's practice is limited to only certain areas. The retirement system will take care of the problem.

Senator Jordan said the primary reason she made her motion is there are some good components to the bill but the testimony did not support that there are threats to public health and safety. With 22 years of recordkeeping, to have so few problems is wonderful. This bill might have come a little too quickly, and perhaps next year, a bill will be brought forward that addresses the Board's concerns but not put people out of business who might be filling a niche in communities.

Senator Martin would consider sending the bill to the Fourteenth Order if amendments can be crafted this year. His intent in seconding the motion was not to kill the bill but rather to allow for time to come up with amendments.

Senator Anthon stated he will oppose the motion. He is in favor of the bill and the policy position. It is a hallmark of professional licensure to have ongoing education, especially in health care. Today when technology and technique and medicine are advancing so rapidly, a practitioner has to keep up. That is the policy behind this bill, and he also feels it is a good policy to have a single standard for all licensees. **Senator Anthon** stressed this is a policy discussion rather than an attack on someone's ability.

SUBSTITUTE MOTION: **Vice Chairman Souza** moved to send **H 11** to the 14th Order for possible amendment. The substitute motion failed for lack of a second.

There being no more discussion, **Chairman Heider** called for a roll call vote on the original motion. **Senators Martin, Lee, Harris, Foreman, and Jordan** voted aye. **Chairman Heider, Vice Chairman Souza, and Senators Anthon and Agenbroad** voted nay. The motion carried.

S 1081 **Relating to the Immunization Assessment Board. Senator Martin** asked Dean Cameron, Director of the Department of Insurance, to present the legislation. **Director Cameron** stated the bill changes a sunset date from 2017 to 2019. In 2009, there were significant budget shortfalls, and Governor Otter recommended cutting funding for immunizations for children on private insurance. The Legislature adopted that recommendation, but shortly thereafter, problems developed. Previously, the State purchased immunizations at a discounted rate, and doctors were able to provide immunizations without regard to insurance coverage. After the recommendation was implemented, physicians were required to keep two separate stocks of vaccines, one for Medicaid patients and another for those privately insured. Those vaccines were purchased at a higher cost.

Director Cameron explained the Idaho Immunization Assessment Program (Program) was adopted to address the cost concerns. The Program was modeled after another state's program but was adapted to Idaho and has since has become the model for other states to follow. The Program provides for the Immunization Assessment Board (IAB) to assess each insurance carrier based on the number of children it insures. Funds are sent to the IAB through the Department of Insurance and then sent to the Department of Health and Welfare (Department). The Department buys one stock of vaccines at a lower cost for both Medicaid patients and insured or self-funded patients, and the vaccines are distributed to local providers. The program does not require any administrative expenses, and every dollar paid by the carriers ends up going toward vaccines.

Director Cameron advised the Program was put in place with a two-year sunset in order to ensure the assessments were not too great and for cost monitoring purposes. The sunset date has been extended for two-year periods since inception, and **S 1081** would extend the sunset date of the Program for an additional two years.

MOTION: **Vice Chairman Souza** moved to send **S 1081** to the floor with a **do pass** recommendation. **Senator Lee** seconded the motion. The motion carried by **voice vote.**

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:29 p.m.

Senator Heider
Chair

Jeanne Jackson-Heim
Secretary

To: Idaho Senate Health and Welfare Committee
2/15/2017

Dr,Art Osterberg
Lic. # OD 453
Issued July 27, 1966

H 11

The 1st part is common sense to pass since all new applicants are trained in the use of drugs.

The 2nd part of H 11 is totally a no pass . It is discrimination, wrong, unfair, and unconscionable.

1. If passed, the law would be a form of genocide to us senior optometrists (the most experienced OD's)
2. A stay of execution would be until December 31, 2018 (22 more months).
3. Execution date to practice in Idaho, January 1, 2019.

What is wrong with my license? Nothing. I have an unblemished record;

1. Over 50 yrs. including military optometry.
2. Master refractionist
3. Current practice: 2nd opinion, limited to no more than 2 days a week
4. Example MD's: Dr. Worden, eye, ear, nose and throat MD

If H 11 is passed into law, who loses? Everyone does.

1. My patients, they want to see.
2. Myself – income – ability to sell practice
3. My wife
4. We will have to sell our ranch

Board of Optometry

Seems like lip service only!

1. "has fuzzy logic" from Dr. King's statement 1/22/2017
2. "leave license alone", Dr. Osterberg's statement to the board 4/14/2016.
3. "That those currently licensed without the therapeutics aspect of licensure be able to retain their optometric license and go forward with the single tier licensure for all other licensees", Dr. Randy L. Andregg, August 8, 2016, past president of IOP.

State of Idaho

Bureau Of Occupational Licenses

Public Record Information (Detail)

IBOL - Licensee Counts
IDAHO BOARD OF OPTOMETRY

Number Of Licenses As Of 2/12/2017

License Type	Current	NonCurrent	Renewable
OPTOMETRIST	4	152	2
OPTOMETRIST W/DPA	8	33	2
OPTOMETRIST W/TPA	449	311	97
Total All License Types	461	496	101

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Thursday, February 16, 2017

SUBJECT	DESCRIPTION	PRESENTER
Page Graduation	Farewell to Committee Page Tia Youts	Chairman Heider
Gubernatorial Appointments	Reappointment of Janet Penfold to the Idaho Board of Health and Welfare	Janet Penfold
	Reappointment of Tom Stroschein to the Idaho Board of Health and Welfare	Tom Stroschein
Presentation	Idaho Caregiving Action Plan	Dr. Sarah Toevs, Director, Boise State University Center for the Study of Aging
HCR 3	Relating to Family Caregivers	Representative Christy Perry
H 8	Relating to Massage Therapists	Mitch Toryanski, Idaho Bureau of Occupational Licenses
H 9	Relating to Massage Therapists	Mitch Toryanski

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Thursday, February 16, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	Senator Anthon
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:01 p.m.
PAGE FAREWELL:	**Chairman Heider** recognized and thanked Tia Youts for her excellent work as the Committee page for the first half of the First Session of the 64th Legislature. **Ms. Youts** thanked the Committee and said she learned a lot about herself and has grown as a person during her time at the Legislature. She plans to attend college in the fall and work toward a degree in pediatric nursing or elementary education. **Senator Souza** asked Ms. Youts the most surprising thing about working as a page at the Legislature. **Ms. Youts** answered she had been warned the Senators are grumpy, and she was pleasantly surprised to learn that was not entirely the case. **Senator Jordan** thanked Ms. Youts and commented she has been an outstanding page and has a bright future. **Chairman Heider** presented Ms. Youts with a gift from the Committee.
PAGE WELCOME:	**Chairman Heider** welcomed Bridger Cardon who will serve as the Committee page for the second half of the 2017 Legislative Session. **Chairman Heider** asked Mr. Cardon to tell the Committee about himself. **Mr. Cardon** informed the Committee he is from Idaho Falls and attends a small high school of six students. He has been able to participate in several overseas trips as part of his studies.
GUBERNATORIAL APPOINTMENT:	**Consideration of the Gubernatorial Reappointment of Janet Penfold to the Board of Health and Welfare. Chairman Heider** introduced Janet Penfold and asked her to tell the Committee about herself and why she would like to be reappointed to the Board of Health and Welfare (Board). **Ms. Penfold** stated she has appreciated serving on the Board for the last 19 years and has learned a lot. She hopes to be able to say she has served on the Board longer than her mother, Frances Field, served in the Legislature. **Senator Martin** asked Ms. Penfold about a specific accomplishment during her time on the Board. **Ms. Penfold** answered she has not accomplished anything individually, but collectively the Board has accomplished quite a bit. When she was first appointed, the Department of Environmental Quality Board was part of the Board. **Ms. Penfold** said she chose to stay on the Board when the Department of Environmental Quality Board was separated because of her interest in health and welfare issues. She has served under three Governors and three Directors, and the caliber of staff serving at the Department of Health and Welfare (Department) is phenomenal. **Ms. Penfold** stated she is impressed by the people for their desire to want to help people and make a difference.

Senator Harris asked Ms. Penfold what is one of the biggest issues coming before the Board. **Ms. Penfold** said there is a lot of waiting to see what happens with the federal government and how it will trickle down to the states. One of the biggest issues the Board discusses is funding for all the Department's programs and services. She feels the State is doing good work and is interested in improving people's lives.

Chairman Heider advised Ms. Penfold the Committee will vote on the reappointment at the following meeting.

GUBERNATORIAL APPOINTMENT:

Consideration of the Gubernatorial Reappointment of Tom Stroschein to the Board of Health and Welfare. Chairman Heider introduced Tom Stroschein and asked him to tell the Committee about himself and why he would like to be reappointed to the Board.

Mr. Stroschein advised he grew up in Aberdeen and attended University of Idaho. He spent 25 years as a sheep herder with 5,000 head of sheep. During the economic downturn in the 1980s, he went to work for Senator Stallings in Washington, DC and worked on agriculture issues. His wife, Ruby, is an appraiser and they have four grandchildren. He is a retired county commissioner and involved in Recovery Idaho.

Senator Martin asked what he and the Board have been able to accomplish, and what the future entails. **Mr. Stroschein** said he has learned quite a bit from Ms. Penfold. He was confirmed for his first appointment to the Board the same year Director Armstrong was confirmed, and it is a privilege to work with Director Armstrong. **Mr. Stroschein** said he is encouraged there is progress on addressing behavioral health and addiction problems. One reason he wants to be reappointed is to continue working on recovery issues.

Chairman Heider advised Mr. Stroschein the Committee will vote on the reappointment at the following meeting.

PRESENTATION:

Idaho Caregiver Action Plan. Dr. Sarah Toevs introduced herself to the Committee on behalf of the Idaho Caregiver Alliance (Alliance) and mentioned she is also from Aberdeen. **Dr. Toevs** stated representatives from the Idaho Commission on Aging and the Idaho Chapter of the American Association of Retired Persons (AARP) are present, as well as caregiver members of the Alliance. (See Attachments 1, 2, and 3 for copies of presentation and handouts.)

Dr. Toevs advised the Alliance includes anyone providing unpaid care for a family member or loved one. The mission of the Alliance is to be the voice of family caregivers, and it has over 350 members, including organizations and individual caregivers. The Alliance's funding to date has come from a $200,000 grant from the Administration on Community Living, which will end in August 2017.

Dr. Toevs commented the Alliance approached the Legislature in 2015 for a concurrent resolution for Idaho to recognize the value of family caregivers and to create a task force to develop a caregiver plan. The Alliance held caregiver summits in Lewiston and Idaho Falls and completed a statewide needs assessment, looking at specific issues such as respite care and behavioral crisis. This year the Alliance is ready to share its action plan.

Dr. Toevs informed the Committee there are more than 300,000 family caregivers in Idaho, providing more than 200 million hours of unpaid care each year. Seventy percent of family caregivers work full or part-time. In 2010, there were six working adults for every retiree, and in 2020 the ratio is projected to be three working adults for every retiree. **Dr. Toevs** reported Idaho is 42nd in the U.S. in providing support for family caregivers and 49th in the U.S. for reporting levels of caregiver stress, worry, and exhaustion. **Dr. Toevs** said caregivers provide increasingly complex medical and psychological care to maintain people in their homes and delay the need for costly institutional care. Forty-eight percent of Idaho's Medicaid budget allocated to long-term care services is spent on institutional care. There is evidence family caregivers reduce readmissions to hospitals and reduce emergency room use, and they enable families and the care recipient to thrive.

Dr. Toevs presented the Alliance's action plan of four goals and ten objectives. The most pressing need is for respite care to give caregivers a break from their duties. Caregivers also need culturally appropriate and local resources, training, and a network of navigators for times of crisis. Respite resources are included on the map provided in the report. While it appears from the map there are many respite providers in Owyhee County, the accuracy of the data is doubtful. There are currently no standards for respite care workers, nor a registry of providers, and there is no central tracking information for respite requests.

Dr. Toevs reported the Alliance has worked to improve caregiver training. Using grant funds, the Alliance arranged for the Powerful Tools for Caregiver (PTC) program to be available in all regions of the State. The PTC program is evidence based and helps build caregiver resiliency, improve communication and time management skills, and assist caregivers' ability to function more effectively. **Dr. Toevs** stated other organizations are starting to expand training opportunities.

Dr. Toevs mentioned the Alliance provided resources to add a new caregiver and respite support button to the Idaho 2-1-1 Careline, and the Alliance will help maintain that option with the Careline. The Alliance has worked to raise awareness about family caregivers, allowing caregivers to be included on boards of other State programs and a wide variety of private organizations. The Alliance believes tax incentives and tax policies could be enhanced to improve support for caregivers.

Dr. Toevs stated the Alliance's next goal is to identify an ongoing funding source to continue its important work, ideally through a public-private partnership. Having resources to ensure data can be collected and report back whether what the Alliance is doing is making a difference. The Alliance is looking for a sponsoring agency with a statewide reach and the ability to coordinate various programs, and it will require people, money, and infrastructure.

Senator Lee inquired if there are states with good support systems for caregivers that could be used as a model for Idaho. **Dr. Toevs** answered Utah and Nevada have strong and innovative caregiver supports. The primary need expressed by caregivers is for respite support. Suggestions for improving local respite support have included using off-duty National Guard members and Medical Corps Reserve members as part of a community respite team.

Vice Chairman Souza asked if the Alliance has connected with any faith-based groups to build a public-private partnership. **Dr. Toevs** replied the faith-based community is extremely important and a good resource for trusted volunteers. The Alliance also considers health care providers as important to achieving outcomes, along with groups such as AARP Idaho and Idaho Parents Unlimited. Providing an infrastructure for these entities to come together is critical to sustain the work begun by the Alliance.

HCR 3

Relating to Family Caregivers. Representative Christy Perry introduced herself to the Committee to present **HCR 3** as a follow-up to the Alliance's presentation. The concurrent resolution highlights the services provided to Idaho citizens in their homes by family and friends without monetary compensation from the State of Idaho. This approach is consistent with Idaho's values of independence, self-sufficiency, and caring.

Representative Perry commented that caregivers provide approximately 201 million hours of uncompensated care annually, and Idaho's health care system depends on at-home caregivers to care for nearly 100,000 Idahoans of all ages. The cost of this care is estimated at $2.1 billion annually. **HCR 3** draws attention to the number of Idahoans in need of care, the complex changes facing uncompensated caregivers, and the cost savings to Idaho because of their efforts to keep citizens out of institutions for as long as possible. The resolution also recognizes the initiative that was taken to understand and address the growing concerns surrounding the increasing demands and medical complexity of cases placed upon caregivers.

Representative Perry stated the resolution asks the Idaho Legislature to support the Idaho Lifespan Family Caregiver Action Plan and its recommendations, including to: 1.) increase public awareness for family caregiving and its burdens and benefits to the families; 2.) provide training to caregivers who are increasingly tasked with managing difficult medical and psychological conditions; 3.) improve caregiver support, including respite care resources; and 4.) integrate family caregivers into health care system discussions and transformations.

MOTION:

Vice Chairman Souza moved to send **HCR 3** to the floor with a **do pass** recommendation. **Senator Harris** seconded the motion. The motion carried by **voice vote.**

H 8

Relating to Massage Therapists. Mitch Toryanski, Legal Counsel for the Idaho Bureau of Occupational Licenses (Bureau), introduced himself on behalf of the Board of Massage Therapists (BMT). **Mr. Toryanski** explained **H 8** adds a criminal-based background check as a licensing requirement for massage therapists for both new applicants and existing licensees. S 1259 (2012) provided for State licensing of massage therapists. Prior to that time, some cities regulated massage therapists, and some local ordinances required a fingerprint-based criminal background check for massage therapists. The massage therapist licensing legislation did not include that requirement, but after having worked with the public for the last five years, the BMT concluded it would be in the interest of public safety to require a background check.

Mr. Toryanski said the bill does not change the information an applicant must give the BMT nor does it change the criteria by which the BMT decides whether or not to issue a license. The requirement increases the likelihood that the criminal history information the Board considers is complete and correct, because the information supplied by the applicant would be verified. There is no fiscal impact to the General Fund, but the Bureau would need additional spending authority to pass through the $37 one-time fee from the license applicants to the Idaho State Police.

Senator Foreman asked whether the current procedure involves fingerprinting. **Mr. Toryanski** answered the only information obtained by the BMT is what the applicant provides. There are no disqualifiers in the law but certain convictions must be reported, such as narcotics convictions, felonies, and crimes of moral turpitude. An applicant with something to hide has an incentive not to report it. **Senator Foreman** suggested the BMT consider obtaining background checks without fingerprinting and asked if the BMT is having problems with either new applicants or existing licensees. **Mr. Toryanski** replied the BMT currently has no way to get information on subsequent crimes after an applicant has been licensed. As for problems encountered by the BMT, there will be testimony later regarding at least one situation involving a massage therapist.

Senator Martin asked for clarification about the $37 background check charge. **Mr. Toryanski** answered it is a one-time $37 pass-through charge.

Senator Harris inquired how long a background check takes and the length of time fingerprints would add to the licensing process. **Mr. Toryanski** responded the BMT intends to invest in a fingerprint scanner to shorten the time for obtaining background check results from four to six weeks to two to three days.

Vice Chairman Souza stated she is uncomfortable with the bill because it comes across as an invasion of privacy. She asked why a simple background check would not accomplish the same result and why fingerprinting is necessary if there have not been many problems or if it doesn't change the criteria on which the BMT would decide an application. **Mr. Toryanski** answered he would like to have others provide testimony to assist with responding to these concerns.

TESTIMONY:

Mark Estess of Eiguren & Ellis introduced himself to the Committee as the Executive Director of the Idaho Chiefs of Police Association. The 2012 legislation preempted the various city ordinances and precluded the cities from conducting this type of background check. It is difficult to give details of past and current cases due to confidentiality issues but some involve human trafficking. The chiefs of police reviewed **H 8** and asked Mr. Estes to convey to the Committee their strong support of the bill.

Vice Chairman Souza asked for further information on how the bill relates to sex trafficking. **Mr. Estess** replied there is no way to get information about people coming into the area to obtain massage therapy licenses and some are brought in by others. **Vice Chairman Souza** stated she does not understand the connection between sex trafficking and fingerprinting massage therapists who may have been practicing for years without any problems. **Mr. Estess** answered he is not the expert in this area. He would be happy to obtain more information for the Committee to better address Vice Chairman Souza's concerns.

Chairman Heider commented he does not believe fingerprints are invasive but rather merely help law enforcement identify people who might be arrested. It is a very standard and normal procedure. **Vice Chairman Souza** responded she has heard from some constituents who are unhappy about the proposed legislation because they see it as invasive.

Senator Foreman said he agrees with Vice Chairman Souza. The motivation is undoubtedly altruistic but he thinks it is unnecessary, most people don't like it, and it's expensive.

TESTIMONY:

Becky Olinger introduced herself to the Committee on behalf of the Idaho State Chapter for the American Massage Therapy Association. The national and state associations strongly support **H 8.** The industry wants to ensure legitimacy of its profession, and this bill is one way to distinguish the profession from another with a similar name that does not have a good reputation. It is possible to purchase a fake identification card and fake diploma from the internet for $1,200 in order to obtain a massage therapy license.

Ms. Olinger informed the Committee that massage therapists work in a wide range of venues, from clinics to doctor's offices to in-home studios and even clients' homes. The clients are potentially very vulnerable because the work is "hands on," sometimes clients are only partially clothed, and clients lie on a table with the therapist standing over them. It is sensitive health care work, and she often receives referrals from chiropractors and doctors. Those professionals are shocked there is no background check requirement for massage therapists, and patients assume the therapist has been checked out.

Ms. Olinger commented the massage therapy license application requires a therapist to self report any convictions and disclose any improper behavior on the part of another massage therapist. Most clients do not know about the Idaho Repository, nor does the Repository cover events happening outside the State of Idaho.

Senator Jordan asked if all massage therapy clients are adults, or if some are children. **Ms. Olinger** replied some of her patients are minors, and there is a requirement that a parent be in the room. **Senator Jordan** further inquired what would prevent a massage therapist from failing to tell the parent about that requirement and being in the room alone with the child. **Ms. Olinger** responded it is part of the license law and their job to inform the parent of the requirement. Some parents are surprised to hear about the requirement, and some are willing to drop off their children and pick them up afterwards.

Senator Lee expressed concern about the rule requiring current massage therapists to have a new requirement. She asked for clarification on how the BMT would apply such a broad requirement to existing practitioners and what the BMT approach to discipline would be. **Ms. Olinger** commented she is unsure whether the BMT has the ability to look at the Repository as part of its process. She is the President of the industry association and cannot address what the BMT might do as far as discipline. As far as doing background checks on current therapists, the legislation has been in place for five years, and she is sure there are some licensees who have an inappropriate background, but she can't prove it.

Senator Lee said she is concerned about unlicensed people performing massage therapy, but she doesn't understand how the background check would solve that problem. Her concern is that the law might be intrusive to those who are law abiding and result in the BMT collecting personal data on licensees. **Ms. Olinger** responded there are 500 members in the state association, and she has not heard from anyone opposed to this legislation. The $37 cost of a background check is a cost of doing business.

Senator Agenbroad said he has heard good arguments on both side of this issue, and he asked if there is any record of identity theft or unauthorized access to personal information by a massage therapist. **Ms. Olinger** answered she has not heard of any situations involving that type of activity. **Senator Agenbroad** further inquired about the opinions of the licensees who are not members of Ms. Olinger's association. **Ms. Olinger** replied she has only heard from the members of her association. There is another national professional association, but she has not spoken with that group and does not know whether they have received any comment on the bill. **Ms. Olinger** added 29 states currently require a background check as part of the licensing process.

TESTIMONY:

Steve Yerger introduced himself to the Committee and stated he became involved in this issue after his wife was assaulted by a massage therapist last year. He learned at that time the licensees do not have to undergo a criminal background check. His wife assumed the licensees had been checked out. **Mr. Yerger** said he talked to 25 people after the incident with his wife, and all of them said they assumed a criminal background check was part of the licensing process. He has been working with the BMT on this matter.

Mr. Yerger works primarily in Idaho and Oregon in armed and unarmed security and Special Investigations Unit work. He has helped corporations set up background check processes in accordance with the law. A simple background check is not always accurate because people can change their name, date of birth, and social security number. He has encountered this many times in his experience. **Mr. Yerger** uses the same database that law enforcement uses to conduct his background checks. If the person entering data into the system mistypes something, even one letter or number, the results of the background check will vary and may be inaccurate or incomplete. He must undergo a background check himself periodically for his work

Mr. Yerger reported the owner of the massage therapy clinic where his wife was assaulted tried to conduct due diligence on the assailant before employing him. The owner checked the Repository and found nothing. After the incident with his wife, **Mr. Yerger** was able to find information on the Repository that the assailant had two previous convictions for the same type of events, violated a no-contact order against one of the victims, and had an additional sealed criminal record. It is likely the clinic owner did not know how to search on the Repository. The best and most reliable background check is by fingerprinting because it is national and it is very difficult to change fingerprints.

Mr. Yerger commented Oregon just had a case where a massage therapist was convicted. When the police did a media release about the case, 10 more women came forward. It is difficult to come forward after a sexual assault. Based on his experience with investigations and background checks, it is safe to say there is more going on than the BMT knows about or than the public hears about. It was difficult for his wife to press charges and she even had a hard time telling Mr. Yerger about it because she blamed herself and felt helpless. The person who did this to his wife lied on his license disclosure and had been operating for some time. After the media release, two other women came forward who did not want to press charges, and subsequently the assailant was found to be operating with an invalid license. It is the government's job to protect people when they can't protect themselves, and regular citizens can't navigate the background check process on their own.

Mr. Yerger reported his wife's assailant spent five days in jail, and his license was revoked but he can reapply for a license after five years. He believes if this bill passes, a number of people will be found not to qualify for a license.

Vice Chairman Souza remarked she appreciates Mr. Yerger's testimony because he is a professional in a related field. She asked if there is a lower level of background check that could be conducted by an expert group and used for people already in the profession who have been successfully performing their work. **Mr. Yerger** replied there are background checks available on the internet for $40 and the quality is not good. A company with the infrastructure and access to the proper database could provide that service. **Mr. Yerger** typically conducts two or three of the lower level background checks on the same person because the results often vary. He just did one check where the person had three different variations of their name. This approach can be more expensive and time consuming than taking fingerprints on a scanner.

Mr. Toryanski was recognized to conclude remarks on the bill. The Bureau serves other boards that require fingerprint background checks, including driving businesses, real estate appraisers, residential care administrators. The Board of Medicine, Board of Nursing, and Board of Pharmacy all require it. The majority of other states do require fingerprinting. People from other countries have been imported to various locations and apply for massage licenses. The people are not who they say they are, and their training and credentials are not as represented. The fingerprint-based background check assures the information received is for the correct individual. People are very surprised when they hear that massage therapists do not have to undergo a background check to be licensed. The BMT has received letters from massage therapists who are not in support of the legislation, but others are very supportive because their clients will have more confidence in them.

Senator Lee asked if there is anything to prohibit the BMT from comparing the information on the license application to the Repository and sanctioning people who have lied on their applications. **Mr. Toryanski** replied there are more than 2,000 licensed massage therapists, who all attest to their records. The BMT is comprised of five volunteers who process renewals, and they would have to hire an employee for that purpose. The legislation contemplates hiring a part-time employee to handle the initial fingerprinting process, but existing staff could handle the work load after the transition. **Mr. Toryanski** explained he has used a number of databases, and the Repository is very cumbersome. In addition, the State of Idaho is moving to a new electronic court system, and it is becoming even more difficult to obtain useful information.

MOTION: **Senator Martin** moved to send **H 8** to the floor with a **do pass** recommendation. **Senator Harris** seconded the motion.

Senator Jordan said she intends to support the motion for several reasons. First, it is instructive that the professional association and the chiefs of police support it. There was a significant problem in Boise City with some people opening spas, but they were not performing actual massage therapy. That was the reason the fingerprint requirement was put into place, and many of the women were found to be working against their will. When the law changed, authority was preempted from the cities, but there was no corresponding transition of responsibility. This is a responsible approach.

SUBSTITUTE MOTION: **Senator Foreman** made a substitute motion that **H 8** be held in Committee subject to the call of the Chair. The motion failed for lack of a second.

Vice Chairman Souza stated she will hesitantly support **H 8** and looks forward to receiving more information from Mr. Estes and Mr. Toryanski. There is enough validity to send the bill to the floor to allow the full Senate to vote on it.

Senator Lee commented she is having a hard time supporting the bill because it does not address the issue of people practicing without licenses. Some of the people Senator Jordan mentioned will not be caught because they don't have a license to start with. This bill might not strike the right balance and she is unsure whether she can support it on the floor.

Chairman Heider called for a roll call vote on the original motion. **Chairman Heider, Vice Chairman Souza, and Senators Martin, Lee, Harris, Agenbroad, and Jordan** voted aye. **Senator Foreman** voted nay. The motion carried.

H 9 **Relating to Massage Therapists. Mr. Toryanski** presented **H 9** on behalf of the BMT. The bill would increase the BMT member honorarium from $50 to $100 for attending a meeting. There are five members who meet six times per year on average. If every BMT member attends every meeting, the total honoraria per year would increase from $1,500 to $3,000, a maximum increase of $1,500 to the Bureau's dedicated fund. There is no fiscal impact to the General Fund. BMT members receive no credit for State service and are not part of the Public Employee Retirement System of Idaho (PERSI). The honorarium is a stipend to partially offset the loss of income absorbed by BMT members for providing a day of State service. The meetings usually last all day and some BMT members travel to Boise from around the State. BMT members must review large amounts of documentation to prepare for each meeting, and there is no compensation for teleconference meetings.

Senator Agenbroad asked how the increase in the honorarium compares to other board honoraria. **Mr. Toryanski** answered the honoraria range from $0 to $100 per meeting. Of the boards served by the Bureau, seven receive no honorarium, 13 receive $50, one receives $75, one receives $100, six receive $35 and two receive $25. Last year, the Board of Pharmacy successfully requested an increase for its board members from $50 to $100.

Senator Martin moved to send **H 8** to the floor with a do pass recommendation. **Senator Jordan** seconded the motion. The motion carried by **voice vote.**

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:44 p.m.

Senator Heider
Chair

Jeanne Jackson-Heim
Secretary

Idaho's Lifespan Family Caregiver Action Plan

Idaho Caregiver Alliance

October, 2016

Acknowledgements

This plan is the product of countless hours of research, outreach, deliberation, and problem solving. It reflects the voice of thousands of often invisible Idaho caregivers and others. The plan is intended to create awareness among policy makers and others and is intended to stimulate dialogue and encourage movement toward an improved environment for Idaho family caregivers. As described in the plan, a perfect storm is brewing, generated by demographic shifts, advances in health care, economic challenges experienced by caregiving families, and the desire to live and age in the community. The system as it is currently configured cannot address the pressure these changes generate. Idaho must look ahead to what can be done proactively to support caregivers and deflect the catastrophe that might well occur if we do not.

We welcome your interest, ideas, and support. Thank you for your leadership, vision, and action toward advancing this plan.

"Under Medicare, we are only allowed a short time in a nursing home after a hospital stay. In 2013, my husband fell and sustained a broken neck. He was also a cancer patient. He was discharged to home at 100 days after spine surgery. The cancer doctor said go home with "hospice." However there are NO hospice services on top of the Greer grade, our area. We had to contend with someone who should have still been in the hospital by ourselves. Total care is hard on backs. In the drug store one day a clerk told me to call the Area Agency on Aging. Our first and only real help. This was after 3 months without help, another hospital stay for my husband, and another nursing home stay. I am trying to stay alive as the only help for my husband and our son, a diabetic since age 2 on insulin for 59 years. I really appreciate the help from the Agency on Aging and wish I had known of it sooner. Thank you."

The voice of an Idaho senior,
No Wrong Door System Assessment, 2015

Idaho Family Caregiver Alliance

AARP Idaho
Ada County Community Paramedics
Advocates for Families/Caregivers
Area Agencies on Aging
Blue Cross of Idaho
Caregivers
Caregiver Support Service Agencies
Boise State University –
Center for the Study of Aging
Community Partnerships of Idaho
Disability Action Center NW
Disability Rights Idaho
Friends in Action/Legacy Corps
Home Care and Hospice Agencies
Idaho Alzheimer's Planning Group
Idaho Area Health Education Center
Idaho Association of Counties
Idaho Commission on Aging
Idaho Department of Health and Welfare Divisions –
Behavioral Health, Public Health, and Medicaid
Idaho Federation of Families for Children's Mental Health
Idaho Health Care Association
Idaho Hospital Association
Idaho Parents Unlimited
Jannus
Living Independence Network Corporation
MS Society
Northwest A.D.A. Center of Idaho
Qualis Health
Regence Blue Shield
Senior Health Insurance Benefits Advisors (SHIBA)
St. Luke's, Mountain States Tumor Institute
Treasure Valley YMCA
Veterans Administration

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ICA VISION: To serve as the voice, convener, and catalyst for support of unpaid family caregivers across the lifespan.

The mission of the Idaho Caregiver Alliance is to advance the well-being of family caregivers by promoting collaboration that improves access to quality support and resources, including respite for caregivers across the lifespan.

Executive Summary

Family bonds and support are hallmarks of the State of Idaho and cornerstones of independence for older adults and individuals with physical or emotional disabilities, or chronic illnesses. The support provided by families is often fundamental to this independence and the value of unpaid family caregiving is receiving increased attention in Idaho and throughout the United States.

Why this attention now?

- In part, it is due to demographic change – 10 years ago, the ratio of working age adults to older adults was 6 to1. By 2020, this ratio will be 3 to 1. In addition, more families of children and adults with disabilities are opting for home-based care. There are and will be fewer and fewer caregivers for a rapidly increasing number of people needing care.
- Family caregivers manage increasingly complex medical and/or psychological conditions without the support and training they need. The supports that do exist are fragmented and difficult to access.
- Family caregiving is not free. The costs include lost income to the caregiver and lost productivity to an employer. For example, the income generating potential for a caregiver is projected to be $600,000 less over a lifetime and employers lose an estimated $33.6 billion annually related to employee caregiving responsibilities.
- Caregiving takes its toll on caregiver health and wellbeing and impacts the entire family.
- Support from family caregivers can delay the need for costly institutional care. In 2014, Idaho spent $271,522,099 or 48% of its Medicaid budget on care in nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICFs/ID) and inpatient psychiatric hospitals.

The absence of a solid support structure for caregivers takes a serious toll on the economic and social wellbeing of families, businesses, and communities across Idaho.

What can Idaho do to support caregivers?

The Idaho Lifespan Family Caregiver Action Plan offers an evidence-based set of recommendations to put Idaho ahead of the caregiver crisis curve and set a course into a future that is economically viable for caregivers, employers, and service systems. The plan proposes:

- ✓ A range of supports that can mean the difference between caregivers being able to manage their caregiving responsibilities and their own health vs. losing their jobs or placing their family members in out-of-home care. These supports can range from respite care to information and training to legal, financial, and tax-based supports.
- ✓ Increased public awareness to ensure that caregivers identify themselves in order to seek support and a general public that recognizes the contributions and needs of caregivers and understands ways by which family caregivers can be supported.

- ✓ A seat at the table as Idaho pursues changes to its primary care, behavioral health, and long-term supports systems. This will ensure that the voice of family caregivers is recognized and their expertise and experience are included in caregiving decisions.
- ✓ A sustained voice for Idaho caregivers through the continuation of the Idaho Caregiver Alliance, an umbrella organization that promotes collaboration to improve access to quality support and resources for caregivers across the lifespan.

What are the Next Steps?

The perspectives and expertise of caregivers and allies from public and private organizations in Idaho provide the foundation for the Idaho Caregiver Action Plan. The Plan, available on the Idaho Commission on Aging and Center for the Study of Aging, Boise State University websites, is designed to identify and enhance local supports for family caregivers.

The aim of the ***ACTION PLAN*** is to be proactive; to prevent or delay the need for costly institutional care, maximize independence, and keep families together in their communities. Implementation of the ***ACTION PLAN*** will require an investment of resources, but as demonstrated by caregiver initiatives in other states, the effort will yield significant dividends.

An electronic copy of the Idaho Lifespan Family Caregiver Action Plan and Executive Summary is available through Center for the Study of Aging at Boise State University, https://hs.boisestate.edu/csa/idaho-lifespan-family-caregiver-action-plan/

Introduction

The work force of unpaid family caregivers is receiving increased attention in Idaho and throughout the United States. This is due, in part, to recognition of the critical role families play in the health care delivery system. The **Idaho Caregiver Alliance (ICA)**, a collaborative initiative of the Idaho Commission on Aging, the Center for the Study on Aging at Boise State University, Jannus Corporation, Idaho Parents Unlimited, Idaho Department of Health and Welfare (Public Health, Medicaid, Children's Behavioral Health, and Service Integration), AARP Idaho, family caregivers and others, is leading this effort in Idaho. The mission of the ICA is to advance the well-being of caregivers by promoting collaboration that improves access to quality support and resources for family caregivers across the lifespan. This document outlines the rationale and goals for a Lifespan Family Caregiver Action Plan for Idaho.

There is a vast, invisible workforce of caregivers in Idaho. Each year, more than 300,000 - **1 out of every 4 adults in Idaho -** assume critical, ongoing care responsibilities for aging parents, siblings, spouses, children, or grandchildren with physical or emotional disabilities, or chronic illnesses[1,2]. These family members provide over **201 million hours of uncompensated care annually** at an estimated value of **$2 billion to Idaho's economy**.[3] This is equivalent to Idaho's current budget for all publicly-funded long-term care services.[4]

300,000

Idaho family caregivers

201,000,000

Hours of caregiving annually

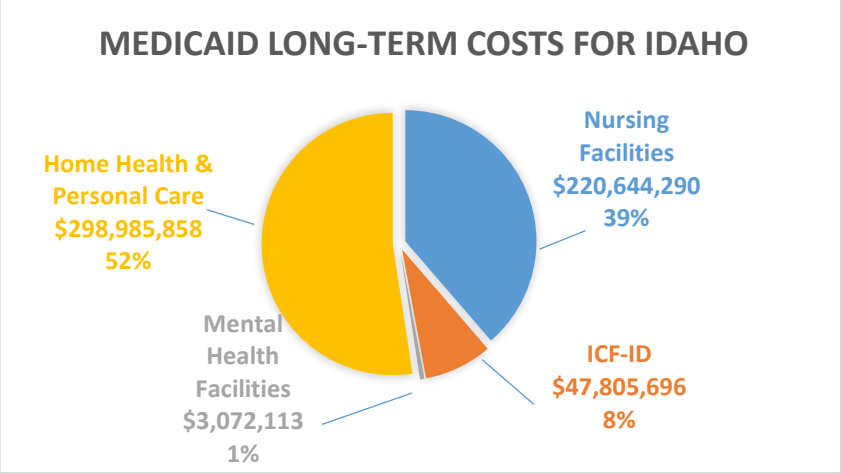

Figure 1 – Idaho Medicaid Long-Term Care Costs

Access to support for family caregivers is important in delaying the need for costly institutional care. As in many states, a significant proportion of Idaho Medicaid expenditures for individuals eligible for both Medicare and Medicaid are for services in nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICFs/ID) and inpatient

[1] *Across the States: Profiles of Long-Term Care and Independent Living Idaho 2012: Valuing the Invaluable Update: Understanding the Impact of Family Caregiving on Work* (AARP Public Policy Institute)
[2] *Idaho Caregiver Needs and Respite Capacity Report, 2014*. (Cirerol, T & Toevs, S.E.)
[3] *Across the States: Profiles of Long-Term Care and Independent Living Idaho 2012: Valuing the Invaluable Update: Understanding the Impact of Family Caregiving on Work* (AARP Public Policy Institute)
[4] *FY 2016 Legislative Budget Book* (Department of Health and Welfare FY 2015 appropriation, p. 2-8)

psychiatric hospitals. In 2014, Idaho's Medicaid spending for long-term care was **$570,507,957,** just under 1/3 of its total budget. Of this amount, **48%** or **$271,522,099 was spent on care in these settings**.[5] An investment in family caregivers reflects Idaho's values of fiscal responsibility and the Governor's commitment, "to using common sense in ways that make better use of our tax dollars now and in the future."[6]

Who is a Caregiver?

As expressed by Rosalynn Carter, "There are four kinds of people in the world: those who have been caregivers; those who currently are caregivers; those who will be caregivers; and those who will need caregivers." Caregiving encompasses many responsibilities and has many different faces. A family caregiver may be a parent caring for a child with serious medical issues, or a young adult taking care of a grandparent with a heart condition. Caregiving may be a sister caring for a brother with schizophrenia, or a husband supporting and caring for a wife with dementia. Often, a caregiver fulfills a combination of these roles. The care provided may range from a trip to the grocery store or a medical appointment, to 24/7 care involving medication administration, wound care, or other complex medical services. A caregiving role may last a few months or a lifetime, and although these responsibilities are taken on willingly and with love, they come at a cost to individuals, families and society.

What do Family Caregivers Provide?

- ✓Complex medication management
- ✓ Care coordination
- ✓ Wound care
- ✓Mental health planning & supervision
- ✓ Personal care
- ✓Financial management
- ✓Health insurance advocacy
- ✓ Transportation
- ✓ Emotional and spiritual support
- ✓ Medical equipment operation
- ✓ Interpreting medical directions

The ICA acknowledges that the term "caregiver" can carry a negative connotation. *Care partner* or *carer* or an individual's relationship to the care recipient (spouse, parent, sibling, etc.) is often preferred terminology. It is important to acknowledge that words matter and can influence our thinking and actions. However, the ICA has opted to use the term "caregiver" based on its use by local and national organizations, funding agencies, and its broad recognition by the general public and stakeholders. There is no intention to demean or diminish the work being done or the reciprocal relationship between the recipient of services and the person providing the support.

Changing demographics. While the number of older adults is increasing across the country, Idaho has the ninth fastest growing population of people over the age of 65. Based on current projections, 20% of the population in Idaho will be 65 or older by 2020, whereas the population of working age adults will

[5] *Distribution of Spending on Long-Term Care* (Kaiser Family Foundation, 2014)
[6] *Idaho indicators aging and work. State Perspectives at Boston College* (Wong, M., McNamara, T., Shulkin, S., Lettieri, & C., Careiro, V., 2008)

only increase by 0.2% a year over the next decade.[7] Ten years ago, there were approximately 6 working age adults for every person age 65 and older. By 2020, this ratio is projected to decrease to 3:1 – a 50% reduction. [8] This demographic shift foreshadows a caregiver crisis; Idaho will have significantly fewer family caregivers to care for a growing aging population.

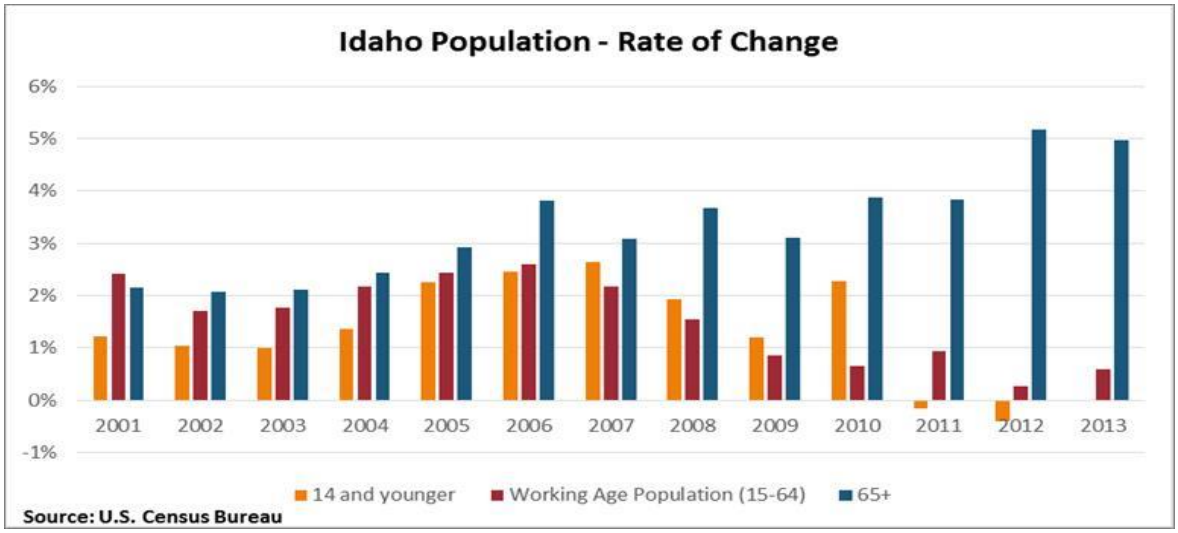

Figure 2 – Change in age distribution of Idaho population: 2001 -2013
Idaho Department of Labor

Caregiving is not just about older adults. It also impacts families caring for children with disabilities. In 2012, 8% of U.S. adults reported providing unpaid care to a child living with health challenges or disabilities, up from 5% in 2010.[9] As the U.S. population ages and as medical advances save and extend more lives and more people across the lifespan opt for home-based care, this upward trend in the need for family caregivers will continue.

The Costs of Caregiving

Impact of Caregiving on the Caregiver and Family

Family caregiving impacts all aspects of a family's economic and physical wellbeing. Caregiving can jeopardize a family's ability to maintain their housing or provide care for a loved one, or cause a family member (including the caregiver) to postpone educational opportunities that could improve their future. The demands of caregiving create stress not only on the caregiver, but other family members as well. For families with children with disabilities, siblings also feel the impact as the family focuses energy and attention on the demands of the child with special needs. The demands are further heightened for individuals providing care for a child and an older family member simultaneously.

[7] *Idaho's Population Growth Slowed During Recession* (Idaho Department of Labor, 2015)
[8] Ibid
[9] *Family Caregivers are Wired for Health*. Pew Internet and American Life Project (Fox, S., Duggan, K., Purcell, K., 2013)

Uncompensated caregiving is not "free." There are many hidden financial, physical, and emotional costs to uncompensated caregiving. Twenty-two percent of caregivers of younger adults with disabilities indicate they are experiencing financial strain from out of pocket support.[10] These contributions reflect a diminished capacity on the part of many working families to take care of themselves and their (other) family members. According to a 2015 retirement confidence survey, 29% or 3 in 10 people say they are currently providing direct financial support to a relative or friend. According to a Pew Research Center study, 28% of adults with a parent age 65 or older helped their parents financially within the past year.[11] The financial impact of caregiving increases with the intensity of the care provided, the geographic distance between care recipient and care provider's places of residence, and access to supportive resources.

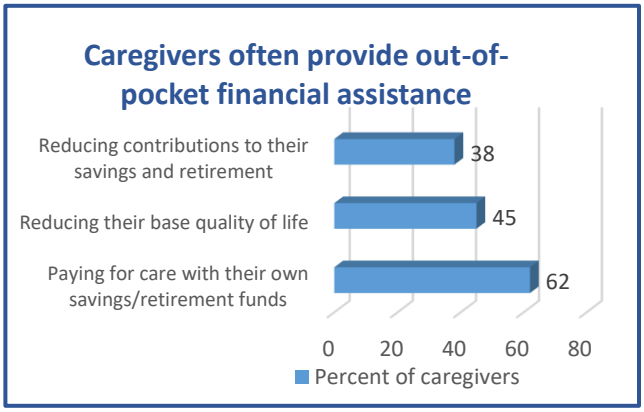

Figure 3 – Out-of-pocket financial assistance
Beyond Dollars: The Expanding Circle of Care, Executive Summary, Genworth Financial, 2016

Families are unable to manage the cost of long-term care. Insurance policies for long-term care can be purchased as a means of paying for all or part of the cost of care in a facility or at home, but this option is becoming increasingly unaffordable.[12] People with low incomes and few financial resources have no option but to rely on Medicaid. At the other end of the wealth spectrum, people can pay for extended care out of their savings. The dilemma is hardest for the large number of people in the middle. With significantly increased premiums and fewer benefits, retirees on fixed incomes are increasingly canceling their long-term care policies.[13] A major factor in the decision to purchase – or keep – long term care insurance is whether the person will have family or friends to provide at least some unpaid help. Many people are counting on such free help, but there is a shrinking number of family caregivers, due to smaller families and other demographic shifts.[14]

Most caregivers are juggling work and caregiving. While each situation is unique, nearly 70% of Idaho caregivers are employed full or part-time and caring for their own children or an aging parent.[15] A national study indicates that 6 out of 10 caregivers have had to make workplace accommodations to meet their caregiving responsibilities (see Figure 4). These changes can range from cutting back work

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[10] Caregivers of Younger Adults: A Focused Look at Those Caring for Someone Age 18 to 49, (AARP Public Policy Institute), June, 2016, p.8
[11] *Family Support in Graying Societies: How Americans, Germans and Italians are Coping with an Aging Population* (Pew Research Center, 2015)
[12] *Long-Term Care Insurance Less Bang More Buck* (Kaiser Family Foundation, March 17, 2016)
[13] *Why Do People Lapse Their Long-term Care Insurance?* (Hou, W., Sun, W., & Webb, A. Center for Retirement Research at Boston College, October 2015, 15-17)
[14] *Long-Term Care Insurance: Is It Worth It?* (Scism,L, Wall Street Journal, May 1, 2015)
[15] *Idaho Caregiver Needs and Respite Capacity Report, 2014*. (Cirerol, T & Toevs, S.E.)

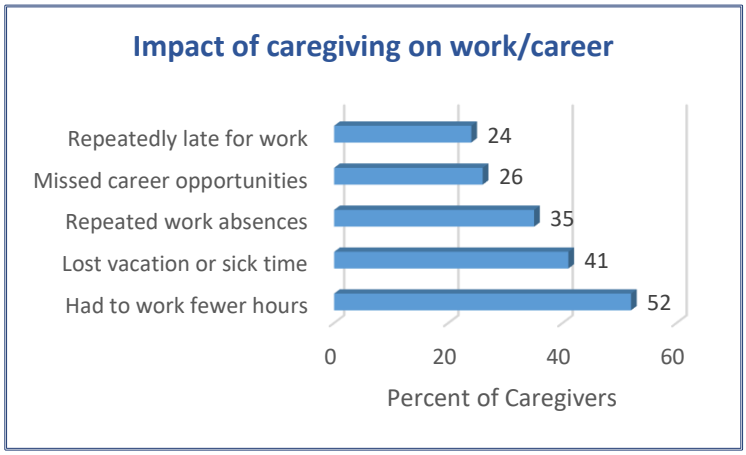

Figure 4 - Impact of caregiving on work/career
Beyond Dollars: The Expanding Circle of Care, Executive Summary, Genworth Financial, 2016

hours to taking a leave of absence, to receiving a warning for poor performance or attendance.[16] The demands of caregiving may also require reducing paid employment or leaving employment altogether. In fact, employment outside the home may be impossible for some parents of children or adults with disabilities, because caregiving is their uncompensated full-time job. A recent study estimates that working caregivers lose about $660,000 in wage wealth over their lifetime because of work sacrifices.[17] Employment difficulties such as these cause a ripple effect: loss of health care benefits, diminished financial independence, and severe physical and emotional stress for the caregiver.

Caregiving can negatively affect the health of the caregiver. According to the 2012 *Stress in America* report, individuals who care for family members who are chronically ill have higher levels of stress and poorer health than the population at large. What's more, while older adults often report lower stress levels, those who shoulder caregiving responsibilities are more stressed and have poorer physical health than their peers.[18]This stress can lead to depression, anxiety, sleep problems, and health issues such as obesity and high blood pressure. Caregivers are also more likely to get sick than the general population, 17% versus 6%, respectively.[19] There is also evidence that spouses caring for a partner with dementia are at an increased risk of dementia themselves.[20] With these negative health impacts, caregivers are ultimately at risk of needing care – and a caregiver – themselves.

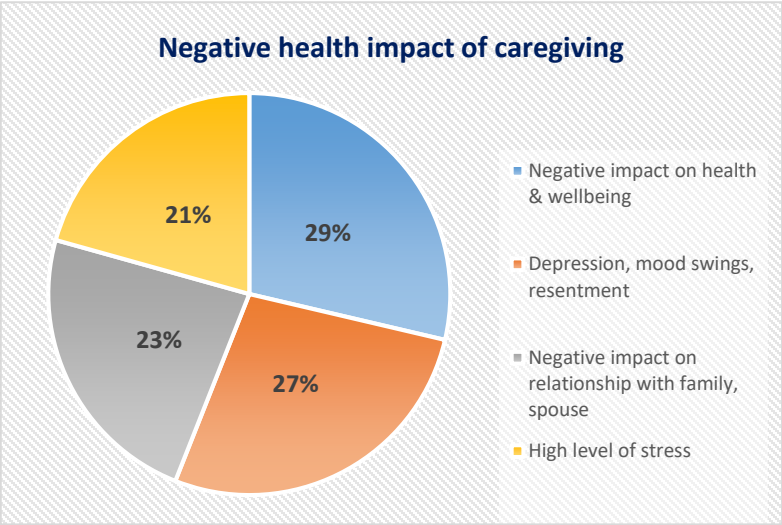

Figure 5 – Negative health impact of caregiving
Beyond Dollars: The Expanding Circle of Care, Executive Summary, Genworth Financial, 2016

[16] *Caregiving in the U.S., Executive Summary* (AARP Public Policy Institute, June, 2015, p.22)
[17] *About Caregiving, Guide to Long Term Care Planning* (Day, T. National Care Planning Council, 2016)
[18] *Stress in America: Our Health at Risk* (American Psychological Association, January, 2012, p. 5)
[19] *Stress in America: Our Health at Risk* (American Psychological Association, January, 2012, p. 8)
[20] *Does caring for a spouse with dementia promote cognitive decline? A hypothesis and proposed mechanisms (*Vitaliiano, R.P., Murphy, Young, H.M., Echeverria, D., & Borson, S., *Journal of the American Geriatric Society, 59*, 900-908)

Economic Consequences of Caregiving on Employers

It is estimated that U.S. businesses lose $25-28 billion annually in lost productivity due to the absenteeism of caregivers.[21] That figure increases to $33.6 billion when including the costs of replacing employees, workday distractions, supervisory time and reduction in hours from full to part time.[22,23] In fact, the average annual cost to employers per full-time working caregiver is $2,110.20.[24]

$2,100

Average cost to employer for caregiving employee

How Can Idaho Support the Caregiver?

We Need Caregiver Supports

Caregivers need support to sustain and expand their caregiving capacity and avoid costly health challenges. These supports include such things as transportation assistance, spiritual and emotional support, and workplace flexibility. These forms of assistance are important, often decisive factors between the care recipient remaining at home or being placed in a nursing home or other facility; between a caregiver remaining employed, or being pushed out of the workforce; between a family being able to remain in their home town, or having to relocate to access needed services. Critical supports include:

✓ ***Respite Care***: Having some "time away" from caregiving prevents or delays burnout, relieves caregiver stress, and allows caregivers time to take care of themselves. A clear understanding of what respite services are and their importance, how to find and access respite care, methods of funding such services, standards for respite providers, and a statewide respite registry are needed to provide this vital form of assistance to caregivers. Respite care is an investment in both family and community wellbeing by keeping caregivers employed and socially engaged.

> *"Caregiving has all the features of a chronic stress experience: It creates physical and psychological strain over extended periods of time, is accompanied by high levels of unpredictability and uncontrollability, has the capacity to create secondary stress in multiple life domains such as work and family relationships, and frequently requires high levels of vigilance."*
>
> *Schulz and Sherwood*
>
> In *Physical and Mental Health Effects of Family Caregiving, 2009*

✓ ***Information and Training:*** Caregivers are increasingly expected to manage complex medical and/or psychological conditions with little to no information, instruction, or support. At present, assistance and information for caregivers is limited, fragmented, and based mostly on the needs of the care recipient, and not resources for the caregiver. Comprehensive information and training are needed for caregivers

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[21] *The Cost of caregiving to the U.S. economy, and what business leaders can do about it Business Journal*, (Witte, D., December 1, 2011. Data are from the Gallup-Healthways Well-Being Index, 2011)

[22] *MetLife Study of Working Caregivers and Employer Health Care Costs* (MetLife Mature Institute, National Alliance for Caregiving, & University of Pittsburgh, February 2010)

[23] *Caregiving in the US. 2015 – Focused Look at Caregivers Age 50+* (National Alliance for Caregiving & AARP Public Policy Institute, 2015)

[24] *MetLife Caregiving Study: Productivity Losses to U.S. Business* (MetLife Mature Market Institute & National Alliance for Caregiving (NAC), 2006. The lost productivity estimates are based on the 2004 survey of U.S. caregivers conducted by NAC and AARP, Caregiving in the U.S. 2004)

to be effective, safe, and supported in their caregiving responsibilities. In addition, caregivers need to be recognized by health care providers as an important part of their family member's medical care team.

✓ ***Financial and Legal Supports:*** Many caregivers face confusing and complicated legal issues connected with their caregiving responsibilities. For example, families caring for children with disabilities require information about guardianship and trusts to provide financial support to their child upon reaching the age of majority. For families caring for seniors, guardianship issues, financial, and end-of-life planning can also be complex. Although Idaho has enacted the Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act, access to this expertise remains challenging and expensive. Therefore, financial and legal resources are needed to help family caregivers navigate the complexities of this nuanced, crucial area of providing support and care for a loved one.

✓ ***Tax-based Supports:*** Caregivers need enhanced tax-based supports to ameliorate the often staggering costs incurred by caregiving. Under Idaho tax code, Title 63, Chapter 30, caregivers are allowed up to three annual $1,000 deductions for qualifying care recipients who receive at least half of their support from the taxpayer. Although a good starting place, this tax credit is inadequate. The growing number of national and state proposed caregiver tax credits and deductions recognize that such tax-based incentives help caregivers maximize their often limited fiscal resources and help reduce the need for publicly funded services. Updating the existing Idaho tax code to provide more comprehensive caregiver deductions as well as tax credits is a step in the right direction to ensure family caregivers remain financially stable and independent.

We Need Public Awareness to Identify Caregivers

Caregivers must be able to identify themselves as such in order to seek support. The very role of caregiving is often misunderstood, and not well defined. Public awareness campaigns and other initiatives are needed to establish a cogent, recognizable definition of caregiving that will help bridge this gap in understanding for both caregivers and the general public.

We Need Involvement in Making System Changes

Caregivers need a seat at the decision-making table as Idaho embarks on making significant revisions to primary care, the behavioral health care system, and long-term care services and supports. These efforts include:

✓ Recognition of family caregivers as an important component of the "medical neighborhood," both as a resource and a potential recipient of services as the **Statewide Healthcare Innovation Plan** (SHIP) transforms primary care clinics into patient or person-centered medical homes (PCMHs).

✓ Inclusion of the voice of family caregivers in efforts to redesign the **Behavioral Health** care system (which encompasses mental health and substance use disorders) in Idaho. Important strides have been made in recognizing the need for preventative and crisis services at the local level; it is imperative that the voice and experience of family caregivers be included in these efforts.

✓ Inclusion of the perspectives of both the care recipient and their caregiver in efforts to coordinate and streamline transitions between care settings (hospitals, assisted living, home) across systems (Medicaid, Medicare, Veterans Health Administration) through the **No Wrong Door Initiative** (an effort by the Idaho Commission on Aging and others to work together to make it easier for people of all ages, abilities and income levels to learn about and access the services they need).

✓ Inclusion of family caregivers in Idaho's efforts to enhance workplace supports and tax policies that support families and the state's economic vitality.

We Need a Sustained Voice for Caregivers Across the Lifespan

The Idaho Caregiver Alliance (ICA), established through a 3-year Lifespan Respite Grant to the Idaho Commission on Aging from the Administration on Community Living (ACL), has made significant strides in recognizing the importance of family caregivers in Idaho. It is imperative ~~that~~ this work be ~~is~~ sustained. The continued presence of ICA as an umbrella organization is critical to the success of efforts underway to support and sustain the unpaid family caregiver workforce, but with grant funds ending, the future of ICA is uncertain. ***An organizational home and funds to sustain the work of the Alliance are needed to ensure the momentum generated through the Lifespan Respite grant is not lost.***

What are the Next Steps?

The perspectives and expertise of caregivers and allies from public and private organizations in Idaho provide the foundation for the following Action Plan. The plan incorporates evidence-based practices to enhance and build local supports for family caregivers. The aim of this ***ACTION PLAN*** is to be proactive: to prevent or delay the need for costly institutional care, maximize independence, and keep families together in their communities. Implementation of this ***ACTION PLAN*** will require an investment of resources, but as demonstrated by caregiver initiatives in other states, the effort will yield significant dividends.

Goal #1: Ensure a streamlined, coordinated system of supports for caregivers across the lifespan, recognizing the unique needs of Idaho's diverse population.

Family Caregiver Supports

Family caregivers often require assistance to navigate the complex systems and information essential to providing quality care. They also need training on fundamental caregiving responsibilities, such as dispensing medications and managing complex medical and psychological conditions, providing personal care, financial management, and coordinating transportation. Further, caregivers need tools and information regarding prioritization of their own physical and emotional wellbeing or "self-care." Receiving this support translates into more effective caregiving and cost savings to families and healthcare and social services systems.

Objective:

#1: Develop statewide respite resources

Steps to accomplish:

A. Convene a respite task force comprised of family caregivers, public and private agencies and organizations, and healthcare and social service providers to:
   - Compile, maintain, and promote use of a resource directory of available respite and respite-like resources such as homemaker, companion services, personal care services, etc.
   - Explore development of a standards-based, statewide respite registry for caregivers across the lifespan
   - Inform caregivers and local information and referral networks about respite and other caregiver support programs offered through the Area Agencies on Aging (AAAs), Centers on Independent Living (CILs), and other entities

B. Improve training for respite providers across the lifespan.
   - Identify online training resources
   - Maintain a library of resources on Idaho 2-1-1 Careline website
   - Market training opportunities to caregivers, service agencies, and individual respite workers through statewide networks

Objective:

#2: Ensure culturally appropriate information and resources are available to caregivers across the lifespan.

Steps to accomplish:

A. Embed information about evidence-based caregiver resources into existing statewide information systems, such as the Idaho 2-1-1 Careline and websites for Live Better Idaho, Behavioral Health, Center for Disabilities and Human Development/Family Support, and others.

B. Compile community resources to support those in a family caregiving role.
   - Partner with AARP Idaho in the development and distribution of a Question and Answer Resource Guide for family caregivers across the lifespan
   - Make these guides available through various audiences including the medical-health neighborhoods built through the seven State Healthcare Innovation Plan (SHIP) Regional Collaboratives and the Regional Behavioral Health Boards (RBHBs)
   - Coordinate with Information and Assistance/Referral specialists at the regional agencies such as Area Agencies on Aging (AAAs) and the Centers on Independent Living (CILs) to promote information and resources for caregivers

C. Promote the availability of information resources for caregivers to employers, health care and social service providers, faith-based organizations, and others.

Objective:

#3: Establish training resources for family caregivers on caregiving responsibilities, techniques, and strategies for self-care.

Steps to accomplish:

A. Oversee implementation of the *Powerful Tools for Caregivers (PTC)* training[25], ensuring that it is offered across Idaho.
   - Identify funding strategies for delivering both the traditional curriculum that focuses on caring for adults, and the newly developed version for caregivers of children
   - Promote the expanded delivery of PTC

[25]Powerful Tools for Caregivers, 2016

- Assess the impact of the training including process (attendance, reach) and outcome (satisfaction and impact of class on participants) measures and share these findings with stakeholders.

B. Collaborate with other organizations on training opportunities for various populations such as:
    - Support an annual Family Caregiver Conference
    - Co-sponsor trainings that have a lifespan focus
    - Coordinate with Idaho Department of Health and Welfare (IDHW), Idaho Parents Unlimited (IPUL) and the Federation of Families for Children's Mental Health (FFCMH) on training for families caring for children/youth with disabilities
    - Provide updates via the Regional Care Coordination Coalitions through Qualis, SHIP Regional Collaboratives, and others

Objective:

#4: Establish a statewide network of experts equipped to serve as information and support navigators or guides for family caregivers across the lifespan.

Steps to accomplish:

A. Partner with existing local information and referral networks to embed assistance for caregivers across Idaho's increasingly diverse populations.
    - Identify individuals with system knowledge and care management experience within these networks in each geographical area of the state
    - Develop training tools to prepare individuals within organizations to serve as guides to needed services and supports for family members
    - Acknowledge and formally recognize people and organizations who guide caregivers to services and supports

B. Identify sustainable funding to hire and train personnel to assist caregivers across the lifespan to access services and supports.

C. Implement marketing campaigns to communicate the availability of assistance for family caregivers and professionals who interact with caregivers.

Goal #2: Increase public awareness about unpaid family caregiving and help people within our communities identify as caregivers.

Public Awareness

A "family caregiver" or "care partner" is a family member or friend who provides physical and/or emotional support or assistance to a loved one of any age who is ill, frail, or has disabilities. Caregivers are relatives or friends who provide support without compensation. Family caregivers are more likely to seek information, respite, and training assistance when they recognize they are in a caregiving role. Such self-identification removes a major hurdle for those who would benefit from assistance. A public campaign is needed to increase awareness about the value of caregivers and to help family caregivers identify and connect with support, information, and training.

Objective:

#5: Family members recognize themselves as caregivers and the general public is aware of the needs and contributions of family caregivers across the lifespan.

Steps to Accomplish:

A. Expand community engagement through continued coordination of regional caregiver summits and statewide Idaho Caregiver Alliance (ICA) meetings.
   - Coordinate with regional entities such as the AAAs, the CILS, and the RBHBs regarding ICA activities and recommendations

B. Employ a variety of media and public awareness strategies to promote the value of family caregivers.

C. Increase awareness and support of family caregiving issues among local, state, and national elected officials.
   - Maintain regular communication with Idaho's local, state, and federal officials regarding ICA activities and recommendations
   - Support November as National Family Caregiver Month through a Governor's Proclamation and other means.

- Advocate for all members of Idaho's Congressional Delegation to join the bipartisan, bicameral Assisting Caregivers Today (ACT) Caucus.

D. Recognize Idaho employers who demonstrate exemplary accommodation of the needs of family caregivers.
    - Inform Idaho employers of the needs of family caregivers and the benefits to both employer and employee of supporting those needs.
        - Develop and distribute awareness information through civic groups, business organizations, and Chambers of Commerce
        - Identify employers who express interest in increased workplace flexibility
    - Promote the use of the WorkFlex Tool Kit[26] to targeted employers
    - Nominate exemplary employers for the *When Work Works* Award[27]

Goal #3: Recognize the importance of family caregiving and embed the voice of family caregivers in policy and system changes.

Systems Change

Caregivers are critical, but often unrecognized, members of the healthcare team. Integrating family caregivers into a team-based, person-centered paradigm with other health care providers will assist them in delivering more effective care. Such integration is critical to achieve the triple aim of improved care (quality and satisfaction), better health, and reduced health care costs. An integrated system provides family caregivers with information about resources and supports, and when appropriate, includes them in treatment planning with their family member and provides the training needed for specialized care.

Objective:

#6: Recognize family caregivers as part of their family members' health care and social support team.

[26] Families and Work Institute, Society for Human Resource Management, & Life Meets Work. (2012). Workflex employee toolkit. Retrieved from http://www.whenworkworks.org/downloads/workflex_employee_toolkit.pdf

[27] The award is part of **When Work Works (WWW)**, a research-based initiative which highlights how **effective and flexible workplaces** can yield positive business results and help employees succeed at work and at home. It is awarded annually.

Steps to Accomplish:

A. Advocate for training programs for community health emergency medical services (CHEMS) and community health workers (CHWs) to include modules on family caregiving.
    - Ensure the curriculum for training CHEMS personnel and CHWs include learning outcomes specific to caregiver identification, assessment, and support

B. Advocate for post-secondary education programs to include curricula that equips health care and social service professionals with the skills to identify and support family caregivers.

C. Develop a process for use of an assessment tool to determine caregiver training and self-care needs
    - Identify and promote the use of an assessment tool
    - Provide caregiver assessment tool kits to health and behavioral healthcare providers and local and regional agencies who interact with caregivers

Objective:

#7: Embed family caregiver perspective and involvement in Idaho's efforts to transform its primary care, long-term care, and behavioral health systems.

Steps to Accomplish:

A. Ensure the Idaho Healthcare Coalition is apprised of family caregiver issues and concerns.
    - ICA's representative to the Idaho Healthcare Coalition (IHC) will share ICA information, reports, and plans at IHC meetings.
    - Advocate for caregiver representation on each of the SHIP's seven Regional Health Collaboratives

B. Increase the awareness and knowledge of family caregiving concerns and resources for members of the BHPC and the RBHBs.
    - Share information between the BHPC and the ICA through reports to both bodies at their respective meetings
    - Ensure that caregivers on the BHPC and the RBHBs are equipped with caregiving information to serve as advocates

C. Promote the involvement of family caregivers in the efforts to coordinate and streamline Idaho's long-term care system via the *No Wrong Door Initiative*.
    - Ensure that the Person-Centered Planning/Counseling training curriculum includes modules on how to identify and support family caregivers

Objective:

#8: Include family caregivers in Idaho's efforts to enhance employment opportunities and tax policies that support families and the state's economic vitality.

Steps to Accomplish:

A. Collaborate with policymakers to minimize barriers that prevent family caregivers from maintaining paid employment.
    - Enact leave policies and benefits that are supportive of caregivers
    - Reduce restrictions on the availability of leave benefits
    - Expand the definition of care recipients and applicable conditions under which leave can be taken

B. Work with employers and organizations representing employers to support the growing population of working caregivers.
    - Enhance caregiver information and support available through benefit plan
    - Implement fair and flexible personnel policies

C. Collaborate with policymakers and others to update the state tax code to provide more comprehensive caregiver deductions and tax credits.

Goal #4: Ensure a coordinated voice for family caregivers in Idaho through the development of a sustainable structure for the Idaho Caregiver Alliance.

Infrastructure

The Idaho Caregiver Alliance (ICA) is a broad coalition of public and private organizations and individuals. The goal of the Alliance is to advance the well-being of caregivers by promoting collaboration that improves access to quality support and resources for family caregivers across the

lifespan. All members realize the value of family caregivers and recognize the limitations of existing systems to provide support to caregivers across the lifespan. The ICA has utilized this shared commitment to

- assess the needs and capacity of caregivers and support systems in Idaho
- engage caregivers throughout Idaho by hosting regional summits in Lewiston and Idaho Falls
- build statewide capacity to support caregivers through the evidence-based Powerful Tools for Caregivers (PTC) program by providing training and technical resources
- conduct a pilot program to deliver emergency respite to caregivers
- convene and report findings to members of the Idaho Legislature, IHC and the BHPC
- represent unpaid family caregivers on the IHC.

The continued presence of ICA as a public-private organization is vital to the success of ongoing efforts to support and sustain the unpaid family caregiver workforce. **An organizational home and funds to sustain the work of the Alliance are needed.**

Objective:

#9: Build on the established foundation of the Idaho Caregiver Alliance and ensure that the Idaho caregivers across the lifespan have a coordinated voice.

Steps to accomplish:

A. Establish sustained funding for the Idaho Caregiver Alliance.
    - Meet with public and private partners to secure commitments for ongoing funding
    - Seek grant and other funding sources to support general operations and specific projects as identified in this action plan

B. Serve as a voice and advocate for family caregivers across the lifespan to ensure the perspective of the caregiver is considered in all agendas.
    - Collaborate with a broad array of stakeholders including, but not limited to:
        - public agencies, such as the Idaho Departments of Health and Welfare, Labor, Education, and Commerce; Idaho Commission on Aging; AAAs; District Health Departments: Veterans Administration Medical Center (VAMC) ad Veterans Hospital Administration (VHA)
        - planning and advocacy groups, such as IHC, BHPC, Developmental Disabilities Council (DDC), Consortium of Idahoans with Disabilities (CID), FFCMH, IPUL, Idaho Alzheimer's Planning Group (IAPG), Justice Alliance for Vulnerable Adults (JAVA), State Independent Living Council (SILC), Senior Health Insurance Benefits Advisors (SHIBA), etc.

- professional associations, such as Idaho Guardians and Fiduciary Association (IGFA), AARP Idaho, Idaho Association of Community Providers, Idaho Hospital Association (IHA), Idaho Health Care Association (IHCA), Idaho Public Health Association (IPHA), Idaho Primary Care Association (IPCA)
- business groups and individual employers (Chamber of Commerce, etc.)
- healthcare delivery and payer systems, such as hospitals, insurance providers, patient-centered medical homes (PCMHs), behavioral health treatment facilities
- churches and other faith-based organizations
- education systems (community colleges and universities, Family Practice Medical Residency of Idaho, etc.)

Objective:

#10: Assure data are available to inform decision-making related to family caregiver supports and services.

Steps to Accomplish:

A. Implement ongoing data collection regarding the needs of family caregivers in Idaho.
   - Continue to gather and use information from family caregivers to inform program planning and implementation
   - Continue to collect and improve existing data about caregivers at state and community levels through the use of Behavioral Risk Factor Surveillance System (BRFSS) and other existing tools
   - Partner with economic development and data analysis organizations to track and synthesize data pertaining to economic impact and implications of family caregiving

B. Implement data collection strategies to evaluate impact of programs and systems change on family caregivers.
   - Use findings to guide quality improvement and program planning
   - Report findings to stakeholders, funders, and policy makers to ensure accountability and responsible use of resources

Acronyms and Abbreviations

ACL	Administration on Community Living (federal agency)
AARP	Formerly the American Association for Retired Persons – now just AARP
AAA	Area Agency on Aging, six of these located across Idaho
BH	Behavioral Health, a division within Department of Health and Welfare
BHPC	State Behavioral Health Planning Council
BRFSS	Behavioral Risk Factor Surveillance System
CHEMS	Community Health Emergency Medical Services
CHW	Community Health Workers – personnel that are part of the Statewide Health Innovation Plan
CIL	Center on Independent Living (same as Independent Living Center; three of these across Idaho)
CSA	Center for the Study of Aging at Boise State University
DDC	Developmental Disabilities Council
FPMR	Family Practice Medical Residency
IAPG	Idaho Alzheimer's Planning Group
ICA	Idaho Caregiver Alliance
ICOA	Idaho Commission on Aging
IDHW	Idaho Department of Health and Welfare
IFFCMH	Idaho Federation of Families or Children's Mental Health, a non-profit organization
IGFA	Idaho Guardians and Fiduciary Association
IHA	Idaho Hospital Association
IHC	Idaho Healthcare Coalition
IHCA	Idaho Health Care Association (nursing homes and assisted living facilities)
ILC	Independent Living Center (same as Center on Independent Living)
IPCA	Idaho Primary Care Association
IPHA	Idaho Public Health Association

JAVA	Justice Alliance for Vulnerable Adults
NWD	No Wrong Door – an initiative of the Idaho Commission on Aging
PCC/PCP	Person-Centered Counseling/Person-Centered Planning
PCMH	Person-Centered/Patient-Centered Medical Home
PTC	Powerful Tools for Caregivers, an evidence-based program teaching caregivers about self-care
RBHB	Regional Behavioral Health Board
SHIBA	State Health Insurance Benefit Advisors
SHIP	State Healthcare Innovation Plan
SILC	State Independent Living Council
VAMC	Veterans Administration Medical Center
VHA	Veterans Hospital Administration

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Idaho Lifespan Family Caregiver Action Plan

Legislative Update, 2017

Idaho Caregiver Alliance

Mission

To advance the well-being of caregivers by promoting collaboration to improve access to quality, responsive supports and services.

Alliance Partners	
Family Caregivers	Idaho Commission on Aging
Idaho DHW: Public Health, Medicaid, Children's Behavioral Health, and Service Integration	Health and Behavioral Health Providers
	Center for the Study of Aging
Idaho Parents Unlimited	Jannus Corporation
Blue Cross	AARP Idaho
And many other public and private organizations	

House Concurrent Resolution 24, 2015

- Create a caregiver taskforce
- Examine policies, resources and programs available for caregivers in Idaho and other states
- Identify innovative ways to support unpaid family caregivers
- Report findings

Idaho Caregiver Needs and Respite Capacity Report, 2014

October 2014

Tami Cirerol & Sarah E. Toevs
Center for the Study of Aging
http://hs.boisestate.edu/csa/

Work Group Members:
Stephanie Bender-Kitz, Friends in Action
Stephen Graci, Idaho Federation of Families for Children's Mental Health
Stephanie Hoffman, Division of Behavioral Health, Idaho Department of Health and

A descriptive analysis of respite in Idaho

Tami Cirerol
Health Science

Stephanie Leonard
Community and Regional Planning

Center for the Study of Aging
Boise State University

Caregivers in Idaho

A Report from the Idaho Family Caregiver Task Force and the Idaho Caregiver Alliance

December, 2015

Impact of Behavioral Crisis Events on First Responders and Families Ada County, Idaho

American Public Health Association Annual Conference
October 31, 2016

BOISE STATE UNIVERSITY
CENTER FOR THE STUDY OF AGING

Idaho Caregiver Alliance

IDAHO ALZHEIMER'S PLANNING GROUP

Idaho Family Caregivers

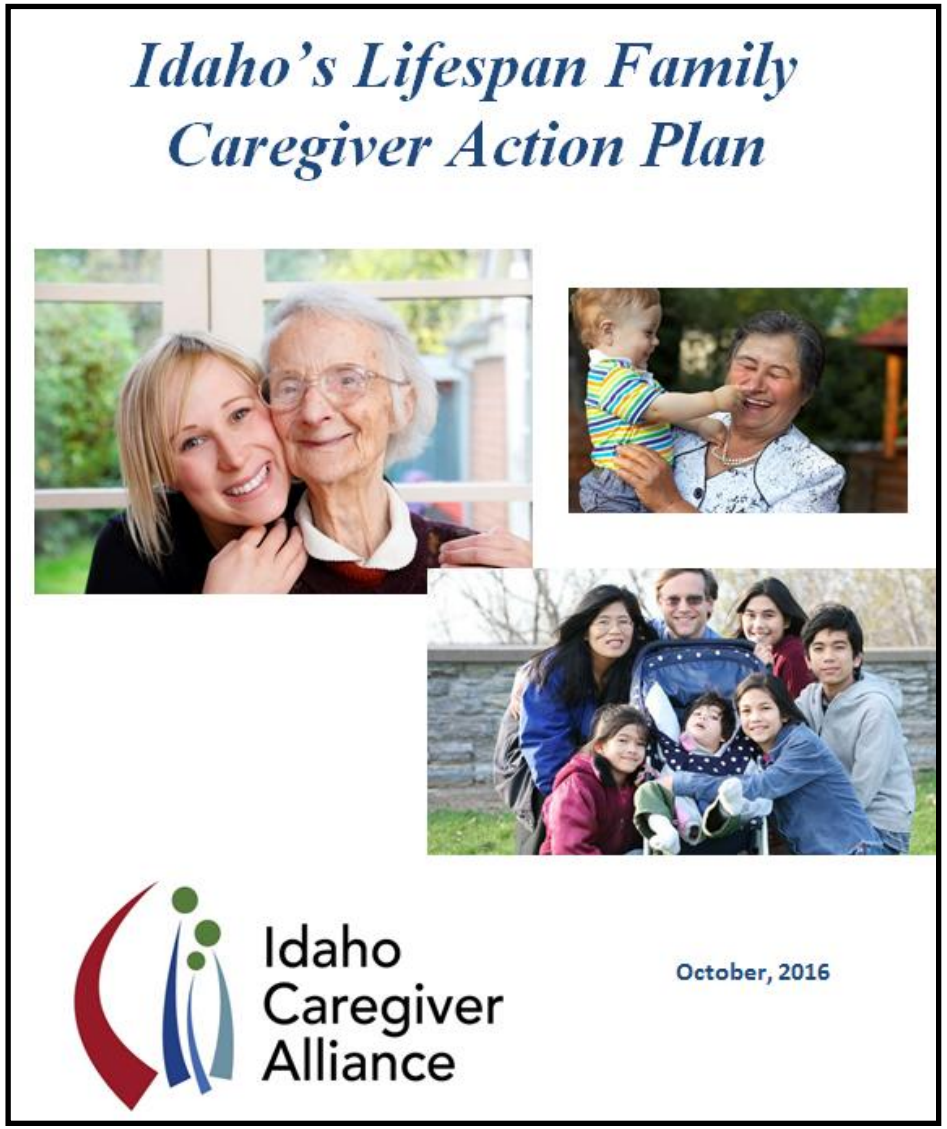
Family Caregivers in Idaho

- 300,000 family caregivers in Idaho
- 201 million hours of uncompensated care
- 70% of family caregivers are employed full or part-time
- Looming crisis
  - 2010: 6:1 ratio working-aged to older adults
  - 2020: **3:1 ratio**
- Idaho is ranked 42nd in providing support for family caregivers
  - Ranked 49th for high levels of worry, stress, and exhaustion experienced by caregivers

Value of Family Caregivers

- Provide $2 billion of unpaid care each year
- Provide complex medical and psychological care
- Delay need for costly institutional care
  - 48% ($271 million) of Idaho's Medicaid budget for long-term care services used to pay for care in nursing and intermediate care facilities (2014)
- Reduce hospital admissions/re-admissions
- Reduce utilization of emergency departments for crisis care
- Enable care recipients and families to thrive

Data-driven Action Plan



Available at: https://hs.boisestate.edu/csa/idaho-lifespan-family-caregiver-action-plan/

Idaho Action Plan Goal 1:

Caregiver Support

Goal 1: Streamlined, coordinated system of supports for caregivers.

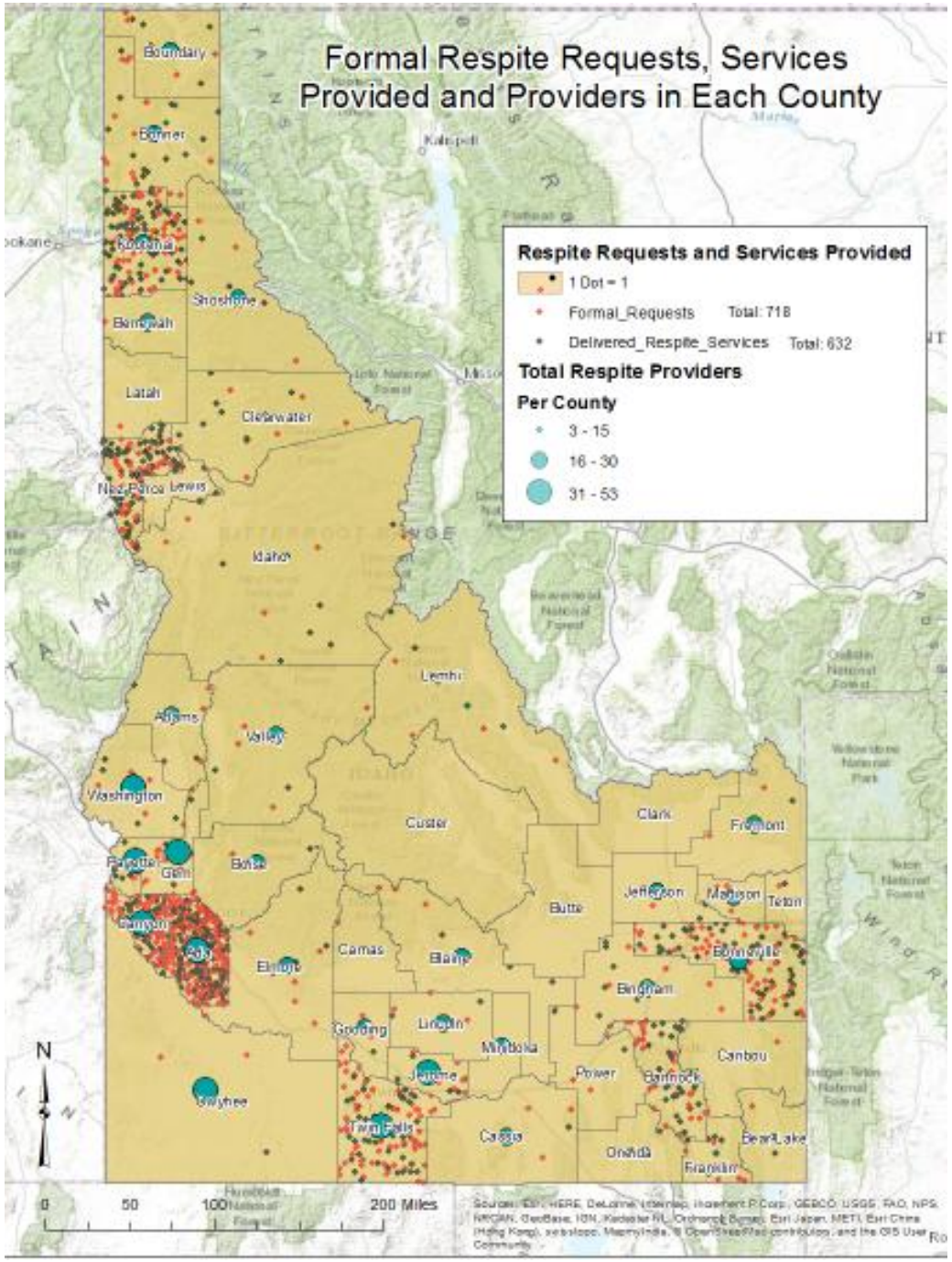
Objective 1 – Develop respite resources.

Objective 2 – Ensure culturally appropriate information and resources are available.

Objective 3 – Establish training resources for family caregivers : responsibilities, techniques, and self-care.

Objective 4 – Establish a network of experts equipped to serve as information and support navigators.

Respite: Statewide Assessment



Respite: Findings

- No statewide standards for respite providers
- No registry for family caregivers or providers
- No central tracking of information about respite requests or units provided
  - Inability to track equal units of respite between organizations
    Ex: voucher vs reimbursement
- Respite described and funded differently by each agency
  - Significant differences in billing charges for similar services
    Ex: respite vs companion services

Caregiver Self-care: Evidenced-based Programs

Boise
Legacy Corps
Kelle Sweeney
(208) 336-5533, ext 243
ksweeney@jannus.org

Coeur d'Alene
Strengthening Villages
Rebekah Forster-Casey
(208) 771-0628
strengtheningvillages@gmail.com

Grangeville
Syringa Hospital and Clinics
Maja Ledgerwood
(208) 315-2797
mledgerwood@syringahospital.org

Idaho Falls
Area Agency on Aging – Area VI
Heather Croft
(208) 522-5370
hcroft@eicap.org

Lewiston
Area Agency on Aging – Area II
Community Action Partnerships
Julie Christianson
(208) 791-0015
j.christianson@cap4action.org

Nampa
Terry Reilly Health System
Laramie Holtman
(208) 318-1326
lholtman@trhs.org

Pocatello
Area Agency on Aging – Area V
Southeast Idaho Council of Governments
Mike Hirschi
(208) 399-3077
mike@sicog.org

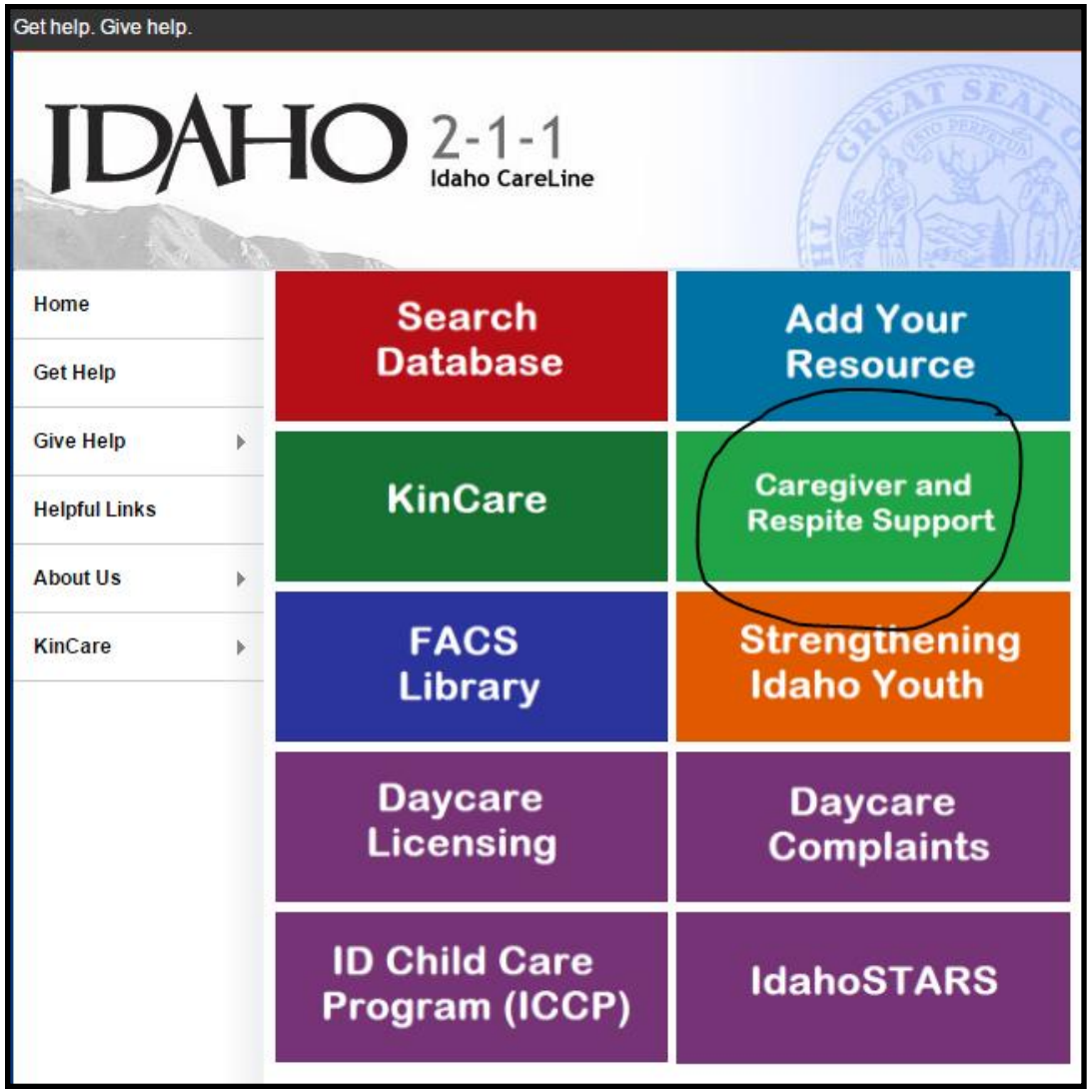
Action Plan Goal 2:

Awareness

Goal 2: Increase public awareness about unpaid family caregiving and help people within our communities identify as caregivers.

Objective 5 – Family members recognize themselves as caregivers and the general public is aware of the needs and contributions of family caregivers across the lifespan.

Awareness: 2-1-1 Careline



Action Plan Goal 3:

Systems Change

Goal 3: Recognize the importance of family caregiving and embed the voice of family caregivers in policy and system change.

Objective 6 – Recognize family caregivers as part of their family members' health care and social support team.

Objective 7 – Embed family caregiver perspective and involvement in Idaho's efforts to transform its primary care, long-term care, and behavioral health systems.

Objective 8 – Include family caregivers in Idaho's efforts to enhance employment opportunities and tax policies that support families and the state's economic vitality.

System Change Initiatives

Idaho SHIP	Regional Collaboratives	Recognition of Caregiver as Partner
Idaho Alzheimer's Planning Group	Multi-disciplinary Work Group	Training, Support, Access to Care
Idaho Behavioral Health Planning Council	Cross-system Collaboration	Linking Resources
Jannus, Inc. Community Partnerships of Idaho AARP Idaho	Public/Private Partnerships	Extending Reach and Sustainability

Action Plan Goal 4:

Infrastructure

Goal 4: Ensure a coordinated voice for family caregivers in Idaho.

Objective 9 – Build on the established foundation of the Idaho Caregiver Alliance and ensure that the Idaho caregivers across the lifespan have a coordinated voice.

Objective 10 – Assure data are available to inform decision-making related to family caregiver supports and services.

What is needed?

- Sponsoring agency
  - State-wide reach
  - Capacity to work across sectors
- Resources
  - People
  - Money
  - Infrastructure

Next Steps

- Legislative action
  - Concurrent Resolution
- Continued collaboration
- Advance the well-being of family caregivers

Thank You

ICA Leadership Team:

Pam Oliason, Pam.Catt-Oliason@aging.idaho.gov
Kelle Sweeney, ksweeney@jannus.org
Marilyn Sword, frontiergroupidaho@gmail.com
Tiffeny Stees, tiffenykiiha@u.boisestate.edu
Sarah Toevs, stoevs@boisestate.edu

Access to Plan and Overview:

https://hs.boisestate.edu/csa/idaho-lifespan-family-caregiver-action-plan/

https://hs.boisestate.edu/csa/files/2016/09/ICA-Action-Plan-Overview.pdf

Idaho Caregiver Alliance
Idaho Caregiver Alliance Action Plan:
Solutions through Partnerships
Public Awareness
Respite Network
Information, Training and Resources
Collaboration across systems
Caregiver-friendly employment and tax policies
Value of caregivers recognized
To achieve these solutions, an organized voice for caregivers is needed.
Outcomes of Action
• Better health for all •
• Saves money by reducing hospitalizations and delaying institutional care •
• Strengthens workforce stability and productivity •
• Improves quality of life for caregiver and family •
For information about ICA and the Idaho Family Caregiver Action Plan:
https://hs.boisestate.edu/csa/idaho-lifespan-family-caregiver-action-plan/
IDAHO ALZHEIMER'S
AARP Real Possibilities in Idaho
CID IDAHO

IDAHOANS ARE FAMILY CAREGIVERS

Every day family caregivers help their parents, spouses, children with disabilities and other loved ones live at home.

More than 300,000 family caregivers annually

Provide 201 million hours of unpaid care annually

3:1

Estimated ratio of working adults to older adults by 2020

While they wouldn't have it any other way, family caregiving is a huge job. Caregivers in Idaho:

- **Perform medical tasks without training**
- **Are not recognized as partners in care**
- **Risk family stability**
- **Don't know where to go for help**
- **Risk losing employment and income**
- **Have little access to respite (a break)**
- **Neglect their own health**

Idaho Caregiver Alliance

The **MISSION** of the Idaho Caregiver Alliance is to advance the well-being of family caregivers by promoting collaboration that improves access to quality support and resources for caregivers across the lifespan.

Source: Idaho Lifespan Family Caregiver Action Plan, October, 2016

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Monday, February 20, 2017

SUBJECT	DESCRIPTION	PRESENTER
Approval of Minutes	Minutes of the Meeting of January 24, 2017 Minutes of the Meeting of February 6, 2017 Minutes of the Meeting of February 8, 2017	Senator Jordan Senator Anthon Senator Agenbroad
Gubernatorial Appointment	Consideration of Reappointment of Janet Penfold to the Board of Health and Welfare Consideration of Reappointment of Tom Stroschein to the Board of Health and Welfare	
S 1060	Relating to Health Care	Rebekah Hall
H 43	Relating to Medical Assistance	Matt Wimmer Administrator, Division of Medicaid

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Monday, February 20, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:04 p.m.
APPROVAL OF MINUTES:	**Senator Anthon** moved to approve the Minutes of the February 6, 2017 meeting. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**
	Senator Agenbroad moved to approve the Minutes of the February 8, 2017 meeting. **Senator Harris** seconded the motion. The motion carried by **voice vote.**
	Senator Jordan moved to approve the Minutes of the January 24, 2017 meeting. **Senator Martin** seconded the motion. The motion carried by **voice vote.**
GUBERNATORIAL APPOINTMENT:	**Vote on the Reappointment of Janet Penfold to the Board of Health and Welfare. Senator Martin** moved to send the Gubernatorial reappointment of Janet Penfold to the Board of Health and Welfare to the floor with recommendation that she be confirmed by the Senate. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**
	Vote on the Reappointment of Tom Stroschein to the Board of Health and Welfare. Senator Agenbroad moved to send the Gubernatorial reappointment of Tom Stroschein to the Board of Health and Welfare to the floor with recommendation that he be confirmed by the Senate. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**
S 1060	**Relating to Health Care. Rebekah Hall** was recognized and introduced herself to the Committee on behalf of the Idaho CMV Advocacy Project (Project) to present **S 1060. Ms. Hall** advised her third child, Keira, was born with congenital cytomegalovirus (CMV). **Ms. Hall** introduced Keira to the Committee.
	Ms. Hall explained she had no knowledge of CMV until her daughter was born severely affected with congenital CMV. It was difficult to find information about CMV but she finally was able to learn enough to become something of an expert on the disease. Several years later, she is disappointed that many people, including health care professionals, have never heard of CMV. Lack of awareness affects Keira who faces inadvertent discrimination by caregivers and others who believe Keira has an infectious disease. **Ms. Hall** feels her daughter is treated like something to be avoided rather than like a child to be loved.

Ms. Hall said the proposed legislation will provide education to prevent the infection of numerous infants with CMV as well as combat current misinformation. The Project's goal is to make complete and accurate information easily available to all Idahoans. To demonstrate the critical need, a 2010 survey of the American Council of Obstetricians and Gynecologists revealed only 44 percent of doctors routinely counsel their patients about CMV. Also in 2010, the National Institute of Health reported the most important reason a CMV vaccine has not been developed is the insufficient education about the problem of CMV, particularly in women of child-bearing age and the lay public. In 2015, an article was published showing the overwhelming effectiveness of CMV awareness and hygienic precautions in prevention the transmission of CMV to babies in utero.

Ms. Hall informed the Committee the Project needs the participation of the Department of Health and Welfare (Department), and the Department has been supportive. The Department believes it can realistically commit to spending $5,000 in the first year. This is a good start, and it will allow for publication of educational materials and distribution to doctors' offices and day care centers. It will also help create a State-sponsored website regarding CMV. The Project hopes to expand funding to include personnel to conduct a more comprehensive public education plan and eventually CMV testing for newborns who fail the initial hearing screen.

Ms. Hall provided the Committee with a binder of information (see Attachment 1) regarding the Project, information about CMV, letters of support, a bibliography of scholarly peer-reviewed articles, samples of education and awareness flyers, and a copy of Utah legislation that was the model for **S 1060**.

Senator Lee asked if there is a state doing a good job with CMV education that could provide a model to help Idaho get up to speed quickly. **Ms. Hall** answered the state doing the best job is Utah, and its Department of Health has an ideal CMV public health website giving comprehensive information on prevention and treatment.

Vice Chairman Souza inquired what time frame would be required to have actual educational materials in physician offices. **Ms. Hall** responded it will likely take a year or two or more because additional funding will be needed, but for the first year, $5,000 is a reasonable expectation from the Department.

Senator Agenbroad asked what caused the change in the fiscal note for the bill. **Ms. Hall** replied the Project had a steep learning curve in bringing this legislation and had a good response to the bill. However, there was a misunderstanding between the Project and the Department regarding how much funding the Department could commit this fiscal year. The Project's goals have not changed, but the expectations are different.

TESTIMONY:

Erica Jensen introduced herself to the Committee to speak in support of **S 1060**. **Ms. Jensen** is a parent who was diagnosed with CMV during her second pregnancy. She was carrying triplets and lost one baby early in the pregnancy. Subsequently, she was sick with cold symptoms and tested positive for mononucleosis. When she expressed concerns to her doctor about her symptoms, he consulted with a specialist for a second opinion. The specialist, Dr. Bobrowski, recommended Ms. Jensen be tested for CMV, and the test was positive.

Ms. Jensen read a letter from Dr. Bobrowski in support of **S 1060** (see Attachment 2).

Ms. Jensen has been a registered nurse for 12 years and remembered reading only one paragraph about CMV in nursing school. Many of the doctors told her it was extremely rare, and when she returned to work at the hospital, she found not one of her coworkers was familiar with CMV. She went on to receive two immunoglobulin infusions as treatment for CMV and delivered two healthy girls a few months later who were CMV free.

TESTIMONY: **Jessica Rachels** was recognized to testify in support of **S 1060**. She introduced her husband and children to the Committee. **Ms. Rachels** said when she was pregnant with her second child, she worked as a child care provider. She was never informed about CMV or that working at a child care caused her to be at higher risk for infection. The American Academy of Pediatrics recommends child care workers should be counseled about the risk of CMV and tested for CMV.

Ms. Rachels did not learn anything about CMV until after the birth of her daughter Natalie, who was diagnosed with congenital CMV. **Ms. Rachels** commented as a child care worker, she washed her hands numerous times throughout the day. When pregnant, she recalls not always making it a priority to wash her hands before eating snacks or lunch. She doubled up on tissues when wiping children's noses thinking that was sufficient protection, and often she did not wash her hands immediately since there was no sink nearby. She did not know she was putting her unborn child's health at risk. If she had been provided education about CMV, her daughter's outcome might have been different, and she would have gladly taken steps to protect her daughter.

Ms. Rachels informed the Committee her daughter suffers from cerebral palsy, has undergone 10 surgeries, and has had several types of devices implanted to improve her quality of life. The State of Idaho has spent $1.1 million to assist with these surgeries and treatments. Over the course of one year, the State could save $100,000 or more for each child that is prevented from having severe disabilities caused by CMV. Education will provide expectant mothers with information to significantly decrease the chances of their unborn children contracting the virus.

Chairman Heider asked if the Project's goal was for the Department to spread CMV education around the State. **Ms. Rachels** responded yes.

TESTIMONY: **Patrick Rachels** introduced himself to the Committee to read a letter from Claire Szewczyk in support of **S 1060** (see Attachment 3).

TESTIMONY: **Dieuwke Dizney-Spencer** introduced herself as the Deputy Administrator for the Division of Public Health at the Department of Health and Welfare to answer questions from the Committee.

Chairman Heider asked if the Department has a current plan to provide information about CMV. **Ms. Dizney-Spencer** replied the Department does not have an active campaign regarding prevention of CMV. She has met with representatives from the Project, and the Department is willing to assist with developing factual information that can be distributed Statewide.

Vice Chairman Souza inquired why the funding was cut so drastically from initial proposal, and whether the Department sees the CMV educational program as important to those affected by CMV and the State. **Ms. Dizney-Spencer** answered the original estimate was based on the State of Utah's budget to implement and maintain the more comprehensive Utah CMV program that includes a screening component. The Department derived its $5,000 estimate based on annual funding for a similar educational program for women considering abortion services, which includes similar printing, mailing, and website services.

Vice Chairman Souza asked for further explanation of the funding for the availability of abortion services and why it is the State's job to inform people about abortion services. She further inquired whether it has to do with last year's ultrasound bill. **Ms. Dizney-Spencer** replied she does not recall the exact legal reference but it began prior to the ultrasound bill. There is a law stating the Department must provide a packet of three booklets of factual information to any woman considering receiving an abortion within the State. **Vice Chairman Souza** stated she is not seeing the connection between the two issues, but it is disturbing to see the difference in the amount of funding for such an important and preventative education program. She asked what is the process for changing the funding within the Department. **Ms. Dizney-Spencer** responded she did not intend to draw a comparison between the two programs but was using the other program to demonstrate the amount needed to distribute information through a website and printed materials. The $5,000 amount is a good starting point. There is a possibility to co-brand existing information, and if the cost to develop information can be minimized, it is easier and less expensive to distribute the information. The Department has additional suggestions for placing information in Women Infants Children clinics and at conferences and educational presentations held around the State.

Chairman Heider asked if the Department feels screening is important to prevent CMV. **Ms. Dizney-Spencer** answered CMV screening is not preventative but would involve screening of newborns to see if the child has been infected. Utah's program provides CMV screening when a child fails its newborn hearing test. Preventive education can be done without including a screening component, which would take some additional work. **Chairman Heider** asked if the Department has enough concern about CMV to help doctors be able to screen for CMV and implement preventative measures. **Ms. Dizney-Spencer** responded the Department is very willing to do anything possible to assist with prevention efforts. Adding mandatory screening would have to be accomplished through legislation.

Senator Jordan inquired whether it is the Department intends to work with cities that license day cares to ensure the cities are informing day care licensees of this issue. **Ms. Dizney-Spencer** answered yes and stated Ms. Rachels has already contacted the Idaho STARS program. CMV education is being added to training for child care providers.

Senator Lee commented it is difficult to find maternal health information on the Department's website. There are many things pregnant women need to know that were not common knowledge in the past, like the importance of avoiding cat litter boxes, and everything possible needs to be done to increase CMV awareness. **Senator Lee** asked for confirmation that the Department stands ready and willing to help with this effort.

TESTIMONY: **Lisa Hettinger**, Deputy Director at the Department, introduced herself to respond to the question. **Ms. Hettinger** advised the Department has been actively working on a new website to make things easier to find. The site is called Live Better Idaho and a big component will be accessing information in the community to make current information more accessible. The Department has been working aggressively with other partners that have information like CMV prevention to continue the outreach. All divisions in the Department are looking at their areas of expertise and coordinating with partners to gather information. The Department intends to use existing information as much as possible and needs some time to look at the screening component. Many health plans already pay for that type of screening, and more research is needed to see if money will be required to implement a screening program. If so, it will be brought forward at the next legislative session.

Chairman Heider asked if **S 1060** is passed this year whether the Department will be more proactive in allocating funds to this endeavor. **Ms. Hettinger** replied the Department will be working to figure out exactly what would be required to implement a screening program and whether funding for screening would be necessary.

MOTION: **Senator Martin** moved to send **S 1060** to the floor with a **do pass** recommendation. **Senator Lee** seconded the motion. The motion carried by **voice vote.**

TESTIMONY: **Chairman Heider** recognized Stephanie Beedman to come forward to make a comment. **Ms. Beedman** explained she is a Boise State University student who is at the Statehouse on a field trip from Lewiston. She happened to walk into the Committee and found the topic very interesting. She is a brand new grandmother and was also a day care provider for 10 years at a facility with 150 children. Her daughter currently works at a child care center with about 100 children and recently gave birth. She never heard of CMV and is breathing a sigh of relief that her daughter and the baby did not contract it.

H 43 **Relating to Medical Assistance. Matt Wimmer**, Administrator for the Division of Medicaid, introduced himself to the Committee on behalf of the Department. The Department is requesting this law change to allow support of behavioral health services for children with serious emotional disturbance in families with incomes up to 300 percent of federal poverty level. These children are at significant risk for poor life outcomes, including unemployment, criminal behavior, justice system involvement, incarceration, and suicide.

Mr. Wimmer informed the Committee behavioral health services for this group of children are currently provided through the Division of Behavioral Health using State general funds. Shifting coverage of these services to the Medicaid program will allow the Department to use federal matching funds to serve more children with significant needs. It will also enable the Department to comply with the settlement agreement in the Jeff D. lawsuit and allow the Department to provide services that will have a significant, long lasting, and positive impact on these children's lives to enable them to reach their full potential.

Mr. Wimmer explained the Department is in the process of developing a system of care that will better meet the needs of these children under the name Youth Empowerment Services, a child-centered provider team approach to care. Under this model, a care coordinator will work with the child, family, service providers, and natural community supports to facilitate a comprehensive approach to care that will help ensure good outcomes and a better life for these children.

Mr. Wimmer advised the net fiscal impact is neutral. There is a fiscal impact to the Medicaid budget of approximately $1.18 million in State general funds, but the impact is fully offset by a reversion from the Division of Behavioral Health's budget. There is also a need in the Medicaid budget for $2.97 million in federal spending authority for the change. This offset is permanent and will carry forward into future budget years as well as the increase in federal funds. The impact is incorporated into the Department budget recommended by the Governor's office.

Senator Foreman asked how 300 percent of federal poverty level was determined as the cut-off. **Mr. Wimmer** answered that is the point today at which families are fully responsible for behavioral health services under the Division of Behavioral Health. It also relates to federal limitations on access to those funds. **Senator Foreman** asked if it is correct that the future impact on the General Fund could double from $1.18 million to $2.36 million. **Mr. Wimmer** replied the fiscal impact noted on the bill is for one-half a fiscal year. The $2.36 million represents a full fiscal year. **Vice Chairman Souza** asked if the bill shifts funding from the General Fund to Medicaid. **Mr. Wimmer** responded that is correct.

Vice Chairman Souza asked how the term "serious emotional disturbance" is defined and who determines the diagnosis to know children fit into this definition. **Mr. Wimmer** answered that "serious emotional disturbance" requires a child be diagnosed with a mental health disorder in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5) used by mental health practitioners and physicians. In addition to having a diagnosis, the child needs to have a significant level of functional impairment that impacts daily life, or the child is unable to do the things one would expect a child of their age to do.

Senator Jordan inquired if there are estimates or examples of future costs and situations that can be avoided by providing these mental health services. **Mr. Wimmer** replied he does not have any quantifiable data, but it is known if children can be reached before teenage years, there is significant potential for savings in juvenile corrections, reduced foster care, and other state services.

Senator Foreman said he read the Jeff D. settlement agreement over the weekend and asked if there is any flexibility if the proposed change did not pass in its exact form presented. **Mr. Wimmer** answered the State has obligations under the agreement and can either use federal funds or more expensive State General Funds to fulfill the obligations.

TESTIMONY: **Jim Baugh** introduced himself as Executive Director of DisAbility Rights Idaho (DRI), a private non-profit organization that provides free legal and advocacy services and public policy analysis concerning the impact of legislation on Idahoans with disabilities. **Mr. Baugh** stated he supports **H 43**. The Jeff D. lawsuit was filed by a legal aid organization about 35 years ago but DRI has peripherally participated in the case through amicus briefs from time to time and occasionally advised and assisted in crafting the settlement. To comply with the settlement and have an adequate children's mental health system would not be possible without an increased commitment of State General Funds. Idaho is always in the top six states for child suicide rates and always in the bottom two to three states for per capita expenditures on children's mental health services.

Mr. Baugh commented this bill will not solve Idaho's mental health services problem, but it is a good step forward with zero General Fund impact, and it will allow the State to take a huge step forward in complying with the settlement. The Medicaid model is the best way to go in this case because it is the best at comprehensive mental health services. The Department has thought this through very well, and it seems to be the only sensible thing to do.

TESTIMONY: **Christine Pisani** of the Idaho Council on Developmental Disabilities and **Jennifer Griffis** provided written testimony (see Attachments 4 and 5).

Senator Foreman said he read a statistic that 20 percent of children under the age of 18 have some sort of serious mental health issue, and asked if it is accurate. **Mr. Baugh** replied mental health statistics are very interesting. The category "seriously emotionally disturbed" is frequently used in many statutes and it doesn't always mean the same thing. In the federal Individuals with Disabilities Education Act, the definition is not the same as in the Idaho Code. That number might include all children with a serious mental health diagnosis or who meet some definition of "serious emotional disturbance." He thinks 20 percent is quite high to meet the Idaho statutory definition, but he does not have a better number to provide.

Senator Jordan thanked the Department for bringing forward this solution. It makes a lot of sense, and it may never be known how many children this helps. **Senator Jordan** commented a school counselor friend had three elementary school students in one week who either attempted or planned suicide, and this help is needed.

MOTION: **Senator Jordan** moved to send **H 43** to the floor with a **do pass** recommendation. **Vice Chairman Souza** seconded the motion.

Vice Chairman Souza observed the CMV legislation could prevent a large impact to people's lives but only $5,000 will be spent, while millions will be devoted to treating serious mental health issues. This bill is important and needed, but it is also important to focus on prevention of issues whenever possible.

Senator Foreman commented he agrees with Vice Chairman Souza but he believes in taking a balanced approach to prioritize a limited number of dollars. The State is off to a good start with the CMV issue, and he is sure it will be increased as time goes on.

The motion carried by **voice vote. Chairman Heider** acknowledged the Department's efforts to address the many issues facing people in the State of Idaho to get the care they need.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:12 p.m.

_____

Senator Heider
Chair

_____

Jeanne Jackson-Heim
Secretary

IDAHO
CMV Advocacy Project

To Whom it May Concern,

Thank you for your support of the Idaho CMV Advocacy Project and bill #S1060. We are passionate about getting CMV legislation passed in Idaho! In this folder you will find:

Who We Are
- Statement of Purpose
- CMV Parent Letters
- Biographies of the CMV Advocacy Team
- Letters of Support

CMV Education and Awareness Flyers
- Facts About CMV Packet
- Facts About CMV Flyer
- "What You Need to Know" Brochure
- CMV Prevention Flyer
- Protect Yourself Flyer
- Educate Yourself Flyer (2 Versions)

Legislation
- "What Would CMV Legislation Mean for Idaho?" flyer
- Senate Bill S1060, Health care/Cytomegalovirus
- Utah State CMV Code

Important Literature
- Scholarly Articles
- Bibliography

We appreciate your interest in our endeavors and in CMV awareness and advocacy. We look forward to working with you in the future.

Sincerely,

The CMV Advocacy Project
Rebekah Hall, Erica Jensen, Jessica Rachels & Claire Szewczyk

Statement of Purpose for Cytomegalovirus (CMV) Bill

The purpose of the CMV bill is twofold. First, it will ensure that the women of Idaho and their doctors have access to the most accurate and up-to-date information available regarding cytomegalovirus prevention, infection, and treatment. Appropriate dissemination of this information will foresee-ably prevent the infection of numerous babies in utero, thereby saving the state of Idaho millions of dollars in the care and treatment of various disabilities that are associated with congenital cytomegalovirus infection. Secondly, because cytomegalovirus is the leading non-genetic cause of hearing loss, the CMV bill will provide for mandated CMV testing for any infant who fails his/her newborn hearing screen. This would allow for early detection of hearing loss and, therefore, improved treatment and long-term outcomes for individuals with CMV-related hearing loss. This first year we will focus only on the education and awareness piece, next session we will address the hearing screening.

IDAHO
CMV Advocacy Project

Rebekah Ponsford-Hall, PsyD
1906 South Elder Street
Nampa, Idaho 83686
(626) 372-2517

To Whom It May Concern:

I'd like to tell you about my daughter, Keira. She is a four-year-old girl with an effervescent laugh and eyes that sparkle and light up a room. She is also the biggest challenge I've faced in my life. The condition she has is preventable and I am passionate about the fact that every pregnant woman in Idaho should be aware of it. My daughter was born with **cytomegalovirus*** (CMV). Harmless to most, CMV is a common virus that infects 80% of us by the time we reach adulthood. However, it can have devastating effects when transmitted to a fetus by a pregnant mother.

When I was pregnant with Keira in 2012, my OB/GYN repeatedly told me that my pregnancy was "boringly healthy." Yet my baby was born with tremendous challenges. Born at 37 weeks, she was technically full term, but she weighed only 4 lbs., 13 oz. She also had microcephaly, an enlarged liver and spleen, petichiae on her skin, and cysts on her brain; all symptoms, I would soon learn from specialists, which were characteristic of CMV.

At my 6 week, postnatal follow up appointment, my OB/GYN attested that CMV had hardly been covered in medical school and after over a decade of practicing obstetrics, he believed Keira to be the first time he had encountered CMV. Unfortunately, my OB/GYN was not alone in believing that CMV was rare. I have since learned that only 13% of women have ever heard of CMV and fewer than half of all OB/GYNs are educating their patients about CMV.

Keira has cerebral palsy, vision impairment, and failure to thrive. She will never walk or talk. She receives her nutrition entirely by G-tube. At age 4, she cannot hold up her own head. She is at high risk for hearing loss and seizures. It is very unlikely that she will outlive her parents or her brothers.

Since her birth, Keira has undergone 14 surgical procedures and spent 100 days in the hospital. She is followed by 16 medical specialists and 7 types of therapists. She takes 7 medications on an ongoing basis. She averages 6 appointments per week, not including school. **To date, Medicaid has paid out $278,303.47 on Keira's behalf.**

Here is what I wish I had been told and the information that I believe all women of childbearing age should have access to:

-1 in 150 children is born with CMV

-CMV is more common that HIV, Spina Bifeda, and Downs Syndrome

-1 in 5 babies born with CMV will be permanently disabled by it

-CMV can be prevented using basic hygienic precautions

-Testing for CMV before and/or during pregnancy can aid in prevention and treatment

-Vancyclovir and Immune Globulin Injections may help treat CMV during pregnancy

I had never heard of CMV until it was too late for my daughter. If my OB/GYN and I had been aware, we may have been able to prevent it and/or mediate its devastating effect on my daughter.

It's unconscionable to continue to keep this information from pregnant women. In the U.S., typical prenatal care routinely screens for a numerous conditions (including HIV, cystic fibrosis, and toxoplasmosis) that are far less common, less devastating, and/or less burdensome on society than CMV. CMV needs to be added to the list of conditions that are screened and followed by physicians.

It has been estimated that educating the public in our state would cost $40,000 the first year and $26,000 annually after that. Several states (including Utah, Texas, and Tennessee) have already begun to implement CMV legislation. I pray that Idaho will soon follow*.

Thank you for taking the time to read our story. Do not hesitate to contact me if you have additional questions.

Sincerely,

Rebekah Ponsford-Hall, PsyD
CMV Mom

** For more information about CMV, visit nationalcmv.org or the Center for Disease Control website*
** To review the CMV bill passed in 2013 by the state of Utah, visit le.utah.gov//~2013/bills/static/hb0081*

Jessica and Patrick Rachels
PO Box 402
Ponderay, ID 83852

To Whom it May Concern:

Hi, my name is Jessica Rachels, and I live in North Idaho. I would like to share with you a little about my daughter Natalie who is a beautiful, social, ten year old girl who caught a nasty virus that I had never heard of while she was still in the womb. My hope is that in educating you about this virus, you can share what you have learned, and we can lessen the chances of your loved ones ever being stricken with this virus. But first, allow me to tell you about Natalie.

Natalie Rachels was born with congenital Cytomegalovirus, (CMV). CMV is a nasty virus that is a member of the Herpesviridae (Herpes) family. It is common and affects people of all ages. By the age of forty, between 50% and 80% of people in the US have contracted CMV. Usually it presents itself as a common cold, although, if the person has a weakened immune system or is an unborn child, it can drastically affect the body. In Natalie's case we were unaware that anything was wrong for several weeks after birth. The first red flag was that her due date was off by a month because an ultrasound revealed that her head size was smaller than average. The obstetrician did not believe that this information was important. So nothing was done, no further tests were recommended and/or administered. After she was born, Natalie repeatedly failed her newborn hearing screenings. At first the nurses and doctors were not alarmed, since babies can be born with a thick coat of vernix which can coat the inside of the ear. She kept failing the screenings; therefore, we were sent to Kootenai Medical Center in Coeur d'Alene for more intensive testing, which showed that Natalie had profound and severe hearing loss. The doctor then ordered a CT Scan which showed that the ear structures were perfectly normal, but that her brain had been damaged. Blood work from Natalie and me showed that we both contracted the CMV virus. Natalie was about two and a half months old, and still seemed like a typical baby minus being deaf and having some reflux issues.

Today Natalie is ten years old. Her father and I were told years ago that she wouldn't make it to see her double digits. We celebrated her tenth birthday, and took her to a roller skating rink, where she seemed to enjoy being pushed around the floor in her wheel chair. Natalie has been in and out of the hospital over the years. She has had ten major surgeries and will have more in the future.

Her care—which includes medical care, therapy, surgeries, personal care items, medical equipment, and the aid of caregivers—over the past ten years has cost over $1,000,000.

The virus caused many different issues including Cerebral Palsy, hearing loss, feeding issues—she currently is fed with the aid of a gastrointestinal tube; scoliosis, hip displacement, muscle tone issues which creates stiffness in some areas of her body, and floppiness in other areas; seizures—thankfully no grand mal seizures, which are kept to a minimum with the help of the implantation of a Vagus Nerve Stimulator; minor visual issues, and pulmonary complications which includes asthma.

Even with all of her difficulties, she is such a happy little girl. Natalie is very social, and loves being around people. She loves toys that light up, and her favorite game is playing peek-a-boo with loved ones who go in and out of the front door. For some reason the door opening and closing makes her giggle and laugh. Thanks to modern medicine, she has bilateral cochlear implants and has the gift of hearing. She enjoys bike rides with her family on her special bike, which has a wheelchair in the front and the driver sits behind pedaling. She enjoys playing on her iPad with touch applications as well as cause and effect applications. She has such a sweet and tender soul that has touched many people. Her smile and laugh can light up a room. Yes, her time is limited, but what an impact and difference this little girl is making on the world!

Due to not being properly educated about the virus while pregnant with my daughter, I worked in a daycare center. My doctor did not think it was important to educate me about CMV; in doing so he

took away my right and choice to protect my child. He could have given me a brochure about CMV, which would have explained how to prevent contracting the virus by practicing universal hand washing procedures, not kissing toddlers on the lips, and not sharing food or drinks. While I worked at a day care center, I had an increased exposure to CMV because of the high rate of coming into contact with bodily fluids, through which CMV is passed. It is not airborne.

Her father and I are advocates for the prevention of the CMV virus. We have given presentations, and have attended two CMV International Conferences. Our dream is to educate others about CMV so that more children can be spared this horrific virus. CMV is the most common congenital infection, and is one of the leading causes of Cerebral Palsy in children. With a law that mandates education and targeted screening, Idaho can see a reduction in the incidences of CMV related illness. Additionally, infants that have contracted the virus in utero will have a faster diagnosis and treatment as a result of the newborn screening. According to the CDC website, "About 1 in 150 children are born with congenital CMV infection. This means that in the United States, about 30,000 children are born with congenital CMV each year. About 1 in every 5 children born with congenital CMV will develop permanent problems, such as hearing loss or developmental disabilities, due to the infection. In the United States, more than 5,000 children each year have permanent problems caused by congenital CMV."

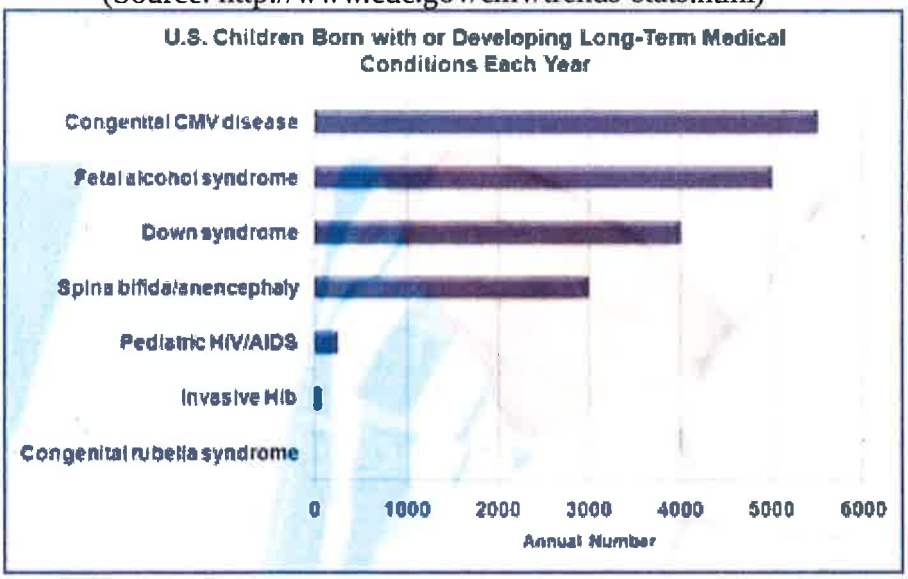
If you are interested in learning more about the virus, please visit the CDC website www.cdc.gov, and you will be amazed at what you never knew about this virus. The National CMV Foundation website address is www.nationalcmv.org. This is an excellent resource for additional information. How is it possible that a common virus such as CMV, which causes a child to be born disabled every hour is still unknown by many?

Sincerely,

Jessica Rachels

Jessica and Patrick Rachels

(Source: http://www.cdc.gov/cmv/trends-stats.html)



Erica Jensen, RN-BSN
12354 S. Abbott Downing Way
Nampa, Idaho 83686
(208) 546-2650

To Whom It May Concern:

I would like to share a bit of my experience with cytomegalovirus (CMV) with you, and why I think it is so imperative that more women be made aware of this virus. CMV is very common, with the vast majority of people being infected with it at some point in their life by adulthood. Normally it is not a big deal - the infected person may notice cold symptoms for a couple days, or they may not be symptomatic at all. However, if the infected person is pregnant, the virus can pass through the placenta. The virus that was pretty harmless to the mom, may now wreak havoc with the baby as he or she is growing and developing. This virus can cause the baby to be born with cerebral palsy, deafness, microcephaly, liver and spleen problems, or even cause death.

At the end of 2010, my husband and I found out that we were expecting triplets. While we were certainly thrilled at the prospect of expanding our family (by quite a bit!), we understood that there are inherent risks with carrying multiples. Because of this, our wonderful family physician referred me to not only an OB/GYN, but also to Dr. Renee Bobrowski, a maternal fetal specialist who specializes in high risk pregnancies. Toward the end of my first trimester I had my first appointment with Dr. Bobrowski, where we found out that we had lost one of the babies. We were heartbroken at this loss. A few days after our appointment with her, I had my first appointment with my OB/GYN and I mentioned to him that I had been feeling sick with cold symptoms for quite awhile and had tested positive for mono about a week earlier. I was concerned that this could affect the babies, and hoping for some reassurance that that hadn't caused the miscarriage. He was quick to reassure me that mono wasn't something to be worried about in pregnancy, and that it'd just take awhile to feel better. I kept pressing the issue and he decided that since I had already seen Dr. Bobrowski once, he'd run it by her. I want to really reiterate at this point that if I had not already seen Dr. Bobrowski because of the triplet pregnancy, this information would not ever have made it to her and I'd have likely gone undiagnosed. I was no longer going to continue seeing her because a twin pregnancy was not as high risk, so the fact that I happened to see her before the OB/GYN could find out that I lost the baby is something my husband and I will forever be so thankful for. I can't even adequately articulate those feelings.

After running my situation past Dr. Bobrowski, she recommended that I be tested for CMV. She said that CMV can give a false positive for mono and with my symptoms it would be worth pursuing. Well, come to find out I did have CMV. He told me this was a very, very big deal and that I may end up losing both babies, or that they could be born with significant disabilities. He was crying as he was telling me this diagnosis, so the severity was not lost on me.

Although obviously overwhelmed and scared, I was also really irritated. So irritated that I didn't know about this! I am a registered nurse, and did my preceptorship in labor and delivery and

IDAHO
CMV Advocacy Project

About Us

The Idaho CMV Advocacy Project is dedicated to promoting awareness and education to Idaho women who are pregnant, planning to become pregnant or just want more information regarding Cytomegalovirus (CMV) and the dangers it can cause to unborn children. It was founded by two parents of children with CMV, Jessica Rachels and Rebekah Hall, and Idaho State University Doctor of Audiology student Claire Szewczyk.

Jessica Rachels

While pregnant with her second child, she was running a small in home childcare and working one day per week at a childcare center. Her OB doctor was aware of her occupation but did not see the importance of educating her on CMV. Regrettably, Jessica continued working in a high risk environment and her choice to protect her unborn baby was taken away. Natalie her daughter was born at 39 weeks and seemed to be a typical, healthy baby minus continuing to fail her newborn hearing screening, a small head size (which was mentioned later), and reflux issues. At two and a half months of age, blood work confirmed CMV and intensive hearing tests showed that she had profound and severe hearing loss. Today Natalie is a happy, social, smiley, giggly eleven year old girl despite being severely affected by CMV. She's undergone ten surgeries, has implanted devices, uses a wheelchair, and is developmentally at a four to six month old age. After attending two CMV conferences Jessica and her husband, Patrick feel blessed to be apart of the Idaho CMV movement. They are excited to see how God can use them and others to educate people around the state on CMV and prevent other babies from being afflicted by this horrific virus.

Rebekah Hall

With a doctorate in clinical psychology from Fuller Theological Seminary's School of Psychology in Pasadena, California, Rebekah works professionally as a diagnostician and treatment provider for children with developmental and intellectual disabilities. She and her husband, Jeff, also a psychologist, had worked in the field for nearly a decade before the birth of their daughter, Keira. After what was thought to be a normal, healthy pregnancy, Keira was born very sick and was diagnosed with CMV at 3-days-old. Keira suffers from microcephaly, cerebral palsy, failure to thrive, and vision impairment. Rebekah is happy to be part of the team that is working toward passing CMV legislation in Idaho to help educate physicians and parents-to-be about the prevention and treatment of CMV.

Erica Jensen

Erica is a Bachelors prepared registered nurse who lives in Nampa with her husband and three daughters. While her first pregnancy was free of any complications, her second pregnancy quickly became high-risk. Originally pregnant with triplets, she and her husband found out that they had lost one baby during the first trimester. But because she was pregnant with multiples, she was already established with a high-risk maternal fetal specialist who was aware of CMV. She was tested for and diagnosed with CMV after persistent cold symptoms and a fever during her first trimester. Even though Erica had worked in healthcare for years, CMV was not something she was familiar with. After much research, she and her doctor settled on a treatment of immunoglobulin infusions, and an amniocentesis later confirmed that the treatments had worked and both of the babies were born free from CMV.

Erica is thrilled to be a part of the team working to raise awareness of CMV, and hopeful that it will make a real difference in the lives of Idahoans

Claire Szewczyk

A first year Doctor of Audiology student at Idaho State University, Claire first became interested in Cytomegalovirus (CMV) when she volunteered for the Cytomegalovirus Public Health and Policy Conference in 2014. As an undergraduate preparing for studies in hearing sciences, she was fascinated that CMV was the number one non-genetic cause of sensorineural hearing loss in children. In 2015, she worked as a member of the Early Hearing Detection and Intervention program in Salt Lake City and a part of the Utah Cytomegalovirus Public Health initiative. It was there she became engaged in advocacy for CMV and helped with a variety of public awareness campaigns. Now as an Idaho citizen, she is proud to be working with a project campaigning for the passage of CMV legislation, as well as dedication towards providing awareness and education of the virus to women across the state.

Renee A. Bobrowski, MD, FACOG

Stella Puppy, LLC
5220 N. Lakemont Lane Boise Idaho 83714

February 11. 2017

Health and Welfare Committee
Idaho State Legislature
Boise Idaho 83702

RE: Senate Bill No. 1060

Dear Committee Members:

I am writing in support of Senate Bill No. 1060 with the goal to not only increase awareness of Cytomegalovirus (CMV) but provide education for prevention.

I am a Maternal Fetal Medicine (MFM) physician, specializing in the care of high risk pregnant women. But long before I became an MFM, I was an intern in Obstetrics and Gynecology and delivered my first baby affected by congenital CMV. That was 28 years ago, and unfortunately it would not be my last. I have seen firsthand the devastating effects of in utero infection, which include hearing and/or vision loss, microcephaly/brain abnormalities, profound mental delay, failure to thrive, seizures and death.

Intrauterine CMV infection is the most common of all recognized intrauterine infections, with the Centers for Disease control estimating that it occurs in up to 2.3% of all live births. Outcomes range from asymptomatic to profoundly symptomatic requiring life long, intensive medical care. Current evidence indicates that most but not all symptomatic congenital CMV infections result from primary infection of the mother.

A CMV vaccine is not currently available, nor anticipated in the near future. There is no cure for CMV. Treatment during pregnancy and/or in the newborn does not guarantee a child will not suffer the sequelae of CMV. It is frequently a life altering disease, affecting not only a child but the entire network of family and friends. We are therefore, at the present time, left with trying to prevent transmission.

The economic and emotional costs of caring for a single child with congenital CMV are enormous. The most recent estimate of nationwide cost of caring for children with congenital CMV was $1-2 billion in the 1990s. Thus the cost of funding this and similar programs in all 50 states is far less than treatment and care for one child affected by

congenital CMV, making it a most worthy investment. Sadly the greatest loss for an affected child is the unrealized potential to lead a happy and productive life.

It has been suggested that up to 85% of women, i.e. future mothers, are NOT aware of CMV infection, transmission or its effects. And one cannot prevent something one is not aware of. Manicklal et al stated in Clinical Microbiology Reviews (2013 Jan:26(1):86-102) that 'successful implementation of strategies to prevent or reduce the burden of congenital CMV infection will require heightened global awareness among clinicians and the general population." There are currently only 5 states with legislation enacted to provide for public education about CMV infection. Idaho has the opportunity to lead the country in developing their public health initiative against CMV.

It is difficult to argue against funding for education in order to prevent even one child being affected by CMV. It is, after all, education that makes prevention a reality.

I kindly ask your support for Senate Bill No. 1060 so that we can build a strong CMV education program for the families of Idaho.

Respectfully,

RBobrowski

Renee A. Bobrowski, MD, FACOG

February 17, 2017

Hannah Josephson
8969 Bennett Road
Nampa, Idaho 83686

To The Idaho State Legislation,

My name is Hannah Josephson, I am a Registered Nurse in the Neonatal Intensive Care Unit at Saint Alphonsus Regional Medical Center. I am writing in support of bill number S1060, seeking funding to educate the public about CMV or cytomegalovirus. This bill is important to me both professionally and personally.

As a nurse I have taken care of patients diagnosed with CMV. Oftentimes in the NICU we test infants for CMV and it is the first time parents have ever heard of the disease. They are left feeling scared and uncertain. An infant diagnosed with congenital CMV who is symptomatic can spend anywhere from two to six weeks in the NICU for treatment. A long stay in the NICU is a huge burden on a family, both financially and emotionally.

I am also a close family friend of one of the bill presenters, Rebekah Hall. Rebekah and I have known each other for almost 20 years. We have become close friends as adults as a result of having children attending the same school and being classmates and friends. I have had the pleasure of watching Jeff and Rebekah raising their sweet little girl, Kiera. Kiera was diagnosed with congenital CMV as an infant, and has suffered many of the comorbidities associated with this diagnosis. I have watched them as they navigate taking care of two active boys and a child with special needs. They have an amazing support system; but the multiple hospitalizations, surgeries, therapies, and daily challenges associated with having a special needs child have provided hardships on this family.

I feel it is very important that you support bill S1060. I believe that providing education to women and families about the effects of CMV and ways to prevent being infected during pregnancy will prove to beneficial to the state of Idaho. Preventing just one infant from from contracting congenital CMV will more than outweigh the costs to the state for providing this education.

Sincerely,

Hannah Josephson
Charge Nurse
Saint Alphonsus Regional Medical Center, Neonatal Intensive Care Unit

I explained to the nurse that CMV parents, scientists and doctors have been trying for years to raise awareness, but the real risk of CMV to pregnancies remains little discussed—a real tragedy for daycare workers in light of recommendations made by the American Academy of Pediatrics (AAP): "In view of the risk of CMV infection in child care staff and the potential consequences of gestational CMV infection, child care staff members should be counseled about risks. This counseling may include testing for serum antibody to CMV to determine the child care provider's protection against primary CMV infection..."[v] (pg 145, AAP Red Book, 2012; pgs 144-145, AAP Red Book, 2015).

According to the study, "Child Care Provider Awareness and Prevention of Cytomegalovirus and Other Infectious Diseases" by Rosemary Thackeray and Brianna M. Magnusson, "Women who are exposed to CMV prior to conception or within the first trimester of pregnancy and seroconvert have increased risk of their infant being infected with CMV (Hyde et al. 2010)." Despite a daycare worker's high risk of contracting CMV, only 18.5% of licensed "in-home" daycare providers have heard of it according to Thackeray and Magnusson who also state: "Providers do not know how to appropriately sanitize surfaces to reduce spread of disease." For example, using baby wipes may clean a surface, but they do not sanitize it. The authors conclude: "Awareness of CMV and how to prevent transmission of infectious disease is low. Intervening with child care providers and parents through child care facilities are key opportunities to reduce prevalence of CMV infection and other diseases" (Thackeray and Magnusson, 2016).

Between "7.9–10% of daycare workers contract CMV infections each year." ("Losing Ground: Awareness of Congenital Cytomegalovirus in the United States, Doutre et al, 2016) [vi]

Sincerely,

Lisa Saunders
CMV Awareness and Policy Advocate, Parent Rep., Congenital Cytomegalovirus Foundation
LisaSaunders42@gmail.com | www.authorlisasaunders.com | http://congenitalcmv.org/ |
PO Box 389, Mystic, CT 06355

[i] (Joseph, MSc, Serene A, et al, 2006)
[ii] (Centers for Disease Control and Prevention (CDC), n.d.)
[iii] (Elizabeth Ann Saunders, 2006)
[iv] (Doutre, S. M. Barrett, T. S. Greenlee, J. & White, K. R. , 2016)
[v] (Infectious Diseases American Academy of Pediatrics, 2012, 2015)
[vi] (Doutre, S. M. Barrett, T. S. Greenlee, J. & White, K. R. , 2016)

To whom it may concern:

I am in support of Idaho's Educational CMV bill.

I was unaware that cytomegalovirus (CMV) was an occupational risk for daycare educators[i] when I became a licensed home daycare provider in Maryland in 1987. I didn't know that CMV was the leading viral cause of birth defects and could devastate my own pregnancy with Elizabeth, who was born severely disabled by congenital (present at birth) CMV in 1989. Today, most U.S. daycare providers are still not aware of their increased risk for contracting CMV. According to the *New York Times*, CMV Is a Greater Threat to Infants Than Zika, but Far Less Often Discussed (2016).

At the time of Elizabeth's birth, I was operating my licensed home daycare center and volunteering in our church nursery, additionally putting my pregnancy at risk. Elizabeth was born with an abnormally small head, known as microcephaly, was profoundly mentally impaired, legally blind, and had cerebral palsy. After her birth, I was given information from the Centers and Disease Control Prevention (CDC) informing me that "People who care for or work closely with young children may be at greater risk of CMV infection than other people because CMV infection is common among young children..."[ii] This information came too late to spare my daughter the years of suffering that lay ahead of her. Nowhere in my daycare licensing literature or training was CMV mentioned. CMV prevention measures were not discussed in my prenatal doctor visits.

Though Elizabeth grew into a very cheerful girl who won the "Best Smiling Award" at school, she couldn't hold up her head and lived as a three-month-old for 16 years, requiring several surgeries such as spinal fusion. She developed epilepsy and was gradually losing her hearing by the time she died at 16 during a seizure[iii] in 2006 while we were living in New York. I had a bad dream shortly after Elizabeth's death about new parents wondering why I hadn't done more to warn them about the precautions to take against CMV. Although I wrote about Elizabeth's adventurous life with her tomboy sister and a series of dysfunctional pets, including a homeless older dog that joined her on the couch in my memoir, "Anything But a Dog: the perfect pet for a girl with congenital CMV" (Unlimited Publishing, 2008, Thousand Books Project Team of Tokyo, Japan, 2017), congenital CMV still remains largely unknown. Recent HealthStyles™ surveys in the U.S. concluded that only 5% of men and 9% of women have heard of CMV (2015 and 2016).[iv]

In 2010, my husband and I moved to Connecticut. In 2012, I received an email from a distressed grandmother about her grandson born with congenital CMV in a Connecticut hospital (I am the parent representative of the Congenital Cytomegalovirus Foundation). The mother of her grandson was a high school student interning in a Connecticut daycare center. The young mother, just like me over 20 years earlier, was unaware she was putting her pregnancy at greater risk by working in daycare with young children. When I visited the family in the hospital, the attending nurse asked me, "Knowing what you do about CMV, why haven't you launched an awareness campaign?"

February 17, 2017

To Whom It May Concern:

My name is Jessica Stich-Hennen, AuD. For the past 10 years, I have been working as a pediatric audiologist in Boise, ID. During my career, I have worked with several children and families who lives were impacted by congenital Cytomegalovirus (CMV).

In adults, CMV is typically harmless. Unfortunately, CMV is most harmful to a fetus during pregnancy. The virus can cross the placental barrier and cause irreversible birth defects (microcephaly, brain damage, hearing loss, vision problems, cerebral palsy). The CDC reports 1 in 150 babies are born with CMV and 1/5 will have long term medical complications.

The purposed Senate Bill #1060 will provide education and awareness regarding CMV in Idaho. Women of our state will be able to understand how to prevent CMV infection and why it is important. When considering the financial burden of medical procedures/treatments in caring for one child with congenital CMV, the $60,000 requested by Senate Bill #1060 is nominal. Respectfully, consider passing Senate Bill #1060.

Thank you for your time.

Sincerely,

Dr. Jessica Stich-Hennen, AuD, PASC
Doctor of Audiology
Specialty Certification in Pediatric Audiology

A&R Case Management

3070 12th Ave. Rd. • Ste. 112 • Nampa • ID • 83686
Phone • 208.463.9313 • Fax • 208.442.0857
Web • http://www.arcasemanagement.com

The Honorable Marv Hagedorn
P.O. Box 83720
Boise, ID 83720-0081

RE: Senate Bill 1060

Dear Senator Hagedorn,

I am writing to request your support of Senate Bill 1060, which provides for much-needed public health funding to provide information on cytomegalovirus (CMV), it's symptoms, prevention and potential birth defects caused by infection during pregnancy.

As a School Counselor in our Idaho public schools and now, as a contract Service Coordinator at A&R Case Management, I have seen the devastating effect of cytomegalovirus (CMV) on children and families. CMV is a common childhood infection, with most children testing positive for the virus by age 5. However, if women have not been exposed to CMV as a child, an infection during pregnancy can cross the placenta and infect the baby. Depending on the stage of pregnancy this can cause a variety of delays or conditions in the child, from severe neurological damage (cognitive delay, cerebral palsy, microcephaly, seizures) to sensory impairments like hearing loss and blindness.

I have worked with a number of families living with CMV and they spend thousands of dollars a year in therapy and medication and countless hours with doctors, therapists and hospitals. A few common concerns are:

- Applying for and receiving Social Security, Medicaid and Developmental Disability programs to help provide funds and medical care.
- Transportation to and from 4-5 therapy appointments per week for treatment of cerebral palsy, speech delay, feeding, occupational therapy and physical therapy
- On-going medical fragility and frequent hospitalizations for the child throughout their lifetime
- Development and monitoring of IEP plans in school

This Senate Bill provides funding for information on CMV: How it is transmitted, how it is prevented and what to do if you are pregnant to prevent infection. Idaho OB/GYNs are not currently discussing cytomegalovirus with women before or during pregnancy. We have the information ready to share and we can prevent thousands of CMV infections each year! The savings to the State Medicaid budget would be tangible as CMV related delays cost Idaho millions in Medicaid spending each year.

Please support Senate Bill 1060. Thank you for your time and consideration of this matter.

Respectfully submitted,

Susan

Susan Spelliscy, B.S. M.Coun.
Children's Service Coordinator

- **1 out of every 4 children born with congenital CMV will develop permanent disabilities** including but not limited to:
    - Hearing loss
    - Vision loss
    - Developmental concerns
    - Intellectual disabilities
    - Small head size
    - Cerebral palsy
    - Lack of coordination
    - Abnormal muscle tone
    - Feeding difficulties
    - Seizures
    - Death

Are there signs or symptoms?

- Most children and adults do not show symptoms when infected. **If symptoms are present, it is usually mild cold-like symptoms such as fever, fatigue, runny nose or congestion, sore throat, etc.**
- When children are born symptomatic, **symptoms might include**:
    - Hearing loss/Failed hearing test
    - Vision loss
    - Jaundice (yellowing of the skin)
    - Pneumonia
    - Rash
    - Enlarged liver/spleen
    - Small heads (microcephaly)
    - Seizures
- Congenital CMV can be diagnosed if the virus is detected in an infant's urine, saliva, or blood **within 3 weeks after birth.**
- Most infants, children, and adults **are not tested for CMV infection**.

IDAHO
CMV Advocacy Project

THE FACTS ON CMV

The dangerous virus that most women have never heard of..

What is CMV?

- Cytomegalovirus (CMV) is a common virus of the herpes family that infects people of all ages.
- 90% of the population will have contracted the disease by 80 years old.
- **CMV is one of the few viruses that can pass through the placenta**. Once the fetus is infected, the virus can cause damage to the brain, eyes and/or inner ears.
- **Congenital CMV is the number one cause of non-genetic sensorineural hearing loss in children.**
- Congenital CMV **causes more long-term health concerns than Down syndrome and fetal alcohol syndrome.**
- Most CMV infections are **asymptomatic or "silent"**, meaning **they do not show any signs or symptoms.**
- **Congenital CMV** is when the CMV infection occurs during a women's pregnancy and her baby becomes infected. CMV is the most common congenital infection in the United States.
- Roughly **30,000 children are born with congenital CMV each year.**

What prevention strategies are there to protect against CMV?

The best way to protect your baby is to protect yourself!

CMV is spread through the direct contact of bodily fluid including saliva and mucus.

- **Do not share food, drinks, toothbrushes, etc. with a child.**
- **Avoid kissing a child on the mouth and always wash your hands** when in contact with saliva.
- **Do not put children's toys and pacifiers into or around your mouth.**
- **Wash your hands, especially after**:
  - Handling children's toys
  - Feeding a young child
  - Wiping a young child's nose or mouth
  - Changing diapers

More Information

If you have concerns about CMV infection or are pregnant or planning to become pregnant, talk to your healthcare provider.

- National CMV Foundation http://nationalcmv.org
- Idaho Advocacy Project http://idahocmv.com
- Utah Cytomegalovirus Public Health Initiative http://health.utah.gov
- CDC – Cytomegalovirus http://cdc.gove/cmv

McVicar, S. B. (2016). Cytomegalovirus (CMV) Public Health Initiative. Retrieved from http://www.health.utah.gov/cshcn/programs/cmv.html

Congenital CMV. (n.d.). Retrieved December 18, 2016, from https://www.nationalcmv.org/congenital-cmv.aspx

What is the treatment for CMV?

- **No drugs or vaccines are presently available** to treat congenital CMV infection. There are some CMV vaccines being tested in humans.
- There is some data from ongoing studies on the use of antiviral medications in infants with symptomatic congenital CMV infection.
- Pediatricians are important in making sure children with CMV infections are treated as needed.
- **Asymptomatic babies appear healthy at birth but still can develop hearing loss and/or vision loss over time.**

Facts about pregnant women and CMV

- Almost half of women have **already contracted CMV** by the time they first become pregnant.
- 4% of women who have never had CMV will **contract it while pregnant**.
- Women who acquire the disease during pregnancy are **more likely to pass the disease to their fetus** verses a woman who becomes re-infected with the disease.
- 50-75% of CMV infections occur in **infants born by mothers where the virus had reactivated/re-infected**.
- **50-80% of the world's population (6 out of 7 people)** carry the dormant virus.
- **90% of healthy adults** will be infected by the time they are 80 years old.

CYTOMEGALOVIRUS (CMV)

can be **transmitted to an unborn baby during pregnancy** leading to **birth defects and long-term disabilities.**

Typically a harmless cold virus, CMV can be devastating to individuals who are immunocompromised or to an unborn child.

Some of the **permanent disabilities** CMV can cause include: **hearing loss, vision loss, developmental concerns, intellectual disabilities, small head size, cerebral palsy, abnormal muscle tone, feeding difficulties, seizures, and even death.**

If you are pregnant, planning to become pregnant, or need more information, please contact your physician and visit:

IDAHO
CMV Advocacy Project

idahocmv.com

CMV is spread through the direct contact of bodily fluids including saliva and mucus

Hearing loss is the most recognized symptom of CMV at birth

1 in 150 children are born with CMV

Nearly 1 in every 5 children born with congenital CMV will develop permanent disabilities

Most CMV infections are "silent" meaning women infected have no signs or symptoms

Newborn Signs and Symptoms

- Hearing/Vision Loss
- Jaundice
- Pneumonia
- Rash
- Enlarged Liver/Spleen
- Small Head
- Seizures
- Failed Hearing Test

The best way to protect your baby is to protect yourself!

DO NOT share food, drinks, toothbrushes, etc. with your child.

AVOID kissing a child on the mouth and always wash your hands when in contact with saliva.

DO NOT put child's toys and pacifiers into or around your mouth.

Wash your hands, especially after:

- Handling children's toys
- Feeding a young child
- Wiping a young child's nose or mouth
- Changing Diapers

If you are pregnant, planning to become pregnant, or need more information, please contact your physician and visit:

IDAHO
CMV Advocacy Project

idahocmv.com

Cytomegalovirus (CMV)

What you NEED TO KNOW

About CMV

Cytomegalovirus (CMV) is a common virus of the herpes family that infects people of all ages.

CMV is one of the few viruses that can pass through the placenta. Once the fetus is infected, the virus can cause damage to the brain, eyes and/or inner ears.

Permanent Disabilities

- Hearing loss
- Vision loss
- Developmental concerns
- Intellectual disabilities
- Small head size
- Cerebral palsy
- Lack of coordination
- Abnormal muscle tone
- Feeding Difficulties
- Seizures
- Death

Did you know?

- **Only 9% of women know about CMV**
- 1 in 150 children are born with congenital CMV
- CMV is spread through the direct contact of bodily fluid including saliva and mucus
- Most CMV infections are "silent", meaning women infected have no signs or symptoms
- **Hearing loss is the primary symptom of CMV at birth**
- 40% of women who become infected with CMV for the first time during pregnancy will pass the infection to their unborn child
- **Nearly 1 in every 5 children born with congenital CMV infection will develop permanent disabilities!**

THE BEST WAY TO PROTECT YOUR BABY IS TO PROTECT YOURSELF!

Cytomegalovirus (CMV) is a common virus of the herpes family that infects people of all ages.

CMV is one of the few viruses that can pass through the placenta. Once infected, the virus can cause damage to the brain, eyes and/or inner ears of the fetus.

If you are pregnant, planning to become pregnant, or need more information, please contact your physician and visit:

IDAHO
CMV Advocacy Project
idahocmv.com

HELPFUL PREVENTION TIPS

CMV IS TRANSMITTED MOST EASILY FROM WET SALIVA TO WET SALIVA

DO NOT SHARE FOOD, DRINKS, TOOTHBRUSHES, ETC. WITH YOUR CHILD

AVOID KISSING A CHILD ON THE MOUTH

DO NOT PUT A CHILD'S TOYS OR PACIFIERS INTO OR AROUND YOUR MOUTH

WASH YOUR HANDS:

- After handling children's toys
- After feeding a child
- After wiping a child's nose or mouth
- After changing diapers

The best way to protect your baby is to protect yourself!

Cytomegalovirus (CMV) is a common virus that can pass through the placenta. Once infected, the virus can cause damage to the brain, eyes and/or inner ears of the fetus.

1 in 150 children are born with congenital CMV.

Nearly 1 in every 5 children born with congenital CMV infection will develop permanent disabilities.

If you are pregnant, planning to become pregnant or would like more information, please contact your physician and visit:

Idaho CMV Advocacy Project

idahocmv.com

CMV is a dangerous virus that most women have never heard of.. Educate yourself!

Cytomegalovirus (CMV) is a common virus that can pass through the placenta. Once infected, the virus can cause damage to the brain, eyes and/or inner ears of the fetus.

CMV is more prevalent than the Zika virus!

1 in 150 children are born with congenital CMV

Nearly 1 in every 5 children born with congenital CMV infection will develop permanent disabilities

If you are pregnant, planning to become pregnant or would like more information, please contact your physician and visit:

IDAHO
CMV Advocacy Project

idahocmv.com

CMV is a dangerous virus that most women have never heard of.. Educate yourself!

Cytomegalovirus (CMV) is a common virus that can pass through the placenta. Once infected, the virus can cause damage to the brain, eyes and/or inner ears of the fetus.

Babies born infected with CMV are frequently born to mothers who worked **as teachers or daycare providers** during pregnancy, and/or **parenting a toddler**.

If you are pregnant, planning to become pregnant or would like more information, please contact your physician and visit:

IDAHO
CMV Advocacy Project

idahocmv.com

What would CMV legislation mean for Idaho?

Every year, an estimated **150 babies** are born with CMV in Idaho.

Of those, an estimated **30 babies** will have permanent disabilities.

The healthcare costs for just one of these children can cost taxpayers as much as **$1,800,000.** This is for the care of just **ONE CHILD** through the age of 18.

A CMV bill in the state of Idaho would provide for:

1. Increased **education** of healthcare providers
2. Increased **public awareness**
3. **Mandated CMV testing** for infants who fail their newborn hearing screens

It is estimated that to put this legislation into practice would cost the state of Idaho **$60,000** in the first year and **$30,000** each year after.

In other words, if CMV legislation led to the prevention of just one baby from having severe CMV related complications in the first year, it could potentially save the state **$482,000.**

Similar legislation has been passed in **Utah, Tennessee, Hawaii, Connecticut, Illinois and Texas.**

For more information please visit:

The National CMV Foundation	nationalcmv.org
Idaho CMV Advocacy Project	idahocmv.com

IDAHO
CMV Advocacy Project

For more information please visit
idahocmv.com

Or email us at
idahocmv@gmail.com

LEGISLATURE OF THE STATE OF IDAHO

Sixty-fourth Legislature First Regular Session - 2017

IN THE SENATE

SENATE BILL NO. 1060

BY HEALTH AND WELFARE COMMITTEE

AN ACT

RELATING TO HEALTH CARE; AMENDING CHAPTER 10, TITLE 56, IDAHO CODE, BY THE ADDITION OF A NEW SECTION 56-1055, IDAHO CODE, TO PROVIDE THAT THE STATE DEPARTMENT OF HEALTH AND WELFARE SHALL MAKE AVAILABLE CERTAIN INFORMATION REGARDING CYTOMEGALOVIRUS.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Chapter 10, Title 56, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW SECTION, to be known and designated as Section 56-1055, Idaho Code, and to read as follows:

56-1055. CYTOMEGALOVIRUS INFORMATION. (1) The department shall make available the following information to the public, particularly pregnant women and women who may become pregnant:

(a) Incidence of cytomegalovirus (CMV);

(b) Transmission of CMV;

(c) Birth defects caused by congenital CMV;

(d) Available preventive measures; and

(e) Other information relating to CMV deemed pertinent by the department.

(2) The department shall make available the information described in subsection (1) of this section to:

(a) Health care providers licensed under title 54, Idaho Code, offering care to pregnant women and infants;

(b) Daycare and child care programs and facilities licensed under title 39, Idaho Code, and persons employed by such programs or facilities;

(c) School districts and persons offering health care or health education in a school district;

(d) Religious, ecclesiastical or denominational organizations offering children's programs as part of their services, and persons employed or volunteering for such programs; and

(e) Other persons and entities that would benefit from such information, as determined by the department.

STATEMENT OF PURPOSE

RS25093C1

The purpose of the bill is to ensure the women of Idaho and their doctors have access to the most accurate and up-to-date information available regarding cytomegalovirus (CMV) prevention, infection, and treatment. Appropriate dissemination of this information will foreseeably prevent the infection of numerous babies in utero, thereby saving the State of Idaho millions of dollars in the care and treatment of various disabilities that are associated with congenital CMV infection.

FISCAL NOTE

$60,000 in the first year for educational materials and $30,000 per year ongoing to the Department of Health &Welfare.

Contact:
Senator Lee Heider
(208) 332-1000
Representative Paulette Jordan
(208) 332-1175

DISCLAIMER: This statement of purpose and fiscal note are a mere attachment to this bill and prepared by a proponent of the bill. It is neither intended as an expression of legislative intent nor intended for any use outside of the legislative process, including judicial review (Joint Rule 18).

26-10-10 Cytomegalovirus (CMV) public education and testing.

(1) As used in this section "CMV" means cytomegalovirus.

(2) The department shall establish and conduct a public education program to inform pregnant women and women who may become pregnant regarding:
- (a) the incidence of CMV;
- (b) the transmission of CMV to pregnant women and women who may become pregnant;
- (c) birth defects caused by congenital CMV;
- (d) methods of diagnosing congenital CMV; and
- (e) available preventative measures.

(3) The department shall provide the information described in Subsection (2) to:
- (a) child care programs licensed under Title 26, Chapter 39, Utah Child Care Licensing Act, and their employees;
- (b) a person described in Subsection 26-39-403(1)(c), (f), (g), (h), (j), or (k);
- (c) a person serving as a school nurse under Section 53A-11-204;
- (d) a person offering health education in a school district;
- (e) health care providers offering care to pregnant women and infants; and
- (f) religious, ecclesiastical, or denominational organizations offering children's programs as a part of worship services.

(4) If a newborn infant fails the newborn hearing screening test(s) under Subsection 26-10-6(1), a medical practitioner shall:
- (a) test the newborn infant for CMV before the newborn is 21 days of age, unless a parent of the newborn infant objects; and
- (b) provide to the parents of the newborn infant information regarding:
  - (i) birth defects caused by congenital CMV; and
  - (ii) available methods of treatment.

(5) The department shall provide to the family and the medical practitioner, if known, information regarding the testing requirements under Subsection (4) when providing results indicating that an infant has failed the newborn hearing screening test(s) under Subsection 26-10-6(1).

(6) The department may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as necessary to administer the provisions of this section.

Enacted by Chapter 45, 2013 General Session

FISCAL NOTE

H.B. 81 1st Sub. (Buff)

SHORT TITLE: Cytomegalovirus Public Health Initiative

SPONSOR: Menlove, R. (Menlove, R. Sub.)

2013 GENERAL SESSION

STATE GOVERNMENT (UCA 36-12-13(2)(b))

This bill costs the Department of Health $30,800 ongoing General Fund beginning in FY 2014 and $4,000 one-time General Fund in FY 2013 for a 0.5 FTE educator and educational materials.

STATE BUDGET DETAIL TABLE	FY 2013	FY 2014	FY 2015
Revenue	$0	$0	$0
Expenditure:			
General Fund	$0	$30,800	$30,800
General Fund, One-Time	$4,000	$0	$0
Total Expenditure	$4,000	$30,800	$30,800
Net Impact, All Funds (Rev.-Exp.)	($4,000)	($30,800)	($30,800)
Net Impact, General/Education Funds	($4,000)	($30,800)	($30,800)

LOCAL GOVERNMENTS (UCA 36-12-13(2)(c))

Enactment of this bill likely will not result in direct, measurable costs for local governments.

DIRECT EXPENDITURES BY UTAH RESIDENTS AND BUSINESSES (UCA 36-12-13(2)(d))

Enactment of this bill likely will not result in direct, measurable expenditures by Utah residents or businesses.

PERFORMANCE NOTE (JR 4-2-404): Not Required

2/8/2013, 08:19 AM, Lead Analyst: Frandsen, R./Attorney: AKJ

State of Utah, Office of the Legislative Fiscal Analyst

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A Diagnostic Paradigm Including Cytomegalovirus Testing for Idiopathic Pediatric Sensorineural Hearing Loss

Albert H. Park, MD; Melanie Duval, MDCM; Stephanie McVicar, AuD, CCC-A; James F. Bale, Jr., MD; Nancy Hohler, AuD; John C. Carey, MD

Objectives/Hypothesis: To determine the feasibility and cost effectiveness of incorporating cytomegalovirus (CMV) testing to determine the etiology of pediatric hearing loss.

Study Design: Retrospective study of children presenting with sensorineural hearing loss (SNHL) at one institution from 2008 to 2013.

Methods: Children aged 3 years or younger who presented to the senior author (A.P.) between May 2008 and September 2013 with confirmed SNHL were evaluated. These children underwent a sequential diagnostic paradigm that incorporated CMV testing if no obvious etiology could be determined from the history or physical examination.

Results: One hundred eleven children with SNHL were evaluated between 2008 and 2013. Eighty-three children underwent CMV testing, imaging, and a genetic evaluation. Those with confirmed or probable CMV-induced SNHL made up 30% of all children tested (n = 25), the largest group identified. CMV screening had the lowest cost compared to genetic testing or imaging for all types of hearing loss, except for those with auditory neuropathy spectrum disorder.

Conclusion: We present the first sequential diagnostic paradigm utilizing CMV testing for children presenting with SNHL. The relatively high incidence of CMV-induced SNHL, the low cost for this assay, and the indirect benefits from early diagnosis support the role of early CMV testing for these patients.

Key Words: Cytomegalovirus, sensorineural hearing loss.

Level of Evidence: 4.

***Laryngoscope*, 124:2624–2629, 2014**

INTRODUCTION

Cytomegalovirus (CMV), a member of the β-herpesvirus family, is the most common infectious cause of congenital sensorineural hearing loss (SNHL).[1] Between 1% and 4% of seronegative pregnant women will seroconvert during pregnancy. With a prevalence of approximately 1% in the United States, it is estimated that 40,000 congenitally infected neonates are born annually.[2] Almost 400 children die each year from this disease, and approximately 7,000 develop permanent disabilities.[3] The most common permanent disability from CMV infection is hearing loss. It is estimated to account for 20% or more of SNHL in young children.[4] More children may be affected by CMV than by other, better known childhood conditions, such as Down syndrome, fetal alcohol syndrome, and spina bifida.[5] This hearing loss has detrimental effects on speech and language development and incurs the major cost associated with congenital CMV infection, estimated to be $4 billion a year.[6,7]

Despite the known significance of this infection, there has been a paucity of studies evaluating the yield of CMV testing for the hearing-impaired child. A recent Triological Society Best Practice article— "What Is the Optimal Workup for a Child with Bilateral Sensorineural Hearing Loss?"—failed to mention any role of CMV testing for these children.[8] Rutherford et al. surveyed members of the American Society of Pediatric Otolaryngology to determine the trends in the evaluation of pediatric SNHL.[9] The authors noted that few respondents ordered CMV testing and mentioned that testing for infectious causes for SNHL is low-yield. The goal of this study is to evaluate the feasibility and cost effectiveness of incorporating CMV testing into a sequential diagnostic paradigm for idiopathic pediatric SNHL.

MATERIALS AND METHODS

We conducted a chart and database review of children aged 3 years or younger who presented to the senior author (A.P.) between May 2008 and September 2013 with confirmed SNHL. Since 2008, these children underwent a sequential diagnostic paradigm that incorporated CMV testing if no obvious etiology could be determined from the history or physical examination (Fig. 1).

SNHL was defined as a bone conduction threshold of 30 dB HL or worse in one or both ears at one or more frequencies

From the Division of Otolaryngology–Head and Neck Surgery (A.H.P., M.D.); the Division of Medical Genetics, Department of Pediatrics (J.C.C.); University of Utah; the Utah Department of Health (S.MCV.); the Division of Pediatric Neurology, Department of Pediatrics and Neurology (J.F.B.), University of Utah School of Medicine; and the Audiology, Primary Children's Medical Center (N.H.), Salt Lake City, Utah, U.S.A.

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DOI: 10.1002/lary.24752

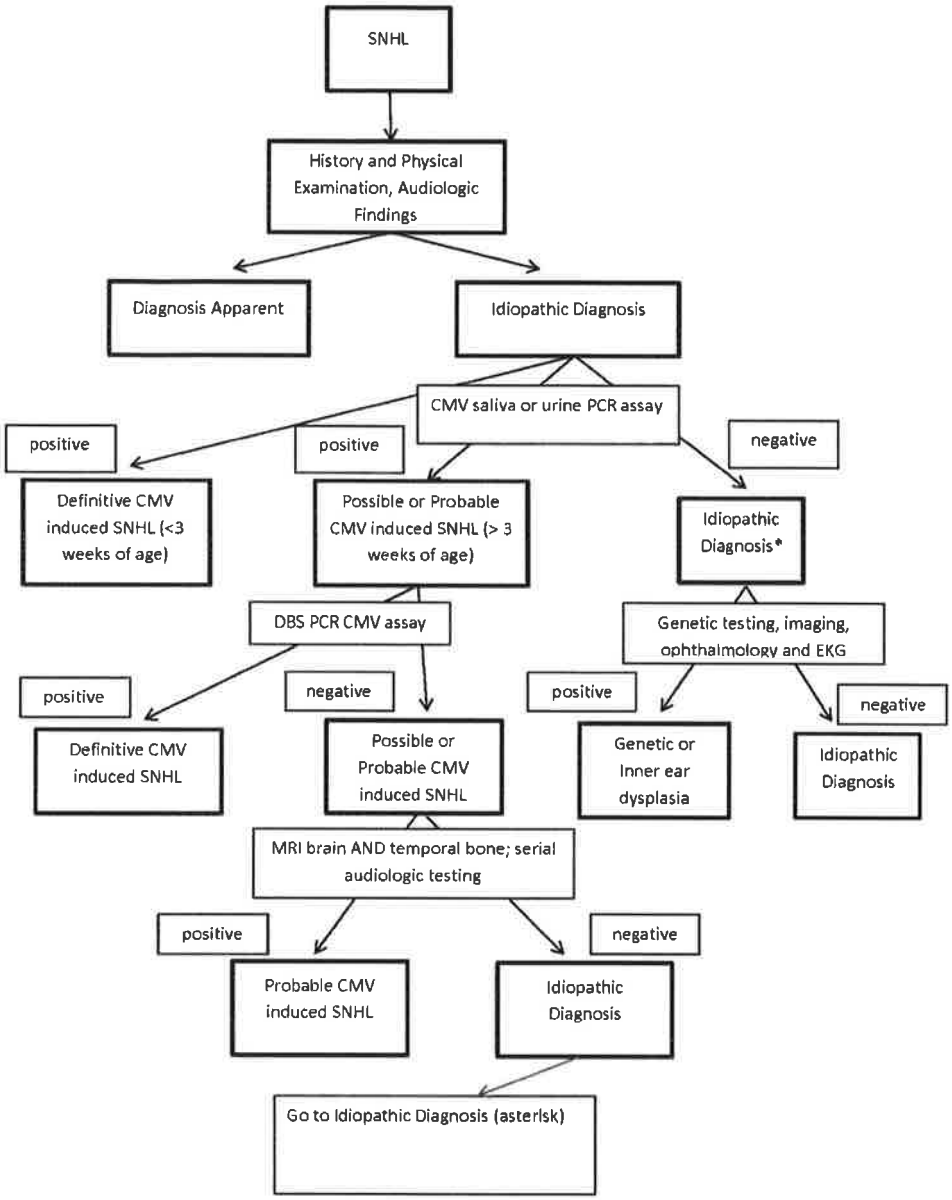

Fig. 1. Flowchart illustrating a sequential diagnostic paradigm that incorporated cytomegalovirus testing if no obvious etiology could be determined from the history or physical examination.

from 500 Hz to 4000 Hz based on results obtained via auditory brainstem response testing (using correction factors and reported as estimated hearing level or eHL) or behavioral thresholds obtained utilizing visually reinforced audiometry or conditioned play audiometry. Hearing loss was classified as follows: mild (30 – 40 dB), moderate to severe (41 – 70 dB), and severe to profound (71 – < 90 dB HL).

Once SNHL was confirmed, all children were evaluated with a complete history: physical examination including evaluation for dysmorphic features and family history and pedigree. If this evaluation did not suggest an underlying etiology of SNHL, CMV testing was recommended.

CMV testing was performed by saliva or urine CMV polymerase chain reaction (PCR) assay, followed by neonatal, dry blood spot (DBS) CMV PCR if urine or saliva assay was positive and the child was older than 3 weeks of age at the time of testing. Because the Utah Department of Health maintains a child's DBS sample for 3 years, testing these specimens for congenital CMV was only possible if the child was younger than 3 years old at the time of evaluation. A confirmed diagnosis for congenital CMV or CMV PCR assay can only be established if the child is tested younger than 3 weeks of age[10]; after that age, a positive CMV PCR assay could represent a postnatally acquired infection.

In children with positive CMV testing, a confirmed diagnosis of CMV-induced SNHL was defined as a positive CMV PCR saliva or urine assay in an infant less than 3 weeks of age—or a positive DBS neonatal CMV PCR result in a child older than 3 weeks of age. For children with a positive urine or saliva CMV assay who are older than 3 weeks of age, CT or MRI brain imaging suggestive of CMV and/or documentation of progressive SNHL were categorized as having probable CMV-induced SNHL. Imaging findings suggestive of CMV included periventricular cysts, polymicrogyria, white matter abnormalities, microcephaly, and intracranial calcifications.[11] In those children with a positive urine or saliva CMV assay who were older than 3 weeks of age, a negative DBS CMV PCR result and normal brain imaging were categorized as not having CMV-induced

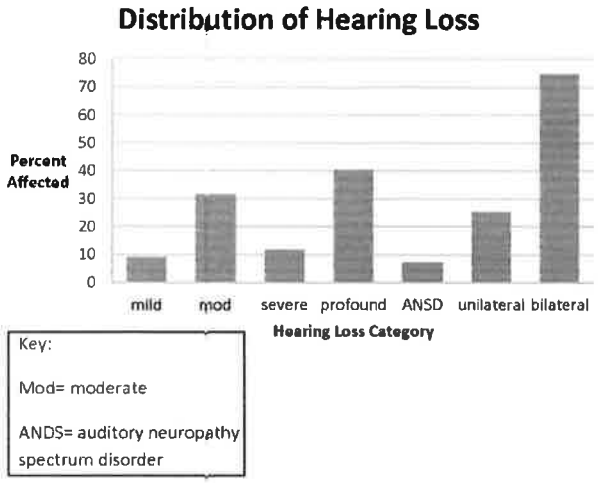

Fig. 2. Hearing loss for the 111 children evaluated between 2008 and 2013.

SNHL and went on to undergo further testing to elucidate the etiology of their hearing loss. Those patients with negative CMV testing underwent temporal bone imaging, ECG, or evaluation by a geneticist.

A large, multihospital standardized-cost accounting database that collects financial and clinical datasets was used to compare the costs for diagnostic testing. This database collects actual patient costs incurred per encounter. Both individual and simultaneous costs of the diagnostic testing were compared. MRI imaging costs included the sum of the professional, sedation, and facility costs. The average costs were as follows: MRI scan of the temporal bone $1591; Gap junction protein beta 2 (GJB2) screen $611; and CMV PCR saliva or urine assay $66. The cost of sequential testing began with the cost of a specific test for 100 patients, followed by a calculation of subsequent testing based on the diagnostic yield for the original and subsequent tests. For example, if the cost for initial screening of a GJB2 mutation yielded a 15% positive result for children with bilateral mild SNHL, the calculated cost of this approach would be $66,710 (100 children × $611 + 85 children × $1591 × 0 (0% yield) + 85 children × $66).

Institutional review board approval from the University of Utah and Primary Children's Hospital was obtained for this study.

RESULTS

Distribution of Hearing Loss and Etiology Based on Examination and History

One hundred eleven children with SNHL less than 3 years of age were evaluated between 2008 and 2013. The distribution of their hearing thresholds is shown in Figure 2. Profound SNHL made up the largest group with 45 (40.5%) affected children. Eighty-two children (75%) had bilateral SNHL. Eight children (7%) had auditory neuropathy spectrum disorder. An etiology for the SNHL could be determined from the history, physical examination, or audiologic findings in 26 children (Fig. 3). A genetic etiology was the most common cause, usually from an undefined familial predisposition to hearing loss (31%) or Down syndrome (12%). Other genetic conditions identified included branchiootorenal, Pendred,

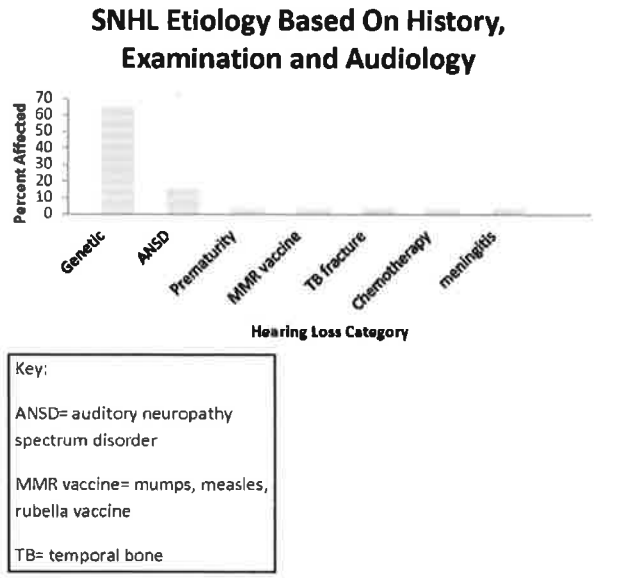

Fig. 3. Etiology determined for 23 children determined by history and physical examination.

Alport, Waardenburg, and CHARGE (coloboma, heart defects, atresia of the nasal choanae, retarded growth and development, genital hypoplasia, ear anomalies, and/or deafness) syndromes. Auditory dyssynchrony was identified in four children. Acquired SNHL causes included a complication from MMR vaccination, a temporal bone fracture, meningitis, and complications from chemotherapy and from prematurity.

Distribution of Hearing Loss Etiology Based on CMV Testing, Imaging, and Genetic Evaluation

Eighty-three children underwent CMV testing, imaging, and an evaluation by a geneticist. The distribution of etiologies following this approach is shown in Figure 4. Those with confirmed or probable CMV-induced SNHL made up 30% of all children tested (n = 25), the largest group with a known etiology of hearing loss

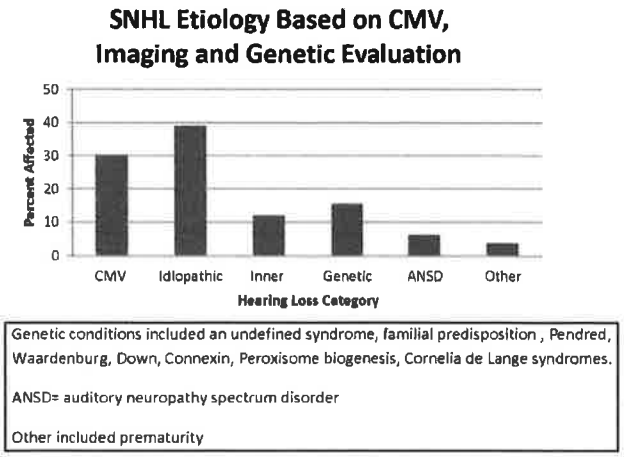

Fig. 4. Etiology determined following cytomegalovirus testing, imaging, and genetic evaluation.

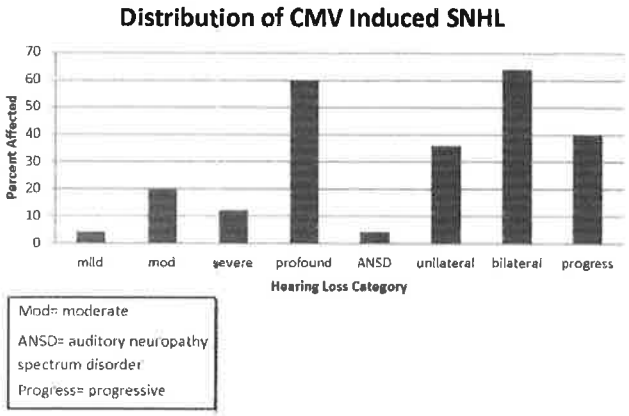

Fig. 5. Distribution of hearing loss attributed to congenital cytomegalovirus infection.

identified. Sixteen children were diagnosed with confirmed CMV, and nine children were diagnosed with probable CMV. Six of the 16 children with confirmed CMV were diagnosed via detection of viral DNA from archived neonatal DBS testing. DBS testing was available for six children out of the nine children with probable CMV-induced SNHL. Those without a known etiology were the largest group at 39% (n = 33). Ten of these children had a positive urine or saliva CMV PCR result after 3 weeks of age. They did not have imaging suggestive of CMV or a history of progressive SNHL. A genetic etiology made up the third-largest group (15%). The distribution of those with a genetic etiology included an undefined syndrome, a familial predisposition to hearing loss, and a number of different syndromes (Figure 4). An inner ear dysplasia made up almost 12% of the affected children. An enlarged vestibular aqueduct (5%) was the most common abnormality identified—followed by cochlear nerve deficiency (4%) and cochleovestibular dysplasia (4%).

Characteristics of CMV-Induced SNHL Patients

Twenty-five children with probable or confirmed CMV-induced SNHL were evaluated with an average follow-up of 305 days. The average initial age at evaluation was 352 days (range 24–1387 days). Only five infants were evaluated at 1 month of age or younger. The average age of CMV testing was 256 days (range 0–1,387 days), slightly earlier than the initial evaluation. Nine children who underwent CMV testing were younger than 1 month of age.

The distribution of CMV-induced SNHL is shown in Figure 5. Profound SNHL made up the largest group with 16 (60%) affected children. One child had bilateral normal otoacoustic emissions but demonstrated a mild SNHL at 2k Hz, bilaterally, and at 500 Hz in the right ear. Sixteen children (64%) had bilateral SNHL. One child (4%) had auditory neuropathy spectrum disorder. Progressive SNHL was identified in 10 (40%) of the children.

Cost Estimates of SNHL Evaluation by Test

The anticipated diagnostic yield by test is shown for GJB2 screening, imaging, and CMV PCR testing in Table I. Because most insurance providers do not cover GJB2 screening in Utah, very few of our patients underwent this test. For that reason, the anticipated diagnostic yield by hearing loss was based on a prior study from our group and from Preciado et al.'s study from 2004.[12,13] The yield for imaging and CMV testing was determined from the 83 children in this study who underwent CMV, genetic evaluation, and imaging. The estimated cost of all three tests, if performed for 100 children with SNHL, is shown under simultaneous testing. This calculation is based on the sum for institutional cost for GJB2 screening ($611), imaging ($1591), and CMV PCR testing ($66). This calculation is based on the assumption that a child underwent CMV testing before 3 weeks of age and did not require DBS CMV PCR testing. The addition of DBS testing would increase the cost by another $66 because both tests cost the same. The following rows indicate the anticipated cost if GJB2, imaging, or CMV testing was performed first. The cost assumes that a positive result would obviate the need for additional testing. CMV screening had the lowest cost for all types of hearing loss. The lowest cost for each hearing loss type was indicated in bold.

DISCUSSION

This study is the first report of a sequential diagnostic paradigm incorporating CMV testing for

TABLE I.
Cost Estimates of Alternative SNHL Evaluation Approaches Based on Diagnostic Yield.

Testing	Bilateral Mild	Bilateral Moderate-Severe SNHL	Bilateral Severe-Profound SNHL	Unilateral	ANSD	Overall
GJB2 screen*	15%	5%	37.7%	0%	0%	19%
Imaging	0%	8%	0%	18%	50%	11%
CMV PCR	20%	23%	36%	36%	17%	30%
Simultaneous	$226,800	$226,800	$226,800	$226,800	$226,800	$226,800
GJB2 screen	$66,710	$218,515	$65,192	N/A	N/A	$195,317
Imaging	N/A	$221,384	N/A	$164,512	**$162,400**	$219,353
CMV PCR	**$55,480**	**$176,154**	**$45,704**	**$108,424**	$138,653	**$160,740**

*Diagnostic yield based on Preciado et al.[12] and Dent et al.[13] study

ANSD = auditory neuropathy spectrum disorder; CMV PCR = cytomegalovirus polymerase chain reaction; GJB2 = gap junction protein beta 2; SNHL = sensorineural hearing loss.

pediatric SNHL in children. We were able to demonstrate that a significant number of children tested positive for CMV infection. In fact, CMV testing had the highest diagnostic yield of all tests performed in this patient cohort.

One may question whether this relatively high yield for CMV testing is due to a higher prevalence of this infection in Utah. A number of studies have demonstrated variability of prevalence by region between 0.4% and 0.7%.[7,14,15] Between March 8, 2004, and December 23, 2004, infants born at one of four Utah hospitals in the Salt Lake Valley were screened for congenital CMV infection.[16] These hospitals serve the Salt Lake Valley, a metropolitan region with approximately one million inhabitants. In 2004, there were approximately 55,000 live births in Utah. The population sampled during this study corresponded to 35% (3,074/8,686) of the infants born at the hospitals. Nine of 3,074 infants (0.29%) were congenitally infected with CMV, indicating a low prevalence of intrauterine CMV infection in Utah (95% CI: 0.15%–0.57%). Thus, even in a low-prevalence state like Utah, early CMV testing can detect a significant number of children with SNHL.

The challenge in diagnosing these patients is the need for early virologic testing. Confirmed CMV diagnosis requires laboratory testing of neonatal samples within the first 3 weeks of life because postnatal exposure to CMV is not typically associated with SNHL.[10] Use of archived neonatal DBS for CMV PCR testing was instrumental in diagnosing six of the 15 (40%) children with confirmed CMV. Unfortunately, Boppana et al. have demonstrated poor sensitivity with this assay.[7] In July 2013, Utah became the first state to implement early CMV testing of all infants under 3 weeks of age who fail their newborn hearing screen twice. We anticipate that a much larger proportion of children will be diagnosed before 3 weeks of age, which will reduce the need for DBS testing and avoid the inherent limitations of this assay.

The overall cost to the patient by performing the CMV testing first was found to be less than if GJB2 screening or imaging was performed first. This result was seen for all types of hearing loss. The diagnostic yield from imaging was less than that reported in a prior study from our group.[17] It is unclear why we found a lower incidence of inner ear abnormalities in this series. Using the 21% value from our earlier study for imaging, however, would have still demonstrated a higher overall cost compared to that of CMV or GJB2 screening with this modality.

Additional indirect benefits not shown in this calculation may also be obtained from a positive CMV diagnosis. A positive diagnosis also identifies those children at risk to develop progressive worsening of their hearing. These children can be targeted for frequent audiologic testing to detect any change in their thresholds. These children may shed the virus in their urine and saliva for years. Careful hygiene through frequent hand washing, avoidance of kissing on the lips, and not sharing utensils and toys can reduce potential transmission. These preventative measures have been demonstrated to reduce transmission to pregnant mothers, the group at highest risk for congenital CMV transmission.[18–20]

Early identification of CMV-induced SNHL provides an opportunity to use antiviral therapy to prevent progressive SNHL. The National Institute of Allergy and Infectious Disease Collaborative Antiviral Study Group (CASG) recently presented a phase III trial of 6 weeks versus 6 months of oral valganciclovir for children less than 30 days of age with congenital CMV disease.[21] They demonstrated that 6 months of oral valganciclovir treatment of infants with congenital CMV disease improves audiologic and neurodevelopmental outcomes to at least 2 years of age. They also found less neutropenia in this trial compared to an earlier CASG study using intravenous gancliclovir and no excess neutropenia with continuation of antiviral therapy from 6 weeks to 6 months.

One strength of this article was the ability to follow the clinical course of a large number of children with SNHL seen by a single investigator utilizing a standard diagnostic approach. An outstanding collaborative environment with the Primary Children's audiology, genetics, neurology, and otolaryngology services made this study possible. The existence of only one children's hospital in the state also improved our ability to minimize any lost patient data.

The major limitation of this study is its retrospective design. Because the electronic medical records are centralized and integrated, we were able to obtain audiologic, clinical notes, imaging, and laboratory results for all patients studied. The relatively low diagnostic yield for imaging and high yield for CMV testing will require confirmation from future prospective studies.

CONCLUSION

In conclusion, we present the first sequential diagnostic paradigm utilizing CMV testing for children presenting with idiopathic SNHL. The relatively high incidence of CMV-induced SNHL, the low cost for this assay, and the indirect benefits from early diagnosis support the role of early CMV testing of these patients.

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Cytomegalovirus Infection in Pregnancy: Should All Women Be Screened?

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Cytomegalovirus (CMV) is the most common cause of congenital infection and complicates approximately 1% of all live births. Primary maternal CMV infection carries a 30% to 40% risk of vertical transmission to the fetus. In cases where maternal CMV infection is suspected, it is important to evaluate the risk to the fetus to provide appropriate counseling and guidance to parents. This article reviews the published literature and summarizes current diagnostic and management recommendations to help answer the question, should all women be screened for CMV infection in pregnancy?
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Cytomegalovirus (CMV) is the most common cause of congenital infection.[1] Moreover, congenital CMV is the most frequently identified viral cause of mental retardation and is the leading nongenetic cause of neurosensory hearing loss.[2,3] In developed countries, congenital CMV infection occurs in 0.3% to 2.4% of all live births.[4] Infection in the newborn can be acquired through close contact (via contaminated blood, urine, and secretions), vertically through transplacental transmission, and postnatally through breast milk.[1] Most symptomatic neonatal CMV infections occur when a woman is newly infected just prior to or during pregnancy.[5,6] Primary maternal CMV infection in

pregnancy carries a 30% to 40% risk of vertical transmission.[1] Of all pregnancies with confirmed vertical transmission, only 10% to 20% of the fetuses will have evidence of clinical infection at birth.[1] As compared with women who are infected in the latter half of pregnancy, women who develop primary CMV infection in the first trimester are more likely to deliver fetuses with sensorineural hearing loss (24% vs 2.5%) or other CNS sequelae, such as mental retardation, cerebral palsy, seizures, or chorioretinitis (32% vs 15%).[7] Mothers who are CMV seropositive prior to pregnancy can also develop a secondary CMV infection either due to reactivation of virus residing at specific sites in the body (primarily the salivary glands) or reinfection with a different viral strain.[6] Such infections tend to be less severe and are usually asymptomatic for both mother and newborn. Infants born to such mothers can also have sequelae of congenital CMV, but this is far less likely (estimated at 0.2% to 2%).[8] In cases where maternal CMV infection is suspected, it is important to evaluate the risk to the fetus of being infected and/or symptomatically affected by CMV to provide appropriate counseling and guidance to parents. We present a case of fetal CMV infection to illustrate and highlight some of the diagnostic and therapeutic issues raised by CMV infection.

Case Report

A healthy 29-year-old woman (G2, P1) with a well-dated spontaneous conception was seen for routine ultrasound examination at 18-0/7 weeks of gestation. The fetus was noted to have echogenic bowel (Figure 1) and intrauterine growth restriction (IUGR) with an estimated fetal weight in the 9th percentile. Her past obstetric history was remarkable for severe preeclampsia resulting in an induction of labor and vaginal delivery at 34 weeks of gestation 2 years earlier. Maternal serologic tests performed in light of the ultrasound findings revealed elevated CMV IgM and IgG titers. Amniotic fluid was strongly positive for CMV DNA by quantitative real-time polymerase chain reaction (RT-qPCR). After extensive counseling as to the diagnosis of fetal CMV and their options, including pregnancy termination, the couple chose to continue the pregnancy. After consultation with an infectious disease specialist, CMV immune globulin (200 U/kg, for a total dose of 10 g intravenous [IV]) was recommended starting at 25 weeks of gestation with subsequent doses of 5 g IV planned at monthly intervals. Fetal magnetic resonance imaging (MRI) at 25 weeks of gestation showed no evidence of intracranial calcifications or abnormalities.

At 30 weeks of gestation, following 2 doses of CMV immune globulin, the fetal heart-rate tracing was noted to have absent variability and repetitive late decelerations (category III). A biophysical profile was 2/10 (2 points for amniotic fluid volume only) and umbilical artery Doppler velocimetry showed reversed end-diastolic flow. A viable female infant was delivered by emergent cesarean weighing 920 g with Apgar scores of 2, 7, and 10 at 1, 5, and 10 minutes, respectively. Cord blood analysis showed an arterial pH of 7.16 and base excess of −12.5 and venous of pH 7.29 and base excess of −8.9. The neonate was intubated and admitted to neonatal intensive care. Chest radiography showed ground glass opacities consistent with congenital CMV pneumonia. Hematologic abnormalities included thrombocytopenia, coagulopathy, elevated transaminase levels, and hyperbilirubinemia. CMV antigenemia was present in the infant's blood, and CMV DNA was identified in urine and cerebrospinal fluid. Placental pathology showed diffuse fibrin deposition and villous edema. Specific immunostaining of the placenta was positive for CMV (Figure 2).

The infant was treated with IV ganciclovir (6 mg/kg twice daily) with subsequent resolution of laboratory and imaging abnormalities over a 10-day period. Ultrasound examination

Figure 1. *Representative perinatal ultrasound image showing fetal echogenic bowel. Fetal echogenic bowel refers to increased echogenicity or brightness of the fetal bowel noted on second trimester ultrasound examination. The diagnosis of echogenic bowel should be reserved for fetuses in which the echogenicity of the bowel is equal to or greater than that of adjacent bone. The differential diagnosis of fetal echogenic bowel includes cystic fibrosis, infection with cytomegalovirus or toxoplasmosis, meconium ileus, and chromosomal abnormalities (including Turner syndrome and trisomy 21, 13, or 18).*

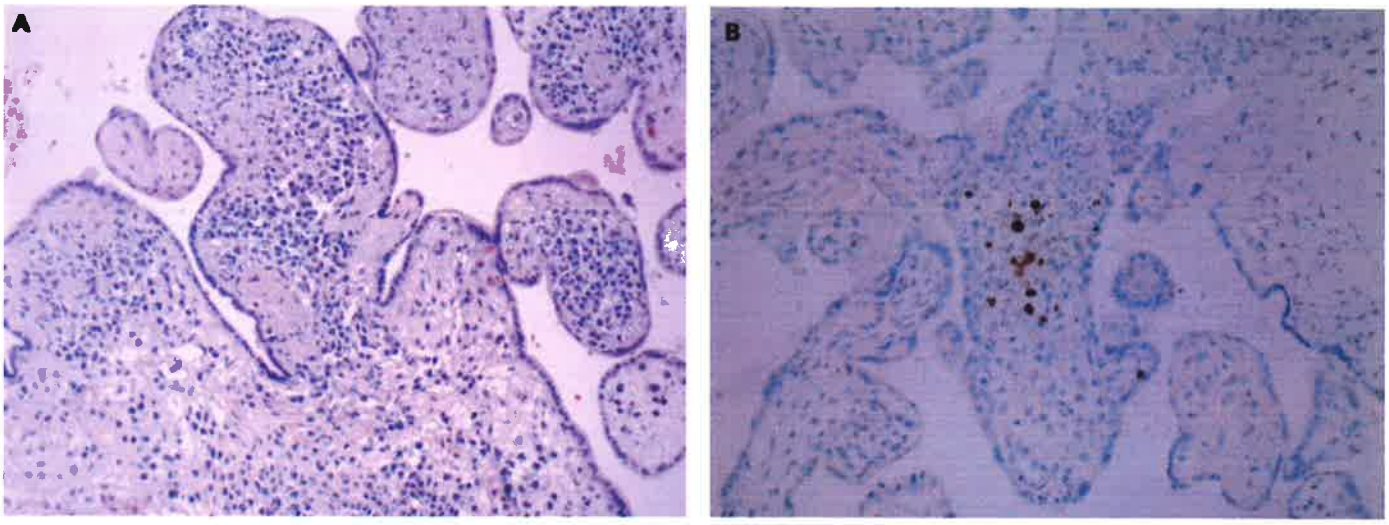

Figure 2. *Representative histologic images of a placenta with cytomegalovirus (CMV) infection.* (A) *Placental histology shows moderate villous edema, intervillous fibrin deposition, amnion hyperplasia, and grade I inflammation.* (B) *Specific immunostaining confirms the presence of CMV infection.*

of the head and abdomen showed no evidence of calcifications, ventriculomegaly, or hepatosplenomegaly prior to treatment. Ophthalmologic examination showed no evidence of retinitis. However, the infant failed multiple newborn hearing screens and appeared to have profound bilateral deafness. Antiviral therapy was continued for 6 weeks. The infant was discharged home in stable condition on day of life 55.

Discussion

CMV infection is very common in the United States, with 50% to 80% of reproductive-age women showing serological evidence of previous infection.[9] Reproductive-age women of middle and higher socioeconomic status are at higher risk for primary CMV, as approximately half are seronegative for CMV antibodies and are therefore susceptible to infection during pregnancy. In day care centers, approximately 80% of young children will develop CMV within 2 years.[10] Although these children are typically asymptomatic, they will continue to shed virus for years after initial acquisition. Many women with exposure to young children will acquire a CMV infection within 1 year.[1,11] Women with impaired cellular response (eg, patients with HIV/acquired immunodeficiency syndrome [AIDS] or those receiving immunosuppressive therapy) are at higher risk of acquiring CMV infection and, because they are less likely to produce neutralizing antibodies, they are also at higher risk of transmitting the virus to their fetuses.[5]

In day care centers, approximately 80% of young children will develop CMV within 2 years. Although these children are typically asymptomatic, they will continue to shed virus for years after initial acquisition.

How Should the Diagnosis Be Confirmed in the Mother?

Maternal CMV tends to be asymptomatic and patients will rarely be diagnosed by clinical symptoms alone. For most infections, evidence of maternal seroconversion (defined as a conversion from a negative to a positive IgM or a 4-fold increase in IgG antibody titer over a 4- to 6-week period) is sufficient to confirm the diagnosis of a primary infection. However, the accuracy of maternal anti-CMV IgM to predict primary maternal infection is complicated by the fact that IgM antibodies can persist for months or even years after primary infection, and also can be found in the setting of reactivation or reinfection with a different strain of CMV.[12]

Another method of determining the timing of maternal CMV infection is to measure antibody avidity, which refers to the strength of antibody binding to a target antigen. As the immune response to a particular antigen matures over time, avidity increases. Thus, detection of low-avidity anti-CMV IgG early in pregnancy suggests a recent acute infection, and can be used to identify pregnant women at increased risk of having an infected fetus.[4,13] In contrast, the presence of high-avidity antibodies at 12 to 16 weeks of gestation indicates a past infection, likely prior to conception. Improvement in CMV IgM testing has been reported by performing gel electrophoresis Western blotting of CMV viral polypeptides and

may provide the most accurate way to diagnose a primary maternal CMV infection.[12] Although available in Europe, this test is not available in the United States.

How Should the Diagnosis Be Confirmed in the Fetus?

In cases of confirmed maternal CMV infection, it is important to evaluate the risk of fetal infection to provide appropriate counseling and guidance to parents. Perinatal ultrasound can aid in identifying structural or growth abnormalities that may suggest symptomatic fetal infection. These abnormalities include echogenic bowel, IUGR, ventriculomegaly, placental thickening, brain calcifications, evidence of hydrops fetalis, and/or abnormal amniotic fluid volume[14,15] (Table 1). These ultrasound findings are not specific for congenital CMV infection, and there may be other causes for these findings[16] (Table 2). Moreover, only 15% of CMV-infected fetuses will display ultrasound abnormalities.[14] However, the presence of ultrasound abnormalities in a pregnant woman with confirmed primary maternal CMV infection is strongly suggestive of fetal infection.[14]

Table 2
Differential Diagnosis of Congenital Cytomegalovirus Infection

- Rubella
- Toxoplasmosis
- Syphilis
- Herpes simplex virus
- Enterovirus

In cases of confirmed maternal CMV infection, it is important to evaluate the risk of fetal infection to provide appropriate counseling and guidance to parents.

Table 1
Ultrasound Features of Congenital Cytomegalovirus Infection

- Cerebral ventriculomegaly
- Microcephaly
- Hyperechogenic fetal bowel
- Hepatosplenomegaly
- Cerebral periventricular echogenicity/intracranial calcifications
- Intrauterine growth restriction
- Abnormal amniotic fluid volume
- Placental enlargement
- Ascites and fetal hydrops

Amniocentesis may be performed to confirm fetal infection, and is recommended in situations where maternal primary or undefined CMV infection is detected in the first half of pregnancy or in cases where sonographic fetal abnormalities are suggestive of infection. Amniotic fluid should be sent for viral culture and for polymerase chain reaction (PCR) testing for the CMV genome. False-negative results may occur if amniocentesis is performed prior to 21 weeks of gestation because the virus is slow growing and may not be excreted by the fetal kidneys in sufficient quantities for detection in early pregnancy.[4] If viral culture and PCR for CMV are both negative, congenital CMV can be effectively excluded at that time; if positive, this suggests the presence of fetal infection, although the impact on the fetus cannot be determined. Further evaluation by serial ultrasound examinations for signs of fetal brain involvement (intracranial calcifications, ventriculomegaly, microcephaly) or DNA quantification by RT-qPCR may provide additional prognostic information.[17] Fetal thrombocytopenia detected by fetal blood sampling has also been reported to be an independent predictor of poor fetal outcome,[18] but is not generally recommended.

Following birth, CMV infection in the newborn should be confirmed by isolating the virus in the urine and/or saliva in the first 2 to 3 weeks of life. Thereafter, PCR can detect the viral genome in the newborn's blood with equal sensitivity and specificity. CMV IgM antibodies are present in only 70% of infected infants and do not effectively rule out congenital infection.[4] Infants with congenital CMV infection should undergo further testing (including a detailed physical examination and additional radiologic and hematologic tests) to determine whether the infection should be classified as symptomatic.

What Is the Prognosis for the Fetus?

A diagnosis of fetal CMV infection does not equate to an affected fetus, as 80% to 90% of fetuses with congenital CMV infection are asymptomatic at birth. For the 10% to 20% of fetuses who are symptomatic at birth, however, outcomes are generally poor.[1,5,19] Signs and symptoms may include neurologic deficits (eg, seizures, chorioretinitis, hypotonia, hearing loss, microcephaly, and intracranial calcifications) as well as hematologic abnormalities (eg, petechiae, thrombocytopenia, and evidence of liver disease as manifested by jaundice, transaminitis, hyperbilirubinemia, and hepatosplenomegaly). Infants may also show evidence of growth restriction and failure to thrive.

Of CMV-infected children who are asymptomatic at birth, 8% to 15% will develop hearing loss and psychomotor delay later in life.[20]

In vitro and animal studies suggest that CMV hyperimmune globulin (HIG) may be effective in minimizing the damage caused by CMV infection.

Of CMV-infected children who are asymptomatic at birth, 8% to 15% will develop hearing loss and psychomotor delay later in life.

Should CMV Hyperimmune Globulin or Antiviral Agents Be Recommended in Pregnancy?

Because of the poor prognosis associated with primary maternal CMV diagnosed early in pregnancy, elective termination should be discussed as an option. Women who wish to continue the pregnancy may be offered one of several medical therapies; however, these should all still be regarded as investigational.

Ganciclovir has been used extensively in newborns with symptomatic CMV infections. In such newborns, a 6-week course of IV ganciclovir has been shown to significantly reduce the incidence of hearing loss, although some newborns will experience neutropenia.[21] Information on the safety and efficacy of ganciclovir in pregnancy, however, is extremely limited. Animal data have shown an increased risk of fetal malformations when ganciclovir was used in higher than normal doses in pregnancy, although case reports in humans suggest no increased risk of malformations.[5]

In a small pilot study, oral valacyclovir was administered to 21 pregnant women with confirmed CMV-symptomatic fetuses. The medication was well tolerated and a decrease in CMV viral load was noted in the cord blood of the treated fetuses; however, given the small sample size, no clear improvement in perinatal outcome could be demonstrated.[22] Further studies are necessary to determine the safety and efficacy of antiviral agents in the treatment of CMV during pregnancy.

For example, when pregnant guinea pigs were exposed to CMV followed by administration of a neutralizing antisera, fetal survival increased significantly as compared with those animals who did not receive passive immunization, and a similar reduction was noted in fetal infection, placental inflammation, and IUGR.[23,24] CMV HIG consists of enriched CMV-specific immunoglobulins and has been studied extensively in post-transplant patients for CMV prophylaxis.[25,26] It is marketed in the United States as Cytogam® (CSL Behring, King of Prussia, PA).

Nigro and colleagues[27] conducted a multicenter, prospective study of 181 pregnant women with primary CMV infection. Of these women, 79 underwent amniocentesis and 55 were found to have CMV-positive amniotic fluid. Of these, 31 women elected to receive 200 U/kg CMV HIG administered monthly, 14 women elected not to receive HIG, and 10 women elected to terminate the pregnancy. Only 3% (1/31) of fetuses who received HIG were symptomatic at birth as compared with 50% (7/14) of the infants whose mothers declined HIG. In this nonrandomized study, administration of HIG to the mother and the presence of fetal ultrasound abnormalities prior to treatment were important predictors of fetal outcome. In a second study by the same investigators, 3 women with CMV-associated fetal cerebral abnormalities received HIG infusions during pregnancy. In all 3 cases, the fetal ventriculomegaly regressed, other associated abnormalities resolved, and the 3 infants were reportedly developing normally by age 5.[28]

Additional case reports from other investigators have suggested that antenatal administration of CMV HIG may be associated with more favorable outcomes in fetuses suspected of having congenital CMV infection.[29-32] CMV HIG has been given by maternal IV injection, intra-amniotic injection, intraperitoneal injection into the fetus, and by direct IV injection into the umbilical vein. The optimum dosage, route of administration, and indications for its use, along with confirmation of its efficacy in randomized, prospective clinical studies, still need to be identified. However, the use of CMV HIG and/or antiviral agents such as valacyclovir in fetuses with confirmed CMV infection may be an option for women who plan to continue the pregnancy.

Is There a Vaccine Available Against CMV?

In 1999, the Institute of Medicine report entitled, *Vaccines for the 21st Century: A Tool for Decision Making,* stated that development of a CMV vaccine was the highest priority for new vaccines.[33] Recently, a vaccine targeted toward CMV envelope glycoprotein B, an antigen that typically induces a serum antibody response, entered phase 2 clinical trial.[34] This vaccine

Recently, a vaccine targeted toward CMV envelope glycoprotein B, an antigen that typically induces a serum antibody response, entered phase 2 clinical trial. This vaccine has already been shown to be immunogenic with an acceptable risk profile.

has already been shown to be immunogenic with an acceptable risk profile. In this trial, CMV infection occurred in 18 of 225 subjects in the vaccine group (8%) and in 31 of 216 subjects in the placebo group (14%). Four congenital CMV infections occurred as a result of maternal infection during pregnancy. There were 3 congenitally infected infants in the placebo group (1 of which went on to develop severe neurologic sequelae) and 1 congenitally infected infant in the vaccine group (who was asymptomatic).[34] Although these numbers are too small to support any definitive conclusions, they are consistent with our knowledge of decreased CMV transmission in women who carry protective antibodies. Future studies are necessary to demonstrate the safety and efficacy of this vaccine before it can be used for primary prevention of congenital CMV.

Prevention of CMV in Pregnant Women

Given the limited success of vaccine prevention of CMV, attention has been directed at patient education as a means of preventing the acquisition of infection (Table 3). Because 15% to 70% of children in day care acquire CMV infection, attempts at prevention have focused primarily on mothers of small children. It has been shown that CMV-seronegative women have a 5- to 25-fold increased risk of developing CMV if exposed to children in day care.[11] In a study of 166 seronegative women with a young child in day care, women given information concerning handwashing, gloves for diaper changes, and avoiding certain types of intimate contact (sharing utensils, kissing on the lips) were compared with those not given this information.[35] Both groups showed an overall seroconversion rate of 7.8%. However, CMV-seronegative mothers who knew their infant's serostatus and were pregnant had a lower risk of seroconversion (5.8%) as compared with those who were not pregnant (41.6%), suggesting that knowledge of their infant's status and the motivation during pregnancy to avoid becoming infected led to a decrease in acquiring CMV. This also suggests that personal knowledge of a woman's own susceptibility to CMV through screening may be useful when designing and implementing prevention strategies.

Currently, the American College of Obstetricians and Gynecologists (ACOG) recommends that all women be educated about the ways that CMV infection may be acquired in pregnancy.[36] They recommend careful handling of potentially infected articles, such as diapers, and thorough handwashing when around young children or immunocompromised individuals. The Centers for Disease Control and Prevention (CDC) confirms the ACOG recommendations, but also adds that pregnant women with children under the age of 6 should avoid sharing utensils and kissing their children on the lips or cheek.[37] Despite these recommendations, a recent survey study by ACOG of 305 obstetrician-gynecologists reported that only 44% routinely counsel their patients about CMV prevention.[38]

Table 3
Strategies to Prevent CMV Infection in Women Who Are or Will Become Pregnant

- Educate women with young children or who work with young children that they are at increased risk and that attention to hygiene will help prevent cytomegalovirus (CMV) transmission
- Careful handing of potentially infected articles, such as diapers
- Thorough hand washing when around young children or immunocompromised individuals
- Avoiding sharing utensils
- Avoid kissing children < 6 years on the mouth or cheek

Adapted from American College of Obstetricians and Gynecologists[36] and Centers for Disease Control and Prevention.[37,38]

Should All Patients Be Screened for CMV?

Although ACOG recommends that pregnant women be educated about CMV prevention, they have not endorsed routine screening in pregnancy.[36] The CDC also acknowledges that screening for CMV in pregnant women is not currently recommended. However, they add that, for women planning to become pregnant, routine CMV screening can help them to understand how careful they must be to prevent infection.[37] The reasons given for not recommending routine screening have included the difficulties in accurate diagnosis given the high false-positive rate of commercial IgM testing, the lack of effective treatment of infection during pregnancy, and the possibility of reinfection or virus reactivation in a seropositive woman. In a recent decision-analytic model evaluating options for maternal CMV screening, Cahill and colleagues[39] noted that universal screening was cost effective as long as CMV HIG achieved at least a 47% reduction in neonatal disease. In countries such as Italy where CMV

screening is more widespread, the high incidence of false-positive CMV IgM has been studied. In a series of 1857 pregnant women with a reported positive CMV IgM test, only 26% were thought to represent a true primary CMV infection as confirmed by additional testing with IgG avidity and CMV immunoblot technology, whereas 54% of cases were believed to represent previous infection without active disease, and 20% were thought to be reactivation/secondary infection.[40] Such studies underscore the need for appropriate confirmatory testing to determine the true fetal risk as well as appropriate specialists to provide counseling for the heightened patient anxiety that could result from more widespread screening. However, with improvements in serologic testing (eg, IgG avidity or IgM immunoblot technology) coupled with effective treatments (CMV HIG, antiviral agents, or vaccination), it is hoped that the introduction of more widespread screening of women for CMV serostatus prior to or at the onset of pregnancy will lead to significant improvements in clinical outcome.

Conclusions

CMV is an important cause of congenital infection and can result in significant perinatal morbidity and health care expense. Although existing data suggest a benefit to HIG prophylaxis, additional clinical trials are needed to confirm these observations. Until then, the use of HIG and other antiviral agents for treatment remains experimental. In the absence of proven therapies for congenital CMV infection, prevention is critical. Most importantly, patients, especially those exposed to young children, should be counseled about the importance of careful hand hygiene practices, an intervention that has been proven to decrease the risk of primary CMV infection and subsequent fetal transmission. ■

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Main Points

- Maternal cytomegalovirus (CMV) tends to be asymptomatic and patients will rarely be diagnosed by clinical symptoms alone. For most infections, evidence of maternal seroconversion is sufficient to confirm the diagnosis of a primary infection.
- Perinatal ultrasound can aid in identifying structural or growth abnormalities that may suggest symptomatic fetal infection. Amniocentesis may be performed to confirm fetal infection, and is recommended in situations where maternal primary or undefined CMV infection is detected in the first half of pregnancy or in cases where sonographic fetal abnormalities are suggestive of infection. Following birth, CMV infection in the newborn should be confirmed by isolating the virus in the urine and/or saliva in the first 2 to 3 weeks of life.
- A diagnosis of fetal CMV infection does not equate to an affected fetus, as 80% to 90% of fetuses with congenital CMV infection are asymptomatic at birth. For the 10% to 20% of fetuses who are symptomatic at birth, however, outcomes are generally poor.
- Because of the poor prognosis associated with primary maternal CMV diagnosed early in pregnancy, elective termination should be discussed as an option. Women who wish to continue the pregnancy may be offered one of several medical therapies; however, these should all still be regarded as investigational.
- Given the limited success of vaccine prevention of CMV, attention has been directed at patient education as a means of preventing the acquisition of infection. Currently, the American College of Obstetricians and Gynecologists recommends careful handling of potentially infected articles, such as diapers, and thorough handwashing when around young children or immunocompromised individuals. The Centers for Disease Control and Prevention adds that pregnant women with children under the age of 6 should avoid sharing utensils and kissing their children on the lips or cheek.
- For women planning to become pregnant, routine CMV screening can help them to understand how careful they must be to prevent infection.

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Cytomegalovirus Vaccine Development

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Abstract

Although infection with human cytomegalovirus (HCMV) is ubiquitous and usually asymptomatic, there are individuals at high risk for serious HCMV disease. These include solid organ and hematopoietic stem cell (HSC) transplant patients, individuals with HIV infection, and the fetus. Since immunity to HCMV ameliorates the severity of disease, there have been efforts made for over thirty years to develop vaccines for use in these high-risk settings. However, in spite of these efforts, no HCMV vaccine appears to be approaching imminent licensure. The reasons for the failure to achieve the goal of a licensed HCMV vaccine are complex, but several key problems stand out. First, host immunology correlation to protective immunity consist is not yet clear. Secondly, the viral proteins that should be included in a HCMV vaccine are uncertain. Third, clinical trials have largely focused on immune compromised patients, a population that may not be relevant to the problem of protection of the fetus against congenital infection. Fourth, the ultimate target population for HCMV vaccination remains unclear. Finally, and most importantly, there has been insufficient education about the problem of HCMV infection, particularly among women of child-bearing age and in the lay public. This review considers the strategies that have been explored to date in development of HCMV vaccines, and summarizes both active clinical trials as well as novel technologies that merit future consideration toward the goal of prevention of this significant public health problem.

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Commentary

Prevention of Maternal–Fetal Transmission of Cytomegalovirus

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Annually in the United States approximately 40,000 pregnant women are infected with CMV (seroconvert) during pregnancy and probably an equal number in Europe. Of those seroconverting during pregnancy approximately 20% of their infants develop neurologic damage and/or hearing deficit. A hopefully final and definitive report by Revello et al. in this journal confirms that the majority of these infections are easily prevented by simple hygienic precautions (Revello et al., 2015).

Between 20% and 60% of women are susceptible (seronegative) to CMV at conception. Maternal immunity from a pre-conception CMV infection protects against a second CMV infection and protects the fetuses from severe postnatal neurosensory deafness and neurologic damage. Thus a primary maternal infection with CMV in early pregnancy causes the majority of congenital disease. After a primary infection during pregnancy, the fetal infection rate varies from 33% to 75% as gestation progresses and disease rates may be as high as 50% if infection occurs during early gestation (Bodéus et al., 2010; Nigro et al., 2005).

The majority of seronegative pregnant women acquire CMV from a child less than three years of age in the home or for pregnant women employed in infant day care centers, from children in their care (Adler et al., 2004; Adler, 1989). CMV seronegative health care providers caring for hospitalized young children and infants, are not at an increased risk (Adler, 2010). Infants acquire CMV in utero, via breast milk, or via contact with other children. These CMV infected infants, unlike older children and adults, have CMV in urine and saliva for an average of 18 months (Adler, 1991). In the US, 60% of the mothers of children in daycare are CMV seronegative, and at least 25% of all young children attending large group child care centers are shedding CMV. The annual infection rate for seronegative women without exposure to children is 2%, but 5 to 25 times higher for exposed women (Adler et al., 2004; Adler, 1989).

The U.S. Centers for Disease Control suggests that pregnant women reduce their risk of CMV acquisition during pregnancy using simple hygienic precautions but this suggestion is not often followed. Studies demonstrating the efficacy of hygienic precautions are compelling (Revello et al., 2015; Adler et al., 1996, 2004; Finney et al., 1993; Vauloup-Fellous et al., 2009). Our U.S. studies of CMV seronegative pregnant women with an infected young child found that the precautions were highly effective ($p < 0.008$) (Adler et al., 1996, 2005, 2015). Women were told about CMV, provided written guidelines detailing hygienic precautions, and provided a demonstration video. None declined testing and none complained the precautions were difficult or provoked anxiety. Overall of 37 pregnant women with a child shedding CMV, only one (3%) who received hygienic precautions seroconverted to CMV during pregnancy. This contrasts with an infection rate of 42% for 154 non-pregnant women and women trying to conceive who also had infected children.

A French study offered 5312 pregnant women CMV serologic screening at 12 week gestation and 97.4% agreed (Vauloup-Fellous et al., 2009). Seronegative women and their spouses received oral and written hygienic precautions. For 2595 seronegative women, the rate of maternal seroconversion during the first 12 weeks of gestation was compared to the rate between weeks 12 and 36. Prior to the receipt of hygienic precautions at 12 weeks the maternal seroconversion rate when adjusted for the number of woman–weeks observed was 0.035% per woman–week compared to a rate of 0.008% per woman–week after intervention ($P = 0.0005$). Maternal primary infections and seroconversions were distributed evenly throughout gestation.

Revello et al. in Italy prospectively observed that of 331 CMV seronegative pregnant women who receive oral and written hygienic precautions for preventing CMV acquisition from a young child only four (1.2%) women seroconverted to CMV during pregnancy (Revello et al., 2015). In contrast of 315 women in a comparison group, CMV infection occurred in 24 (7.6%) women during pregnancy.

In each report, the efficacy of hygienic precautions has been >75%. Given the ease and effectiveness of this intervention it is appropriate that CMV education and hygienic precautions be implemented clinically. All pregnant women with frequent contact with a child <3 years of age should be identified as early in gestation as possible and offered serologic testing (IgG antibodies to CMV only). If seronegative, women should be given the precautions. Subsequent testing during pregnancy would be optional based on the level of concern of the woman and

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the results of ultrasound findings. Screening for fetal disease by ultrasound is nearly universal in developed countries. If ultrasound findings are normal, the risk of CMV fetal or neonatal disease is low and hence repeat testing should be unnecessary (Nigro et al., 2005).

In each published study women knew they were seronegative and hence at risk. Is serologic testing necessary for motivation and for the precautions to be effective? We do not know. Also we do not know how often seropositive women become reinfected during pregnancy and if maternal reinfection leads to fetal disease. These questions can be answered in subsequent studies but are not reasons to delay implementation of the precautions for seronegative women.

Serologic screening of high risk pregnant women for CMV is as feasible as is current screening for syphilis, hepatitis, rubella, and HIV. The assays for IgG to CMV have an accuracy equal or great than the accuracy for the other infections. Serologic screening for CMV IgM or IgG avidity should not be done.

Although seronegative health care workers are not at risk, pregnant childcare employees are. Pregnant childcare employees should be informed about CMV, assess their risk by serologic testing or avoid if possible caring for children less than 2 years age for the duration of pregnancy. The efficacy of hygienic precautions for childcare employees is unknown.

For seronegative pregnant women who are at high risk because of exposure to a young child in the home or in large group childcare, hygienic precautions are simple, inexpensive, and highly effective.

Conflict of Interests

None.

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Renee A. Bobrowski, MD, FACOG

Stella Puppy, LLC
5220 N. Lakemont Lane Boise Idaho 83714

February 11. 2017

Health and Welfare Committee
Idaho State Legislature
Boise Idaho 83702

RE: Senate Bill No. 1060

Dear Committee Members:

I am writing in support of Senate Bill No. 1060 with the goal to not only increase awareness of Cytomegalovirus (CMV) but provide education for prevention.

I am a Maternal Fetal Medicine (MFM) physician, specializing in the care of high risk pregnant women. But long before I became an MFM, I was an intern in Obstetrics and Gynecology and delivered my first baby affected by congenital CMV. That was 28 years ago, and unfortunately it would not be my last. I have seen firsthand the devastating effects of in utero infection, which include hearing and/or vision loss, microcephaly/brain abnormalities, profound mental delay, failure to thrive, seizures and death.

Intrauterine CMV infection is the most common of all recognized intrauterine infections, with the Centers for Disease control estimating that it occurs in up to 2.3% of all live births. Outcomes range from asymptomatic to profoundly symptomatic requiring life long, intensive medical care. Current evidence indicates that most but not all symptomatic congenital CMV infections result from primary infection of the mother.

A CMV vaccine is not currently available, nor anticipated in the near future. There is no cure for CMV. Treatment during pregnancy and/or in the newborn does not guarantee a child will not suffer the sequelae of CMV. It is frequently a life altering disease, affecting not only a child but the entire network of family and friends. We are therefore, at the present time, left with trying to prevent transmission.

The economic and emotional costs of caring for a single child with congenital CMV are enormous. The most recent estimate of nationwide cost of caring for children with congenital CMV was $1-2 billion in the 1990s. Thus the cost of funding this and similar programs in all 50 states is far less than treatment and care for one child affected by

congenital CMV, making it a most worthy investment. Sadly the greatest loss for an affected child is the unrealized potential to lead a happy and productive life.

It has been suggested that up to 85% of women, i.e. future mothers, are NOT aware of CMV infection, transmission or its effects. And one cannot prevent something one is not aware of. Manicklal et al stated in Clinical Microbiology Reviews (2013 Jan:26(1):86-102) that 'successful implementation of strategies to prevent or reduce the burden of congenital CMV infection will require heightened global awareness among clinicians and the general population." There are currently only 5 states with legislation enacted to provide for public education about CMV infection. Idaho has the opportunity to lead the country in developing their public health initiative against CMV.

It is difficult to argue against funding for education in order to prevent even one child being affected by CMV. It is, after all, education that makes prevention a reality.

I kindly ask your support for Senate Bill No. 1060 so that we can build a strong CMV education program for the families of Idaho.

Respectfully,

Renee A. Bobrowski, MD, FACOG

February 20th, 2017

Public Testimony Before Senate Health and Welfare Committee
Regarding Health Care/Cytomegalovirus #S1060

Senator Heider, Senator Souza and Members of the Committee,

My name is Claire Szewczyk and I am a first year audiology graduate student at Idaho State University. I am also one of the co-founders of the Idaho CMV Advocacy Project, a grassroots campaign that was started to spread awareness across the state.

In 2014 I was an undergraduate student at Utah State University working for the Sound Beginnings program in Logan, Utah. It was there I met and worked with Daisy, a young girl who inspired the Cytomegalovirus Public Education and Testing law for the state of Utah. I, like the majority of the hundreds of thousands of women in the state, had never heard of "Cytomegalovirus" or "CMV" before. That was until I became an employee for the Utah Department of Health.

The law that was passed by Utah directed the Department of Health to create an educational program to inform pregnant women, and women who may become pregnant, about CMV. As a former employee, I was also a part of the Cytomegalovirus Public Health Initiative and was able to see firsthand how this program impacted the state. In the three and a half years since its inception, the Utah Cytomegalovirus Public Health Initiative has provided a substantial amount of resources to women and families – everything from brochures and pamphlets for hospitals, physicians and daycares, to public transit campaigns, public service announcements, and even a public health conference. The program made such an impact to the community, I even had people who would tell me, "Oh I saw your advertisement about CMV on the bus today!" or "There were brochures about CMV at our health fair!"

Cytomegalovirus is also the number one non-genetic cause of sensorineural (inner ear) hearing loss. Outside of genetic factors, sensorineural hearing loss is the most common birth defect – with three times the prevalence of Down syndrome! Hearing loss is a very important thing to consider with the development of children. It causes delay in the development of speech and language. The language deficit causes learning problems that result in reduced academic achievement. Communication difficulties often lead to social isolation and poor self-concept, and ultimately it may play a role in vocational choices. Just think about that – Cytomegalovirus is the number one contributor to sensorineural hearing loss accounting for almost 50% of cases and sensorineural hearing loss is the number one birth defect in children. Yet only about 9% of women in the United States know what CMV it is!

It is time for Idaho to change this. We can make a difference by following suit with Utah through the passage of this bill for a CMV educational program. The consideration of this legislation would only be doing a service for the many children impacted by CMV every day. As a future audiologist, I can do nothing but advocate for this.

Thank you for the opportunity. I am happy to answer any questions you may have.

Claire Szewczyk
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C. L. "Butch" Otter
Governor

Debra Parsons
Chair

Christine Pisani
Executive Director

February 20, 2017

Senator Lee Heider, Chairman
Senate Health and Welfare Committee
Statehouse
Boise, ID 83720

RE: HB 43 Medicaid Services for Children with Serious Emotional Disturbance

Chairman Heider and Committee Members:

The Council on Developmental Disabilities is authorized by federal and state law to monitor systems and policies and to advocate for improved and enhanced services that enable Idahoans with developmental disabilities to live meaningful lives, included in their communities. The Council is comprised of 23 volunteers appointed by the Governor.

The Council applauds the Department of Health and Welfare for ensuring quality outcomes are more likely achieved for children with SED through the services this legislation will provide. The Council supports House Bill 43 as the expansion of services to children with serious emotional disturbance (SED) will significantly improve health, education, employability, and quality of life outcomes for children who experience SED.

Christine Pisani
Executive Director

Dear Senate Health and Welfare Committee,

I am writing in support of HB 43, which would allow IDHW to provide coverage for children under age 18 with serious emotional disturbance with family incomes up to 300% of the federal poverty level. This bill is critical to the successful implementation of the Jeff D. settlement agreement and will allow many Idaho children to receive necessary treatment for serious emotional disturbance.

For the past five years our daughter, who is now 11, has been living in residential treatment centers outside he state of Idaho. My husband and I made this heartbreaking decision because the intensive treatment services she needed were not available within Idaho's communities. It is my desire to see effective, community-based treatment available for Idaho children and families. Parents and children should not have to experience the trauma of long-term separation in order to receive needed mental health treatment. This bill is an important step in that direction.

Thank you in advance for your support for this bill, as well as future efforts of IDHW to improve the children's mental health system in Idaho.

Sincerely,

Jennifer Griffis
Grangeville, ID
jengriffis@gmail.com
208-507-1754

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Tuesday, February 21, 2017

SUBJECT	DESCRIPTION	PRESENTER
H 41	Relating to Individuals with Disabilities	Senator Burgoyne
Presentation	Child Welfare System Report	Lance McCleve and Amanda Bartlett, Office of Performance Evaluations

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Tuesday, February 21, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:10 p.m.
H 41	**Relating to Individuals with Disabilities. Senator Burgoyne** introduced himself and Representative Troy to the Committee to present **H 41.** The federal ABLE Act was signed into law in December 2014, and this legislation has been in process since that time. It is consensus legislation and has the support of the Governor.

Senator Burgoyne explained ABLE stands for "Achieving Better Life Experience." The ABLE Act permits those with developmental disabilities and others with disabilities that began prior to age 26 to open savings accounts in strictly-regulated state programs without jeopardizing their eligibility for Supplemental Security Income (SSI), Medicaid, and other federal assistance programs. The ABLE Act is in the same part of federal code as the college savings program and there are similarities in how they are administered. In 2015 Congress amended the law to allow residents of one state to open an ABLE account in another state.

Senator Burgoyne informed the Committee other states spent as much as $1 million to establish their ABLE account programs, and those programs are maintained through assessment of service charges against account holders. If Idaho was to adopt its own ABLE account program, the start-up costs and maintenance service charges would likely be very high due to Idaho's small population. **H 41** would allow Idaho residents to open ABLE accounts in other states, and the bill also provides a technical assistance component to help Idaho residents understand how to use the accounts.

Senator Burgoyne commented prior to the enactment of the ABLE Act, federal law provided that anyone with more than $2,000 in assets was ineligible for federal aid. The ABLE Act allows contributions of up to $14,000 per year to a maximum of $100,000 to be held in special accounts. Most people with developmental disabilities will never reach that maximum balance. An ABLE account is similar to a Special Needs Trust (SNT), which is a mechanism for people to set aside money for needed items not covered by Medicaid or other assistance. SNTs can be expensive, however, and ABLE accounts can be an adequate substitute for some people.

Senator Burgoyne stated the Idaho Council on Developmental Disabilities, Idaho's College Savings Program, DisAbility Rights Idaho, the University of Idaho Center on Disabilities and Human Development, Idaho Parents Unlimited, the Idaho State Independent Living Council, the Living Independence Network Corporation, the Department, and the Governor's Office all support this bill.

Senator Burgoyne commented this legislation would allow Idaho residents to open ABLE accounts in other states and specifically provides that Idaho will not establish an ABLE account program. The bill includes a financial literacy training component, as well as technical assistance relating to the ABLE Act. A parent, guardian, or conservator with an interest in a disabled person's welfare might receive this technical assistance. The authorization is subject to an appropriation and the technical assistance function will not happen unless the needed $45,000 per year is approved by the Legislature in a separate appropriations bill.

Senator Burgoyne explained the federal government disregards ABLE accounts for purposes of eligibility, and it is unknown whether there are any purely state or local assistance programs that would not be covered by the federal exemption. However, the bill provides that ABLE accounts maintained by Idaho residents in other states will be disregarded from need-based State or local grants. The purpose of the ABLE Act is to allow disabled individuals to achieve a degree of dignity and independence and not be held down because they can't save money. He often sees people who are unable to obtain dental care because Medicaid doesn't cover it. Failing to have dental care can turn into a medical problem covered by Medicaid, and a few of that kind of case would exceed the cost of the ABLE program.

Senator Burgoyne said it is extremely difficult for vulnerable adults to maintain freedom and independence. There are financial and other benefits to ABLE accounts. Medicaid recipients could set money aside for education or training, or to repair wheelchairs, purchase adaptive devices, and so forth. When a Medicaid participant dies, Medicaid is entitled to recover benefits from the ABLE accounts, and that is a potential benefit to the State. Some Medicaid expense might be avoided if people have money to pay for things not covered by Medicaid.

Senator Burgoyne stated here is no information available through non-profits or the private sector for ABLE account participants to receive training about the accounts. A few states have ABLE account programs and websites specific to their own programs. There is a federal website portal and it will be important for that website to have the correct information for Idaho residents. The modest amount requested for the half-time position will allow participants to be informed and assist with training in financial literacy. The ABLE account program would be administered through the State Independent Living Council (SILC) with an existing position.

Vice Chairman Souza inquired whether someone could open an ABLE account in more than one state. **Senator Burgoyne** believes the answer is yes. **Vice Chairman Souza** asked if a person could have both an ABLE Account and a special needs trust. **Senator Burgoyne** answered he is not entirely certain. **Heather Conder**, a local attorney, introduced herself to the Committee to answer yes.

Representative Caroline Nilsson Troy was recognized to continue the presentation. **Representative Troy** commented the bill is only 46 lines but it took several years to develop the legislation. Time was a benefit due to the federal rule change allowing non-residents to open ABLE accounts in other states. Idaho has a financial interest in allowing ABLE accounts and ensuring their proper use. It is expensive to set up an ABLE program because the Social Security Administration (SSA) requires daily updates on expenses coming out of ABLE accounts to make sure participants are spending appropriately and staying under the savings cap.

Representative Troy stated Idaho Medicaid does not cover all needs of adults with disabilities. The program is much like a health savings account (HSA), and money can only be spent on specific health needs, such as vision and dental care, wheelchairs, and so forth. Medicaid may be able to recover some taxpayer investment. Upon the death of an account holder, the State has a claim against the unused portion of the ABLE account to help reimburse Medicaid expenditures. The technical assistance piece of the bill will help citizens make the best use of the program to use funds in the most sensible way. No new positions will be created with this bill, and it utilizes existing government in a responsible and innovative manner.

Chairman Heider asked if a participant could use an HSA instead of an ABLE account. **Representative Troy** answered it is not allowed, and current law caps savings at $2,000. **Chairman Heider** asked why Idaho does not set up its own ABLE account program. **Representative Troy** answered it would require a large pool of participants and it would be expensive for Idaho to set up its own program. By working through states that have already established ABLE accounts, it would be more efficient with a larger participant pool.

Senator Harris asked who monitors the accounts. **Representative Troy** replied the accounts are monitored daily by the SSA.

TESTIMONY: **Jack Hanson** introduced himself to the Committee to speak in support of **H 41.** (See Attachment 1.) **Mr. Hanson** said the technical assistance portion of the bill will help him understand money and how saving money works. He can start saving for a house of his own, things like eye glasses and eye glass repair not covered by Medicaid, or a car for him and his girlfriend. If he saves more than $2,000, he loses his Medicaid benefits, Supplemental Nutrition Assistance Program benefits, and SSI.

Mr. Hanson commented the 2014 federal ABLE Act allows people with disabilities to save more than $2,000 without losing his benefits. He will never be able to save $100,000, but he might be able to save up to $15-20,000 because he is a hard worker and is looking for a job. **H 41** will give him peace of mind knowing any savings in an ABLE account will not count against him for any state or federally funded benefits now or in the future.

Chairman Heider asked if Mr. Hanson has up to $2,000 in spendable income to put into an ABLE account every month. **Mr. Hanson** replied he does not have a job and the answer is no. He has been working with Senator Martin on this issue since February 2016. Senator Martin is one of his closest friends and he considers Senator Martin to be a mentor.

TESTIMONY: **Toni Brinegar** introduced herself to the Committee to speak in support of **H 41.** Shortly after her son's birth, he slipped into a coma. After 24 hours, she was told her son had a brain hemorrhage and would need immediate brain surgery. The baby had surgery, arrested on the table, and was brought back. Her son will turn 18 this year. This experience was her introduction into the world of disability. An image of her son's brain looks like someone took an eraser and erased big pieces of his brain. Despite that, her son experiences joy on a daily basis and is a gift.

Ms. Brinegar explained transportation became an issue as her son grew and she was no longer able to lift him into their vehicle. She and her husband chose to modify their mini-van and purchase a Bruneau turning seat for him to access the van. That piece of equipment cost $5,000 and it was used. The equipment now needs to be replaced and the cost is $9,500. This is an example of an expense for which she and her husband have to set aside money for her son because they aren't going to be around forever to provide for him.

Ms. Brinegar commented one of the components of **H 41** that would be helpful to her family is the technical assistance piece. Now, she must take a day off from work or stay up very late to do research on her options. Having someone in Idaho who could help would make her life better.

Chairman Heider asked if Ms. Brinegar has money to put into an ABLE account for her son. **Ms. Brinegar** answered her grandmother invested some money for her son, and the account has almost reached $2,000. She is looking to move those funds from the current account to an ABLE account.

TESTIMONY: **Mel Leviton** introduced herself as Executive Director of the SILC. (See Attachment 2.) The SILC's mission is to promote independent living philosophy for all Idahoans with disabilities. **Ms. Leviton** supports **H 41** as furthering the SILC's mission. The SILC serves people from across all disability types regardless of the age the disability occurred.

Ms. Leviton said currently Idahoans are limited to getting technical assistance and complex information regarding ABLE accounts from a Washington, DC based call center and website, called the ABLE National Assistance Center (Center). To begin the process, a person must complete an online form and wait to be contacted by someone at the Center. While the Center provides much valuable information, including a list of states that accept out-of-state participation, it also requires a certain degree of financial literacy and language proficiency.

Ms. Leviton explained a person can have only one ABLE account. There are currently 14 states that allow out-of-state participation, the two closest being Washington and Oregon. Some participating states also have websites that are equally complicated and provide only state-specific information. While the resources might be viable for some, they are of little value for someone who has difficult reading, limited understanding of financial matters, or no internet access. There will be no information on how Idaho benefits would be impacted by having an ABLE account.

Ms. Leviton commented HSAs are employer-based, so if there is no employer, there can be no HSA. Through ABLE technical assistance, peoples with disabilities, families, and community partners will receive assistance, training, and information from well-qualified, in-state SILC staff. The SILC will provide a dedicated web page, phone, and in-person training with the most current information. Financial literacy is limited within the disability community. When someone has subsisted on very little money, as little as $735 per month in the case of an SSI recipient, the person does not have experience in money management. Someone on SSI could earn up to $85 per month without losing any benefits. At $86 per month, $1 in benefits is lost for every $2 earned, up to $1550 per month, at which time all SSI benefits would be lost. The numbers change annually. Sometimes there are expenses that can be deducted to make the determination, and it is a complicated issue.

Ms. Leviton stated the SILC will provide financial literacy workshops across the State, including in rural areas, to help people with disabilities and their families gain financial management skills needed to build a brighter future. SILC staff will also provide face-to-face instruction in accessible spaces on how ABLE will affect benefits, how certain benefits will still be retained, and how to set up ABLE accounts in participating states. Instruction can be provided in many formats such as large print and Braille. SILC staff will make four to five week-long regional trips to include small cities as well as remote communities to provide workshops. Follow-up will be done by telephone and electronic support as requested.

Ms. Leviton mentioned the SILC is grateful to the Governor for recommending funding for this legislation in his FY 2018 budget. Personal savings and an understanding of financial matters greatly improves quality of life.

TESTIMONY: **Heather Conder** introduced herself to the Committee as a Boise attorney who works with families of children and adults with disabilities to speak in support of **H 41**. **Ms. Conder** said she prepares a number of SNTs and feels the ABLE Act is very important.

Ms. Conder stated she recognizes there are questions about the need for ABLE accounts if SNTs are available. An ABLE account allows families to conserve assets, in contrast to the way an SNT is administered and taxed. There are two types of SNTs, first party and third-party. **Ms. Conder** explained a first-party SNT allows an individual to put away his own assets, excluding social security benefits which cannot be put into the SNT. A third-party SNT allows someone else to put money aside for an individual. The first-party SNT is established with a person's own money, often from a personal injury settlement or an inheritance, and it must contain required language providing for Medicaid payback to satisfy a Department of Health and Welfare lien. A third-party SNT established with anyone else's money does not include provisions for Medicaid payback because the funds were never characterized as belonging to the beneficiary. The SSA monitors ABLE accounts, while an SNT does not have specific reporting provisions.

Vice Chairman Souza clarified her earlier question related to understanding the parameters that would limit someone from having multiple sources of savings and thanked Ms. Conder for answering the question.

TESTIMONY: **Christine Pisani** introduced herself to the Committee on behalf of the Idaho Council on Development Disabilities (Council) to speak in support of **H 41.** (See Attachment 3.) The Council is authorized by federal and State law to monitor systems and policies and to advocate for improved and enhanced services to enable Idahoans with developmental disabilities to live meaningful lives. The Council is comprised of 23 volunteers appointed by the Governor.

Ms. Pisani explained the Council has advocated for ABLE accounts since 2013. The ABLE Act allows people with disabilities to save without jeopardizing their benefits. One of her constituents helped persuade Senator Risch to support the ABLE Act legislation through her story about being forced to drive an accessible van with a door that had to be closed with a bungee cord. That constituent would like to save for a better accessible van through an ABLE account.

Ms. Pisani commented ABLE accounts will allow for short- and long-term savings opportunities and the ability for friends and families to contribute to ABLE accounts on behalf of individuals with disabilities, providing the same type of flexible savings tools available to other Americans. Adults with disabilities struggle to make ends meet and lack information and knowledge about financial opportunities and the consequences of financial decisions. In 2013, more than 12 million Social Security Disability Insurance (SSDI) and SSI beneficiaries received monthly benefits, which is often their only source of income. Medicaid eligibility is dependent on eligibility for SSI. The asset limit of $2,000 creates a disincentive to work and save for financial needs and perpetuates a cycle of poverty.

Ms. Pisani informed the Committee that working-age adults with disabilities and families with children with disabilities have additional costs related to health care, assistive technology, education, housing, transportation, personal support services, and employment. Savings from ABLE accounts may be used to fund qualified essential expenses such as medical and dental care, prevention and wellness, education, financial management, administrative services, funeral and burial expenses, employment training, housing, and transportation. The Council recognizes educating about financial literacy has the potential to assist with understanding how credit works and how quickly debt can accrue. People might better understand how to protect financial information, decreasing the risk of financial exploitation, a serious issue with the disability population.

Ms. Pisani said she has been doing this work in Idaho for 20 years, and to her knowledge there is no non-profit that could provide the type of financial literacy education necessary for the wide variety of people with disabilities. There is a complex set of information that must be well understood, including SSA rules, Medicaid eligibility, SSI, qualifying disability-related expenses, SNTs versus ABLE accounts, and the ABLE Act itself. Best practice indicates face-to-face statewide education will accommodate the unique learning needs of the disability community and address challenges such as remote locations or lack of internet access.

Ms. Pisani stated the Council fully supports **H 41**. This legislation is a great step in the right direction to further the independence of people with disabilities and provide peace of mind for their families.

Senator Foreman commented the key issue driving this legislation is the SSA's $2,000 asset limit and asked why that was implemented. **Ms. Pisani** said she does not understand the logic but it is a federal requirement.

Senator Jordan asked when the $2,000 asset limit was established. **Ms. Pisani** answered she does not know but perhaps Jim Baugh will be able to answer that question.

TESTIMONY: **Jim Baugh** introduced himself to the Committee as the Executive Director of DisAbility Rights Idaho (DRI), a private non-profit organization that provides legal and advocacy services for people with disabilities. **Mr. Baugh** commented this legislation might sound strange because of the way the safety net was designed in the 1970s. The notion was to give people access to safety net services, but only if they are poor enough or disabled enough. The moment a line was cross, the person was no longer entitled to any benefits. To leave the safety net is like jumping off a cliff, because all benefits go away if a person earns one more dollar than the limit. This has the effect of trapping people in poverty. Over the last 10 years, disability advocates have worked to make leaving the safety net more like an off-ramp than a cliff so there is a way to earn some money but not lose all benefits and perhaps get to a point where benefits are no longer needed.

Ten years ago, the Legislature passed the Medicaid for Workers with Disabilities program that allows people to maintain Medicaid benefits as they earn more money until they get to a point where no longer require the benefit. This approach has not been done with savings, and the ABLE Act is the first step. The U.S. Congress created a program to be administered by the Internal Revenue Service and SSA where every penny will be monitored. Idaho can be proud of **H 41** because it doesn't cost much to set up, but very few people receiving SSI will be able to save $2,000 to $5,000 because they can barely pay for food and rent. There are very few ABLE accounts to be set up, and that means there is not a big body of money to be invested. The returns from investment will be insufficient to fund administration of the program. The smaller the state, the less benefit due to the scale. **H 41** will allow other states to assume the obligation of paying the administrative costs while allowing Idahoans to take advantage of the program.

Mr. Baugh asked who will use ABLE accounts if so few people can save any money. He has a brother with Down's Syndrome, and it is unlikely his brother can save more than $2,000. However, when his mother's estate was settled, his brother inherited $9,000. **Mr. Baugh** put the inheritance into an SNT for his brother. Had his brother not had Mr. Baugh to set up the SNT, his brother would have lost all his benefits until the money was spent down. **Mr. Baugh** thinks the program could be set up better, but it can work for some Idahoans. This bill is the best chance to make it work.

TESTIMONY: **Dana Gover** introduced herself to the Committee to speak in support of **H 41.** (See Attachment 4.) She became disabled at age 18. **Ms. Gover** said she was brought up on a ranch and was raised to believe it is important to save money.

Ms. Gover explained when she became disabled, there was no program for personal care services in Idaho. When the Legislature approved personal care services, she was on Medicaid and worked and went to college. She was told she would not be able to save more than $2,000. She is now on Medicaid for Workers, and she can save up to $10,000. She has expenses for work and is paying her parents back for a van that her parents had to buy because she could not save enough money to buy it for herself. If she lost her benefits, she would lose her personal assistance services. Providers come to her home to help her get up and get dressed so she can go to work. Medicaid does not cover these expenses.

Ms. Gover mentioned about two years ago, her great aunt left her $10,000 so she set up an SNT. The attorney took $5,000 and she used the rest to have a roll-in shower installed. With an ABLE account, she would be able to save money to purchase a home for herself. She does have money she would love to put into an account or to repair her wheelchair or van.

TESTIMONY: **Charlene Quade** provided written testimony in support of **H 41** (see Attachment 5.)

Senator Burgoyne was recognized to conclude his presentation of **H 41**. He urged support of the bill.

MOTION: **Senator Harris** moved to send **H 41** to the floor with a **do pass** recommendation. **Vice Chairman Souza** seconded the motion.

DISCUSSION: **Senator Foreman** said he has concerns because the bill gives tax breaks to some but not to others, and it is a redistribution of wealth. The bill also grows State government spending, and transfers functions from the private sector to the public sector. There are agencies better suited to handling education and set-up of the accounts.

Senator Lee commented she was contacted by a number of constituents who were surprised Idaho did not allow for ABLE accounts. Families in her community are very dedicated to their loved ones and are working extra jobs and finding whatever non-profit help they can. The families are concerned about their adult children and are trying to plan for a time when the family can no longer be the support. This is just a small piece to help families take care of each other rather than the government doing it.

There being no more discussion, **Chairman Heider** called for the vote. The motion carried by **voice vote. Senator Foreman** requested he be recorded as voting nay.

PRESENTATION: **Child Welfare System Report. Chairman Heider** recognized Lance McCleve from the Office of Performance Evaluations and asked how long he would need to present the report. **Senator Lee** suggested the presentation be rescheduled to allow adequate time. **Mr. McCleve** said the presentation would be better if he had longer than 15 or 20 minutes. **Chairman Heider** asked the Secretary to reschedule the presentation for a day the following week.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:20 p.m.

Senator Heider
Chair

Jeanne Jackson-Heim
Secretary

Alan Jack Hansen, Jr.
District 15
11539 W. Tahiti Street
Boise, ID 83713
208-631-2234

Good morning Chairman Heider and Members of the Committee. My name is Alan Jack Hansen Jr. and I live in District 15. Senator Martin is one of my closest friends. Thank you for having this hearing today. I am here to ask for your support on House Bill 41, the ABLE technical assistance position and protection of benefits legislation. Thank you to Representative Troy and Senator Burgoyne for their sponsorship.

The technical assistance position in this legislation will help me understand money and how saving money works. It will help to pick out the right ABLE savings account for me. It will also make way for other people with disabilities to save for the supports and needs that they have.

With an ABLE savings account I can start saving for a house of my own. It will also help me save for things that Medicaid will not cover like eye glasses and eye glass repair. I can also save for a car for me and my girlfriend.

I cannot save more than $2000 because of a Social Security rule. If I save more than $2000 I lose my needed Medicaid benefits, my SNAP, and my Social Security. With ABLE

legislation that passed in Congress in 2014, this allows people with disabilities **for the first time** to save more than $2000 without losing my benefits with a $14,000 annual savings and a total limit of $100,000. I will never be able to save up to $100,000, but I might be able to save up to $15 or $20,000 because I am hard worker and I am looking for a job.
This legislation also gives me peace of mind knowing that any savings I have in an ABLE account will not count against me for any state or federally funded benefits now or in the future.

Thank you for listening today. I am happy to answer any questions you may have at this time.

SILC
Idaho State Independent Living Council

Mel Leviton, Executive Director, Idaho State Independent Living Council
House Bill 41, Senate H&W Committee, February 21, 2017

Good morning, Mr. Chairman, members of the committee. My name is Mel Leviton. I'm the Executive Director of the Idaho State Independent Living Council (SILC). The SILC's mission is to promote the Independent Living philosophy for all Idahoans with disabilities: choice, self-determination and access for all. House Bill 41 furthers this mission. The SILC serves people from across all disability types, regardless of their age when the disability occurred.

Others (will provide) have provided you with the details of ABLE accounts and how they are beneficial. I'll direct my comments to the SILC's piece of the legislation.

Currently, Idahoans are limited to getting technical assistance and complex information regarding opening an ABLE account from a Washington DC based call center and website: the ABLE National Assistance Center. To begin the process, a person must complete an on-line form and wait for additional contact from someone at the center. While the Resource Center provides a lot of valuable information, including a list of states that accept out-of-state participation, it also requires a certain degree of financial literacy and language proficiency. Participating states also have websites. Those are equally complicated and provide only state specific program information. While these resources may be viable for some, they're of little value to someone who has difficulty reading, limited understanding of financial matters, or no internet access. Additionally, these out-of-state resources will have no information about how Idahoans local benefits might be impacted by having an ABLE account.

Through the ABLE technical assistance provided by the SILC, PWDs, families, and community partners will receive assistance, training and information from well qualified, in-state SILC staff. Assistance will be provided on a dedicated webpage, by phone and through in-person training with the most up-to-date information about ABLE programs available to Idahoans.

We know, through collaborative work with our partner agencies such as the Council on Developmental Disabilities, that financial literacy is limited within the disability community. When an individual or family has subsisted on very little money - $735 a month in the case of an SSI recipient - they don't have experience in money management beyond paying the bills in front of them until the money is gone. Specialized savings, investment and general money management requires experience and education.

The SILC will provide financial literacy workshops across our state, including in our most rural areas, that will help PWD and their families, gain the financial management skills needed to build a brighter future. SILC staff will also provide face to face instruction regarding how ABLE may affect benefits, how certain benefits can still be retained beyond previous resource limits of $2000, and how to set up ABLE accounts in participating states.

We know that to accommodate the unique needs of our community, information and assistance is best provided through face-to-face workshops In accessible spaces that allow for sign language interpreters, support to understand complex ideas and materials provided in large print, Braille and other alternate formats. SILC staff will make 4-5, week-long regional trips to include small cities as well as some of our most remote communities to provide workshops. Follow-up to financial literacy and ABLE workshops will include telephone and electronic support as requested.

We are grateful to the Governor for seeing the value of this project and recommending funding the SILCs piece of this legislation in his FY18 budget appropriation.

Personal savings and an understanding of financial matters, greatly improves quality of life. ABLE Accounts and improved financial literacy will do just that.

I stand for questions.

Further response related to the budget, should questions arise:

Current SILC staffing and resources will contribute ABLE and financial literacy activities, including material development and training.

Additionally, within the ABLE project budget is salary + benefits (.5FTP) and operating expenses including: extensive statewide travel to provide ABLE workshops and financial literacy training in our frontier regions, as well as the development and maintenance of an ABLE webpage within the SILCs website, IT support and printing costs.

- $45,000 increase to fund ABLE .5FTP and technical assistance activities: Personnel – $23,900, salary and $11,850 benefits; $9,250, operating – employee development, general services (IT phone, data, printing, increased website development) and extensive statewide travel.

- $45,000 increase to fund Emergency Preparedness .5FTP and technical assistance activities: Personnel - $23,900, salary and $11,850 benefits; $9,250, operating – employee development, general services (IT phone, data, printing, increased website development) and extensive statewide travel.

The combination of projects makes good fiscal sense with extensive travel linked to make the most of SILC resources. Technical assistance for both programs will be provided by 1FTP, allowing the SILC to recruit and retain a well-qualified employee.

IDAHO COUNCIL ON
DEVELOPMENTAL
DISABILITIES

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C. L. "Butch" Otter
Governor

Debra Parsons
Chair

Christine Pisani
Executive Director

February 21, 2017

Senator Lee Heider, Chairman
Senate Health and Welfare Committee
Statehouse
Boise, ID 83720

RE: HB 41 ABLE Technical Assistance Position and Protection of Benefits

Chairman Heider and Committee Members:

The Council on Developmental Disabilities is authorized by federal and state law to monitor systems and policies and to advocate for improved and enhanced services that enable Idahoans with developmental disabilities to live meaningful lives, included in their communities. The Council is comprised of 23 volunteers appointed by the Governor.

The Council has been involved in advocating for ABLE savings accounts since 2013 with members of Congress. The landmark legislation passed in 2013 opened the door for people with disabilities to save for the very first time without jeopardizing their benefits due to the social security administration rule of having no more than $2000 in assets.

ABLE accounts offer people with disabilities both short and long term financial saving opportunities. It also provides the ability for friends and family to contribute resources to ABLE accounts on behalf of individuals with disabilities. The ABLE Act provides individuals with disabilities the same types of flexible savings tools that all other Americans have through college savings accounts, health savings accounts, and individual retirement accounts.

Why the ABLE Act is Important

Reports indicate that adults with disabilities continue to struggle to make ends meet and lack information and knowledge about financial opportunities and the consequences of certain financial decisions (National Disability Institute, 2014, 2015). In 2013, more than 12 million Social Security Disability Insurance (SSDI) and SSI beneficiaries received monthly benefits, which is often their only source of income. Medicaid eligibility for coverage of long-term services and supports for individuals with disabilities is also dependent on eligibility for SSI. For many people who receive Social Security and Medicaid benefits, the asset limit of $2,000 creates a disincentive to work and save for short and long term financial needs, and perpetuates a cycle of poverty.

Working-age adults with disabilities and families who have children with disabilities experience additional costs related to healthcare, assistive technology, education, housing, transportation, personal support services, and employment. Savings from ABLE accounts may be used to fund qualified disability expenses which include a variety of essential expenses such as medical and dental care, prevention and wellness, education,

financial management, administrative services, community-based supports, funeral and burial expenses, employment training, assistive technology, housing and transportation.

The Council recognizes through our work in Idaho with people with disabilities and the experience of other states, that educating people with disabilities about financial literacy will go beyond just setting up an ABLE account. Financial literacy has the potential of assisting people with disabilities to understand how credit works and how quickly debt can be accrued from the use of credit. There is also the potential of people beginning to understand how to better protect financial information, decreasing the risk of financial exploitation.

A word about non-profits in Idaho doing this work. I have been doing this work for 20 years in Idaho, and to my knowledge there is not a non-profit who could provide the type of financial literacy education proposed to meet the unique learning abilities of the wide variety of people with disabilities in our state. There are debt counseling organizations who may appear like a good fit for this type of work. However, there is a complex set of information to be well understood by the agency providing this education that includes social security administration rules, Medicaid eligibility, social security income, qualifying disability related expenses as they relate to the IRS, special needs trust vs. ABLE savings accounts, and the ABLE Act itself.

It has already mentioned that best practice dictates that face-to-face education be conducted statewide to accommodate the unique learning needs of the disability community, including sign language interpretation, support to understand complex ideas, plain language, information provided in Braille, accessible spaces used for training, and large print to name a few. The ability to do these things are not skills acquired overnight. Many people will likely need information and assistance from someone who is both knowledgeable regarding the ABLE Act as well as familiar with the range of challenges facing Idaho citizens, some of whom may be in remote locations lacking internet or cell phone service.

The Idaho Council on Developmental Disabilities fully supports HB 41 and believes this legislation is a great step in the right direction to furthering the independence of people with disabilities and an ability to provide families some peace of mind for their family members.

Christine Pisani
Executive Director

Dear Senators,

My name is Dana Gover I would like to respectfully ask for your support for House Bill 41. This Bill will provide technical assistance in Idaho on how to choose an ABLE Account so I can save money towards my disability related expenses. I work because of a wonderful program that was approved in Idaho by the legislature called the Medicaid for Workers program. I acquired a disability at the age of 18, due to a car accident. My neck was broken and as a result I am paralyzed and medically defined as a quadriplegic. Due to my disability, I require extensive personal care assistance services (home healthcare aid) to help me with my daily activities of living so I can live independently in the community and work.

My sister and I were brought up on a farm our parents instilled into us at a very young age that saving money was key to our future. However, after I became disabled, in the 1980's, I was told that I could not save over $2000.00 because extra savings would make me not eligible for personal care assistance services through Medicaid. I could not understand this concept as I wanted to save money so I could purchase items not covered by my health insurance or insurance through Medicaid. For example, a wheelchair accessible home with a roll-in shower, wheelchair accessible van (costs $48,000), specialized exercise equipment, gym membership and medical supplies not covered by insurance.

When I heard about ABLE accounts through a disability magazine, I went online to see if there is an Idaho resource person who can help me understand which ABLE plan will meet my needs. I called a local non-profit organization that helps people with disabilities and they didn't know about the different options available for ABLE accounts in other states. States that have these ABLE Accounts list different investment options that I am not familiar with and don't clearly understand. Frankly every dollar I earn is very important and I don't want to risk losing it based on my lack of knowledge about the different ABLE Accounts available in other states.

Idahoans with disabilities and families need technical assistance on how ABLE accounts work. After reading House Bill 41 it states that technical assistance and training would be available if this bill is passed. The bill also says that the State Independent Living Council (SILC) in Idaho will provide training and technical assistance to people with disabilities and non-profit organizations. This would be great SILC can help people with disabilities understand the options under ABLE accounts plus train non government organizations on what these accounts can or can't do offered by other states. This would be such a great opportunity for Idahoans with disabilities if House Bill 41 is passed. Thank you for taking the time to read my testimony and please Vote YES on House Bill 41.

Respectfully and Sincerely,

Dana Gover
1106 S Vermont Ave
Boise, ID 83706
208-761-3073
danagoforit@gmail.com

House Bill 41

Good morning, Mr. Chairman, members of the committee.

My name is Charlene K. Quade, I live at 4802 East Arrow Junction Drive, Boise, Idaho. I am the parent of an adult daughter with Intellectual Disability, aged 31, and I serve as her Co-Guadian and Co-Conservator under Idaho law.

I am an Attorney with C. K. Quade Law, PLLC, at 600 East Riverpark Lane, Suite 215, Boise, Idaho. I hold a Bachelors of Science Social Work with an emphasis on School Social Work. Prior to law school, I worked as a Qualified Intellectual Disabilities Professional, designing, implementing, and licensing programs for persons with Intellectual Disabilities and Dual Diagnosis in Minnesota. In 2000 I entered law school where I excelled in Wills, Trusts, Probate, Wealth Preservation, and Tax Law, and in the fall of 2001 the Hamline University School of Law's Journal Public Law & Policy published my student journal article A Crystal Clear IDEA: The Court Confounds the Clarity of Rowley and Contorts Congressional Intent.

Originally licensed in MN, I am also licensed in Idaho and Washington. The focus of my legal practice centers on providing legal services for persons with disability, veterans, and elders. I am only one of two Attorneys in the State of Idaho admitted to the Special Needs Alliance-- a national, non-profit organization committed to helping individuals with disabilities, their families and the professionals who serve them—working regularly with public benefits, guardianships/conservatorships, planning for disabilities and special education issues.

I serve as the Trustee of a Third Party Special Needs Trust, the Court Appointed Guardian Ad Litem for beneficiaries of Trusts, including Special Needs Trusts. Our Firm serves hundreds of individuals, parents, and guardians throughout the state of Idaho with respect to Special Needs Planning for the life and long term care of individuals with disability.

Others provided you with the over arching concept of the ABLE Act, its personal benefits, and how it would impact their lives or the lives of their loved ones or those they serve.

I will direct my comments and handout to the following: (i) definition of a First Party and Third Party Special Needs Trust; (ii) the contrasts between the ABLE Act, First Party, and Third Party Special Needs Trusts; and (iii) the Public Policy the supports the enactment of House Bill 41.

I will proceed in reverse order and take any questions at the conclusion—

Why Public Policy supports the enactment of House Bill 41.

First: It allows third party persons to contribute assets similar to a 529 account in Idaho, AND allows for a Medicaid Pay Back on the assets remaining in the account on death, similar to Estate Recovery for Elders on Medicaid.

Second: It allows for the Beneficiary to save funds for high value purchases, which in turn result in a value associated with cost savings—in transportation, services, education, and supports and resources for the individual, and, when the funds purchase a high value vehicle—say a Handicapped Accessible Van or a Home, those assets are subject to Estate Recovery or Medicaid Payback upon the death of the beneficiary.

Third: It avoids the often abused and exploitive practice used by families of little means, to leave all assets intended to benefit the beneficiary—to a sibling or other family member with the expectation but not legally enforceable wish that they use the funds for the benefit of the person with disability.

Fourth: It allows for the family and the Beneficiary to conserve assets in the establishment and maintenance of the ABLE Account in contrast to the costs associate in the establishment, administration, and taxation of a SNT.

Prior to answering any questions, I offer an abbreviated definition of a First Party, Third Party SNT, and direct you to the instructive attachment highlighting the Differences Between the ABLE Accounts and a Third Party SNT.

First Party SNT, established with the Beneficiary's own monies—often from a personal injury settlement or an inheritance—must contain requisite language providing for Medicaid Pay Back—similar to Estate Recovery for elders allowed to live in the community and upon death the assets satisfy any lien by the Department of Health and Welfare.

Third Party SNT, established with the monies of anyone BUT the Beneficiary's own monies—does not include provisions for Medicaid Pay Back—because the funds were never characterized to belong to the beneficiary.

In sum:
Public Policy supports the passing, funding, and enforcement of House Bill 41.

It is a win win-- cost sum benefit for both the Citizens—third parties and persons with disability and the State of Idaho.

Handout attached:

DIFFERENCES BETWEEN ABLE AND A 3RD-PARTY SPECIAL NEEDS TRUST ("SNT"):
compiled and prepared by Attorney Sean Beck, and the Legal Team of C. K. Quade Law, PLLC, 600 East Riverpark Lane, Suite 215, Boise, ID, 83716.

DIFFERENCES BETWEEN ABLE AND A 3RD-PARTY SPECIAL NEEDS TRUST ("SNT"):

- ABLE requires disability with an onset prior to the age 26;
  - SNT lacks an age restriction.
- ABLE has Medicaid payback provision;
  - SNT allows settlor to choose successor beneficiaries.
- ABLE restricts amounts saved at both state and federal level. Federal rules (affecting federal benefits, like SSI) allow saving up to $14,000 per year, and a total of $100,000.
  - SNT has no amount limits or restrictions
- ABLE is cheaper to set up, doesn't require attorney involvement or Trust document (although a pooled SNT may be closer in price). ABLE will have reasonable, ongoing maintenance fees.
  - SNTs prices vary widely, but are undoubtedly more expensive; especially if a professional trustee is involved.
- ABLE doesn't require a trustee, potentially providing more choice and control for a beneficiary and family. This may also allow more potential exploitation, however.
  - SNT trustees may offer similar control and support through electronic purchasing methods (such as debit cards).
- ABLE must be established by the individual beneficiary, parent, guardian, or agent under power of attorney (cannot be established by non-guardian grandparent).
  - SNT can be established by any party (other than beneficiary -for 3rd party SNT).
- ABLE amends the tax code to encourage contributions to an ABLE savings account that allow investments to grow tax free.
  - SNT has no special tax recognition.
- ABLE beneficiaries may take cash distributions directly; provided they use them for qualified disability expenses.
  - SNT should not be given direct cash disbursements.
- ABLE account use is limited to "qualified disability expenses," which differ somewhat from a Special Needs Trust distribution. While allowing broader discretion for some basic housing and living expenses, it is more restrictive in entertainment, extracurricular, vacation, and hobby-related expenses. The POMS and Federal Register lists: Education; *Housing*; Transportation; Employment training and support; Assistive technology and related services; Health; Prevention and wellness; Financial management and administrative services; Legal fees; Expenses for ABLE account oversight and monitoring; Funeral and burial; and, *Basic living expenses*. However, POMS also warns that housing-related expenses will be treated as in-kind support and maintenance.
  - SNT less restrictive for standard uses to increase enjoyment and quality of life.
- ABLE has more strict reporting requirements, the responsibility of both the program and account holder. For example: 529A(d)(4) requires states to submit electronically to the Commissioner of Social Security, on a monthly basis and in the manner specified by the Commissioner of Social Security, statements on relevant distributions and account balances from all ABLE accounts.
  - SNT has no specific reporting provisions; though, if Medicaid and SSA can require an accounting be given.
  -
- Prepared by Attorney Sean Beck, and the Legal Team of C. K. Quade Law, PLLC, 600 East Riverpark Lane, Suite 215, Boise, ID, 83716.

https://www.irs.gov/government-entities/federal-state-local-governments/tax-benefit-for-disability-irc-section-529a

https://secure.ssa.gov/poms.nsf/lnx/0501130740

https://www.federalregister.gov/documents/2015/06/22/2015-15280/guidance-under-section-529a-qualified-able-programs#h-19

AMENDED AGENDA #2

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Wednesday, February 22, 2017

SUBJECT	DESCRIPTION	PRESENTER
Approval of Minutes	Minutes of the Meeting of February 9, 2017 Minutes of the Meeting of February 14, 2017	Senator Lee Senator Souza
H 38	Relating to Mental Health	Ross Edmunds, Administrator, Division of Behavioral Health
H 7	Relating to Massage Therapists	Mitch Toryanski, Legal Counsel, Idaho Bureau of Occupational Licenses
H 11	Relating to Optometrists	Mitch Toryanski

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Wednesday, February 22, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:09 p.m.
APPROVAL OF MINUTES:	**Senator Lee** moved to approve the Minutes of the February 9, 2017 meeting. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**
	Vice Chairman Souza moved to approve the Minutes of the February 14, 2017 meeting. **Senator Lee** seconded the motion. The motion carried by **voice vote.**
H 38	**Relating to Mental Health. Ross Edmunds**, Administrator for the Division of Behavioral Health, Department of Health and Welfare (Department), introduced himself to the Committee. **Mr. Edmunds** explained the concept of a mental health directive (MHD). A person of sound mind prepares in advance what he or she would like to have for care and treatment should the person not be able to make decisions for him or herself. The family can use the MHD to make decisions for the person.
	Mr. Edmunds stated there are two different ways someone can be committed to the Department. The first is when a person is at risk of life-threatening harm to himself or someone else, or is gravely disabled, the person can be civilly committed to the Department through a court process. The second type is a restoration to competency, when a court deems a person charged with a crime is not competent to stand trial and cannot contribute meaningfully to his or her own defense. After being committed to the Department, the person is sent to an institution where competency is restored so the person can go back and stand trial for the crime.
	Mr. Edmunds informed the Committee **H 38** has to do with the second type of commitment and amends Idaho Code § 18-212. When a person is committed to the Department for restoration of competency, the Department becomes the legal guardian for the person and has a legal obligation to restore the person to competency. If the person has a MHD that says the person doesn't want to take a certain type of medication, yet that is the medication that would restore the person to competency, the bill would allow the Department to ignore the MHD to provide the necessary treatment. Currently, the law allows the Department to act contrary to a MHD in a civil commitment, but not for a restoration to competency commitment. The bill would allow the Department to proceed in the same manner for both types of commitment.
	Mr. Edmunds explained the Department has determined the bill has no fiscal impact. There will be no increase in the population served, but the bill simply allows the Department to meet its obligations under the law as it exists today.

Senator Martin asked if a person has committed a crime and is awaiting trial in a facility, could the person go before a judge to get a court order to avoid treatment. **Mr. Edmunds** answered the bill would allow the Department to act contrary to an advance MHD. When a person comes to an institution, the person can refuse medication, even with a MHD in place. The only way the Department can require medication is through a commitment order from the court that includes a medication override. **Senator Martin** asked for clarification if the Department would be acting in accordance with a court order. **Mr. Edmunds** replied that is correct.

MOTION: **Senator Lee** moved to send **H 38** to the floor with a **do pass** recommendation. **Senator Anthon** seconded the motion.

DISCUSSION: **Senator Foreman** inquired whether the bill would allow the Department to override the MHD solely to prosecute the person, or if there is a medical reason or concern for disregarding the MHD. **Mr. Edmunds** responded there are two different issues. The first is a court order override of a person's refusal to take medications. The second is the MHD. The bill gives the Department the ability to provide necessary treatment without regard to the MHD because the person has been committed to the Department. If a person refuses medication, then the Department must have a direct court order related to the specific commitment that contains a medication override. **Senator Foreman** further inquired whether the Department can proceed with treatment contrary to a MHD without a court order for the purpose of prosecuting the person. **Mr. Edmunds** explained there are two different issues. The first is a person's refusal to take medication at the time he or she is committed. The second is an advance MHD. The bill would allow the Department to ignore the advance MHD. If a person refuses medication upon commitment, the Department must have a court order to require medication. The purpose of the medication could be to bring the person to a level of competency that would allow the person to stand trial for a crime. The Department's role is not to assist with prosecution, but to restore competency to allow the person to meaningfully contribute to his or her own defense to have a fair trial. **Senator Foreman** asked if the Department can override the MHD without a court order if the person is committed and facing trial. **Mr. Edmunds** answered today, the Department cannot override the MHD without a court order. The bill would give the Department the ability to act contrary to the MHD without a direct court order based on the fact the person is committed to the Department, and the Department is legally responsible to restore them to competency. If at the time of treatment, the person refuses any treatment, a court order would be necessary to provide treatment.

There being no more discussion, **Chairman Heider** called for the vote on the original motion. The motion carried by **voice vote. Senator Foreman** requested he be recorded as voting nay.

H 7 **Relating to Massage Therapists. Mitch Toryanski**, Legal Counsel for the Idaho Bureau of Occupational Licenses (Bureau), introduced himself to present **H 7** on behalf of the Idaho Board of Massage Therapy (BMT). **Mr. Toryanski** introduced Linda Chatburn, a licensed massage therapist and member of the BMT.

Mr. Toryanski stated the bill gives the BMT the ability to review and approve the curriculum of massage therapy schools registered with the Board of Education (BOE). Students are graduating from some registered massage therapy schools that do not meet the BMT's curriculum standards. BOE rules say the education programs of proprietary schools are supposed to prepare students for employment. Massage therapy schools are required to follow applicable trade or curriculum standards set by the BMT. After enrolling in a massage therapy program, paying tuition, and completing the course, some students find they are not qualified to be licensed.

Mr. Toryanski explained the BOE has one staff person who processes dozens of registration requests from many different schools in a wide variety of fields. The BOE staff person cannot review all curriculum offered by the schools and does not have massage therapy expertise. The BMT has agreed to review and approve the curriculum of the applicant schools for the BOE. It will result in more work for the BMT, but students who enroll in the registered proprietary schools will know prior to enrollment that their training will allow them to be licensed and go to work. The curriculum review will be accomplished without the BOE having to hire more people. The bill is an example of two state agencies working together to accomplish a goal with existing resources.

Mr. Toryanski informed the Committee the bill will have no impact on the General Fund or the Bureau's dedicated fund because the BMT will perform the curriculum reviews during regularly-scheduled meetings. The bill provides a limited government approach to a consumer protection issue.

Vice Chairman Souza asked how long the BOE has been involved in reviewing curricula for schools other than the public school system. **Mr. Toryanski** answered he did not know, but the Executive Director of the BOE is present.

Matt Freeman, Executive Director for the BOE, introduced himself to respond to the question. **Mr. Freeman** explained the Legislature gave the BOE authority to register proprietary schools in 2009.

Vice Chairman Souza inquired how many schools the BOE reviews. **Mr. Freeman** estimated 36 proprietary schools, and the BOE also registers private post-secondary institutions that offer degrees.

Chairman Heider asked once the BOE reviews a particular school's curriculum, if the school is accepted going forward or if a new review is required every time the school registers. **Mr. Freeman** replied proprietary schools register on an annual basis. If the curricula has not significantly changed, it is a fairly quick registration process. **Chairman Heider** asked once the BOE agrees a school has an appropriate curriculum if subsequent graduates will be accepted from that school. **Mr. Freeman** responded there are a number of requirements for registration in addition to reviewing the curricula. Once the schools are registered, they are lawfully allowed to offer a program in Idaho. The BOE registers the schools, and the BMT licenses the massage therapists.

Senator Lee asked for clarification that when schools register with the BOE, it is not a BOE endorsement of the curriculum or any statement about the quality of the school. **Mr. Freeman** replied that is correct. It is simply a registration and there is no representation about quality or employability.

Senator Harris inquired who sets the curriculum standards. **Mr. Freeman** answered for the BMT, educational content standards are established in rule. This includes the coursework, content, and hours required for massage therapists.

Senator Lee wondered if massage therapy schools are not currently required to register as private proprietary schools. **Mr. Freeman** answered that is incorrect. Massage therapy schools are proprietary schools required to register with the BOE, and BOE rules require that a proprietary school's course of study follow applicable trade board curriculum standards. The curriculum standards for massage therapists are contained in administrative rule for the BMT. The BOE has a staff of one person who does not have the expertise to determine whether or not a massage therapy school's curriculum meets the BMT requirements.

Senator Anthon stated he is struggling with the bill and asked if his reading of Idaho Code is correct that the BMT is only authorized to determine the qualifications of an applicant and whether someone should be licensed. **Mr. Freeman** deferred the question to Mr. Toryanski.

Senator Anthon said he sees a difference between licensure and determining curriculum. Perhaps the schools should be allowed to decide their own curricula, and students will either pass or fail the licensing exam. **Mr. Toryanski** answered it is reasonable for a citizen who wants to go to massage therapy training to assume that if a school is registered by the State, then it must meet the State's standards. The BOE is supposed to ensure the curriculum is up to trade board standards, but the BOE does not have the manpower or expertise to do it. The BMT has the expertise and can do the review. If a school approached the BOE about registration, the registration application would include the curriculum. The BOE would then give the curriculum to the BMT and ask that it be reviewed to determine if it meets BMT standards. The BMT would look at the classes and ensure sufficient course hours were devoted to the required topics.

Senator Lee asked if the BMT only matches the curriculum to the massage therapy standards. She is concerned about what would happen if the BMT kept schools out of business due to other marketplace concerns. **Mr. Toryanski** replied the BMT exists for one reason only and that is to keep the public safe. If the BMT is acting in a way to minimize competition, then the BMT is acting against the instructions of the Governor and against their charge in statute. The BMT already reviews all the curriculum, but it is done at the time individual licensure applicants come forward to submit their paperwork. The BMT must review everyone's curriculum individually to ensure it meets the BMT standards. If the BMT is authorized to review the curriculum for a school registration, then the BMT would know applicants qualify for licensure based on graduation from that school. It could serve to streamline the licensing process for the BMT.

Chairman Heider commented the duties of a board generally are not to approve curriculum but to approve the people for licensure based on their education. For the BMT to approve the curriculum of 200 educational programs seems a bit onerous. **Mr. Toryanski** agreed it is true the BMT is concerned with individual licensure. The BMT is a volunteer board and wants regulation of schools to stay with the BOE. The BMT recognizes there is not enough manpower at the BOE to review the curriculum and has offered to take on the task.

Senator Agenbroad asked whether massage therapy schools are eligible to receive any kind of student aid, and if this legislation would change that. **Mr. Toryanski** responded schools receive funding depending on how they operate, but all massage therapy schools are already supposed to meet the minimum standard. There would be no effect on funding as a result of this bill. **Senator Agenbroad** said he is more interested in the ability of the student to obtain a student loan to attend the schools. **Mr. Toryanski** answered the BMT is focused only on ensuring the public is safe, and he does not know how to answer that question.

Senator Harris inquired whether any other boards at the Bureau approve curricula in this manner. **Mr. Toryanski** replied the Board of Cosmetology regulates cosmetology schools, and the BMT would be the second board at the Bureau with this authority.

MOTION: **Senator Martin** moved to send **H 7** to the floor with a **do pass** recommendation. **Vice Chairman Souza** seconded the motion.

DISCUSSION: **Senator Lee** said she still has some questions and is unsure of her support for the bill.

Senator Anthon stated he will oppose the motion. Idaho Code requires applicants to pass a nationally-recognized competency exam. He commented the schools should teach what they want to teach, and the success of the students will be recognized by whether or not they pass the exam. For example, the University of Idaho College of Law is an excellent school, but only 60 percent of his graduating class passed the Idaho State Bar Exam. That result is due to other factors and not because a regulatory agency did not approve the curriculum.

There being no more discussion, **Chairman Heider** called for the vote on the original motion. The motion carried by **voice vote. Senators Lee, Anthon, Agenbroad, and Harris** requested they be recorded as voting nay.

H 11 **Relating to Optometrists. Mr. Toryanski** was recognized to remind the Committee that **H 11** would require all optometrists to become certified to use pharmaceutical agents for diagnostic and therapeutic purposes. If the Committee is willing to reconsider the bill, the Board of Optometry would appreciate having it sent to the Fourteenth Order for amendment.

Chairman Heider remarked a proposed amendment would extend the implementation date of the bill by two years.

Senator Lee said she was hopeful current licensed optometrists could be grandfathered so the requirement would only apply to new licensees. It would allow a few optometrists at the end of their careers to continue their current practices.

Vice Chairman Souza remarked that grandfathering would be accomplished by adding more years until the effective date of the deadline, thereby accomplishing the goal of giving these few practitioners time to finish out their careers.

Senator Foreman commented he too was hoping the amendments would allow all current practitioners to continue practicing until their normal retirement and not just extend the deadline for a couple of years. The proposed amendment is not what he wants to see.

Senator Jordan asked whether others could submit amendments if the bill is sent to the Fourteenth Order. **Chairman Heider** responded the bill would be sent with the proposed amendments. **Senator Jordan** asked whether a different amendment could be submitted. **Chairman Heider** answered yes.

MOTION: **Vice Chairman Souza** moved to reconsider **H 11**. **Senator Lee** seconded the motion. The motion carried by **voice vote.**

MOTION: **Vice Chairman Souza** moved to send **H 11** to the Fourteenth Order for possible amendment. **Senator Lee** seconded the motion. The motion carried by **voice vote.**

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:00 p.m.

_____
Senator Heider
Chair

_____
Jeanne Jackson-Heim
Secretary

AMENDED AGENDA #1

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Thursday, February 23, 2017

SUBJECT	DESCRIPTION	PRESENTER
Presentation	Revised Immunization Exemption Form	Dick Armstrong, Director, Department of Health and Welfare
Presentation	Relating to Immunizations	Leslie Manookian

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, February 23, 2017

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:08 p.m. **Chairman Heider** informed the attendees that the purpose of the meeting is only to receive information, and no votes will be taken. He thanked attendees for coming to the meeting and advised attendees to keep comments directed to the issues.

PRESENTATION: **Revised Immunization Exemption Form. Richard Armstrong**, Director of the Department of Health and Welfare (Department) introduced himself to the Committee to provide a follow-up to an earlier presentation. There has been concern expressed about the Department's opt-out form for immunizations. The Department reviewed the form to make it shorter and revised language that some people found offensive (see Attachment 1).

Director Armstrong stated the original form contained one page devoted to education and informed consent and a second page designed to meet legal obligations of the Department and school districts related to immunizations. The Department concluded the education component could be handled more efficiently. The revised document is exclusively designed to address public health and school district statutory responsibilities.

Director Armstrong mentioned Idaho rules require schools to maintain immunization documentation on a form provided by the Department. Duties contained in Idaho Code require the Director to protect the public from the spread of infectious or communicable diseases or from contamination. There is a long-standing body of case law that also applies and requires the Department to exclude students from school during an outbreak unless they are immunized or the threat of disease is contained. When a disease enters a school, the Department has the legal obligation to rapidly and efficiently remove children who are at risk. The revised opt out form is specifically designed to provide the tools on a common form. For example, the Spokane, Washington schools recently employed this strategy during an outbreak of mumps and removed 160 children from school who were not immunized or had compromised health from some other medical condition.

Director Armstrong explained the revised document lists the diseases for which immunizations are available, along with a physician's statement section for children who are not eligible for immunizations due to health conditions. The bottom section allows for an exemption for religious or other reasons along with a short statement that the parent or guardian understands in the event of a disease outbreak, the child may be excluded from school for the duration of the outbreak. The Department must ensure parents are aware of the unilateral action a school may take.

Senator Foreman commented the acknowledgment on the form that their child may contract a vaccine-preventable disease might be problematic, and he asked if that sentence could be left off the form. **Director Armstrong** answered the Department's goal is to make it as easy as possible for a parent with an objection to opt out of immunizations. Legally, the Department must know the parent understands there are diseases with a vaccine available. It must be clear that the parent assumes the responsibility for the decision.

Senator Foreman suggested all the information about immunizations be put on a separate sheet. The schools could be asked to give it to the parents and obtain an acknowledgment that the parent received the information sheet. **Director Armstrong** replied part of what government is supposed to do is be efficient. **Director Armstrong** said he spends most of his time working with his staff to make sure they are only doing what they must do to meet the letter of the law without burdening school districts, public health districts, and citizens with unnecessary paperwork and documentation. The opt-out forms must be managed and stored, and part of the goal is to have a simple form that will reduce the cost of administrative overhead by everyone involved. The Department is trying to strike a balance between personal responsibility and accountability, and the role and responsibility of public health. The revised form contains the shortest statement the Department felt it could use and still meet its statutory obligation.

Senator Jordan stated the revised form is a significant improvement, and she asked if parents must sign an acknowledgment of risk when a child signs up to play school sports. **Director Armstrong** replied there are acknowledgments on sports forms.

Vice Chairman Souza complimented Director Armstrong on the simplicity of the revised form. She asked if the Department was planning to create an information-only page using the previous page one information about the vaccinations. **Director Armstrong** answered yes. The Department has not yet consulted with all of its partners in the immunization network nor talked to 114 school districts. The education material will be developed and what it looks like will depend on the work group.

Vice Chairman Souza referred to Dr. Hahn's previous testimony in which she stated it was common for a parent to opt a child out of one or two immunizations, while some opt out of all immunizations. If a parent opted out of the chicken pox immunization, then in the event of a chicken pox outbreak, the child would be pulled out of school, but not if there was an outbreak of measles if the child was already vaccinated for measles. **Director Armstrong** said the most common occurrence is that the parent arrives at school and opts out, then returns to school a week or two later to let the school know the immunizations have been given.

Senator Anthon asked if the Department intends to implement the sample form provided. **Director Armstrong** responded the suggested form will be provided to the stakeholder coalition and they will be encouraged to use it. The Department has no authority over an individual school district, and he realizes some districts have been very strict in requiring immunizations. If a school district makes a different decision, the Department has no statutory authority to enforce the form, and a school district could employ a more stringent form. **Senator Anthon** stated the school districts administer how they accept the students and whether or not to use the form, but the rules mandate the Department to provide the form. He asked if this situation will arise in the future if the form is not implemented next school year. **Director Armstrong** answered the Department created the form and will send it out. **Senator Anthon** asked if the form will be provided to the school districts for the next school year. **Director Armstrong** answered that is the Department's intention. If a school district wants to add something to the form, the Department has no authority to tell the school district what to do. The Department assumes the

vast majority will use the form provided, but he can't force someone if they want to add something else.

Senator Foreman asked in the event a parent only completes the bottom section of the form and does not complete the rest, if the Department will accept the form. **Director Armstrong** replied the Department's instructions will be that the school district employee ask the person whether the opt out applies to all immunizations on the list. If someone absolutely refuses to fill out the top part, the Department will assume it applies to all immunizations.

Vice Chairman Souza commented she was surprised to hear some school districts act independently in how they deal with this issue and asked how that fits with the exemption statute. She does not read the statute as allowing school districts to use their own discretion. **Director Armstrong** answered he has run into the situation and does not know if it is still occurring. School districts are not subdivisions of the Department, and he can't make people do things, and there is the possibility it could happen.

Senator Lee said she appreciates all the work that has gone into the revised form. In her district, it is likely parents won't have any problem signing the statement acknowledging the child will be removed from school in the event of an outbreak, but she does think some parents will not agree with the statement that the child might contract a vaccine-preventable disease. A parent might not sign the form at all if they don't agree with those two statements. **Senator Lee** asked how these sentences can be statutory when Idaho Code allows the parent to submit only a signed statement. **Director Armstrong** responded the Department wants parents to know their child is at risk of a preventable disease if there is an outbreak. The statement is only to acknowledge schools are incubators of disease. It places no liability on the parent, who has already accepted the responsibility by opting out, and he wants to make sure the parent knows it is not the Department's or the school district's responsibility. This is protection for the institutions.

Senator Anthon asked if the form is promulgated by the Department. **Director Armstrong** answered yes. **Senator Anthon** inquired whether the school has any right to say whether or not it will use the form. **Director Armstrong** replied the school is required to use a form provided by the State to document the situation.

PRESENTATION: **Relating to Immunizations. Leslie Minookian** introduced herself to the Committee as a former executive who worked on Wall Street for several years, and she has produced an award-winning documentary on vaccines. (See Attachment 2 for presentation.) **Ms. Minookian** said she has served on many national and local non-profit boards. There is generally a perception that those who question vaccinations are uneducated, and that is far from the truth. The average parent who challenges and questions is actually highly educated. She understands and appreciates that Director Armstrong believes everything he says and is trying to do what is best for Idahoans. The parents who have an issue are trying to do what they think is best for their children. She would like to sit down with the Department and discuss the science and share her observations on what is happening around the country.

Ms. Minookian mentioned the childhood vaccine schedule has tripled from 22 doses of 7 vaccines in the 1980s to 69 or 70 doses of 16 vaccines today. There were not massive disease outbreaks in the 1980s that warranted introduction of the increased vaccines and dosages. Vaccines contain many toxins and contaminants, such as mercury, aluminum, formaldehyde, antibiotics, monosodium glutamate, monkey kidneys, cells from aborted human fetuses, and chicken embryos. Certain vaccines are far more reactive for children who receive them, and contamination could be the reason. Vaccine safety studies are deeply flawed and do not use proper placebos. To study whether or not a pharmaceutical product is safe, the placebo should be something inert. In vaccine safety studies, however, another vaccine or a solution that contains mercury or aluminum is used as the placebo. These other components mask any adverse reactions from the vaccine and do not provide a true picture.

Ms. Minookian said children's health in America is in decline, and the U.S. has the worst infant mortality rate in the developed world and the highest vaccination rate in the first year of life. Countries that give half the number of vaccines have an infant mortality rate roughly one-third that of the U.S. No one can predict whose child will have an adverse reaction from a vaccine, and vaccine makers have no liability for their vaccines. A vaccine maker cannot be sued; instead there is a trust fund set up using a $.75 per vaccine tax levied on all vaccines. This fund has paid out $3.3 billion to compensate victims of vaccine injury, and many are denied compensation. Thirty thousand adverse effects are reported every year, with 13 percent of those classified as serious.

Ms. Minookian referred to comments made by Director Armstrong at the Committee's meeting of January 18, 2017 and advised that a study showed vaccinations do not account for the impressive declines in mortality seen in the first half of the 20th century. Nearly 90 percent of the decline in infectious disease mortality happened before the widespread use of vaccines or antibiotics. Clean drinking water, public sanitation, and rising socioeconomic conditions were the cause. Tuberculosis has all but died out in the U.S., despite there being no vaccine in wide use. Polio died out across Europe at the same rate as in the U.S., even though there was no vaccine used in Europe.

Ms. Minookian commented all live virus vaccines have the ability to shed and spread disease after the vaccination. Some killed and weakened vaccines can also spread disease and cause changes in the diseases themselves. Thousands of people who were vaccinated for whooping cough have no or very mild symptoms, yet they can spread the disease to both vaccinated and unvaccinated individuals. The pertussis vaccine only protects against a single strain of bacteria and causes a 40-fold increase in the colonization of parapertussis in animal tissues.

Ms. Minookian stated there have been tens of thousands of whooping cough cases around the U.S. in the last five to ten years, and 80 to 90 percent of those who contracted whooping cough were fully vaccinated. The greatest risk to young children for whooping cough is their older, vaccinated siblings, but the Centers for Disease Control (CDC) continues to blame outbreaks on the unvaccinated. An independent research study found 100 people need to be vaccinated to avoid one case of the flu, making the vaccine 99 percent ineffective. During a 2006 outbreak of mumps in the Midwest, 99 percent of children who got mumps were vaccinated. In the recent U.S. measles outbreak, over 50 percent of measles cases were adults who were vaccinated in childhood. A 2011 measles outbreak in Canada resulted in 725 cases despite 90 to 95 percent of the population having been vaccinated. The most susceptible were older children ages 12 to 17.

Ms. Minookian mentioned vaccine-induced immunity is not permanent and pushes the diseases to a time when they are more dangerous. It is safer to get most childhood diseases before puberty. Levels of immunity that are conferred by vaccines fall away and then people are more susceptible. The idea that an unvaccinated child should be excluded from school is not supported by the data. Most children getting the diseases are vaccinated. Anyone is at risk, not just the unvaccinated. Vaccines induce antibodies, but antibodies does not mean immunity.

Ms. Minookian advised there is a tremendous amount of corruption in vaccine research. A doctor at the CDC reported high officials altered data in studies to conceal the fact that the Measles-Mumps-Rubella (MMR) vaccine causes autism. Merck & Co. (Merck) is the subject of a federal lawsuit for falsifying data on its mumps portion of the MMR vaccine and Merck is the only vaccine provider licensed to sell MMR in this country. Former scientist employees of Merck allege they were threatened with jail and forced to put animal antibodies and other things into the safety studies to make the studies prove the vaccine was more effective than it was. A group of 12 scientists have come together and submitted a letter to the CDC chief of staff. They allege special interests are influencing their ability to do their jobs and affecting scientific integrity and policy.

Ms. Minookian commented that herd immunity is a myth. If vaccines work the way they are purported to work, the outbreaks in fully and nearly fully vaccinated populations would never happen. Herd immunity is real when people contract diseases naturally and derive lifelong protection, and get community boosting when their children and grandchildren contract diseases. Vacccine-induced herd immunity is assumed but the science data shows it is an illusion, and it is not necessary for 95 percent of the population to be vaccinated.

Ms. Minookian said the Department is mandated to protect public health, but Idaho Code does not require one person's life to be risked for the herd. The CDC states it uses tracking registries and data to identify areas of under-vaccination to bring them into compliance. The U.S. Department of Health & Human Services has floated the idea of a national adult immunization plan and an initiative to track everyone and their vaccination status. This plan would allow people to be detained anywhere, any time, indefinitely without appeal involving diseases such as flu or measles.

Ms. Minookian stated the Department says its exemption form helps school administrators track exemptions and provide statistical information to the Department. Many parents do not want to be tracked and opt out of the voluntary registry. Requiring parents to detail which vaccinations they do not want their children to receive is the same as forcing participation in the vaccine tracking registry. Idaho Code clearly states the form is not required, yet it is pushed on the parents, which makes parents mistrustful that the Department will follow Idaho Code. When there is an outbreak, all families are notified, not just the unvaccinated. Vaccination status is not proof of immunity. Requiring any form is the same as having a surreptitious vaccine registry.

TESTIMONY: **Betsy Moynihan**, a school nurse in the Boise School District, introduced herself to the Committee. She sees many parents at school who do not have their children vaccinated and want to sign the exemption form. She reviews the form with the parents and many are shocked to read the immunization information. Many times parents just don't want the MMR immunization, and sometimes most of the immunizations have already been given but the series isn't finished. The information is helpful to the parents because they are not as knowledgeable. **Ms. Moynihan** said she is disappointed the old form won't be used. She does not talk anyone into having their children immunized, but so many just don't understand and need the education. She has never had a parent be upset by the exemption form.

Her school prints the form on pink paper so it is easy to identify which students are not immunized in the event of an outbreak.

Vice Chairman Souza commented that the Director has promised to make the informational handout available to the parents.

TESTIMONY: **Dr. Tom Patterson** introduced himself to the Committee as a pediatrician for the last 21 years. He is an associate clinical professor of pediatrics at the University of Washington and a pediatric provider at Family Medicine Residents of Idaho. He understands not everyone will react to a vaccine the same way or receive the same level of protection from a vaccine. If there is an outbreak, it is important to know who has been vaccinated and who has not. This is about protecting children rather than violating rights of privacy. He would want his child to be excluded from school if his child was not immunized.

Dr. Patterson commented the Department's form is good. For every procedure he does, including immunizations, he must have informed written consent, and not vaccinating is also a procedure. When a child presents to the emergency room with a fever, he evaluates the child in the context of the vaccination history, meaning the child might be susceptible to things he doesn't usually look for like pneumococcal disease or haemophilus influenzae Type B (HIB). He has seen one unimmunized child who requires constant care due to HIB, and the child has lived in a facility his entire life.

Dr. Patterson said immunizations are the number one greatest advance of modern medicine. He would prefer to have some side effects rather than death or disability from a disease. Diseases confer about six to nine years of natural immunity, while the vaccine confers six to seven years of protection. He has seen chicken pox decrease and other diseases disappear. He used to make a living from rotoviral gastroenteritis with dehydration. After the first rotovirus vaccine, there were some safety concerns. **Dr. Patteron** mentioned medical providers and the general public can report adverse effects from vaccinations to a vaccine safety data link website. Since the second rotovirus vaccine came out, he has seen only one case of rotoviral gastroenteritis.

Dr. Patterson mentioned he recently participated in a mock debate on the side of anti-vaccine. The experience helped him realize the person who doesn't vaccinate loves their child and does the best they can for their child, and he doesn't want to take that away. If a child has had all vaccines but one, the school would have to exclude for every outbreak without the form. The herd immunity is different for every disease. This is not about vaccination, it's about keeping kids safe. He doesn't want anyone to be vaccinated who doesn't want to be vaccinated.

TESTIMONY: **Sarah Walton-Brady** introduced herself to the Committee as the parent of three children. She recently learned one of her children may have autism. **Ms. Walton-Brady** said she has issues with the old form, and she will likely take issue with the new form. She is pro-choice about vaccinations. She did not like the old form because did not want to agree with the printed statements on the form or explain the reason for her exemption. She understands the Department may not want to be legally liable. Vaccine inserts list many side effects including possible death. She suggested adding "hold harmless" language to the exemption form.

TESTIMONY: **Dr. Greg Ferch** introduced himself to the Committee as a 25-year practicing chiropractor who has studied the immunization issue. Decisions are often made based on assumptions that immunizations will protect people. However, 97 percent of whooping cough cases will occur in people who are immunized. Since the chicken pox vaccine was introduced, the incidence of chicken pox has been reduced, but there has been an increase in shingles. Hepatitis B immunity only lasts four to five years. The lowest rate of shingles occurs in pediatricians because they are constantly exposed to sick children. There are more cases of shingles in parents and grandparents because they are no longer caring for children with chicken pox and getting a natural booster of protection.

Dr. Ferch mentioned a school will be shut down and hazardous material remediation done because someone broke a thermometer on the sidewalk. Yet there is mercury in immunizations at much higher levels than exposure to a broken fluorescent light bulb. The CDC said Lumber Liquidators flooring caused cancer because of formaldehyde saturation of the flooring, but formaldehyde is included on the list of vaccine ingredients. Parents have reported that within hours after vaccination, their previously normal child lost ocular tracking ability, speech and language, and ability to ambulate. **Dr. Ferch** said he is willing to have his data challenged scientifically. Informed consent means both sides of the subject are informed, not just one side.

TESTIMONY: **Miste Karlfeldt** introduced herself to the Committee as the Executive Director of Health Freedom Idaho. There has been a lot of information presented on both sides of the issue. Parents are making immunization decisions based on information and take issue with the statement that they are knowingly putting their children at risk if they do not vaccinate. If the exemption form is used as education, it should also include the vaccine insert that shows the potential harm from vaccines. Education should be between the parent and the doctor, not between the parent and the school. It is the parent's decision whether or not to immunize and they should not have to report their choice to the State. **Ms. Karlfeldt** believes the exemption form is just a workaround for the immunization registry, and it does not truly allow for an opt-out.

TESTIMONY: **Samantha Congdon** introduced herself as a registered nurse and president of the School Nurse Organization of Idaho, representing 102 school nurses throughout the State of Idaho. (See Attachment 3.) She is not here to discuss the pros and cons of vaccines but rather to talk about the form used in schools. Parents have the right to opt out of having their children immunized. Some parents take great issue with the front of the current form, and **Ms. Congdon** allows them to write in that space that they do not agree with the form. However, the form allows school staff to quickly identify students who might be at a higher risk of disease in the event of an outbreak. Her district uses an electronic medical records system but other districts use secretaries and parent helpers to go through school records to find the exemption forms. If a parent wrote an exemption on a sticky note, it would be very difficult to find that in a student's cumulative file in a timely manner.

Ms. Congdon informed the Committee that having a standardized form helps the schools. The only data given to the Department are numbers of students and number of exemptions, not names or anything else. The form is part of the student's confidential school file, and it can only be obtained by subpoena. The National Association of School Nurses has published a Framework for the 21st Century in School Nursing Practice. The model focuses on the student, school, and community. Some parents don't have a family medical provider, and they call the school nurse to ask for medical advice. Not everyone comes from an intact, stable household or has a parent that can do the research. She appreciates the Department adjusting the exemption form and urged that the standard exemption form be maintained.

Director Armstrong was recognized to conclude the remarks. He informed the Committee the Department does not maintain a central database, and there is no centralized reporting. The Department gets global statistics only. The CDC can't get any personal information about immunizations because the Department does not have the information. He stated the Department always enjoys hearing from constituents to improve its services.

Senator Anthon commented that, based on his reading of the law, the current form is an overreach. He can't understand why it would be necessary to identify what church or religious organization a family belongs to, and that information has nothing to do with statistics or sorting out children in the event of an outbreak. It is unnecessary to justify a philosophical exemption, which is a parent's right under the law. He hopes the Department will take steps to correct a mistake that was made.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:38 p.m.

Senator Heider
Chair

Jeanne Jackson-Heim
Secretary

Child's Name: _____

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

IDAHO SCHOOL IMMUNIZATION REQUIREMENTS EXEMPTION

In the event of a disease outbreak, a child exempted from Idaho school immunization requirements may be excluded from school for the duration of the outbreak, both for his/her own protection and for the protection of others. Please check the box(es) below, and date each line regarding all vaccine-preventable diseases for which an exemption is claimed.

- ☐ **Diphtheria (DTaP, Tdap, Td)** _____ Date
- ☐ **Tetanus (DTaP, Tdap, Td)** _____ Date
- ☐ **Pertussis (Whooping Cough) (DTaP, Tdap)** _____ Date
- ☐ **Measles (MMR)** _____ Date
- ☐ **Mumps (MMR)** _____ Date
- ☐ **Rubella (German Measles) (MMR)** _____ Date
- ☐ **Polio** _____ Date
- ☐ **Hepatitis B** _____ Date
- ☐ **Hepatitis A** _____ Date
- ☐ **Meningococcal** _____ Date
- ☐ **Varicella (Chickenpox)** _____ Date
- ☐ **Varicella Disease History:** My child has had chickenpox, but was not diagnosed by a licensed healthcare professional _____ Date

☐ MEDICAL EXEMPTION **(This exemption requires the signature of a licensed physician.)**

As the child's physician, I certify that the physical condition of this child is such that the immunization(s) checked above would endanger the health of the child.

- ☐ This medical exemption is permanent.
- ☐ This medical exemption is temporary. Duration of temporary exemption: _____/_____/_____

I hereby request that this child be exempted from the Immunization Requirements for Idaho School Children (IDAPA 16.02.15) due to a medical condition for which immunizations are contraindicated.

Name of Physician (PRINT) _____ Signature of Physician _____ Medical License # _____ Date _____

As the child's parent/guardian, I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak, both for his/her own protection and for the protection of others. I am aware that my child may contract a vaccine-preventable disease.

Name of Parent/Guardian (PRINT) _____ Signature of Parent/Guardian _____ Date _____

Full Name of Exempted Child (PRINT) _____ Child's Date of Birth (Month, Day, Year) _____

☐ RELIGIOUS/OTHER EXEMPTION

As the child's parent/guardian, I am exempting for religious or other reasons. I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak, both for his/her own protection and for the protection of others. I am aware that my child may contract a vaccine-preventable disease.

Name of Parent/Guardian (PRINT) _____ Signature of Parent/Guardian _____ Date _____

Full Name of Exempted Child (PRINT) _____ Child's Date of Birth (Month, Day, Year) _____

Herd Immunity Presentation to Senate Health and Welfare Committee

By Leslie Manookian
Board Member of Health Freedom Idaho
February 23, 2017

CDC Vaccine Schedule to Age 18

1983

Vaccines	Doses
Diphtheria	5
Tetanus	6
Pertussis	5
Measles	1
Mumps	1
Rubella	1
Polio	4
	23

2014

Vaccines	Doses
Diphtheria	6
Tetanus	6
Pertussis	6
Measles	2
Mumps	2
Rubella	2
Polio	4
Hib	3
Rotavirus	3
Hepatitis B	3
Pneumococcal	4
Influenza	19
Chicken Pox	2
Hepatitis A	2
HPV	3
Meningococcal	2
	69

Source: CDC

Adult Vaccine Schedule:

If you live to 80 and follow CDC's schedule, you'll get another 91 doses of 11 vaccines

- Flu shot annually (63)
- Shingles – (1)
- TDaP – (3)
- Tetanus-Diphtheria (every 10 years=12)
- Varicella – (2)
- HPV – (3)
- MMR – (6)
- Pneumococcal – (1)

Source: CDC

Vaccine Ingredients:

Cells from aborted fetuses
Monkey kidneys
Chicken embryos
Mouse brain
Chicken kidneys
Monkey lung tissue
Cow milk protein
Sheep blood
Cow heart
Cow pancreatic enzymes
Human blood protein
Gelatin – various animals
Calf serum

Aluminum
Mercury
Formaldehyde
Yeast
Antibiotics
MSG
Polysorbate 80
Disinfectant
Soy protein
Antibacterials
Viruses
Bacteria
Genetically engineered organisms

http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf

Vaccines: Flawed Safety Studies

- Placebos are not placebos
- Vaccines studied singly but given in large combinations
- Vaccine safety studies use healthy subjects
- Vaccine research compares vaccinated to vaccinated populations
- No large, long-term clinical study comparing vaccinated to unvaccinated

Vaccines: Declining Health of Children

- 54% of US kids chronically ill or obese[1]
- 26% at risk of developmental disability (0-6yrs)[2]
- 1 in 50 kids has autism, 1 in 31 boys (3%)[3]
- 31% are overweight or obese[4]
- 1 in 400 diabetic (+20% in 10 years)[5]
- 1 in 300 boys, 1 in 333 girls develop cancer[6]

1 https://www.acco.org/Information/AboutChildhoodCancer/ChildhoodCancerStatistics.aspx
2 http://www.academicpedsjnl.net/article/S1876-2859(10)00250-0/fulltext - sec3.1.2
3 http://www.cdc.gov/nchs/data/nhsr/nhsr065.pdf
4 http://www.academicpedsjnl.net/article/S1876-2859(10)00250-0/fulltext - sec3.1.2
5 http://health.usnews.com/health-news/news/articles/2012/06/09/diabetes-rising-rapidly-among-us-kids
6 http://www.jeffgordonchildrensfoundation.org/site/c.5oIDJRPyGfISF/b.6874173/k.4BBE/Childhood_Cancer_Stats.htm

Poor Health of Population

- US spends $2.7 TRILLION on healthcare
- US spends $270 BILLION on drugs
- US spends $8745 per capita on healthcare vs. OECD average of $3484
- US life expectancy 78.7, OECD avg. 80.2 years, Iceland, Japan, Switzerland 83 years
- US infant mortality rate 6 per 1000 live births, OECD avg. 4, Iceland 1.1, Slovenia 1.6, Japan 2.2

Organization for Economic Cooperation and Development, OECD

Vaccine Injury Reports to Vaccine Adverse Reporting System (VAERS) since 1989

- 64,513 reports of “serious” adverse reactions
- 163,010 reported visits to ER
- 49,569 reported hospitalizations
- 65,934 did not recover
- 5,736 reported deaths

VAERS is a passive surveillance system and estimates are that only 1%-10% of all adverse reactions are reported, some reports come from outside US

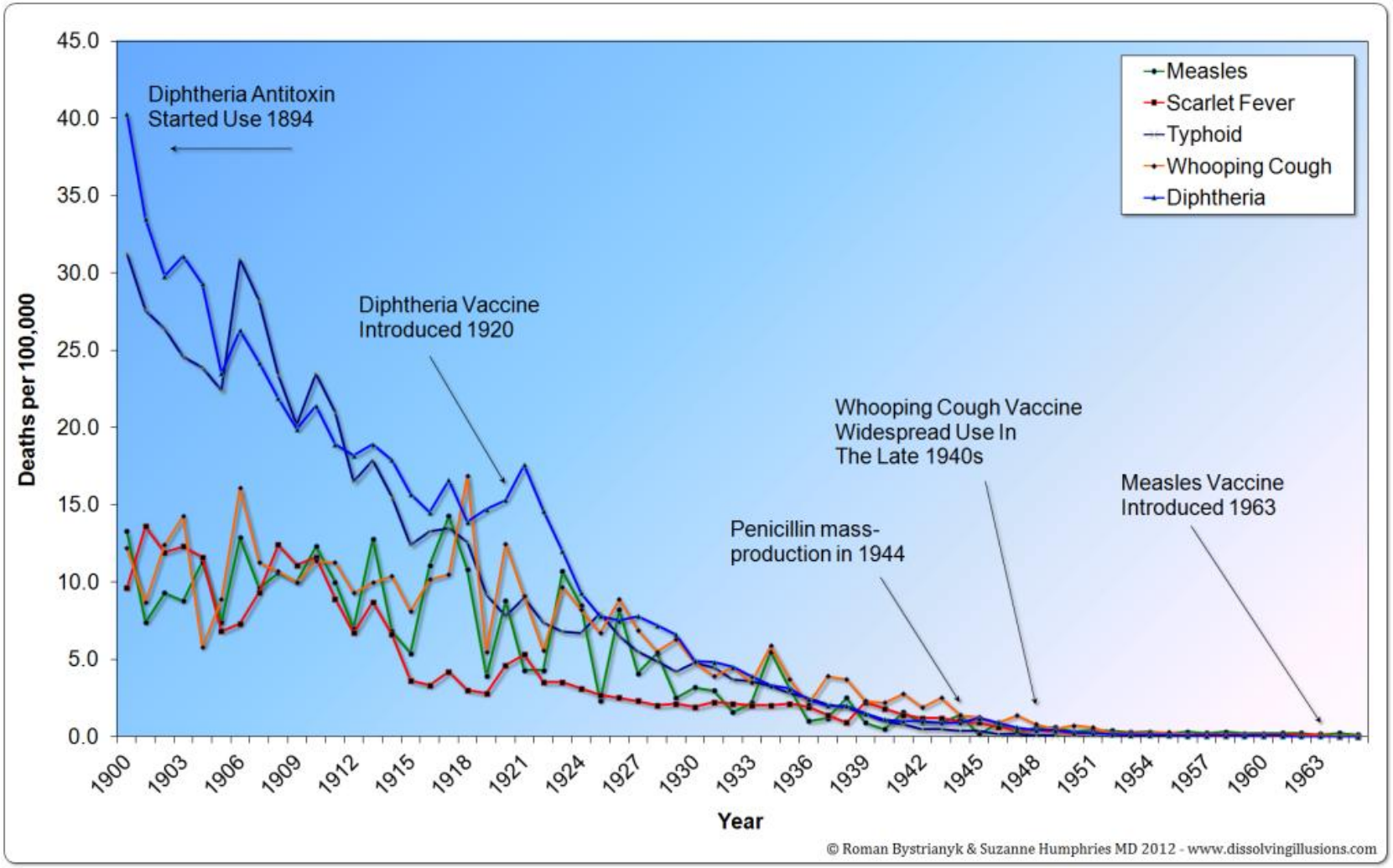
https://vaers.hhs.gov

“Annual summary of vital statistics: trends in the health of Americans during the 20th century”

- “Thus vaccination does not account for the impressive declines in mortality seen in the first half of the twentieth century….
- “Once again, nearly 90% of the decline in infectious disease mortality among US children occurred before 1940, when few antibiotics or vaccines were available.”
- “State and local health departments implemented these public health measures including water treatment, food safety, organized solid waste disposal, and public education about hygienic practices.”

http://www.ncbi.nlm.nih.gov/pubmed/11099582

Declining Disease Mortality in US Before Vaccinations



Live flu vaccine “symptoms”

The nasal spray sometimes causes mild “symptoms”, including:

- Runny nose
- Congestion or cough
- Headache
- Vomiting
- Muscle aches
- Fever

https://www.google.com/search?client=safari&rls=en&q=nasal+flu+vaccine+causing+flu+symptoms&ie=UTF-8&oe=UTF-8
https://www.ncbi.nlm.nih.gov/pubmed/15954490

Vaccinated Spread Disease

- Measles transmission from a twice vaccinated individual https://academic.oup.com/cid/article/58/9/1205/2895266/Outbreak-of-Measles-Among-Persons-With-Prior
- Sibling Transmission of Vaccine-Derived Rotavirus (RotaTeq) Associated with Rotavirus Gastroenteritis http://pediatrics.aappublications.org/content/125/2/e438
- The Safety Profile of Varicella Vaccine: A 10-Year Review https://academic.oup.com/jid/article/197/Supplement_2/S165/844351/The-Safety-Profile-of-Varicella-Vaccine-A-10-Year

Vaccine Shedding

- Detection of Fecal Shedding of Rotavirus Vaccine in Infants Following Their First Dose of Pentavalent Rotavirus Vaccine https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4459210/

- Shedding of Ann Arbor strain live attenuated influenza vaccine virus in children 6-59 months of age https://www.ncbi.nlm.nih.gov/pubmed/21513761

- Detection of measles virus RNA in urine specimens from vaccine recipients https://www.ncbi.nlm.nih.gov/pmc/articles/PMC228449/

Pertussis (Whooping Cough)

- Vaccination increases rates of non vaccine strain in lungs 40-fold
- Study Finds Parents Can Pass Whooping Cough to Babies http://www.nytimes.com/2007/04/03/health/03coug.html?_r=0
- Acellular pertussis vaccines protect against disease but fail to prevent infection and transmission… http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3063653/
- Immunized People Getting Whooping Cough http://www.kpbs.org/news/2014/jun/12/immunized-people-getting-whooping-cough/

Does the flu vaccine work?

- "A review of 50 studies that included more than 70,000 adults found that 100 people needed to be vaccinated to avoid one case of flu. That means the vaccine failed 99 percent who took it — they received no benefit at preventing the flu."
- "Nor has it been shown to prevent flu complications, such as pneumonia, hospitalizations and death, in well over 90 percent who receive it.
- "There are no good studies showing that the flu vaccine is effective for seniors," he says. "When you take apart and break down a recent study that the government uses to promote the flu vaccine to senior citizens, you'll find that 217 elderly people had to take the high-dose flu vaccine to prevent a single case of flu — that's a 99 percent failure.

http://www.newsmax.com/Health/Headline/flu-shot-failure-David-Brownstein/2015/09/23/id/692861/

Vaccine Failure

- Analysis of Mumps Vaccine Failure https://www.ncbi.nlm.nih.gov/pmc/articles/PMC96204/
- Largest Measles Epidemic in North America in a Decade https://academic.oup.com/jid/article/207/6/990/898747/Largest-Measles-Epidemic-in-North-America-in-a
- Primary versus secondary failure after varicella vaccination: implications for interval between 2 doses https://www.ncbi.nlm.nih.gov/pubmed/23838789

Antibodies and Waning Immunity

- Loss of Vaccine-Induced Immunity to Varicella over Time http://www.nejm.org/doi/full/10.1056/NEJMoa064040#t=article
- Implications of vaccination and waning immunity http://rspb.royalsocietypublishing.org/content/276/1664/2071
- Study Calls Into Question Primary Justification for Vaccines http://www.greenmedinfo.com/blog/study-disproves-cdcs-primary-justification-vaccination
- Antibody Response To Vaccine Does Not Equal Immunity or Protection http://www.vaccines.me/articles/cgezx-antibody-response-to-vaccine-does-not-equal-immunity-or-protection.cfm

Dr. Thompson's statement

I regret that my coauthors and I omitted statistically significant information in our 2004 article published in the journal *Pediatrics. The omitted data suggested that African American males who received the MMR vaccine before age 36 months were at increased risk for autism. Decisions were made regarding which findings to report after the data were collected, and I believe that the final study protocol was not followed.*

https://morganverkamp.com/statement-of-william-w-thompson-ph-d-regarding-the-2004-article-examining-the-possibility-of-a-relationship-between-mmr-vaccine-and-autism/

http://www.newsmax.com/Health/Headline/autism-vaccine-coverup-CDC/2015/08/03/id/665245/

Merck mumps vaccine lawsuit

- "…efficacy tests for the measles, mumps, rubella vaccine (MMR) were faked."
- "This is a major federal case alleging fraud in vaccine testing; it encapsulates how medical research can be manipulated to achieve desired results, and why it may be wise to question the integrity and the validity of "science-based medicine."
- "…Merck knew its measles, mumps, rubella (MMR) vaccine was less effective than the purported 95% level"
- Merck began a sham testing program in the late 1990's to hide the declining efficacy of the vaccine."
- Whistleblowers were "threatened with jail were they to alert the FDA to the fraud being committed."

http://ahrp.org/former-merck-scientists-sue-merck-alleging-mmr-vaccine-efficacy-fraud/

More CDC Whistleblowers

- “It appears that our mission is being influenced and shaped by outside parties and rogue interests... and Congressional intent for our agency is being circumvented by some of our leaders. What concerns us most, is that it is becoming the norm and not the rare exception,” the letter states. “These questionable and unethical practices threaten to undermine our credibility and reputation as a trusted leader in public health.”

http://www.huffingtonpost.com/carey-gillam/spider-bites-cdc-ethics-c_b_12525012.html

True Purpose of Vaccine Information - to bring people into "compliance"

- "To identify areas of undervaccination for measles and other vaccine-preventable diseases, state and local health departments monitor compliance with school immunization requirements"
- "The coverage target is ≥95% vaccination coverage for the following vaccines: MMR; diphtheria, tetanus toxoid, and acellular pertussis (DTaP)[†]; poliovirus; hepatitis B (HepB); and varicella"
- "…health department or school personnel conduct a vaccination coverage survey or census of enrolled students to determine compliance with school requirements
- "Results of the school-level reviews are reported to the grantee health department, which then reports aggregated totals to CDC"

https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6133a2.htm

School Nurse Organization of Idaho

snoi.org@gmail.com
https://snoi.nursingnetwork.com/

February 13, 2017

Dear Honorable Senate Members of the Health and Welfare Committee,

We are writing to voice our concerns regarding the change to Idaho's immunization law proposed in Senate Bill 1050. As school nurses, we value the current document because it enables us to have meaningful conversations with parents to ensure they understand the risks associated with opting to not vaccinate their children. Changing the requirement of a state form for vaccine exemption at school entry gives way for potentially long lasting public health ramifications because it would allow parents who aren't truly choosing to be exempt from requirements to write a statement saying they do not want to vaccinate their child just because it is more convenient.

The current standardized document is easily accessible to parents and school personnel. It explains the nature of the vaccine preventable diseases and possible outcomes should the disease be acquired. It allows the parent to simply state their reason for exemption and acknowledge that they have read the form. Idaho is surrounded by states whose exemption process is more tedious requiring a healthcare provider to sign off on their exemption request. Our current process is already too easy by most standards, and the proposed changes have the potential to be detrimental to the overall public health of our communities. The current document allows school nurses or in many cases the school secretary to properly document and track students who are at risk. This is important in the instance of an outbreak of a vaccine preventable disease so the school personnel can easily identify and remove students, per law, to protect those students as well as the public and to decrease the outbreak. Making the exemption process easier by having the only condition being a "signed statement" allows opportunity for parents to avoid the required immunizations out of convenience.

Our parent organization, The National Association of School Nurses recently published Framework for 21st Century School Nursing Practice. This model is a collaborative approach focusing on not only the student, but "whole school, whole community, whole child". This framework encompasses the daily work we do in caring for not only our students, but also the communities in which we work and live. We are promoters and protectors of public health. Senate Bill 1050 has the potential to weaken our immunization standards and procedures and could affect not only student outcomes, but our entire community. Those who are unable to be immunized, immune compromised, and those who are too young to be fully vaccinated are going to be at greatest risk. We stand against Senate Bill 1050.

Sincerely,

See Attached List

School Nurse Organization of Idaho

snoi.org@gmail.com
https://snoi.nursingnetwork.com/

Alicia Jordan, BSN, RN, NCSN - Kuna
Allison Serr, BSN, RN - Rupert
Anna -Liisa Pjesky, RN - Dalton Gardens
Amber Brumley, BSN, RN - Orofino
Angela Rich, LPN - Boise
Barbie Vander Boegh, BSN, RN - Caldwell
Becky Syltie, RN - Eagle
Betsy Howard, BSN, RN, NCSN - Meridian
Bonnie Powers, BSN, RN - Boise
Carolyn Gingrich, BSN, RN - Meridian
Christen Potter, RN, MEd - Boise
Christina Williams, BSN, RN - Meridian
Cindy Perry, BSN, RN, NCSN - Post Falls
Claudia Terrell, RN, NCSN, Med - Boise
Colene Letterle, RN, MEd, NCSN - Meridian
Deborah K.S. LaFond, BSN, RN, NCSN - Meridian
Jackie Mass, RN, NCSN - Eagle
Jane Withers, RN - Boise
Jeannine Suter, BSN, RN - Boise
Jenny Rowland, BSN, RN - Eagle
Joy Harris, BSN, RN - Nampa
Judy Gerstenberger, BSN, RN - Spirit Lake
Julie Douty, MSN, RN - Greenleaf
Karma Laan, RN - Weiser
Kathie Gouley, BSN, RN, NCSN - Bellevue
Kim Sherrer, BSN, RN - Emmett
Kori Hibbard, RN - Boise
Kristen Hurless, BSN, RN, CPN - Meridian
Kyle Hodges, RN – Burley
Leanne Bullamore, BSN, RN - Coeur d'Alene
Linda Lubeck, BSN, RN, NCSN - Hailey
Marcia Watt, BSN, RN, NCSN - Meridian
Mary Dennis, BSN, RN - Nampa
Mary Morgan, FNP, MSN - Meridian
Mary Lou Cunningham, BSN, CNBC, MHS – Boise
Maureen Elia, BSN, RN – Boise
Melanie Lucas, RN - Rupert
Meredith Malan, BSN, RN - Meridian
Michelle Harding, BSN, RN - Coeur d'Alene
Nicole Kopping, BSN, RN - Meridian
Pam Bender, RN, NCSN - Caldwell
Pam Carson, BSN, RN - Boise
Pamela Peterson, BSN, RN - Nampa
Phoebe Gray - RN, PNP - Boise
Samantha Congdon, BSN, RN - Meridian
Sarah Olsen-Smith, BSN, RN, MA - Boise
Shelva Gaudette - RN, Ret LtCol, IDANG - Eagle
Sue McDonald, BSN, RN, NCSN - Boise
Sue Ropski, RN, MS, MPA, NCSN - Meridian
Susan Morgan, RN, NCSN, MEd - Emmett
Teresa Berg, BSN, RN - Kuna
Terri Lindemann, BSN, RN - Boise
Vicki Trefz, BSN, RN - Post Falls
Victoria Kimball, BSN, RN - Post Falls
Yvonne Trude, RN, MS - Rigby

School Nurse Organization of Idaho

AMENDED AGENDA #1

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Monday, February 27, 2017

SUBJECT	DESCRIPTION	PRESENTER
Presentation	Child Welfare System Report	Rakesh Mohan, Lance McCleve, and Amanda Bartlett, Office of Performance Evaluations

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, February 27, 2017

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:12 p.m.

PRESENTATION: **Child Welfare System Report. Rakesh Mohan**, Director of the Office of Performance Evaluations (OPE), was recognized to present the OPE report. (See Attachments 1, 2, and 3 for report and presentation.) **Mr. Mohan** thanked the social workers, foster parents, and Department of Health and Welfare (Department) staff who were so helpful in preparing the report. **Mr. Mohan** especially recognized Miren Unsworth for her assistance.

Mr. Mohan explained there are not many charts and graphs in the report because it is very qualitative in nature. The report includes three new concepts. First, the report discusses a systems approach, and child welfare issues have not been addressed from this perspective in the past. Second, OPE made a strong recommendation for State oversight, possibly through a joint legislative standing committee. It was the first time OPE made this recommendation on an issue and it was a difficult recommendation to make based on the topic, issues, and problems. The recommendation would provide for accountability through policy-making authority, visibility to the public about the issues, and accessibility to all stakeholders. Third, Appendix E includes evidence-based preventive measures developed by a consultant from Yale University based on research of practices across the U.S.

Mr. Mohan reported the same consultant is working on one additional component, to be completed in June 2017, a paper defining "the best interest of the child". OPE will inform the Committee when this piece has been completed.

Vice Chairman Souza asked for a brief overview of what is contained in Appendix E. **Mr. Mohan** answered that is a tough question, and he will let the team answer it.

Senator Lee thanked Mr. Mohan for his steadfast leadership in getting the report completed so quickly. She asked whether Mr. Mohan has previously made such a bold recommendation to institute a joint legislative standing committee. **Mr. Mohan** answered OPE has never made such a recommendation in the past. He agonized over the decision but ultimately felt it was the right thing to do. In 2005, prior to the establishment of the Office of Drug Policy, OPE made a recommendation for an interagency committee to coordinate substance abuse prevention programs. This is a much stronger recommendation that he discussed at length with Lance McCleve. It was the best solution to provide needed interdisciplinary and interjurisdictional oversight. Twenty-one other states have a similar type of committee in place.

Lance McCleve of the OPE introduced himself to the Committee to present his work on the Child Welfare System report. Throughout the evaluation, OPE found critical gaps that have led to program inconsistency, lack of program fidelity, and minimal system accountability. These gaps prevent the system from consistently achieving the high level goals set through policy and the program design process. Closing the gaps will require work from the Department and all players in the Child Welfare System.

Mr. McCleve said the evaluation came to OPE in 2016 after concerns were expressed in Joint Health and Welfare Committee hearing testimony about foster care legislation. OPE found very quickly that the problems were not new and were not unique to Idaho. The first major finding is a critical shortage of foster parents that critically undermines the system's ability to perform as designed. There are other issues with short-term placements that prevent consistent quality placements and make placements difficult. Second, workload is an issue that goes back a while. The Department has made efforts to address workload, but the evaluation showed more can be done. The issue is not simply that the work doesn't get done, but workload problems lead to compromised performance and a persistent expectation gap within the program. Third, there is a culture of compromise in the program in which poor performance is explainable, excusable, and expected. That condition critically undermines meaningful accountability and affects how staff actually implement policies. Finally, there is a need for a systems approach to address problems in order to consistently achieve outcomes.

Mr. McCleve explained these problems are difficult to solve because they are persistent in child protective systems. Most issues will not be solved but can be managed over time, especially as multiple players in the system change. The child protective system (CPS) consists of all agencies and groups who work together on child welfare issues.

Vice Chairman Souza mentioned Mr. McCleve's statement that the problem issues are not really solvable, and she asked whether they are not solvable with the current State situation, or not solvable at all, even if necessary changes are made. **Mr. McCleve** answered there is a lot of room for improvement in the system and it could operate much better than it does. In this case, the term "solution" is not definite, like two plus two always equals four. In the context of the CPS, problems can be explained in multiple ways. Individual values influence how child protective services work, what is focused on, and the decisions made. There are other pieces of the system like courts and foster parents with different foci who will explain the same facts with a different approach. These matters affect the ability to solve a problem, because it can't definitively be said to be solved if someone else can see it another way and suddenly it's a problem again. There are also significant consequences for failure. When trying to work through problems, experiments can't be conducted, because every case involves a child. There is no single solution like adding more social workers. All solutions will improve the system, but constant review of the program will be required.

Mr. McCleve advised the system is comprised of multiple groups: courts, law enforcement, schools, Children and Family Services, other divisions of the Department, and federal partners. All pieces interact strongly and there are some closely-knit relationships. For example, the court and the Department each have to carry out the program, and changes in the Department can affect the court and vice versa. Scheduling times for court was a challenge for the Department. The result was social workers were standing around waiting for court times. Some teleconferencing was implemented to save social worker time. There are different sets of guidance for different partners. The most important thing is ongoing, open collaboration and accountability for each partner as well as system-wide accountability. Every outcome is the result of the behavior and actions of some combination of system components. No outcome is isolated to any one group.

Mr. McCleve said the partners see the need for collaboration and are working in that direction. The Department has put together a Child Welfare Steering Committee that now includes some legislative representation. Federal accountability comes in the form of Child and Family Service reviews, which hold the Department accountable to seven outcomes and systemic factors that address CPS program expected outcomes. The Department just completed its third round of reviews, and it is a fairly comprehensive but high-level process. If the Department is not in substantial compliance, it must develop a performance improvement plan. Judicial oversight is done by making decisions on a case-by-case basis. Removing children from homes and returning them to their homes can only be done by law enforcement or order of the court. Guardians ad litem have a unique role as special advocates to represent the interests of children and provide additional information to the courts that is independent of what the Department provides. Idaho citizen review panels were established throughout the State to observe the actions of CPS and make recommendations to the Department in an annual report.

Mr. McCleve advised there have been improvements and positive changes to the CPS. However, there are two important shortcomings at the system level. First, there is a lack of accessibility and visibility that can lead to people feeling ostracized or shut out or deliberately pushed away. Second, the CPS lacks system-wide oversight. Failing to look at the system as a whole results in unclear, fragmented, or diffused responsibility for child protection outcomes, which makes it difficult for the system to function as efficiently as possible.

Mr. McCleve reported the shortcomings became apparent as a result of the OPE review, interviews, and surveys. OPE discussed the fact that other states have worked to address the same shortcomings using different approaches, such as dedicated ombudsmen, non-legislative committees, and legislative committees. The OPE recommendation is that some entity be formed to bring all the players together, have a consistent system-wide view, and manage the issues long-term to continuously improve the system. All but one of the preventive measures in Appendix E would be administered through other groups besides the Department.

Mr. McCleve mentioned the "best interest of the child" material will be published in a supplemental document in June 2017. There will be no recommendations or findings, just useful information. Two areas for possible future study are community services and the Court Appointed Special Advocate (CASA) program. Community services can be difficult to access, and those that can be accessed are not always most appropriate to meet needs of children and families. CASA was mentioned several times during the study, but it was not part of this OPE evaluation.

Chairman Heider commented there are so many groups having input and they are all run by different organizations. He asked how those things could be coordinated for the benefit of the child. **Mr. McCleve** answered the study felt like a little thread on a sweater that when it was pulled, it kept coming out and pretty soon there was a big pile of yarn. It is a serious challenge for the CPS in general, and it is a complex undertaking. A significant number of cases go through the system and work out as well as possible. The biggest challenge in collaboration involves the courts and the Department, as well as other different branches and levels of government. Currently, good will allows work to get done, but good will might not always be there. It also takes strong leadership and lot of effort. With the oversight recommendation, there will be a more formally established process. The CPS program has a dedicated identity that doesn't exist with other groups

Chairman Heider asked if a part of the system is working such as CASA, does that group take the lead, or is the Department always in charge. **Mr. McCleve** responded there are some clearly defined boundaries and responsibilities but there are also gray areas where discussion is needed. There is no formal way to handle the gray areas at this time; the groups work out those issues among themselves.

Mr. Mohan explained the Chairman's comment about coordination is the reason OPE made the recommendation for a joint oversight committee. The legislature has authority or persuasive power, which will be helpful, and the Legislature is a very people-centered body. **Chairman Heider** stated the Legislature has the least authority in the Child Welfare System. When it comes to CASA, foster parents, or law enforcement, they all have their own responsibilities, and it gets back to the question of who will be charge of the child. All groups need to coordinate their opinions and get behind what is best for the child. **Mr. Mohan** agreed no one body can oversee all entities, but the Legislature is in a position to do more than other entities.

Amanda Bartlett of the OPE introduced herself to the Committee to continue the presentation. **Ms. Bartlett** said early in the review process, staff asked themselves what should be accomplished for the children. Everyone can agree children should be safe and have stability and a life where they can flourish and grow. It is challenging because a child's needs are constantly changing, and there are generally two parents who have a say in the child's life. When the State determines a child's safety is threatened to the extend the child can no longer remain in the home, then the State becomes the guardian. At that point, there are many entities trying to do the best they can with available resources to achieve desired outcomes. Central to the process is Child and Family Services, that is entrusted with the authority to manage the cases, make placement decisions, perform assessments, and provide resources for the family.

Ms. Bartlett said there are many branches that need coordinated efforts, but there are also gaps within the Department. First, there is a gap in placement services, including foster parent recruitment, retention, relationships, and placement support. Second, there are gaps in program capacity, including high work loads, challenges in streamlining redundant or difficult work flow processes, and retention of good social workers. Finally, OPE found a gap within the culture itself. Faced with challenges and lack of available resources to address challenges, there is a belief that social workers cannot consistently provide quality social work and meet all the necessary requirements.

Senator Martin asked if OPE has identified a solution to foster parent issues. **Ms. Bartlett** replied part of the solution is in recognizing that all problems are interconnected. OPE made a number of recommendations, but the Department will have to make a multifaceted effort to see improvement, starting with placement services. OPE found the number of foster parents is decreasing and because of that, there is a threat to the fidelity of the program. When a child comes into care, the first task is to find a place for the child to stay. The child has specific needs, and the goal is to keep siblings together, maintain children in their communities and cultural communities, and keep the child close to their parents. A child may have mental health or medical needs and there must be appropriate services available. Ideally, there will be a placement that is well suited to meet all of a child's needs. Now, with a declining number of foster parents, there are not enough choices. Instead of a needs-based placement, it becomes an availability placement. This is a problem within social work because there is a sense of anxiety that comes over a social worker when having to make placement decisions.

Vice Chairman Souza asked if it is key for the Committee to understand why there is a decrease in foster parents. **Ms. Bartlett** responded that is important. OPE thinks the Department already has a recruitment plan and it should be continued. The recruitment plan identifies multiple strategies for recruiting more foster parents, but the plan did not include a goal of how many foster parents are needed in a region or city to provide adequate placement options. The next question would be what resources are needed to meet that goal. The current recruitment plan assumes it will operate within existing resources, and OPE suggested finding out if more resources will be needed. The Department also needs a robust retention plan, and that plan should include ways to support foster parents and understanding why there is so much turnover. Currently, there are as many foster parents leaving the program as there are becoming newly licensed. In the foster parent survey, some of the issues identified by foster parents involved relationship issues with the Department. For example, one question asked whether or not the Department understood foster parents' needs, and only 17 percent answered yes. There were mixed results on whether or not financial supports were sufficient. It is estimated that the cost of room and board exceeds what foster parents receive, and foster parents are paying money out of pocket. This limits the pool of people who could potentially be a foster parent. There is more specific detail on this issue in the full report.

Ms. Bartlett explained the foster parent shortage is directly related to the second gap of program capacity. The OPE survey asked whether or not social workers think a problem often arises because of insufficient time, and 88 percent answered yes. The survey asked similar questions of judges, foster parents, and CASA volunteers, and all agreed time is precious and scarce. Social workers estimated they are carrying 38 percent more cases than they can effectively serve. The Department recently did a workload study and estimated that the average social worker carries 13.5 cases, and those cases involve an average of 20 children. These numbers represent 28 to 38 percent more than what social workers and their managers think can be adequately handled. There are no magic staffing numbers, and the issue is not about getting to a specific number of cases but also determining the behavior of the children in their case loads. The more challenging the case, the fewer cases can be handled. The newer and less experienced the staff, the fewer cases a social worker can handle. Social worker travel also is a factor, depending on whether the case is in a rural area requiring significant travel time. The Department is constantly working to understand this number better. When there are social workers with scarce time, there are real consequences, and that includes inability to meet practice requirements, difficulty engaging families, and decreased quality of services.

Ms. Bartlett reported one social worker described the situation as having to settle for C-grade work with an expectation of A-grade results. OPE received a comment from a judge who said he believes most Department workers want to do a good job and are good people, but their case loads are too big and their resources are too small. He would give them a grade of "C" if he was a teacher.

Ms. Bartlett stated that OPE recommends continuing staff retention efforts, especially involving professional ladders and professional development. The Department should identify staffing shortages and create a plan to enhance external processes. The work load issue must be addressed, either by increasing resources or workers, or decreasing the work oad by incorporating more efficient work processes and systems. For example, efforts such as using teleconferencing for court appearances should be continued. The staffing issue and the foster parent shortage are chronic issues that have been worked on for more than 10 years. While some progress has been made, the problems persist. OPE encourages the Department to continue and strengthen efforts, and to ask for additional resources if needed.

Ms. Bartlett commented both the foster parent and social worker issues contribute to the cultural gap. The OPE survey results showed 94.8 percent of social workers are committed to improving the situation for children and families on their case loads. However, there are strained relationships. Department staff has concerns they are under constant scrutiny and criticism, and they feel defensive. When making big decisions for children, there are lots of different opinions, and that problem can only be managed, not solved. There is also a detrimental cycle of priority and compromise. Every day children come into care with urgent critical safety needs that must be addressed today. When there are urgent needs, other important needs like building relationships with foster parents are deprioritized or less time is spent on those needs. One social worker commented there is a lack of realistic expectations. Best practices won't matter if the work force can't implement them due to work load issues.

Ms. Bartlett said OPE recommends an ongoing assessment of the culture. There are practice standards, policies, and law, but when someone is in the field making decisions and it is unrealistic to meet all considerations, then the social worker must decide which of the considerations is the most important. Some accountability is lost as a result because there is a belief the expectations are unrealistic and compromises are understandable. It is important to make sure the culture improves as resources improve.

Ms. Bartlett mentioned there were similar problems identified in many other states. The issues are compounded when there is mismanagement, but the consistency of the problems from state to state demonstrates the difficulty of achieving desired outcomes. OPE referenced a report from a federal commission to eliminate child abuse and neglect, which found there must be an integrated and cross-program monitoring and evaluation approach, and recognizing the outcomes for children and families are the product of multiple programs. One social worker told OPE that working in child welfare and social work feels like the engineers who worked on the Apollo 13 mission. They were told to find a way to fit a square peg in a round hole rapidly, using only random items in a box, and they just had to make it work. The problems faced in the Child Welfare System are complex and high stakes. Many times people achieve good results with limited supplies through creativity, resourcefulness, and commitment. There will always be another issue to address, but it is important to have a system where the parties have better tools in the box to work with.

Senator Lee referred to the responses from the Department and the Governor's office in the full report. One was the assertion that if the Department had party status in courts, it would make a difference. **Senator Lee** inquired whether that issue came up during the OPE research. **Mr. McCleve** responded OPE did not look into it directly because it was not part of the evaluation. The matter was brought up, and in talking to social workers, it seemed to be a regional issue. Social workers felt they could do their jobs better if they just didn't have to go to court because it is beyond their expertise and challenging to present their work in an effective way. This issue was absent from some of the other states' reports, but OPE did come across mentions of party status. A number of CPS agencies in other states are considered parties to the case.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:26 p.m.

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Senator Heider
Chair

_____

Jeanne Jackson-Heim
Secretary

Child Welfare System

Report highlights

February 2017

Gaps in placement services, program capacity, organizational culture, and system-level oversight prevent the state's child welfare system from performing at the high level of expectation set through policy making and program design processes.

Findings

A worsening shortage (8% decrease between 2014 and 2016) of foster parents threatens the fidelity of the state's child welfare system.

> There is a sense of anxiety that comes over you because you have to find someone to take [the children]. —Social worker

Compromised performance and a persistent expectation gap are the effects of excessive workloads.

> I believe that most health and welfare workers want to do a good job and are good people. I also believe that...because they are overwhelmed, they are only capable of doing an average job. I'd give them a grade of "C" if I were a teacher. But there is ample room for them to be improved. —Judge

Additional staff are likely necessary to improve workloads, but alone, adding staff will not be sufficient to address workload challenges. Workload should be addressed by examining processes, expectations, documentation, technology, and other requirements for opportunities to improve efficiency.

> Because of resource constraints, social workers have to settle for C-grade work. The problem is that there is an expectation for A-grade results. —Chief of social work

The belief that workers cannot consistently meet requirements and quality expectations has led to a culture of compromise in which poor performance is explainable, excusable, and expected; a condition that critically undermines meaningful accountability.

Addressing complex, entrenched problems of child welfare requires a systems approach with ongoing system-level oversight.

Legislative standing committees dedicated to child welfare, children, or families have been established in many other states, any one of those states could function as a model for Idaho.

We estimate social workers are carrying on average

28–38%

more cases than what program managers, supervisors, and social workers believe social workers can carry while still serving every case effectively.

Organizational culture is undercut by a constant feeling of crisis. Social workers described a detrimental cycle of priority and compromise.

Despite collaboration and multiple forms of accountability, Idaho's child welfare system lacks system-wide accountability and oversight.

Recommendation

We recommend the formation of a formal, system-wide oversight entity with authority to ensure ongoing accountability, visibility, and accessibility for all child welfare partners and stakeholders.

Office of Performance Evaluations ope Idaho Legislature

View the report: www.legislature.idaho.gov/ope/

Evaluation report
February 2017

Child Welfare System

Office of Performance Evaluations
Idaho Legislature

Promoting confidence and accountability in state government

Executive summary

Evaluation context

In public testimonies during the 2016 legislative session, policymakers heard dissatisfaction with Idaho's child welfare system. Problems faced by the system are not unique to Idaho and are seen by experts as exceptionally difficult to solve and manage.

In this evaluation we were able to identify gaps in the four key areas of the system:

- Out-of-home placements
- Workload challenges
- Organizational culture
- Systems approach

Together, these gaps prevent the state's child welfare system from performing at the high level of expectation set through policy making and program design processes.

Further, the findings of our own evaluation, supported by the findings of the research and evaluation of other groups, indicate that addressing the complex and entrenched problems of child welfare requires a systems approach with ongoing system-level accountability, collaboration, and oversight.

Out-of-home placements

When circumstances threaten the safety of a child, three large-scale efforts are necessary to achieve desirable results in out-of-home placements: (1) find an out-of-home placement, (2) support the out-of-home placement, and (3) facilitate a collaborative effort toward returning children and youth to their home as soon as possible or arranging for an alternative permanency option.

A worsening shortage of foster parents threatens the fidelity of the state's child welfare system. Finding an out-of-home placement can be a difficult and stressful process for social workers, foster parents, and children. Often several calls must be made before a foster parent will agree to bring children or youth into their home.

Because of the shortage, foster parents are asked to do more, stretch their capacity, or create more space in their home. To make a placement, social workers said they have apologetically asked foster parents to accept children or youth with characteristics or behaviors outside the foster parent's stated preferences, knowing the request would place additional strain on the family.

When social workers are not able to find an out-of-home placement near a child's home, they must turn to placement options outside of the area. Out-of-area placements solve the short-term problem of finding a bed for the child but lead to long -term problems over the span of the case.

If social workers are not able to find a placement for the child within hours, they will have to personally spend the night in the office or a hotel with the child. This need has not been common in Idaho; however, the shortage of available foster homes in other states shows the potential for a problem to turn into a crisis.

Child and Family Services is aware of the need to increase the number of available placements for children and youth in care by improving recruitment and retention of foster parents and has made multiple efforts to improve recruitment and retention. The efforts are laudable but have been primarily focused on training and recruitment and have not been able to sufficiently address the shortage of foster parents.

Although recruitment is important for improvement, retention is a better solution to the problem. Currently, foster parents are quitting at nearly the same rate as Child and Family Services is able to recruit them. Overall, the number of licensed foster parents decreased by 88 (8 percent) from March 2014 to March 2016.

We found that inconsistent supports and services for foster parents, a lack of understanding of the wants and needs of foster parents, and underdeveloped relationships with foster parents affect foster parents' satisfaction with their experience, their effectiveness, and their willingness to continue being foster parents.

Social workers need to have well-developed relationships with foster parents to bridge a gap that has formed by the difference in experience, training, and expectations of foster parents and social workers. The gap can lead to disagreements and leave social workers feeling frustrated or attacked and foster parents feeling disappointed, marginalized, and uninformed. Child and Family Services is attempting to improve relationships with foster parents, but it struggles with communication and investing the necessary time.

Recommendation

To improve the recruitment and especially the retention of foster parents, we recommend that Child and Family Services continue its recruitment efforts but also explore opportunities to strengthen its recruitment plan. The plan can be strengthened by determining the number of licensed foster parents needed by region and further specifying what additional resources are necessary to recruit those foster parents.

Given the costs and limited effectiveness of recruitment, we recommend Child and Family Services develop a robust foster parent retention plan. The plan should include strategies for improving the consistency of supports provided to foster parents, communication with foster parents, and the quality of relationships developed between social workers and foster parents.

CASAs are court-appointed special advocates for children who have been allegedly maltreated.

Workload challenges

Without question the most common theme we found in our evaluation was the perception that social workers do not have enough time to serve their cases effectively. About 87 percent of Child and Family Services staff agree that problems often arise because they do not have the time necessary to do the job. We also heard this concern from foster parents, court-appointed special advocates (CASA) volunteers, judges, prosecutors, and defense attorneys.

In 2007 Child and Family Services conducted a workload analysis that found the need for 36 percent more staff. Since then, Child and Family Services has been able to increase case carrying staff by about 10 percent.

Our survey of staff found that, on average, program managers, supervisors, and social workers believe that social workers are carrying approximately 38 percent more cases than they can effectively serve. Similarly, Child and Family Services' most recent analysis of average monthly caseloads showed 13.5 cases per month per worker, approximately 28 percent more cases than program managers, supervisors, and social workers believe social workers are able to carry while serving every case effectively.

We found that the most significant consequences of excessive workload, or even the perception of excessive workload, are compromised performance and a persistent expectation gap within Child and Family Services.

Research consistently shows that manageable caseloads and workloads are essential for child welfare to achieve its intended outcomes. Unmanageable workloads negatively affect workers' ability to meet practice requirements, engage families, deliver quality services, and achieve positive outcomes for children and families.

One chief of social work we interviewed expressed the consequence well:

> "Because of resource constraints, social workers have to settle for C-grade work. The problem is that there is an expectation for A-grade results.

A judge echoed this perspective:

> I believe that most health and welfare workers want to do a good job and are good people. I also believe that their case loads are too big and their resources are too small. Because they are overwhelmed, they are only capable of doing an average job. I'd give them a grade of a "C" if I were a teacher. But there is ample room for them to be improved.

Social workers' performance is challenged by significant competing demands on their time. Social workers are faced with situations where they must choose between activities they believe to be of the highest importance knowing that they will fall short of measured expectations. When social workers make decisions about priority, what they choose may not align with managerial priorities or expectations, which compromises the program's managerial control.

Workload is a critical factor in Child and Family Services' performance and should be approached as a high priority. Additional staff are likely necessary to improve caseloads, but alone, adding staff will not be sufficient to address Child and Family Services' workload challenges. Workload should be addressed by examining processes, expectations, documentation, technology, and other requirements for opportunities to improve efficiency.

Recommendation

Child and Family Services is aware of the need to retain staff and has been making efforts to address turnover. For example, Child and Family Services created a career ladder for social workers. The career ladder was intended to differentiate entry-level, professional, and expert social workers and help retain social workers by rewarding veteran staff with opportunities for advancement.

Retention is a challenging task with no simple solution. Given the importance of retention for managing workloads, we recommend that Child and Family Services continue with its retention efforts but take advantage of the systems approach we propose in chapter 5 to seek out and implement solutions to stabilize the workforce and improve retention.

Recommendation

Child and Family Services should identify staffing shortages and develop a plan for addressing those shortages. To avoid a deterioration of effort over time, Child and Family Services should work with the Legislature to develop a multiyear plan for ensuring staffing levels are sufficient to manage workloads.

Any plan for workload management should consider the qualifications and competencies of the worker, case status, and case complexity. Having enough staff to carry workloads is necessary but not sufficient for program performance. Therefore, the staffing-level plan should also account for other efforts to manage workloads, such as enhanced work processes and supports and improved work effectiveness.

Recommendation

In addition to streamlining internal processes, we recommend that Child and Family Services continue working with partners and stakeholders to explore opportunities for enhancing external processes.

For example, in response to inefficiencies because of uncertainty around court hearing times, Child and Family Services, in cooperation with the courts, developed a pilot project to allow video conferencing in hearings for social workers. Video conferencing allows social workers to continue working while waiting for hearings to begin.

By identifying and taking advantage of additional opportunities to improve and facilitate interactions and processes with partners and stakeholders, Child and Family Services can reduce workloads, expedite processes, and improve timeliness.

Organizational culture

Research has shown organizational culture of child welfare agencies to be an important factor in staff turnover, adoption of new practices, service quality, and youth outcomes.

Child and Family Services' culture is characterized by its commitment to and focus on children and families. In our survey of Child and Family Services staff, 94 percent said they believe all staff are committed to improving the situation for children and

families in their caseloads. This commitment was also apparent to us through our interviews and open comments in our survey. We also found that the Child and Family Services' team approach is in line with industry practice. We believe the team approach will serve as a greater strength to the program as the culture of accountability is improved.

The organizational culture of Child and Family Services can also be described as a culture of compromise with a conflicted sense of efficacy in the face of difficult demands and limited resources and strained relationships with stakeholders and partners.

Conflicted sense of efficacy

There is a permeating belief among staff that more is demanded of them than they can do. Because of this belief, each aspect of the organizational culture is undercut by a need to address the constant feeling of crisis. The ongoing feeling of crisis influences staff behavior and has contributed to the condition of several areas of organizational culture that need to be improved. When explaining what had most affected confidence in Child and Family Services, one chief of social work summarized the perception among staff well:

> [My] confidence is improved by proactive efforts to enhance best practice in Idaho; [but] tempered by a lack of realistic expectations for workers in the field. All the best practices won't matter if the workforce can't implement them due to workload issues.

The belief that workers cannot consistently meet requirements and quality expectations has led to a culture of compromise in which poor performance is explainable, excusable, and expected; a condition that critically undermines meaningful accountability. We are not under the impression that anyone within Child and Family Services is happy about the condition. However, the condition has become an intrinsic reality that is an ongoing struggle to address.

Strained relationships

Another of the difficulties that Child and Family Services faces in its relationship with stakeholders and partners is differing perspectives on the purpose of and expectation for the program. For example, we found in our survey substantial and meaningful

differences in how various partners emphasize aspects of the role of the child welfare system.

The differences in perspective are expected and are not necessarily harmful. However, the expectations of each group and the lens through which they judge decisions, actions, and outcomes is heavily influenced by which aspects of the system they emphasize. The variations in expectations can lead to difficult situations and, at times, strained relationships between Child and Family Services and its partners.

Strained relationships with stakeholders and partners also stem from a culture of defensiveness or guardedness. Staff often expressed to us a belief that the program and their actions are under constant scrutiny and criticism.

A chief of social work expressed the situation well:

> It is hard to feel like you are always being scrutinized or criticized from every angle. The workers here feel like they are constantly having to defend themselves to everyone.

Recommendation

We recommend that Child and Family Services begin an ongoing assessment of its organizational culture and take steps to remedy problematic aspects. Although organizational culture can be difficult to change, resolving deep-seated beliefs and values that are unproductive or even counterproductive is essential for Child and Family Services' long-term success.

In particular, Child and Family Services should focus on improving consistency in its beliefs, values, and practices for management, accountability, and its approach for conducting business. Child and Family Services should also ensure consistent commitment among staff to understanding and responding to the wants and needs of partners and stakeholders.

Before significant progress can be made in any of these areas, Child and Family Services must address staff's conflicted sense of efficacy and constant sense of crisis driven by the gap between expectations and practice.

If necessary, Child and Family Services should seek independent, external assistance in identifying and addressing organizational culture challenges.

Systems approach

Child welfare is a complex arrangement of systems, agencies, community partners, and stakeholders that span jurisdictions and disciplines. Any change in an individual part of a system affects the context of the systems, and any change to the context of the systems affects the parts and function of each system.

Cooperation, coordination, and collaboration are critical for an interrelated and interdependent system such as child welfare to function well. Systems also rely on individual and shared accountability. The individual parts of the system, such as organizations or stakeholders, can be held individually accountable for their responsibilities. However, individual accountability alone results in diffused accountability for outcomes that depend on the performance of multiple parts of the system. A flexible and robust governance or oversight structure is essential for effectively supporting shared accountability for system-level outcomes.

Child and Family Services has multiple layers of external feedback and accountability that monitor performance, including federal accountability, judicial accountability, guardians ad litem, and the citizen review panel (Keeping Children Safe).

The child welfare system also has developed a number of collaborative efforts, including the workforce recruitment and retention panel, statewide stakeholder meetings, the Idaho Supreme Court Child Protection Committee, the Idaho Foster Youth Advisory Board, the Governor's Children at Risk Task Force, and the newly established Child Welfare Executive Steering Committee.

Despite collaboration and multiple forms of accountability, Idaho's child welfare system lacks system-wide accountability and oversight for child welfare outcomes. Most of the existing forms of accountability generally focus on the performance of Child and Family Services.

Idaho has no system-level accountability or oversight for child welfare outcomes. Its systems framework lacks an integrated and cross-program monitoring and evaluation approach to assess the effectiveness of all systems involved in addressing risk factors and supporting families. The lack of system-level accountability results in unclear, isolated, fragmented, or diffused responsibility for outcomes and improvements.

Lack of system-level accountability is not unique to Idaho. In 2012 the federal Commission to Eliminate Child Abuse and Neglect Fatalities was established by the Protect Our Kids Act of 2012, which passed with bipartisan support. The commission's final report was released in March 2016. The report included a chapter on accountability of child welfare systems with the following finding:

> Congress has historically found that leadership and accountability for reducing child abuse and neglect must extend beyond child protective services (CPS) agencies at the federal, state, and local levels, and the Commission believes this applies similarly to reducing fatalities. There must be an integrated and cross-program monitoring and evaluation approach that assesses the effectiveness of all systems involved in addressing risk factors and supporting families. Such an approach would recognize that outcomes for children and families are the product of multiple programs, supports, and community circumstances, not of discrete programs or services delivered to families in isolation.

Collaboration and feedback loops have resulted in (1) Child and Family Services making efforts to improve procedures and practices and (2) other partners improving various aspects of the system. However, a lack of visibility and accessibility to all stakeholders and the public is a major shortcoming of existing collaboration efforts. Stakeholders and the public may not be able to identify the multitude of collaborative groups. Even more challenging, they may not be able to find a way to provide input to the collaborative groups.

The inaccessibility and lack of visibility of the various groups can contribute to a feeling that stakeholders are being excluded from the system or the belief that the child welfare system is not transparent or that it deliberately excludes input.

The bottom line to this discussion is that Idaho's child welfare system has started to take a systems approach to child welfare but lacks visibility, accessibility, and system-wide oversight.

Recommendation

To provide system oversight, address system-level gaps, and address ongoing child welfare challenges, we recommend the formation of a formal, system-wide oversight entity with authority to ensure ongoing accountability, visibility, and accessibility for all child welfare partners and stakeholders.

One way that states have established system-wide oversight is through special legislative committees. Many states have established legislative standing committees dedicated to child welfare, children, or families. Any one of those states could function as a model for Idaho.

The structure, authority, and function of such committees varies from state to state. Most are given responsibility for providing system-wide oversight, guidance, support, and accountability while providing a forum for multidisciplinary and multijurisdictional discussion and decision making.

If the Legislature decides to establish such a committee, the committee would be able to build upon the hard work already being done in the child welfare system and complement and enhance existing collaborative efforts. The Child Welfare Executive Steering Committee recently established by Child and Family Services could potentially function as designated council to the oversight committee.

The collaboration between a legislative standing committee and the executive steering committee could also be a means of tackling large interjurisdictional initiatives at a system level.

In addition to the findings and recommendations we have presented within this report, throughout our evaluation we identified at least three areas that were beyond our evaluation scope but may merit attention at a system level.

Community resources and services

Families involved in child welfare cases are required to complete case plans before being reunified with their children. Case plans generally specify services for parents and children to complete. These types of services could include education and training for parents, health and medical, respite, or substance abuse assessment and treatment. In our interviews with Child and Family Services staff and our surveys of judges, CASAs, and Child and Family Services staff, we heard considerable concern about

the availability and accessibility of appropriate services for families and children.

CASA program

Through our surveys we found significantly differing perspectives as to whether CASAs are seen as effective sources of accountability for Child and Family Services activities. Approximately 77 percent of CASAs believe they are effective sources of accountability, whereas 41 percent of foster parents and 26 percent of Child and Family Services staff agree. Our survey results do not necessarily indicate problems within the CASA program; however, the widely differing perspectives indicate that the program is an area that could benefit from additional study.

Preventive measures

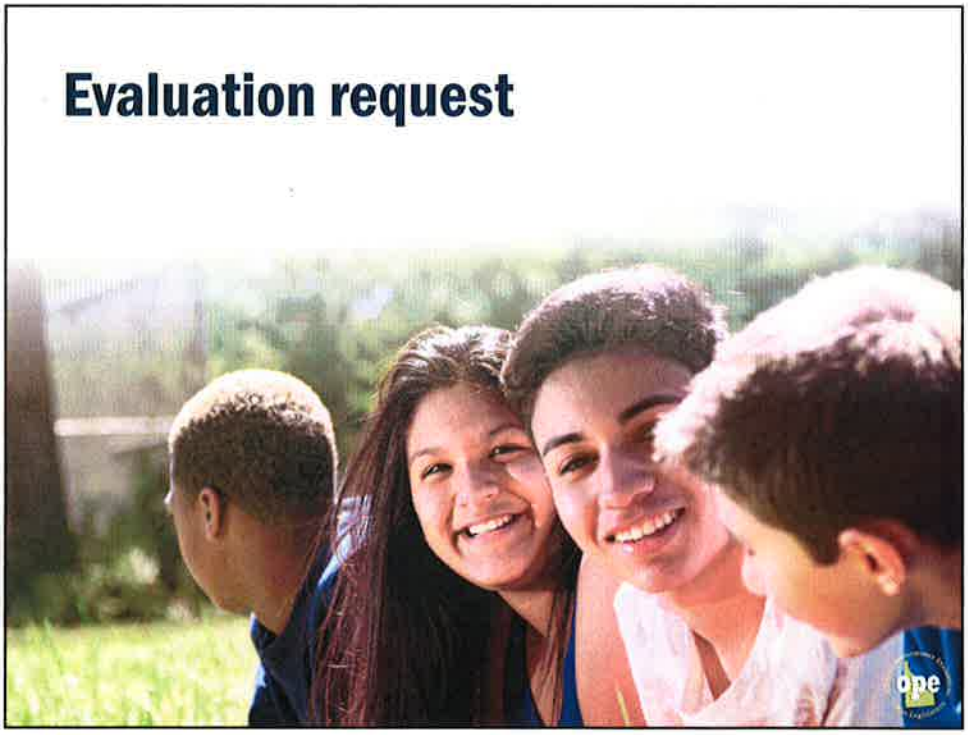
Most preventive programs in Idaho are not administered or overseen by Child and Family Services and require various state and community partners to work together. We were asked to identify preventive child protection options. Appendix E has the results of our efforts and explains evidence-based options that Idaho could consider implementing.

Office of Performance Evaluations

ope

Idaho Legislature

Child Welfare System
February 21, 2017
Lance McCleve
Amanda Bartlett
Office of Performance Evaluations
ope
Idaho Legislature


Evaluation request
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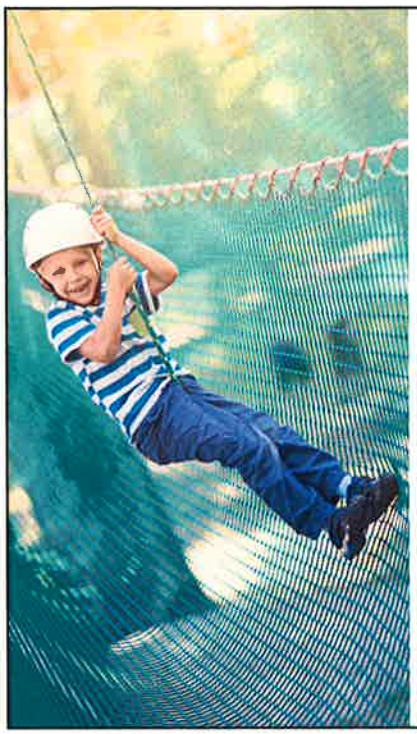
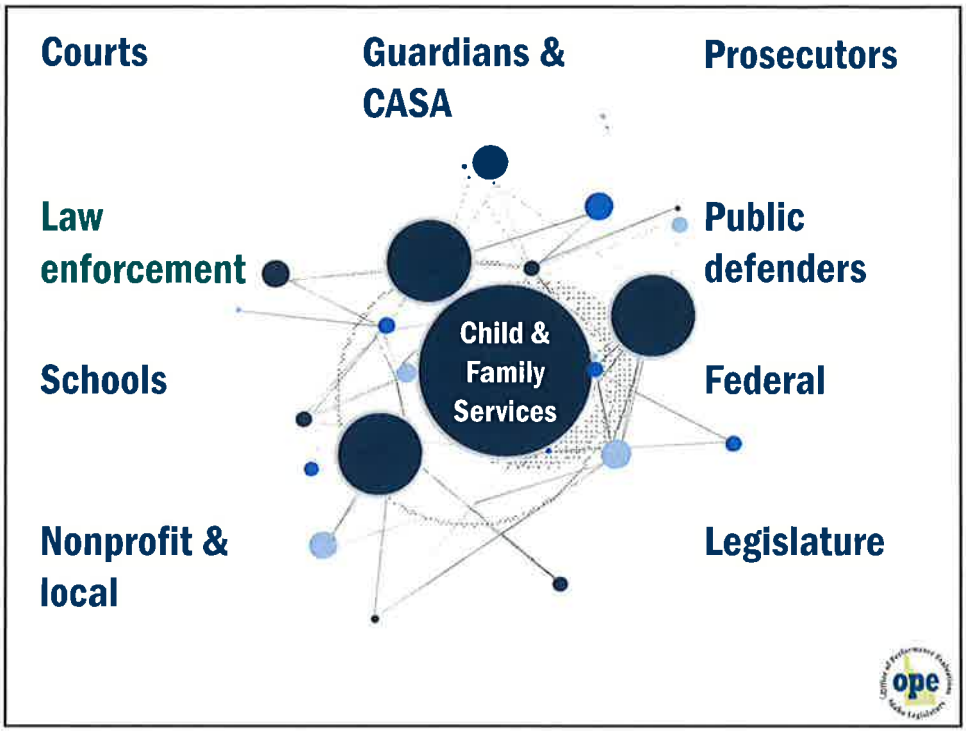


Child welfare problems are difficult to manage.

- Explained multiple ways
- Widely differing views
- Significant consequences for failure
- Constraints of the problem and resources change over time

Child welfare problems are difficult to manage.

- Understanding comes after formulating a solution
- Unique with no definite set of solutions
- One problem symptom of another problem
- Never definitively solved



Collaborative working groups

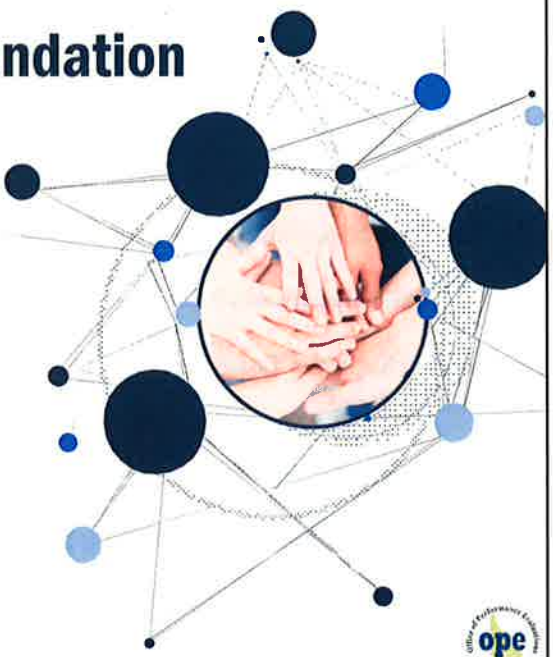
- Workforce recruitment and retention panel
- Stakeholder meetings
- Idaho Supreme Court Child Protection Committee
- Idaho Foster Youth Advisory Board
- Governor's Children At Risk Task Force
- Child Welfare Executive Steering Committee

Levels of accountability

- Federal
- Judicial
- Guardians ad litem
- Citizen review panel

Recommendation

Form a formal, system-wide oversight entity to ensure accountability, visibility, and accessibility.



Areas for additional attention

- Community services
- CASA program
- Preventive measures

Child welfare gaps

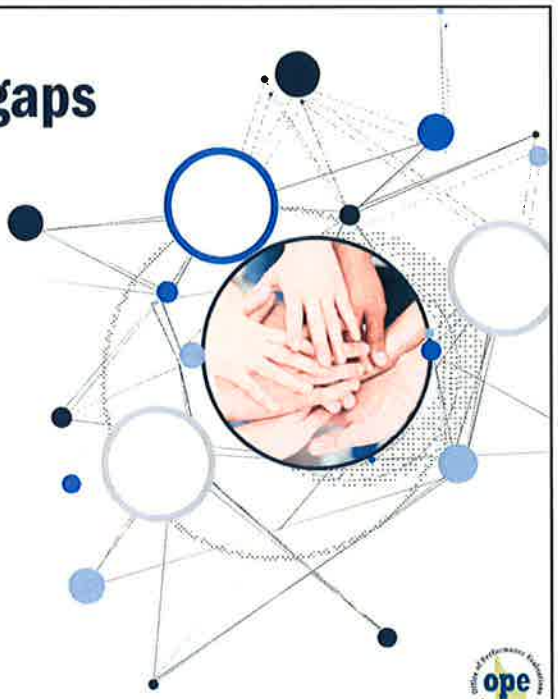
- Placement services
- Program capacity
- Program culture

Child welfare gaps

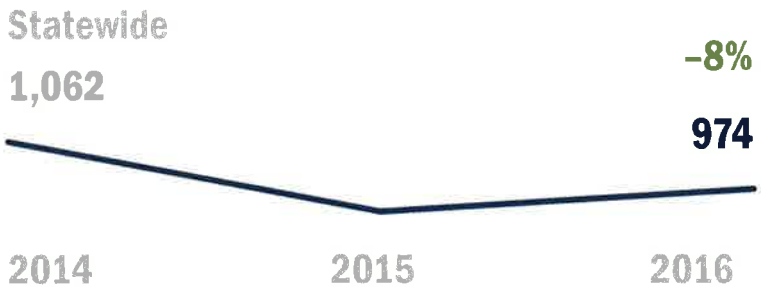
Placement services

Program capacity

Program culture



The number of licensed foster parents is decreasing.



Source: Child and Family Services, Foster Care Report, July 2017.
Point-in-time comparisons taken from March of each year.

"There is a sense of anxiety that comes over you because you have to find someone to take [the children]."

Child and Family Services
Social worker

Retention is recruitment.

Recommendations

Continue recruitment efforts

Set a goal and specify needed resources

Develop a robust retention plan

Child welfare gaps

Placement services

Program capacity

Program culture

88%

Agreed that problems often arise because of insufficient time

Social workers estimate they are carrying

38%

more cases than they can effectively serve.

13.5 average monthly cases per month per worker

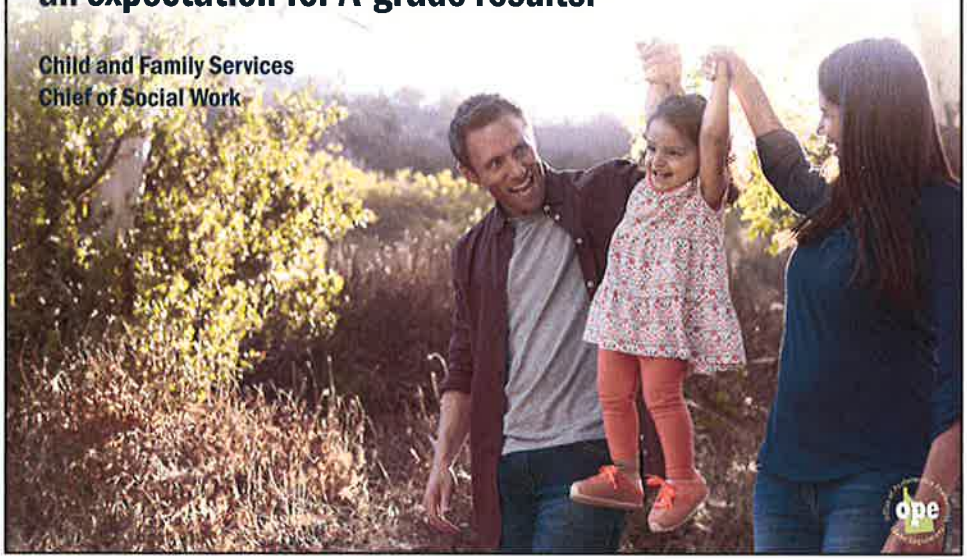
Inability to meet practice requirements

Difficulty engaging families

Decreased quality in services provided

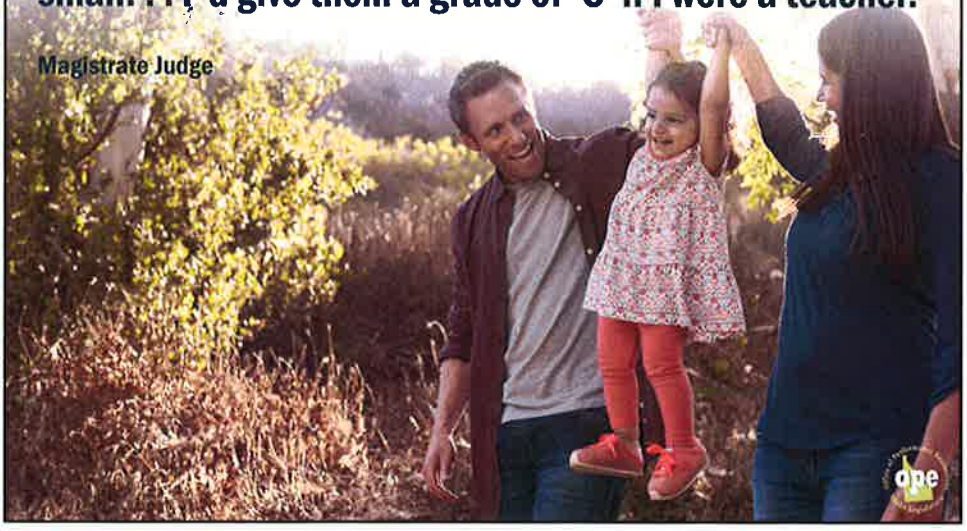
"Because of resource constraints, social workers have to settle for C-grade work. The problem is that there is an expectation for A-grade results."

Child and Family Services
Chief of Social Work

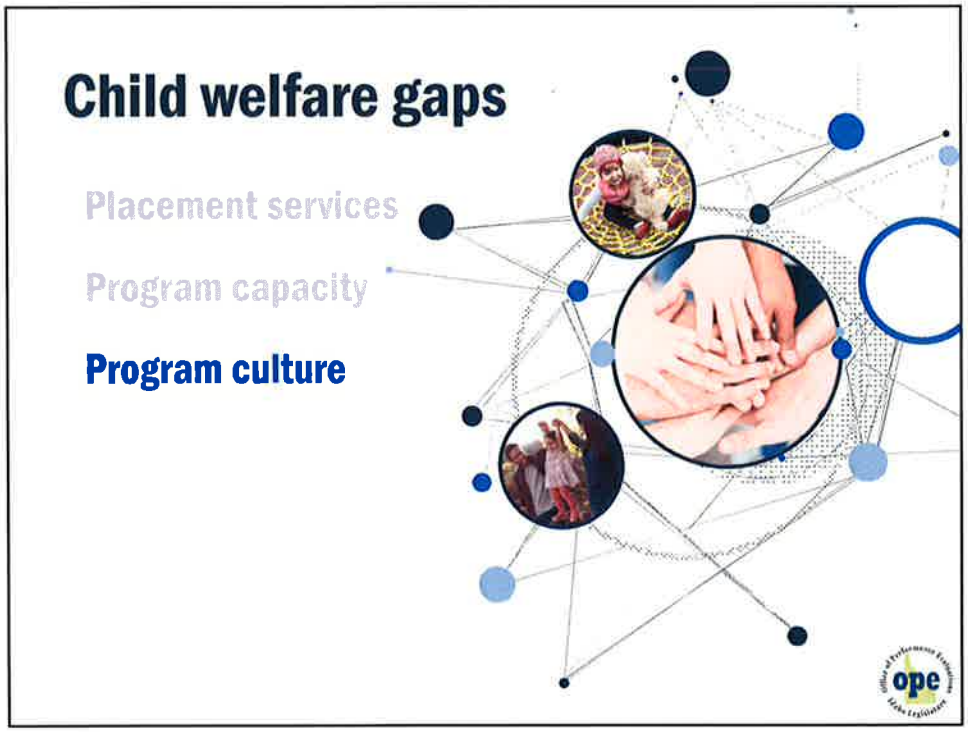


"I believe that most health and welfare workers want to do a good job and are good people. I also believe that their case loads are too big and their resources are too small. . . I'd give them a grade of 'C' if I were a teacher."

Magistrate Judge



Recommendations
Continue staff retention efforts
Identify staffing shortages and create a plan
Work with partners to enhance external processes
ope


Child welfare gaps
Placement services
Program capacity
Program culture
ope

Commitment to children and families

Strained relationships stem from a culture of defensiveness.

Detrimental cycle of priority and compromise

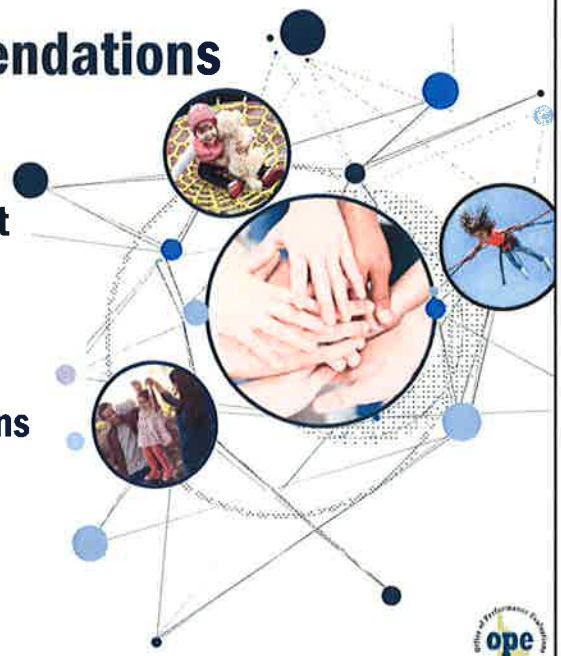
"[My] confidence is improved by proactive efforts to enhance best practice in Idaho; [but] tempered by a lack of realistic expectations for workers in the field. All the best practices won't matter if the workforce can't implement them due to workload issues."

Child and Family Services
Social worker

Recommendations

Ongoing assessment of the culture

Address the gap between expectations and practice

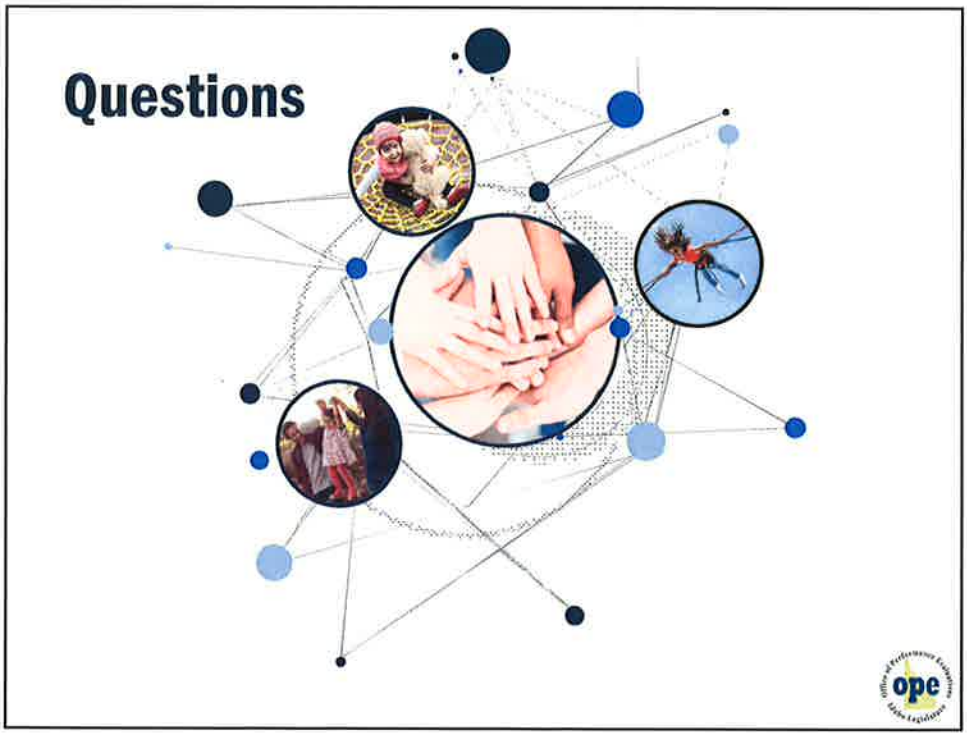


"There must be an integrated and cross-program monitoring and evaluation approach . . ."

"Such an approach would recognize that outcomes for children and families are the product of multiple programs, supports and community circumstances . . ."

Source: Movieclips.com

Source: Movieclips.com


Questions

AMENDED AGENDA #1

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Tuesday, February 28, 2017

SUBJECT	DESCRIPTION	PRESENTER
RS25380	Unanimous Consent Request to Send to Senate State Affairs for Printing	Morgan Howard
HCR 8	Relating to Department of Health and Welfare Rules Governing the Idaho Child Care Program	Rep. Kelly Packer
H 81	Relating to the Idaho Conrad J-1 Visa Waiver Program	Rep. Caroline Nilsson Troy
H 128	Relating to Medicaid	Matt Wimmer, Administrator, Division of Medicaid

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Tuesday, February 28, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	Senator Anthon
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:14 p.m.
RS 25380	**Unanimous Consent for Referral to Senate State Affairs for Printing. Morgan Howard** introduced herself to the Committee on behalf of Senator Johnson.
UC REQUEST:	**Chairman Heider** asked for unanimous consent to send **RS 25380** to the State Affairs Committee for printing. There were no objections.
HCR 8	**Relating to Department of Health and Welfare Rules Governing the Idaho Child Care Program. Representative Kelly Packer** introduced herself to the Committee to present **HCR 8**. The concurrent resolution would reject IDAPA 16.06.12, § 750(10) of the rule. The House Health and Welfare Committee felt the section was too inclusive and was a catch-all for any offense and would limit facilities from receiving their licenses. Since there is already a long list of exclusionary items, it was too broad.
MOTION:	**Senator Martin** moved to send **HCR 8** to the floor with a **do pass** recommendation. **Senator Lee** seconded the motion.
DISCUSSION:	**Vice Chairman Souza** read aloud the wording of the rule proposed to be deleted. **Representative Packer** commented some of the offenses were listed in a previous section, but it was felt this language is too broad. **Senator Jordan** stated she will oppose the motion. She understands the concern about being too broad, but in the context of looking out for child care situations, the establishments are different and there is a broad range of danger that can exist for children, and this rule is appropriate in that context. The motion carried by **voice vote. Senator Jordan** requested she be recorded as voting nay.

H 81 **Relating to the Idaho Conrad J-1 Visa Waiver Program. Representative Caroline Nilsson Troy** introduced herself to the Committee to present **H 81**. **Representative Troy** informed the Committee Idaho ranks 48th of the 50 states for the number of practicing physicians per capita. Ninety-six percent of the State of Idaho has a shortage of primary care physicians. The J-1 program was established by the Legislature in 2004 to help address the shortage of doctors, especially within primary care. It allows qualifying Idaho health care organizations in a federally designated shortage area to apply for the placement of a foreign physician as a recruitment option of last option. The health care organization must show that for six months prior to the application, there has been a concerted effort to recruit an American citizen as a doctor. If unable to recruit an American physician, the organization can submit a waiver to the Idaho Department of Health and Welfare (Department). The Department recommends up to 40 foreign trained physicians per year to the U.S. Department of State for a J-1 visa. J-1 physicians must be medical doctors or doctors of osteopathy, either currently licensed or eligible for licensure by the Idaho Board of Medicine. They must agree to serve a minimum of three years in the qualifying location, and they must serve Medicaid, Medicare, low income, uninsured clients and offer a sliding fee scale.

Representative Troy stated while 30 slots are available each federal fiscal year, Idaho has only used 13 J-1 visa applications since 2005, and there have been no requests yet this year. The current J-1 program covers only very specific areas of pediatrics, family medicine, internal medicine, obstetrics, gynecology, general surgery, and psychiatry. **H 81** will expand access to care for the underserved by allowing up to 10 of the 30 spots to be filled by a specialist located in a federally designated shortage area. The health care organization applying to fill a specialist position must demonstrate a need for the type of specialty requested.

Representative Troy commented in her legislative district, Gritman Hospital has been attempting to recruit an oncologist for a joint cancer care center to be opened in conjunction with Pullman Regional Medical Center. The cancer care center has been built in Moscow but it has been unable to recruit an oncologist despite lengthy efforts.

Representative Troy explained the legislation also allows for a flex waiver, meaning if all applications aren't used in the first six months, then ten of the remaining J-1 visas can be applied for by Idaho health care organizations who are not located in federally designated shortage areas. For example, St. Luke's is based in Boise but operates a clinic in Riggins. Even though St. Luke's itself is not located in a shortage area, the bill would allow St. Luke's to recruit a physician to serve in another area such as Riggins. No more than five of the ten flex waiver slots could go to specialists. This legislation balances the urgent need for primary care physicians in underserved areas with the growing need for additional specialists. If the rural areas use the J-1 visa program as a recruitment option, all 30 slots could still go to primary care physicians.

Senator Martin asked if there is a provision in the bill or in Idaho Code that specifies how it is determined that a health care organization has adequately tried to find a local physician before using the J-1 visa program. **Representative Troy** answered this could be made clear through rule. **Senator Martin** further inquired whether it is correct there is currently no definition or prescribed time or process for making that determination. **Representative Troy** deferred the question to Brian Whitlock.

Brian Whitlock introduced himself as President and Chief Executive Officer of the Idaho Hospital Association to respond to the question. **Mr. Whitlock** pointed out page 5 of the bill, where current Idaho Code § 39-6107(2) specifies a six-month vacancy requirement. **Senator Martin** asked if there is any requirement tied to effort. **Mr. Whitlock** again referred to Subsection 2 that states, a waiver request application will "only be considered for health care facilities that can provide evidence of sustained active recruitment." In the past, recruitment efforts have included newspaper advertisements and outreach to medical schools. This documentation would be submitted to the Department before the application could be submitted to the U.S. Department of State.

Senator Martin inquired if there is a financial benefit to the organization to fill a position under the J-1 visa system rather than use a local doctor. **Mr. Whitlock** responded in the specific situation described by Representative Troy, the facility has been actively recruiting for more than six months. The American doctors who have applied have gone elsewhere, possibly for more money in bigger cities.

Vice Chairman Souza asked if there is a financial incentive for physicians under the J-1 visa program to come to smaller areas of the State. **Mr. Whitlock** replied J-1 visa applicants have done their residency in the U.S. and enjoyed their time here, and they typically want to contribute and give back to their communities. Specifically, the J-1 visa is a primary care, rural-focused program. Other states allow specialists to be considered for J-1 visas, and these specialists would have the opportunity to practice in larger communities in other states. There is no financial incentive to come to Idaho.

Senator Lee inquired if there are areas in Idaho that would particularly benefit from this legislation. **Representative Troy** replied the majority of Idaho is federally designated as underserved, with the exception being a few pockets of urban areas.

MOTION: **Vice Chairman Souza** moved to send **H 81** to the floor with a **do pass** recommendation. **Senator Harris** seconded the motion. The motion carried by **voice vote.**

H 128 **Relating to Medicaid. Matt Wimmer**, Administrator for the Division of Medicaid at the Department of Health and Welfare, introduced himself to the Committee. **Mr. Wimmer** stated the bill is a step to reform payment methods to promote better and more efficient patient care. The bill is consistent with the existing statute but expands on it to direct the Department to explore Idaho-based approaches to care management. As indicated in the fiscal note, it requires that the Department's approach to value-based purchasing be cost neutral or cost negative.

Mr. Wimmer explained new purchasing models pay health care providers based on demonstrated ability to provide efficient care that has a positive impact on patient health, rather than on a per-procedure or fee-for-service basis. Under a fee-for-service system, a doctor who performs a great appendectomy gets paid the same as someone who performs a poor appendectomy. If a patient must be seen multiple times, payment is made for each visit. Value-based purchasing seeks to reward providers for health systems that deliver high standard, cost-efficient care by providing higher payments for those services. The value-based payment system has been pursued in numerous other forms by other state Medicaid organizations, commercial insurers in Idaho and nationwide, and Medicare. Overall, the programs have been successful in delivering better outcomes at reduced costs.

Mr. Wimmer informed the Committee the Department has improved quality of care under the patient-centered medical home program in the past few years. That program pays primary care practices who are recognized as patient-centered medical homes by national organizations and rewards those providers for pursuing higher standards of care. This approach has resulted in fewer hospital admissions, reduced emergency room utilization, and controlled costs. **H 128** allows the Department to extend the approach beyond primary care to develop regional care networks that will reward primary care, hospital, specialist and other provider groups who work together effectively to improve patient care. The approach will include episodic payments to incentivize quality for a single episode of care like a knee replacement or birth. The bill allows the Department to pursue appropriate federal authority to enable value-based purchasing. The Department will bring specific rules back to the Committee to support future efforts. The Department has been fairly effective in controlling per member, per month Medicaid costs, and this bill provides the best option for future improvements.

Senator Foreman referred to line 35, subparagraph b, which says, "the Department is authorized to pursue waiver agreements with the federal government as needed," and asked for explanation of that language. **Mr. Wimmer** replied the language would enable a managed-care type approach. Because the federal requirements for Medicaid programs are often very restrictive, the only way to enable some programs is by a labor agreement, as with the behavioral health and dental plans. This language recognizes under the current system, the Department would have to apply for a waiver to use different approaches. More detail will be specified in rule.

Senator Harris inquired whether the federal government has certain requirements that qualify a provider to be paid for value as opposed to paid for service. **Mr. Wimmer** responded it depends on the structure. Managed care regulations provide a little more flexibility but with a labor requirement attached.

MOTION: **Senator Jordan** moved to send **H 128** to the floor with a **do pass** recommendation. **Vice Chairman Souza** seconded the motion.

DISCUSSION: **Senator Foreman** said he would like to support the motion, but the language about negotiating agreements with the federal government is too open and general.

Vice Chairman Souza referred to line 30 of the bill and stated the key word is "may" and that gives her comfort. The bill does not say the Department "must" or "shall" enter into agreements, it only provides an opportunity to save money or achieve a better outcome.

Senator Jordan mentioned it's easier to put the pieces together after having worked on this issue for a long time. The waivers are pretty specific for programs or plans. While the language may sound broad in the legislation, between the rules and the actual waiver applications, the specifics come into focus. This is a good program for Idaho.

Senator Agenbroad said his experience is that the waivers get very specific. There are guidelines for the federal and State governments as well as the provider. To move to more outcome-based medicine, it is necessary to give the Department flexibility to get there.

The motion carried by **voice vote. Senator Foreman** requested he be recorded as voting nay.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 3:42 p.m.

Senator Heider
Chair

Jeanne Jackson-Heim
Secretary

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Wednesday, March 01, 2017

SUBJECT	DESCRIPTION	PRESENTER
Approval of Minutes	Minutes of the February 15, 2017 Meeting Minutes of the February 16, 2017 Meeting	Senator Martin Senator Foreman
H 115	Relating to Physicians and Surgeons	Anne Lawler, Executive Director, Board of Medicine
H 129	Relating to Dietitians	Anne Lawler

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Wednesday, March 01, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Foreman, and Jordan
ABSENT/ EXCUSED:	Senators Anthon and Agenbroad
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:01 p.m.
APPROVAL OF MINUTES:	**Senator Martin** moved to approve the Minutes of the February 15, 2017 meeting. **Senator Jordan** seconded the motion. The motion carried by **voice vote.**
	Senator Foreman moved to approve the Minutes of the February 16, 2017 meeting. **Senator Martin** seconded the motion. The motion carried by **voice vote.**
H 115	**Relating to Physicians and Surgeons. Anne Lawler,** Executive Director of the Idaho State Board of Medicine (BOM), introduced herself to the Committee. **Ms. Lawler** informed the Committee **H 115** amends two licensure sections of the Medical Practice Act (MPA) relating to the Interstate Medical Licensure Compact (Compact).
	Ms. Lawler explained Idaho became the third state to join, and there are now 18 states in the Compact. The Compact provides physicians a way to obtain an expedited license in any of the Compact states, once the home state clears the applicant. One of the steps to qualify an applicant for the Compact is to run a current fingerprint-based criminal background check. For example, if a hypothetical Dr. Souza was licensed in Idaho and wanted to be licensed in Utah, Wyoming, and Montana, Dr. Souza would submit an application in the home state of Idaho. The application would come to the BOM, and once the BOM has verified the doctor meets the requirements of the Compact, then the BOM would send a letter of qualification to the Compact. The Compact would notify Utah, Wyoming, and Montana that Dr. Souza is eligible for an immediate license, once she pays the fees to those states. The Compact reduces the time for licensure in each state, which can ordinarily range from six weeks to nine months.
	Ms. Lawler stated the MPA specifically authorizes the BOM to conduct fingerprint background checks for all physician applicants for new licensure. However, the BOM has been advised by Compact leadership and the Federal Bureau of Investigation that it is advisable to add language to Idaho Code that authorizes background checks specifically for qualifying an existing physician for the Compact. **H 115** adds language to clarify this additional use of background checks.
	Ms. Lawler advised there is no fiscal impact to the General Fund or the BOM dedicated fund. Fees for the background checks will be borne by the physicians who seek to be qualified for the Compact.

Vice Chairman Souza inquired whether existing physicians had a background check done for initial licensure but that background check was not part of the Compact. **Ms. Lawler** answered that is correct. The initial licensure background checks do not qualify for the Compact. A background check done for the Compact is good for one year. **Vice Chairman Souza** asked if there is an advantage to a doctor to be in the Compact if the doctor is not thinking of leaving the State, and if it is mandatory to be in the Compact. **Ms. Lawler** responded it is not mandatory to be part of the Compact. It is purely voluntary for physicians who may want to practice across state lines or who want to do telehealth. Some radiologists are licensed in 25 or 30 states because the nature of their practice is to work remotely. Many physicians in border towns want to practice in neighboring states. The Compact makes it much faster to get a license in the other state.

Senator Lee asked for clarification that the Compact is voluntary for physicians, and the number of physicians who take advantage of the Compact. **Ms. Lawler** replied the Compact is just starting up and it is unknown how many physicians are taking advantage of it. It is not required for any physician in any Compact state to be in the Compact. It is simply another opportunity to be quickly licensed in multiple states, and there are no background checks for existing licensees.

MOTION: **Vice Chairman Souza** moved to send **H 115** to the floor with a **do pass** recommendation. **Senator Martin** seconded the motion. The motion carried by **voice vote.**

H 129 **Relating to Dietitians. Ms. Lawler** introduced herself on behalf of the Dietetic Licensure Board (DLB), which is part of the BOM. The BOM regulates medical doctors, doctors of osteopathy, physician assistants, respiratory therapists, athletic trainers, and dieticians. **Ms. Lawler** said the purpose of the bill is to update and amend the Dietetic Practice Act (DPA). This bill represents the first substantive update since the DPA was passed in 1994. The changes in the bill result from changes in dietetic practice and new terminology adopted by the National and State Academy of Nutrition and Dietetics. **H 129** aligns the DPA with the MPA, but it does not add any regulation or create new licensure. There is no fiscal impact to the General Fund or the BOM's dedicated fund.

Ms. Lawler commented the original bill, **H 45**, had passed out of committee in the House when the BOM received feedback from numerous national nutritionist groups that opposed the legislation. These groups incorrectly believed the bill was intended to prevent nutritionists from practicing in Idaho. To address the groups' concerns, the BOM reworked some language and reviewed the changes with the national groups, to their satisfaction, and brought this new legislation.

Ms. Lawler provided history of development of **H 129**. In 2015, a work group was convened with members of the DLB, BOM staff, Idaho Academy of Nutrition and Dietetics (Academy) representatives, and practicing Registered Dieticians (RDs). The work group met monthly for 16 months to craft this legislation and reviewed other practice acts in neighboring states along with the Idaho Nurse Practice Act and Idaho hospital rules pertaining to dietetic practice. Also, the work group sought input from the Idaho Medical Association, Idaho Hospital Association, Board of Nursing, Idaho Association of Chiropractic Physicians, and Idaho Association of Naturopathic Physicians. The BOM has also been working with the National Association of Nutrition Professionals and the Board for Certification of Nutrition Specialists to address concerns from the original version of the bill.

Ms. Lawler explained the purpose of the bill is to reorganize and align the DPA with the MPA. The most significant changes to the DPA include:

- Definitions formerly under Powers and Duties of the DLB were updated and moved to the Definitions section;
- A new section that contains the scope of dietetic practice was updated to reflect advancements in the profession since 1994, especially pertaining to Certified Diabetic Educators;
- Protected titles were updated to reflect current national practice, and exemptions were added to clarify anyone who is otherwise licensed under Title 54, such as a physician or nurse, is not violating the statute by practicing dietetics within their own scope of practice;
- The option to "discipline" a license was added, affording more options for disciplinary action such as education;
- The requirements for licensure were updated to match the national certifying agency's requirements;
- Expedited licensure was reworded to "Licensure by Endorsement;"
- A two-year renewal option was added to the existing one-year renewal;
- Grounds for discipline were updated to add the milder option of restricting a license;
- A new Idaho Code § 54-3510A added sanctions for discipline imposed; and
- A section amended in **H 45** was reverted back to the original language of Idaho Code, with the exception that a code reference was deleted.

Ms. Lawler stated dietitians are health professionals with special skills to work with patients on a medical level to improve health outcomes. For example, dietitians who are certified diabetic educators are trained to adjust insulin doses. All dietitians are trained to work with patients on tube feed or intravenous feeding, which are highly medical interventions. Professional dietitians have been licensed for 23 years to ensure the public is protected. In 1994, there were fewer than 8 million Americans diagnosed with diabetes. Today, there are 22 million, and the numbers are growing. There are 89,000 RDs in the U.S., including 600 RDs in Idaho, who could be better utilized to fight this disease.

Senator Foreman asked about the language allowing discipline of licensees who are convicted of driving under the influence (DUI) or drug offenses. It concerns him that those offenses don't pertain to the practice of dietetics and the discipline would be layered on top of any sanctions levied by the State. He is also troubled by the fact that some of the sanctions added to the bill seem to be punitive rather than restorative. **Ms. Lawler** replied the authority of the BOM to discipline for driving under the influence or drug offenses was added to align with the MPA. The BOM has learned from the Professional Recovery Network (PRN) that helps rehabilitate physicians with addiction issues that a person who is arrested for a DUI has probably driven drunk between 200 to 500 times. The language does not mandate the BOM take action against someone with a DUI but allows the BOM to help the person seek recovery, education, and support. The goal is to help people get back to a place where they are practicing safely. A number of physicians sit on the PRN committee who have gone through the PRN program, and they are very thankful they did because it changed their lives. People who have had DUIs often start drinking more heavily, and many times the effects creep into their work. The bill gives the BOM authority to look into the matter if there is a concern because the BOM's mission is to protect the public.

Ms. Lawler stated the disciplinary sanctions are just options for the BOM and it does not mean they will all be imposed in each case. Education is foremost with the BOM in each case of discipline, but certain things happen where it's okay to take a punitive approach. The administrative fines imposed by the BOM almost always involve a case of intentional covering of the truth. If an applicant purposely fails to disclose something they are asked about, that is considered a lie, and in that instance an administrative fine might be imposed. For example, on a license renewal, a licensee is required to report any malpractice claims. If the licensee doesn't report and the BOM finds out about it, there might be a fine.

Vice Chairman Souza mentioned she appreciated the explanation about the penalties and inquired whether the language about conviction of a misdemeanor in Idaho Code § 54-3511 is standard language for other medical professions. **Ms. Lawler** replied the language is consistent with the MPA. The misdemeanor penalty is criminal, and that would be used when someone is holding himself out to be a dietician when unlicensed under the DPA; the County prosecutor would be the one to pursue that charge.

Senator Martin referred to page 5, lines 8 to 12 of the bill and commented it look like the requirement for DLB members to be dieticians is being deleted. **Ms. Lawler** answered that language refers to the initial DLB that was empaneled after the DPA was passed. The language is being deleted because it is no longer applicable. Idaho Code § 54-3504(2) specifies the DLB shall consist of four members: three dieticians and one public member.

TESTIMONY: **Dr. Henry R. Thompson** introduced himself as a pediatric gastroenterologist working at St. Luke's to speak in support of **H 129**. He is the Medical Director for Pediatric Subspecialists and is the current Medical Director for the Pediatric Dieticians at St. Luke's Children's Gastroenterology where he supervises 12 dieticians. This bill will allow the dieticians to practice at the same level on both an inpatient and outpatient basis and fully utilize their skill set, which will greatly help meet the needs of people in Idaho. There are four pediatric gastrointestinal doctors who cover the entire State of Idaho. It is challenging to be everywhere to everybody, and if he can use his full team to work to their level of training, it improves access to care. On the inpatient side, dieticians use approved protocols to write orders related to total parenteral nutrition and medical intravenous nutrition. On the outpatient side, however, he needs to read and approve every single order for changing a tube feed to a patient, which does not make sense and is not an efficient use of anyone's time.

Senator Lee commented the bill was presented as not changing any scope of practice, and she asked what the bill will specifically do for Dr. Thompson's practice. **Dr. Thompson** replied the bill will allow dieticians to practice in the entire arena where they work. Sometimes, the law has not entirely kept up with the times. RDs are allowed to perform certain tasks in an inpatient setting but not an outpatient setting. The bill does not change what they do but it changes some of the downstream effects on other people's workflow.

TESTIMONY: **Megan Williams** introduced herself as the President of the Academy, representing over 400 dieticians from across the State of Idaho in support of **H 129**. **Ms. Williams** said her training included four years in an accredited program, one year of internship, and sitting for a national credentialing exam. Dieticians work to improve the health of Idahoans across the State in varied settings, including health care, business and industry, community and public health systems, schools, colleges, military, government, research, food service management, teaching, consulting, media, writing, public speaking, and private practice.

Ms. Williams explained in 1994, the practice of dietetics was in its infancy. Now dieticians can receive specialty certifications to expand competency in many skills. She is a certified diabetes educator, and titrating insulin under the supervision of a medical provider is a small thing she can do to decrease a patient's risk of developing complications related to diabetes as well as decrease medical expenses. An inpatient dietician or someone working in outpatient nutrition support can more effectively care for a patient requiring tube feeding or parenteral nutrition by ordering changes to these therapies or required labs under the direction of a medical provider. Insulin titration, feeding, and lab orders are just a few examples of how the language of the bill was updated to reflect the current practice of dietetics. The bill protects the title of dietician and does not restrict those who provide nutrition services. The Academy appreciates the work of the BOM to reflect and update current practice.

Senator Lee asked in Ms. Williams's experience as President of the Academy whether it is widespread that individuals use the term "dietician" without being licensed. **Ms. Williams** responded she is unaware of an instance where the BOM has had to intervene. She more commonly sees the term "nutritionist" used freely. The Academy is always vigilant for misuse of the term because the educational standards for a dietician are different than for a nutritionist.

MOTION: **Senator Martin** stated he had a conflict of interest pursuant to Senate Rule 39(H) but intended to vote. His granddaughter is in a dietician program in Utah at this time. **Senator Martin** moved to send **H 129** to the floor with a **do pass** recommendation. **Senator Harris** seconded the motion. The motion carried by **voice vote. Senator Foreman** requested he be recorded as voting nay.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 3:38 p.m.

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Senator Heider
Chair

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Jeanne Jackson-Heim
Secretary

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Thursday, March 02, 2017

SUBJECT	DESCRIPTION	PRESENTER
S 1126	Relating to Safe Havens	Senator Davis
Approval of Minutes	Minutes of the February 20, 2017 Meeting Minutes of the February 21, 2017 Meeting	Senator Anthon Senator Harris

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Thursday, March 02, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	Vice Chairman Souza
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:06 p.m.

S 1126 **Relating to Safe Havens. Senator Davis** introduced himself to the Committee and provided background on the Idaho Safe Haven Act. In 2001, there had been a series of tragedies where newborn babies were left in dumpsters. **Senator Davis** said he was asked to do something to help prevent these occurrences, despite some controversy over the idea of a safe haven law. A reporter acquaintance, Suzanne Hobbs from Pocatello, was a strong proponent.

Senator Davis stated abandonment of a child is still a crime, but the Legislature agreed to trade the life of a child for a criminal proceeding. Idaho was among the first to adopt a safe haven law. While some states have not included a time period for the safe haven, Idaho chose 30 days as the time for a baby to be surrendered after its birth with no questions asked. **Senator Davis** provided the Committee with a photo of the original safe haven bill signing by Governor Kempthorne in 2001 (see Attachment 1). He informed the Committee since 2001, there have been 28 "safe haven" babies surrendered. Of that number, 25 were adopted, one passed away, and two are currently in foster care in pre-adoptive homes. **Senator Davis** reported that some time after Idaho's safe haven law was enacted, Ms. Hobbs and her husband, who were unable to have children, adopted a "safe haven" baby girl.

Senator Davis commented he subsequently heard from Ms. Hobbs that fire stations should be included in the law as places a baby could be dropped off. This language was inadvertently omitted from the original bill. Instead, the law says a fire department can accept a baby if responding to a 911 emergency call. **S 1126** adds "fire stations" and "tribal entities" as locations where a baby can be surrendered. **Senator Davis** obtained confirmation from the tribes they were supportive of the change, and David Gates of the Idaho Fire Chiefs Association and the Pocatello Fire Department advised these two groups also strongly support the bill (see Attachments 2 and 3). Mr. Gates also urged eliminating the requirement that a fire department be responding to a 911 emergency call in order to accept a child.

Senator Davis mentioned that, unfortunately, the problem is ongoing. In Twin Falls, on New Year's Eve 2016, a newborn was left on the side of the road in a diaper bag. The bill is a greater opportunity to do more good by: 1.) publicly reemphasizing the Safe Haven Act; 2.) aligning the law with what most fire departments' belief that the Safe Haven Act already applies; and 3.) using the opportunity to make additional changes to allow fire department personnel to accept a baby off premises without a 911 emergency call having been made. **Senator Davis** would agree with the Committee's decision to either recommend the bill as is, or send it to the Fourteenth Order for amendment to polish the language.

TESTIMONY: **Allana Hobbs** introduced herself to the Committee as Senator Martin's intern to speak in support of **S 1126**. Her research showed 26 states have included fire stations in their safe haven laws. It would also be a good idea to remind the public about the Safe Haven Act and let them know fire stations can accept newborns.

Senator Jordan mentioned she was surprised to learn fire stations were not safe havens under this law. She inquired of Senator Davis if he thinks the suggested change is a positive one, and further commented Ada County has several freestanding Emergency Medical Services stations which might also be included as safe havens. **Senator Davis** answered one thing lawyers don't get to do very often that is a fun thing to do is private adoption. It is a time when a courtroom is filled with joy and happiness, and that is how he feels about this bill. **Senator Davis** would welcome a motion to amend the bill to add Mr. Gates's suggestions.

MOTION: **Senator Jordan** moved to send **S 1126** to the Fourteenth Order for possible amendment. **Senator Martin** seconded the motion. The motion carried by **voice vote.**

APPROVAL OF MINUTES: **Senator Anthon** moved to approve the Minutes of the February 20, 2017 meeting. **Senator Martin** seconded the motion. The motion carried by **voice vote.**

Senator Harris moved to approve the Minutes of the February 21, 2017 meeting. **Senator Lee** seconded the motion. The motion carried by **voice vote.**

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 3:29 p.m.

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Senator Heider
Chair

_____

Jeanne Jackson-Heim
Secretary

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IDAHO FIRE CHIEFS ASSOCIATION

Idaho Fire Chief's Association

David G. Gates - President
Pocatello Fire Department
Fire Chief
408 E. Whitman
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March 2, 2017

• • •

Representative Lee Heider
Health & Welfare Committee
Idaho Senate

Cc/ Senate - Health & Welfare Committee

Safe Haven Amendment SB1126

Chairman Heider,

I would like to express the Idaho Fire Chiefs Association's strong support of the proposed amendment to the Safe Haven legislation, which would include fire stations as a Safe haven.

Currently the definition of "Safe haven" includes hospitals, physicians and their staff, advanced practice nurses, physician assistants, and medical personnel when making an emergency response to a "911" call from a custodial parent. The addition of fire stations to the definition would be beneficial to those who are in need of this statute.

Fire stations are staffed with personnel who are trained to act in an emergency and should be trusted to assist parents who would like to safely relinquish their newborn infant to a safe place. There are numerous fire departments across state that could provide a safe alternative to child abandonment.

I would also like to express a concern I have with another part of the statute, but I do not want, in any way, to derail the current amendment. Within the definition, EMS providers are defined as Safe Haven "medical personnel when making an emergency response to a "911" call from a custodial parent…," and that has caused issues recently when trying to implement Safe Haven in our jurisdiction. It is not uncommon for fire and EMS services to respond to citizens who have walked into the fire station, flagged down a responder to request aid, or have stopped to assist a person in obvious trouble. The fire or EMS services are then initiating the response and not responding to a 911call. EMS providers should be empowered to act a Safe Haven in any circumstance. Our legal counsel is stating the "Safe haven" language is clear and there is no room for interpretation; the response must be initiated by a 911 call. The language "when making an emergency response to a "911" call from a custodial parent" is unduly limiting to EMS personnel. If the process would allow, I would like to ask that an additional change be considered. I would like to propose changing "Medical personnel when making an emergency response to a "911" call from a custodial parent…" to Medical personnel acting/serving in the capacity as a licensed provider, affiliated with a recognized Idaho EMS agency. This change

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would be intended to provide additional opportunities for EMS providers to assist an infant in need.

On behalf of the IFCA, thank you for taking the time to consider the important legislation.

Sincerely,

David G. Gates – MBA/EFO
President/Fire Chief
Idaho Fire Chief's Association/Pocatello Fire Department

408 East Whitman
Pocatello, ID 83201

208.234.6201
Fax: 208.233.4043

David G. Gates - Fire Chief

March 2, 2017

Representative Lee Heider
Health & Welfare Committee
Idaho Senate

Cc/ Senate - Health & Welfare Committee

Safe Haven Amendment SB1126

Chairman Heider,

I would like to express the Pocatello Fire Department's strong support of the proposed amendment to include fire stations in the Safe Haven legislation.

Currently the definition of "Safe haven" includes hospitals, physicians and their staff, advanced practice nurses, physician assistants, and medical personnel when making an emergency response to a "911" call from a custodial parent. The addition of fire stations to the definition would be beneficial to those who are in need of this statute.

Fire stations are staffed with personnel who are trained to act in an emergency and should be trusted to assist parents who would like to safely relinquish their newborn infant to a safe place. There are numerous fire departments across state that could provide a safe alternative to child abandonment.

I would also like to express a concern I have with another part of the statute, but I do not want, in any way, to derail the current amendment. Within the definition, EMS providers are defined as Safe Haven "medical personnel when making an emergency response to a "911" call from a custodial parent…," and that has caused issues recently when trying to implement Safe Haven in our jurisdiction. It is not uncommon for fire and EMS services to respond to citizens who have walked into the fire station, flagged down a responder to request aid, or have stopped to assist a person in obvious trouble. The fire or EMS services are then initiating the response and not responding to a 911call. EMS providers should be empowered to act a Safe Haven in any circumstance. Our legal counsel is stating the "Safe haven" language is clear and there is no room for interpretation; the response must be initiated by a 911 call. The language "when making an emergency response to a "911" call from a custodial parent" is unduly limiting to

EMS personnel. If the process would allow, I would like to ask that an additional change be considered. I would like to propose changing “Medical personnel when making an emergency response to a "911" call from a custodial parent…” to Medical personnel acting/serving in the capacity as a licensed provider, affiliated with a recognized Idaho EMS agency. This change would be intended to provide additional opportunities for EMS providers to assist an infant in need.

Thank you for taking the time to consider the important legislation.

Sincerely,

David G. Gates – MBA/EFO
Fire Chief - Pocatello Fire Department

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Tuesday, March 07, 2017

SUBJECT	DESCRIPTION	PRESENTER
Approval of Minutes	Minutes of the February 23, 2017 Meeting Minutes of the February 27, 2017 Meeting Minutes of the February 28, 2017 Meeting	Senator Agenbroad Senator Souza Senator Lee
H 191	Relating to Pharmacy	Pam Eaton Idaho State Pharmacy Association

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
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Phone: 332-1319
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MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Tuesday, March 07, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	Senator Anthon
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.
APPROVAL OF MINUTES:	**Senator Agenbroad** moved to approve the Minutes of the February 23, 2017 meeting. **Senator Harris** seconded the motion. The motion carried by **voice vote.**
	Vice Chairman Souza moved to approve the Minutes of the February 27, 2017 meeting. **Senator Lee** seconded the motion. The motion carried by **voice vote.**
	Senator Lee moved to approve the Minutes of the February 28, 2017 meeting. **Senator Martin** seconded the motion. The motion carried by **voice vote.**
H 191	**Relating to Pharmacy. Pam Eaton**, President and Chief Executive Officer (CEO) of the Idaho Retailers Association, introduced herself to the Committee on behalf of the Idaho Retail Pharmacy Council and the Idaho State Pharmacy Association. **Ms. Eaton** explained after two similar bills were presented earlier in the session relating to pharmacist dispensing of tobacco cessation medication and tuberculosis skin testing, legislators asked if there were other medications that would be appropriate for pharmacists to dispense without a prescription. **H 191** is the result and would make it as easier for Idaho consumers to access medications for low risk conditions.
	Ms. Eaton commented Idaho has a successful track record of allowing direct consumer access to low risk prescriptive medications. Since 2011, the Legislature has approved bills to allow pharmacists to dispense immunizations, fluoride supplements, opioid antagonists, and epinephrine auto-injectors. Rather than continue a piecemeal approach through separate legislation, **H 191** would authorize the State Board of Pharmacy (BOP) to add to the list of allowed medications through open negotiated rulemaking for low risk conditions that could improve public health in Idaho.
	Ms. Eaton stated the bill does not authorize any specific drug or product and would not give pharmacists discretion to prescribe any drug or product. Instead, the bill would give the BOP limited rulemaking authority to promulgate rules for specific drugs for conditions that do not require a new diagnosis, are minor and self limited, have a CLIA wave test that is used to guide decision making, or are used on a short-term emergency situation. The bill would also restrict the BOP from including any controlled substances, compounded drugs, or biological products. Any new rules promulgated by the BOP would be reviewed by the Legislature.

Ms. Eaton said the bill is needed because Idaho has a shortage of health care providers, especially for patients who are uninsured or underinsured. **Ms. Eaton** referred to a letter provided to the Committee from Aquinas College (see Attachment 1), stating that the U.S. is one of the few countries in the world that limits access to certain medications by requiring the patient to obtain a prescription from a health care provider, which can be an inefficient process. For example, someone wanting a motion sickness patch in anticipation of taking a cruise must schedule an appointment with a prescriber, wait for the appointment, take off work to attend the appointment, make a copayment for an office visit, obtain a prescription, and take the prescription to a pharmacy to be filled. Increasing access to medications such as these can result in increased competition and access, lowered costs, and improved quality.

Ms. Eaton informed the Committee travel medications will likely be a good starting point for the BOP. Looking at what other states allow, the list could also include medications for cold sores and lice. For example, a lice outbreak at her daughter's school was difficult to eradicate because over the counter treatments were ineffective and most parents did not obtain a prescription from a doctor for more effective lice shampoo.

Ms. Eaton mentioned the bill does not involve a radical change that will set Idaho apart from other states. Idaho's approach is slightly different because it allows changes to be made through rulemaking rather than by separate legislation, but Idaho has the tightest restrictions on rulemaking of any state in the country. The BOP has been recognized for its transparent and evidence-based decision making. She is confident the BOP will only do what is best for the patient and have concern for patient safety.

Ms. Eaton further commented this is not an expansion of the scope of practice. The practice of pharmacy is evolving, along with research and education, and pharmacists are trained more thoroughly to perform this type of work. She provided letters of support from the Idaho State University School of Pharmacy faculty and pharmacy students, the American Association of Retired Persons, the Idaho Society of Health System Pharmacists, and another economist (see Attachments 2, 3, 4, 5, and 6).

Chairman Heider said he has heard concerns that the bill would allow pharmacists without additional training to begin prescribing in every aspect of medicine, while previous legislation has involved one drug at a time. **Ms. Eaton** responded the bill spells out what can and cannot be prescribed and in what situations. Also, pharmacists would not be allowed to prescribe medications for off-label purposes, or in other words, for a purpose it was not originally intended for. **Chairman Heider** asked if "off-label" means a doctor prescribes one thing, and a pharmacist could give a comparable drug. **Ms. Eaton** replied that is "substitution."

Vice Chairman Souza referred to the smoking cessation legislation and mentioned the bill required special training for those specific products. She asked whether there would be additional training for any new medication that pharmacists could start prescribing, and whether there is any anticipated increase in liability for the pharmacists as a result of the increased authority. **Ms. Eaton** answered the BOP will determine on a case-by-case basis whether additional training is needed for patient safety, and it will be included at the time of rulemaking. No additional liability is anticipated for the pharmacists. Research was conducted with insurance companies who provide liability insurance, and in other states where pharmacists have prescriptive authority, insurance rates did not increase.

TESTIMONY: **Trent Galloway** introduced himself as a fourth year student pharmacist at Idaho State University where he is obtaining his doctorate in pharmacy. **Mr. Galloway** stated he and his fellow pharmacy students strongly support **H 191**, and they are ready, willing, and able to provide the services described in the bill. He and his fellow students see the bill as an important step in helping pharmacists be better utilized to their full ability in Idaho, and they were excited the bill passed the House unanimously.

TESTIMONY: **Laura Churns** introduced herself as a pharmacist and the Director of Pharmacy Legislative and Regulatory Affairs at Albertson's Companies (Albertson's) to speak in support of **H 191**. Albertson's is one of the largest food and drug retailers in the U.S. and operates in 35 states and the District of Columbia. In Idaho, Albertson's operates 41 stores with 38 in-store pharmacies. Including the corporate office, Albertson's employs more than 4,400 Idahoans.

Dr. Churns commented the scope of service contained in the bill may sound new for Idaho, but these are normal services Albertson's successfully provides in other states. For example, Albertson's pharmacies provide travel health services in 13 states, and the program is well received by the patients as a quick and convenient way for a patient to be screened and obtain travel medications at night or on weekends. Another service provided is rapid strep testing. **Dr. Churns** described a recent patient encounter in Washington where the patient was a teacher who came down with a sore throat on a Friday night. The teacher was scheduled to leave town the following morning to attend an event with her daughter. Upon presenting at an Albertson's pharmacy that evening at 8:00 p.m., the teacher was tested for strep. When the test came back positive, she was able to receive an antibiotic and begin treatment immediately at less cost than going to the doctor's office and without seeking emergency care.

TESTIMONY: **Susie Pouliot** introduced herself as the CEO of the Idaho Medical Association, the largest organization representing physicians in the State of Idaho, to speak in opposition to **H 191**. **Ms. Pouliot** stated if passed in its current form, the bill would be the most liberal independent prescribing law in the U.S. There are currently only two states that allow independent pharmacists to prescribe, California and Oregon, and there are additional parameters in those two states' laws that do not exist in **H 191**. California and Oregon laws include the drug classes allowed to be prescribed, and both states require consultation with their respective state medical boards and other entities to develop prescribing protocols, including protocols for patients under the age of 18. There are no such requirements in **H 191**, and the BOP would have discretion to decide how to use its broad new authority.

Ms. Pouliot commented the bill contains no specific guidance on the classes of drugs a pharmacist could prescribe. Such drugs could include travel medications, lice treatment, pink eye, or others, or even contraceptives. There is no specific direction from the Legislature on age limit or parental consent parameters for prescribing contraceptives as included in other state laws. The prescription of contraceptives will likely be a controversial policy issue that would be decided by rulemaking. While Idaho has a higher bar and all rules are ultimately approved by the Legislature, the rulemaking process does not afford the same level of public scrutiny, attention, or broad-based input as the legislative process.

Ms. Pouliot referred to **H 195** and **H 212** as examples of bills which outline in great detail the parameters for scope of practice, specific educational requirements, and specific drugs and types of patients the providers are allowed to treat. **H 191** is dramatically different from that approach because the bill contains none of those parameters and presents a question of whether the Legislature will cede its authority to the Executive branch to determine these policies. It also puts the BOP in the inappropriate position of acting as an advocate for the pharmacy profession rather than its proper role as a regulator of the profession to protect the public. Advocacy should remain solely in the realm of provider associations, not the regulatory boards, and **H 191** could change that.

Senator Foreman commented Ms. Pouliot brought up some good concerns, but the bill answers those concerns for him. The State is of necessity an advocate for everybody. The BOP would be allowed to write proposed regulations, and the necessary safety valve is legislative review. The bill would make health care more affordable and more available. **Senator Foreman** said **H 191** does not bother him, because all rules come back to the Legislature and the bill is not a blank check. **Ms. Pouliot** thanked Senator Foreman for his perspective and responded she fully understands the rulemaking process. She pointed out this bill is distinctly different than the past approach where the Legislature sets the parameters in statute first and the regulatory boards follow along with rules. **H 191** reverses that approach to allow the BOP to set parameters in rule, albeit with legislative review.

Senator Martin mentioned if this authority is granted to the BOP, a certain amount of money will be transferred from physicians to pharmacists. He asked if the financial issue is a concern to Ms. Pouliot's members. **Ms. Pouliot** answered the financial issue has never come up with her members, because everyone is aware there is a shortage of physicians. There are some good arguments to be made for expanding access for patients to obtain health care in places other than a doctor's office. Her only concerns are with the way the bill is drafted because policy parameters are not strictly defined in the bill.

Vice Chairman Souza commented that sometimes during the rulemaking process the entire Committee room is packed with people, and the process is followed very closely. The Legislature takes rulemaking very seriously, and it is an important part of the Legislature's job especially with Idaho's new constitutional amendment. **Ms. Pouliot** thanked Vice Chairman Souza and said she will try to comfort her members with that encouragement.

TESTIMONY: **Francoise Cleveland** introduced herself on behalf of AARP Idaho and its 85,000 members to speak in support of **H 191**. **Ms. Cleveland** reported that according to the U.S. Census Bureau and Social Security Administration, one in three older Idahoans rely solely on Social Security for their income at an average of $14,603 per year, with an estimated one of every six dollars spent on health care. Every opportunity to reduce costs for the senior population should be examined. Older Americans use prescription drugs more than any other segment of the U.S. population, typically on a chronic basis. For older adults, prescription drugs are critical to improve quality of life.

Ms. Cleveland stated AARP Idaho supports cost-reducing policies that increase access to quality health care. Providing alternate access for prescription medication saves both time and money for the patient as well as any caregiver involved. The pharmacists are one of the most successful health care providers in Idaho, and this bill will increase the availability of health care, especially in rural communities.

TESTIMONY: **Alex Adams** introduced himself as the Executive Director of the BOP. **Mr. Adams** advised the BOP approach to rulemaking is "what do we want - evidence-based change; when do we want it - after peer review." He feels the BOP has done a good job of sorting fact from fiction, as exemplified by the tobacco cessation bill. With that legislation, the BOP reviewed the peer-reviewed literature, talked to other states and jurisdictions that had implemented similar services, learned from other states' experiences, and brought a bill based on those experiences. Education, screening, referral, documentation, and notification requirements are all critical elements that will be considered in rulemaking for each drug, class of drug, or device that is authorized under **H 191** on an individual basis. It would not be possible to write "one size fits all" criteria in legislation.

Pam Eaton was recognized to summarize the bill presentation. Idaho has the most stringent rulemaking process in the country and is the only state where the Legislature looks at the rules and approves or does not oppose them. In other states, agencies can pass rules without oversight. **Ms. Eaton** informed the Committee she moved to Idaho from Washington, where she held a similar position on behalf of industry groups. In Washington, the only way to stop agencies from implementing overreaching rules with immediate effect was to file a lawsuit or ask the Legislature to pass a law to stop the rule after the fact. Idaho's rulemaking process is exceptional, and her counterparts in other states are jealous.

MOTION: **Senator Martin** moved to send **H 191** to the floor with a **do pass** recommendation. **Vice Chairman Souza** seconded the motion.

DISCUSSION: **Senator Lee** stated she appreciates the hard work that has gone into developing the legislation and intends to support the bill. She always considers how much discretion to give agencies and understands the concern. If this was an environment without scarce resources or no areas of limited access, she might look at it differently. The legislation can always be readdressed in future should the BOP take its discretion too far. She commends the BOP for its efforts to increase access in a measured, peer-reviewed, and data-driven way, and she looks forward to considering new proposals and constituency concerns in the future.

Senator Jordan said she too will support the bill because of Idaho's rulemaking process compared to other states without the same robust level of review. There are a number of people in the State who are uninsured or underinsured, and some have the additional burden of being underemployed. It is critically important for people to have access to basic health care, and if there are ways to facilitate that access through appropriate avenues, it is a win-win for everybody.

Vice Chairman Souza concurred with Senator Lee's comments about the close scrutiny of the Legislature and Senator Jordan's comments about improving access to health care. For people who don't have a lot of money and are struggling, health care premiums can be exorbitantly high and out-of-pocket expenses are particularly difficult. People often will forego having small things taken care of due to high deductibles or no insurance. This bill might help someone decide to stop smoking or purchase head lice shampoo or take a first step to stop an issue from progressing and becoming a expensive problem. She intends to support the bill.

The motion carried by **voice vote.**

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 3:44 p.m.

_____

Senator Heider
Chair

_____

Jeanne Jackson-Heim
Secretary

Fred Wood
Idaho House of Representatives
P.O. Box 83720
Boise, ID 83720-0038

Dear Dr. Wood:

I write to you in regards to Idaho House Bill 191 in my capacity as a Professor of Economics at Aquinas College.

The United States is one of the few countries in the world that "bottlenecks" access to certain medications by conditioning them on first obtaining a prescription from a physician or other healthcare provider licensed by the state.

For low-risk medications this creates system-wide inefficiencies. As one example, an individual who seeks a basic motion sickness patch in preparation for an upcoming cruise must traditionally:

- Schedule an appointment with a prescriber
- Take off work and pay a co-payment for an office visit
- Receive a prescription from the prescriber
- Take the prescription to a pharmacy to be filled

This increases costs to the healthcare system and particularly the consumer in both direct out-of-pocket cost and time-cost. In addition, it wastes critical primary care time that could otherwise be spent on higher priority care.

With respect to low-risk medications and low-risk health conditions, increasing access at pharmacies can unleash the benefits of private sector competition, namely increased access, lowered costs, and improved quality.

Several states have recently taken action to make consumer access to low risk medications easier, and the results that have been published have been very positive.

Sincerely,

Lewis Butler

Idaho State
UNIVERSITY

College of Pharmacy
Office of the Dean
921 South 8th Avenue, Stop 8288 • Pocatello, Idaho 83209-8288
1311 East Central Drive • Meridian, Idaho 83642-7991

February 20, 2017

Representative Fred Wood
Chairman, Health & Welfare
Idaho House of Representatives
P.O. Box 83720
Boise, ID 83720-0081

Senator Lee Heider
Chairman, Health & Welfare
Idaho State Senate
P.O. Box 83720
Boise, ID 83720-0038

Dear Chairman Wood and Chairman Heider:

As faculty members at Idaho State University College of Pharmacy, we write to you in strong support of House Bill 191.

This bill would increase patient access to simple, low-risk medications. Such an approach increases consumer access and can lower healthcare costs.

The Idaho State University College of Pharmacy recognizes the transformative potential of this bill for our profession. We have been training our students for many years to ensure our graduates are prepared for a broadened scope of prescriptive authority. Pharmacists are recognized as medication experts on the healthcare team, and they are consistently rated as among the most trusted professionals in the country.

As educators of future pharmacists, we are eager and excited to increase access to heathcare, particularly in a state with one of the lowest physician to patient ratios in the country. This bill is an important step in helping pharmacists be better leveraged to achieve their full potential in the state of Idaho, which can significantly improve public health goals for our state.

Sincerely,

Paul S Cady

Paul S. Cady, PhD
Dean & Professor

Phone: (208) 282-2175 • www.pharmacy.isu.edu
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Signature	Name	Idaho City of Residence
	Catherine Cashmere, PharmD	Pocatello
	Srinath Parshikanti, Ph.D	Pocatello
	Cara Liday PharmD CDE	Pocatello
	Brooke Bautista PharmD	Pocatello
	Richard Rhodes	Pocatello
	JAMES LAI	Pocatello
	Rebecca Hoover, PharmD	Pocatello
	Teddie Gould, PharmD BCPS	Pocatello
	Prabha . S. Awale PharmD Ph.D.	Pocatello
	Tracy Pettinger, PharmD	Blackfoot
	Brecon Powell PharmD	Idaho Falls
	JOHN ERRAMOUSPE PharmD, MS	POCATELLO
	Michelle Ivie, PharmD	Pocatello
	KERRY L. CASPERSON Ph.D.	Blackfoot
	Christopher Owens, PharmD	Pocatello

February 20, 2017

Representative Fred Wood
Chairman, Health & Welfare
Idaho House of Representatives
P.O. Box 83720
Boise, ID 83720-0081

Senator Lee Heider
Chairman, Health & Welfare
Idaho State Senate
P.O. Box 83720
Boise, ID 83720-0038

Dear Chairman Wood and Chairman Heider:

As student pharmacists at Idaho State University College of Pharmacy, we write to you in strong support of House Bill 191.

This bill would increase patient access to simple, low-risk medications. Such an approach increases consumer access and can lower healthcare costs.

All student pharmacists today graduate with a Doctor of Pharmacy degree that requires a minimum of six years of college to complete. We receive extensive training in pharmacology, pharmaceutics, pharmacokinetics, and we undertake a rigorous study of therapeutics. Pharmacists are recognized as medication experts on the healthcare team, and they are consistently rated as among the most trusted professionals in the country.

As future pharmacists, we are eager and excited to help address patient care needs within our education and training. This bill is an important step in helping pharmacists be better leveraged to their full potential in the state of Idaho, which can significantly improve public health goals for our state!

Sincerely,

Trent Galloway

Signature	Name	Idaho City of Residence
	John Travis	Meridian
Nain Travis		Meridian
Catalina Murguia	Catalina Murguia	Meridian
	Leticia Juarez	Boise
	David Tran	Meridian
	Brad Moon	Boise
	Jason LaFlamme	Meridian
	Brady Atwood.	Meridian
Dalila DelReal	Dalila DelReal	Meridian
Brooke Elliott	Brooke Elliott	Horseshoe Bend
Alison Waltman	Alison Waltman	Middleton
Jessica Marchetti	Jessica Marchetti	Meridian
Monica McLain	Monica McLain	Boise
Jennifer Diaz	Jennifer Diaz	Nampa
	Danielle Dulisse	Boise
	Eric Quiroz	Boise
	Kyle Allen	Meridian

Signature	Name	Idaho City of Residence
	Nathan Spann	Boise
	Jacqueline Spann	Boise
	Kevin White	Boise
	Dustin Stacey	Boise
	Amy Nelson	Caldwell
	Maisie Trang	Boise
	Gabi Nam	Boise
	Shanna Riomondo	Nampa
	Paul Davidson	Kuna
	Brittany Hoffel	Eagle
	Chelsy Okuma	Boise
	Justin Bell	Nampa
	Jennifer Ruwo	Boise
	Stephen A-Barky	Boise.
	Sabrina Sherwood	Boise
	Trent Galloway	Meridian

Signature	Name	Idaho City of Residence
	Mike Adams	Caldwell
	Julia Weber	Nampa
	Rebekah Dunlap	Boise
	Heather Shannon	Eagle
	Jodi Broyles	Meridian
	Marcus Michaels	Caldwell
	Melissa Malmin	Boise
	Cory Lankford	Emmett
	Ana M. Fish	Boise
	Dave Hall	Boise
	Megan Seewald	Boise
	Dan Nguyen	Nampa
	Nute Gutierrez	Nampa
	Akwasi Nim	Meridian
	Blake Schumacher	Meridian

Signature	Name	Idaho City of Residence
	C McKay	Middleton
	Richard Howard	Boise
	Drew Spanner	Boise
	Matt Phillips	Meridian
	Cassie Huckday	Nampa
	Haylee Muretto	Boise
	Kristin Cleverdon	Meridian
	Xiao Huang	Meridian
	Phillip Bettis	Nampa
	Emilie Medina	Meridian
	Garett Uhlorn	Boise
	Steve T. Flynn	Meridian
	JANETTE RODRIGUEZ	Meridian
	Todd Lundquist	Nampa
	Nick Matthis	Boise

Signature	Name	Idaho City of Residence
	Megan Echeverria	Boise
	Lindsey Collin	Boise
	Melvina Lake	Meridian
	Maribel Rincon	Eagle
	Marlee Motyer	Meridian
	Tanna Schlader	Meridian
	Grayson Bosen	Nampa
	Geoffrey Whitbeck	Meridian
	Taylor Smith	Boise
	Kaden Schultz	Nampa
	Fiona Mole	Boise

Signature	Name	Idaho City of Residence
Kathlene Bailey	Kathlene Bailey	Mountain Home
Sara Cox	Sara Cox	Boise, ID
Jennalyn Crapuchettes	Jennalyn Crapuchettes	Boise, ID
April Smith	April Smith	Boise, ID
Farheen Zehra	Farheen Zehra	Boise, ID
Jordan Davis	Jordan Davis	Nampa, ID
Dallas Evans	Dallas Evans	Boise, ID

Signature	Name	Idaho City of Residence
Angela Martin	Angela Martin	Boise
Chelsea Bagby	CHELSEA BAGBY	BOISE
Kylee J. Laffoon	Kylee Laffoon	BOISE

Name	Signature	City of Residence
Jenn Nguyen	[illegible]	Pocatello
Tucker Taufoou	[illegible]	Pocatello
Marianne Debra	[illegible]	pocatello
Cassidy Egan	Cassidy Egan	Pocatello
Kylie Hutchison	Kylie Hutchison	Pocatello
Kailey Moore	Kailey Moore	Idaho Falls
Jeremy Necbaue	[illegible]	Pocatello
Kayla Brawley	Kayla Brawley	Pocatello

Signature	Name	Idaho City of Residence
Mervan R Newbold	Mervan Newbold	Boise
[illegible]	James J. Hunt	Boise
Michael Hembree	Michael Hembree	Boise
[illegible]	Heather Waber	Caldwell
[illegible]	LEIGHTON MURR	BOISE
[illegible]	TIMTING FU	MERIDIAN

Signature	Name	Idaho City ofResidence
	Nate Reed	Pocatello
	Oscar Walch	Blackfoot
	Parker Webster	Pocatello
	Joshua Warner	Idaho Falls
	John Hall	Idaho Falls
Camilla Hancock	Camilla Hancock	Pocatello
	Jerad Cox	Pocatello
	JAMES CLINT HOUSLEY	POCATELLO
	TRAGER HINTZE	POCATELLO
Ryan Algate	Ryan Algate	Pocatello
	Curtis VanDerlin	Pocatello
	Annette Sprankle	Pocatello
	Jacob Crossley	Pocatello
CPR	Cotton Radford	Pocatello
	Jordin Millward	Pocatello
	Justin Alward	Pocatello

AARP Real Possibilities in Idaho

250 S. 5th Street, Suite 800 | Boise, ID 83702
1-866-295-7284 | Fax: 208-288-4424 | TTY: 1-877-434-7598
aarp.org/id | aarpid@aarp.org | twitter: @AARPIdaho
facebook.com/AARPIdaho

March 2, 2017

Senator Lee Heider, Chairman
Senate Health and Welfare Committee
Idaho State Capitol
Boise, ID 83720

RE: H 191

Dear Chairman Heider and Members of the Committee,

On behalf of 185,000 AARP Idaho members, I am encouraging your full support for House Bill 191. This bill would allow the Idaho Board of Pharmacy the rulemaking authority to designate to pharmacists the prescriptive authority for drugs within certain classifications.

According to the U.S. Census Bureau and the Social Security Administration, one in three older Idahoans rely solely on Social Security for their income at an average of $14,603 per year. With an estimated one of every six dollars spent on health care, every opportunity to reduce unnecessary cost for the senior population should be examined. Older Americans use prescription drugs more than any other segment of the U.S. population and typically on a chronic basis. For older adults, prescription drugs are critical in managing their chronic conditions, curing diseases, keeping them healthy and improving their quality of life.

AARP Idaho supports cost-reducing policies which increase access to quality health care. Providing alternative access for prescription medication saves both time and money for the patient as well as for any family caregiver involved. Since pharmacists are one of the most accessible health care providers in Idaho, this bill will increase availability to health care, especially in rural communities or when a patient cannot secure a timely appointment to see a provider. As highlighted in the U.S. Public Health Service's evidence-based report, *Improving Patient and Health System Outcomes through Advanced Pharmacy Practice, A Report to the U.S. Surgeon General 2011*, increasing pharmacist involvement in patient care results in greater cost savings across the health care spectrum.

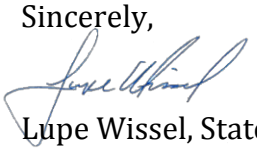
Since this authority would be given through the administrative rules process, the important principles of governmental transparency and public scrutiny would still be followed thus

AARP Real Possibilities

ensuring public safety. Ultimately, the legislature would still have the authority to reject the language before the final rule goes into effect.

For these reasons, we urge your support for H 191 and appreciate your consideration of this legislation. If you have any questions, please don't hesitate to contact my Associate State Director of Advocacy, Françoise Cleveland at (208) 855-4005.

Sincerely,



Lupe Wissel, State Director
AARP Idaho

Idaho Society of Health System Pharmacists

Statement of support for HB-191

The Idaho Society of Health System Pharmacists (ISHP) is in full support of Idaho House Bill - HB191 which amends and adds to existing language that helps provide clarity towards the pharmacist's role in providing medications where there is patient need. Currently this includes such medications like naloxone and epinephrine kits that may be prescribed and administered in certain circumstances like opioid overdose or to enable a patient to have the medication available to help mitigate an allergic reaction.

Amending 54-1704 allows for broadening of the types of low-risk conditions pharmacists are able to assist clinicians with providing care to the residents of Idaho. House Bill 4, the Tobacco Cessation bill, which enables pharmacists to provide tobacco cessation products directly to patients, recently evidenced this. The language allows pharmacists to assist with bridging the gap between appointments should the provider not be available in an emergent situation. Pharmacists are in a unique position to provide this front line care. Language such as this also enables our profession to identify areas in which we can have impact and with working through the Board of Pharmacy and the Idaho Legislature create programs for pharmacists to facilitate timely access to low-risk drug therapies.

In conclusion, ISHP, as a representative of pharmacists across Idaho, supports House Bill – HB191, so that patients and caregivers can have timely access to approved therapies and help mitigate emergent situations.

Sincerely,

ISHP Board

Lindsay Kaster, PharmD, BCOP, ISHP President
Chris Oswald, PharmD, BCPS, BCCP, ISHP Immediate Past President
John Sullivan, PharmD, ISHP Legislative Affairs Chair
Ryan Fitzgerald, ISHP Executive Director
Rob Wills, PharmD, BCPS, ISHP President Elect

UNIVERSITY OF Nebraska Medical Center

COLLEGE OF PHARMACY
Department of Pharmacy Practice

February 17, 2017

Representative Fred Wood
Chairman of Health & Welfare Committee
Idaho House of Representatives
P.O. Box 83720
Boise, ID 83720-0038

Dear Representative Wood,

As a health economist with hands-on experience implementing and evaluating healthcare delivery models like that proposed in H 191, I write to you to share my experiences.

My most direct experience is in evaluating models in which medications for influenza and strep throat are made available directly at a pharmacy (with screening procedures and referral mechanisms in place). In one of our pilot studies, among the patients with influenza-like illness who sought care at pharmacies:

- 34.6% of the patients had no primary care physician;
- 38.7% of the patients visited the pharmacy outside of normal physician office hours; and
- Because of strict evidence-based guidelines, only 11% of patients left with an antiviral, and 0% left with an antibiotic.

Thus we found the model to lower overall healthcare costs from avoided emergency room visits, avoided urgent care visits, and even reduced overall volume of prescriptions. Moreover the model was safe, effective, and highly rated by patients in follow-up surveys.

If you have any questions about my research, I would be happy to connect at your convenience (dklepser@unmc.edu; 402-559-4927).

Best regards,

Donald G. Klepser, PhD, MBA
Associate Professor
Vice Chair of Pharmacy Practice

986045 Nebraska Medical Center / Omaha, NE 68198-6145
402-559-5366 / FAX 402-559-5673

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

3:00 P.M.
Room WW54
Thursday, March 09, 2017

SUBJECT	DESCRIPTION	PRESENTER
Approval of Minutes	Minutes of the February 22, 2017 Meeting Minutes of the March 1, 2017 Meeting Minutes of the March 2, 2017 Meeting	Senator Jordan Senator Martin Senator Harris
HCR 9	Relating to Rare Diseases	Representative Wintrow
H 195	Relating to Chiropractic Practice	Ryan Fitzgerald Idaho Association of Chiropractic Physicians
S 1142	Relating to the Health Care Assistance Program	Senator Hagedorn

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Thursday, March 09, 2017
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Harris, Anthon, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	Senator Lee
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.
APPROVAL OF MINUTES:	**Senator Jordan** moved to approve the Minutes of the February 22, 2017 meeting. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**
	Senator Martin moved to approve the Minutes of the March 1, 2017 meeting. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**
	Senator Harris moved to approve the Minutes of the March 2, 2017 meeting. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**
HCR 9	**A House Resolution Relating to Rare Diseases. Representative Wintrow** introduced herself to the Committee to present **HCR 9**. **Rep. Wintrow** stated the resolution is written to raise awareness about rare diseases that occur in Idaho, especially in young children, and the lack of pediatricians and pediatric neurologists. She has already received e-mails of interest from people who want to get involved and create networks to help with this issue. **Rep. Wintrow** yielded to Tonya Harvey to present additional information.
	Tonya Harvey introduced herself to the Committee as the mother of a two-year-old son with a rare disorder. Her son was born a happy full-term baby but shortly after his birth, he began showing a variety of symptoms and struggled with breathing and eating. They saw numerous specialists and attended up to four doctor appointments per week, but no one could diagnose the problem. At 11 months, her son became unresponsive at day care and was hospitalized for nearly three weeks. They were referred to Seattle Children's Hospital, and six months ago he was diagnosed with glucose transporter type 1 deficiency syndrome, a rare genetic metabolic disorder involving deficiency of a protein required to carry sugars across the blood frame barrier. The disorder leaves the brain starved of fuel and energy, and there is no cure. The treatment is a special diet that tricks the brain to use fats for fuel instead of sugar.

Ms. Harvey said her goal is to advocate for awareness and change for rare disorders. There is one genetics clinic in all of Idaho and there is a nine month wait list. Her son almost died while awaiting treatment at that clinic. She feels Idaho's programs are overcrowded and underfunded. Her son is on all of the State programs, and they have been waiting months for home nursing. Physicians must be educated on the importance of early recognition of disorders to avoid devastating impacts on brain development. It creates stress on families to travel outside of Idaho, and other states reap the financial benefit for that treatment. Idaho should invest more time, attention, and resources on children's disorders. A communications network is needed for Idaho's specialists to network with specialists in surrounding states to manage patients in Idaho with less travel. Idaho needs pediatricians and family practice doctors who are willing to devote a portion of their practice to rare disorders.

Ms. Harvey commented she is grateful for all her son's doctors, and Seattle Children's Hospital has proven to be a life changer for her son because they preserved his brain development by acting quickly. Not all moms are as aggressive at finding a diagnosis as she is, and she wants to be an advocate to support families affected by rare disorders and complex diseases.

Senator Jordan asked if Ms. Harvey is aware of information about states with more resources dedicated to these rare diseases as a model for what the ideal might look like in Idaho. **Ms. Harvey** replied Seattle Children's Hospital works closely with the University of Washington and has a number of neurologists, while St. Luke's Children's Specialty Unit has the only pediatric gastroenterologist and pediatric pulmonologist in the entire State. Seattle and Salt Lake City are good resources for specialists, but it would be nice to reduce travel out of state for doctor visits.

Senator Souza commented the Legislature has been discussing telehealth. She asked if it would be helpful to use some kind of video conferencing or technology solution with a specialist in Seattle for some of the visits, or must the neurologist perform a hands-on examination. **Ms. Harvey** answered she doesn't know anything about telehealth. She has since learned about Project Echo, and she thinks it would have been instrumental in getting an earlier accurate diagnosis and avoid needless procedures and travel. Project Echo has committees that review cases as a group and uses a Skype-type consultation that is cost effective and more efficient.

Dr. James M. Quinn introduced himself to the Committee to describe Project Echo, an extension of a community health program in New Mexico. A specialist in hepatitis noticed a huge increase in hepatitis C in the area, and the doctor tried to get people to come to Albuquerque to the hospital. There were many rural patients who did not want to travel that far, and there were patients who didn't speak English. The specialist began a program to travel to the rural areas to treat the patients, and those patients got as good treatment as the patients who traveled to Albuquerque.

Dr. Quinn commented medicine should be brought to the people, not the other way around. Traveling to a large city from a rural area is intimidating and expensive, especially when multiple trips are required. Clinics in rural areas and large health centers can be connected by computer technology. The patient can be in a familiar environment and have the same discussion with the doctor as if physically present. **Dr. Quinn** suggested obtaining New Mexico's model as a template. People will go along with this approach if legislators support it and take the information back to their constituents. Patients will save money, time, and their jobs, and the State will save money by not sending Medicaid dollars to neighbor states. This would keep people in their homes.

Rep. Wintrow was recognized to summarize the presentation. The resolution is a good start in raising awareness of the issue. She agrees with the concept of bringing the knowledge to the patients and creating learning communities to support doctors in Idaho.

MOTION: **Senator Jordan** moved that **HCR 9** be sent to the floor with a **do pass** recommendation. **Senator Martin** seconded the motion. The motion carried by **voice vote.**

H 195 **Relating to Chiropractic Practice. Ryan Fitzgerald** introduced himself to the Committee on behalf of the Idaho Association of Chiropractic Physicians (IACP) to present the bill, which addresses the administration of injectable intravenous (IV) nutrients by Idaho chiropractors.

Mr. Fitzgerald said over the last 40 to 50 years, nutritional substances formerly provided to patients by oral and topical means are now administered by injectable and IV methods. Idaho chiropractic physicians (DCs) have provided nutrition via oral and topical means since the inception of chiropractic in Idaho, and many DCs have obtained advance training to provide injectable and IV micronutrients to their patients. Due to federal regulatory changes by the Food and Drug Administration (FDA) in 2008 and 2012, the labeling and regulation of injectable and IV nutrients has changed from a basic natural substance to a prescriptive product which has eliminated the ability of Idaho DCs to provide these treatments.

Mr. Fitzgerald worked with other industry groups and state agencies to develop a balanced approach to allow chiropractic patients to continue accessing these treatments. **H 195** allows a DC who has completed standardized, accredited, post-doctoral education to obtain a clinical nutrition certification by the Idaho State Board of Chiropractic (BOC). The certification would allow the DC to administer IV and injectable nutrients for patients. The bill will establish a specific list of vitamins, minerals, sterile fluids, and emergency substances that can be utilized by chiropractors holding the certification. The bill also provides a set of standards to ensure patient safety, including the requirement for the DC to follow specific safe dosing requirements established by the FDA.

Mr. Fitzgerald stated the bill requires a certified DC to obtain the nutritional substances from a distributor licensed by the Board of Pharmacy to ensure compounding of nutritional substances and the measurements or dosing of those substances will be completed by a licensed pharmacist at a licensed pharmacy outlet. A certified DC would be required to obtain informed consent when providing this type of treatment and must maintain lifesaving certifications and equipment to ensure patient safety in the case of an adverse effect. Finally, the bill directs the BOC to establish continuing education requirements and guidelines for biennial recertification for DCs holding a certification in clinical nutrition.

Mr. Fitzgerald informed the Committee the first few pages of the bill include clean-up language from the Legislative Services Office. Pages 4 through 7 of the bill contain identical language as **H 10** which has already been signed into law by the Governor. Beginning on page 8, the bill includes a new section outlining the stated formulary and safety standards, while page 9 provides the accredited education DCs will be required to obtain. The last page adds chiropractors to the list of health care providers identified by the Board of Pharmacy who can obtain and administer limited substances.

Mr. Fitzgerald commented the bill is a basic and transparent approach to the use of nutritional substances with specific standards and education that all licensees and the regulatory board can understand. There is no fiscal impact to the General Fund, but it does establish a certification fee to cover the cost of reviewing applications by the BOC. This bill has involved three to four years of work and represents the balanced approach requested by legislators.

TESTIMONY: **Dr. Tim Clenha** introduced himself to the Committee to speak in support of **H 195**. **Dr. Clenha** is a DC who has practiced in Boise since 1989. He moved here from California as an athlete to play football and track at Boise State University in 1980. He finished his bachelor's degree in health science in 1985 and his doctorate in chiropractic from the University of Western States in 1989.

Dr. Clenha said his nine years of education prepared him in all basic health sciences, nutritional studies, sports injuries and prevention, general patient care, phlebotomy, and blood lab analysis. He is a diplomate as a board-certified chiropractic orthopedist, which is an additional 400 hours of training covering simple and complex bone and soft tissue injuries utilizing splints, casts, and taping procedures and provided training in treatment using nutritional supplements. He served 13 years as one of the sports DCs for the Idaho Steelheads. He served in nearly all capacities in the IACP, including three years as president. He worked on the task force for **H 195** over the last 18 months to coordinate efforts with University of Western States in Portland on educational standards and with the BOC on statutory language.

Dr. Clenha informed the Committee an Idaho DC is often the initial health care provider, especially in rural areas. Idaho ranks near the bottom of states in regard to physician to citizen ratio, and patients will seek out DCs for conservative treatments not requiring hospitalization. DCs often see acute musculoskeletal pain caused by pathogens such as bacteria and viruses. Often the patients have conditions unresolved by other health care treatments and want safe, non-addictive, and conservative approaches to care, sometimes as a last resort.

Dr. Clenha commented the chiropractic profession, begun in 1895, ranks nationally as the third largest health care provider behind allopathic medicine and dentistry. The average DC has completed a four-year bachelor's degree prior to the 4,500 hours required for the doctorate, including an average of 250 hours in nutritional studies. The majority of over 700 DCs in Idaho practice nutrition in their offices daily. As a profession, DCs balance physical, chemical, and emotional components of life and focus on the significance of a health lifestyle, educating patients on proper daily ergonomics, prescribing preventative and rehabilitative exercises, and counseling on proper nutrition that limits inflammation-causing pain and disease. DCs routinely perform spinal manipulation, utilize various physiotherapies like ultrasound and electric muscle stimulation, and perform x-rays to better evaluate a patient's condition. They take blood work and look for imbalances and deficiencies and then prepare a treatment plan to restore health.

Dr. Clenha stated oral supplementation of vitamins, minerals, essential fatty acids, digestive enzymes, and probiotics are routine treatments in his office. When these measures are followed and the illness persists, there is time for advanced nutritional delivery methods by subcutaneous, IV, and intramuscular (IM) nutrient administration. An unhealthy gut prevents and delays healing, and a very sick individual who presents in a dehydrated and malnourished state needs an expeditious route of nutritional delivery.

Dr. Clenha mentioned in 2007 he completed a 36-hour post-graduate course taught by an adjunct professor of Texas Chiropractic College. The course provided him with skills to perform advanced nutritional delivery methods. His patients signed a consent form and received nutrients such as IM B-12 and specific doses of IV vitamin C, among other micronutrients. The positive outcomes far surpassed his expectations, and he continued to practice in this manner until he received a cease and desist letter from the BOC in July 2016 when he stopped performing this treatment.

Dr. Clenha advised the bill would establish standardized and accredited post doctoral education all DCs must complete, whether they are previously trained or not, in order to provide these additional nutritional methods. As a physician who obtained proper training 10 years ago, he is willing to return to school to ensure he meets all necessary standards established by the BOC. **H 195** would re-establish his ability to use injectable vitamins and minerals, assure appropriate education and training from a federally accredited chiropractic university, and provide necessary oversight and safety standards in treatment of patients. Patients will have access to the health provider of their choice, offering alternatives to patients.

Senator Harris asked how much time the additional training will take to complete. **Dr. Clenha** answered 100 hours.

TESTIMONY: **Suzie Pouliot** introduced herself to the Committee on behalf of the Idaho Medical Association, representing medical doctors and doctors of osteopathy, to speak in opposition to the bill. The IMA opposes **H 195** because of a lack of evidence-based, peer-reviewed studies that demonstrate the results asserted in anecdotal stories from patients who undergo these treatments. Many of the treatments that would be allowed under the bill would likely have to be paid for out of pocket because insurance companies typically do not cover these services.

TESTIMONY: **Dr. Marshall Priest**, a Boise cardiologist for 38 years, introduced himself to speak in opposition to **H 195** because it is outside the scope of practice for chiropractors as defined by the National Board of Chiropractic Examiners in 2015. The only true medical indication for the IV infusion of vitamins and minerals is for intestinal malabsorption, such as Crohn's disease, short gut syndrome, and human immunodeficiency virus. Vitamin and mineral infusions are often packaged as immunity drips, anti-aging drips, and energy drips, none of which have any scientific evidence to support their efficacy.

Dr. Priest explained potassium is one of the elements that would be allowed for infusion, and the normal limits of potassium in the human body are very narrow. Exceeding that narrow limit could potentially trigger a fatal cardiac arrhythmia. Iodine is another element listed for infusion, and iodine in certain people creates a severe allergic reaction called anaphylaxis which creates difficult breathing, airway obstruction, and cardiac collapse requiring resuscitation. **Dr. Priest** expressed concern regarding accountability for adverse outcomes potentially relatable to infusion of these substances and the ability to provide comprehensive resuscitation in patients who have a severe adverse reaction. He asked the Committee to consider the lack of scientific evidence and studies and the potential implications of putting this language into Idaho Code.

Senator Jordan mentioned she understands the absence of studies and inquired whether there are studies showing adverse reactions when the proposed protocols are implemented in the chiropractic community. **Dr. Priest** answered he does not know of any studies either supporting the efficacy or showing adverse outcomes.

Senator Martin asked if Dr. Priest is aware of any patient reactions resulting from these treatments prior to the time they were precluded. **Dr. Priest** replied he is not aware of any.

Mr. Fitzgerald was recognized to summarize the bill presentation and stated this practice has been ongoing in Idaho chiropractic offices for many years. It has been available in Oklahoma since 1986, with over two million injectable nutrient treatments and no adverse effects. The bill ensures safety standards, and the BOC will bring rules to establish specific safety measures to be included in DC offices such as oxygen and epinephrine. Patients are seeking these treatments and they are currently being done in other medical offices, so he challenges the comments regarding the efficacy of the treatments.

Vice Chairman Souza asked for more specifics about the safety equipment and procedures for the chiropractor offices. **Mr. Fitzgerald** responded Alex Adams of the Board of Pharmacy helped draft the bill. DCs will use FDA guidelines that limit dosages to micro amounts. The IMA and Board of Pharmacy will provide guidance on safety procedures, including epinephrine and oxygen as well as lifesaving certifications and equipment. The rules may also provide for automated external defibrillators (AEDs) in offices, and many DCs have AEDs in their clinics now.

MOTION: **Senator Harris** moved to send **H 195** to the floor with a **do pass** recommendation. **Vice Chairman Souza** seconded the motion.

DISCUSSION: **Senator Anthon** spoke in favor of the motion as the minimal amount of regulation necessary to protect the public health and welfare. He would almost argue the bill goes too far and appreciates the parties have worked together to bring the legislation. His test is to talk to the local doctors in his area, and he trusts their opinion. One of his local doctors is present today and would testify in favor of the bill. This is good legislation and he supports it.

Senator Martin commented he appreciates the work of Senator Hagedorn and others in crafting the bill, and he also supports the legislation.

The motion carried by **voice vote.**

S 1142 **Relating to the Health Care Assistance Program. Senator Hagedorn** introduced himself to the Committee and explained he co-chaired a task force in summer 2016 to address health coverage for the Medicaid "gap" population. He referred to the task force's final report (see Attachment 1) and reviewed the unanimous recommendations in the report.

Senator Hagedorn stated **S 1142** contains all the task force recommendations except for Medicaid expansion and covers eligible participants with regular primary care and care management for chronic conditions. The cost is roughly $10 million which will be insufficient to cover the enter gap population, but many with chronic conditions are obtaining care through emergency rooms and hospitals providing charity care. Those costs are passed on to the insurance companies and subsequently to the insured through premiums.

Senator Hagedorn explained the objective is to get these patients healthy through a managed primary care system. The bill will transfer the current system from a volume-based fee-for-service model to a value-based system of care through clinics utilizing a care coordination and case management model. The program will pay a dollar amount per month per patient to a medical provider to improve and maintain the patient's health. It will be up to the medical provider to take the risk on how many times to see the patient to accomplish that goal, so it will be to the provider's benefit to get the patient healthy as soon as possible.

Senator Hagedorn said he started working last summer with Director Armstrong to put a bill together. The Department of Health and Welfare (Department) already has some programs moving in the same direction. The objective is not to compete with federal requirements for Medicaid but to set up an Idaho system to provide primary care and incentive for providers to provide managed care.

Senator Hagedorn informed the Committee a program participant must fill out an application and have income, household composition, and citizenship verified to ensure eligibility. The Department will set out other eligibility requirements in rule regarding smoking-related illness and other chronic conditions, as the funding will come from the Millennium Fund. Providers must also meet certain criteria to provide health care services, as well as agree to collect and submit usage and clinical data based on the population served so the program can be adjusted to properly meet the needs of patients with chronic conditions. A monthly fee for each participant who receives primary care and limited prescription care coordination services will be paid to the provider, and the provider will charge the participant a fee not to exceed $20.

Senator Hagedorn commented there is a population in need of assistance, and Idaho needs to change the market and bend the health care delivery model cost curve. He asked that the bill be sent to the Fourteenth Order for amendment to clarify the care management and member accountability as well as the clinical and utilization data to be collected and reported.

Vice Chairman Souza asked if this is an ongoing entitlement or a handout. **Senator Hagedorn** answered it is not an entitlement but rather help people with chronic illness get well and lower costs for a population that currently costs Idaho taxpayers a tremendous amount of money. **Vice Chairman Souza** inquired if the proposal is similar to direct primary care. **Senator Hagedorn** replied a direct primary care physician testified to the task force about a direct primary care program. That physician said to keep his doors open, he needs to see between 800 and 1,000 patients per month. A fee-for-service primary care physician testified he needed to see 3,500 patients per month to continue operating. The direct primary care doctor has more time to spend with patients to understand and care for their needs. The public will see the benefit of seeing a doctor regularly.

Vice Chairman Souza commented the typical doctor visit in a regular doctor office is seven to ten minutes, and in the direct primary care setting it tends to be 20 to 40 minutes. This extended time gives the physician a chance to inquire about a patient's life stressers to turn illness visits into wellness visits. She asked if the program will sunset or if it will be an ongoing effort. **Senator Hagedorn** responded the bill sunsets in June 2022 to find out if the program is effective, based on provider and patient feedback. It is likely the program will be amended every year to fine tune it, based on what the federal government does with Medicaid and insurance programs. For the last eight years, the focus has been on insurance, and there has been no focus on the delivery of health care. A fee-for-service doctor must spend 40 percent of his revenue collecting fees and can only see patients seven minutes a day. This program will allow a doctor to spend more time with patients. There will be a shortage of doctors at first, and some things might need to be changed to make it work, but Idaho needs to move in this direction.

Senator Harris referred to Idaho Code § 56-276 and asked the amount of the monthly fee to be paid to the provider. **Senator Hagedorn** answered it is unknown at this time. The estimate is from $700 to $1,000 annually per patient. Some providers will take a chance and agree to see patients for $45 a person, and then evaluate whether there was a return on investment. The first year, any primary care provider is eligible to go under contract with the Department to take a certain number of contracts.

Senator Anthon also referred to Idaho Code § 56-276 and the fee not to exceed $20 paid by the participant, and he asked whether it will be a monthly fee. **Senator Hagedorn** replied it will be a fee per visit. The participant is the patient. The provider will receive a monthly stipend from the Department every month. If the participant needs to see the doctor, there will be some type of fee charged, as determined by the provider. **Senator Anthon** commented the language might need to be tweaked a bit.

Senator Jordan acknowledged Senator Hagedorn's work on this project. She referred to the fiscal note regarding funding of $10 million from the Millennium Fund and commented the Joint Finance and Appropriations Committee (JFAC) took an action the previous day that calls into question whether that sum will be available. **Senator Hagedorn** answered he is aware of the JFAC bill, and that is a policy question to be determined. Spending from the Millennium Fund might have to be reconsidered if **S 1142** passes. **Senator Jordan** inquired if there is funding available today, or if the earliest funding would be in FY 2018. **Senator Hagedorn** answered until the JFAC bill passes both houses, funding is available today in the Millennium Fund.

Chairman Heider said he appreciates all who came to testify. Since time does not permit additional testimony, he asked for a show of hands who is in favor of the bill, and how many are against. (A significant majority of hands raised were opposed to sending the bill to the floor.) (See Attachments 2 and 3 for additional testimony.)

MOTION: **Vice Chairman Souza** moved to send **S 1142** to the floor with a recommendation it be referred to the Fourteenth Order for possible amendment. **Senator Foreman** seconded the motion.

DISCUSSION: **Senator Jordan** declared she will vote against the motion. She is grateful for the effort and conversation on the issue. The federal government proposal announced this week includes continued Medicaid expansion, and she believes that approach is clearly the best for Idaho from a fiscal responsibility standpoint. The $10 million program cost could be used for matching funds at least through FY 2020. She expressed concern that people did not have an opportunity to testify.

The motion carried by **voice vote**. **Senator Jordan** requested she be recorded as voting nay.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:07 p.m.

Senator Heider Chair	Jeanne Jackson-Heim Secretary

FINAL REPORT

Healthcare Alternatives for Citizens below 100% of Poverty Level

Members of the Working Group

Senator Marv Hagedorn, Co-Chair
Senator Patty Anne Lodge
Senator Steven Thayn
Senator Jim Guthrie
Senator Maryanne Jordan

Representative Tom Loertscher, Co-Chair
Representative Fred Wood
Representative Judy Boyle
Representative John Vander Woude
Representative Sue Chew

Staff

Elizabeth Bowen, Senior Legislative Research Analyst
Jared Tatro, Principal Budget and Policy Analyst
Jackie Gunn, Committee Secretary
Jennifer Kish, Committee Secretary

November 22, 2016

I. Working Group Charge

The Healthcare Alternatives for Citizens below 100% of Poverty Level Working Group was authorized by the Legislative Council at its meeting on June 17, 2016. The purpose of the working group was to investigate and identify alternative policies for providing health care to Idahoans in the "coverage gap," i.e., low-income individuals who neither qualify for Medicaid nor qualify for subsidies to purchase health insurance on the state exchange.

II. Meetings

The working group met six times at the State Capitol in Boise on the following dates:

1. July 20, 2016;
2. August 11, 2016;
3. August 29, 2016;
4. September 28, 2016;
5. October 24, 2016; and
6. November 22, 2016.

III. Scope of Investigation and Findings

At its meetings, the working group considered information and proposals presented by a number of stakeholders. The working group also heard public testimony from 35 individuals and considered over 500 written public comments submitted to the Legislative Services Office between July and November. A complete list of persons who presented or testified to the working group may be found in Appendix I of this report. The written comments are on file in the Legislative Services Office: Division of Research and Legislation.

Based on the information, proposals, and comments considered, the working group finds that it would be in the best interest of the state to provide health care of some kind to the individuals in the coverage gap. The gap population includes the working poor as well as individuals who face significant or potentially significant challenges due to physical, mental, or behavioral health conditions. Investing in this population now to ensure better health and productivity will likely benefit the state, fiscally and otherwise, in the long term.

IV. Recommendations

Having completed its authorized investigation, the Healthcare Alternatives Working Group has identified two potential methods by which to provide health care of some kind to individuals in the coverage gap. Both methods have advantages and disadvantages as discussed below.

One method would be to expand the state's Medicaid plan to cover individuals whose income is at or below 138% of the federal poverty level. This would qualify the state for increased federal funding under the Affordable Care Act; however, the state would, by 2020, be required to provide 10% matching funds to cover the expansion. For Medicaid expansion to be a viable option, certain provisions of the Affordable Care Act would need to remain in effect in 2017 and thereafter. In light of the recent election results, it is unknown at this time if Medicaid expansion will continue to be an option going forward.

Another method would be a state-funded program that provides health care of some kind to at least some individuals in the gap. It is the belief of the working group members that a comprehensive state health program could be prohibitively expensive; therefore, a state program might need to be limited in scope, both in the number of persons covered and in the type of care provided.

Again in light of the election results, the working group will not recommend a specific method at this time. The working group does, however, make the following recommendations:

1. A policy to provide health care of some kind to the gap population should be enacted by the 2017 Legislature;

2. If legislation to expand Medicaid of any type is considered by the Legislature, such legislation should include a conditional sunset clause in the event that federal policy changes;

3. All Medicaid populations, including any expansion populations, should be moved to managed care as soon as possible;

4. A state-funded program should include a direct care component for primary and preventative care; and

5. Funds for a state program or for the state share of Medicaid expansion should come from the Millennium Fund and from the general fund as needed.

APPENDIX I

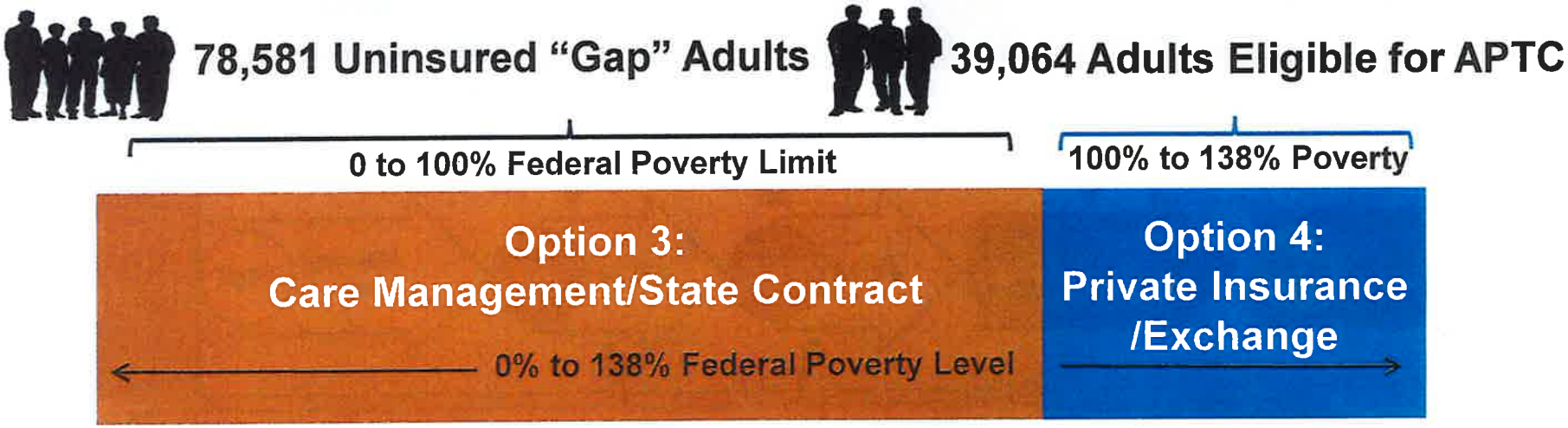
Persons who presented or testified to the working group

Persons who presented or testified to the working group (date of presentation or testimony)

1. Aaron White (9.28.16)
2. Alec Porteous, Maine Department of Health and Human Services (8.11.16)
3. Anna Rostock (9.28.16)
4. Bill Leake, Idaho Public Health Districts (9.28.16)
5. Brittany Ruland (9.28.16)
6. Bruce Belzer, Idaho Medical Association (9.28.16)
7. Chelle Gluch (9.28.16)
8. Clella Steinke (9.28.16)
9. Corey Surber, Close the Gap Coalition (9.28.16)
10. Darin Lee, St. Alphonsus Hospital (8.11.16)
11. Dannielle Ryals (9.28.16)
12. Deborah Bachrach, Manatt (8.29.16)
13. Deborah Fournier, New Hampshire Department of Health and Human Services (10.24.16)
14. Dick Cauchi, National Conference of State Legislatures (10.24.16)
15. Elizabeth Bowen, Legislative Services Office (8.29.16; 9.28.16; 10.24.16)
16. Elting Hasbrouck, Valley County Commissioner (9.28.16)
17. Erika Bliss, Qliance Medical Group of Washington (8.11.16)
18. Francoise Cleveland, AARP Idaho (9.28.16)
19. Frank Monasterio (9.28.16)
20. Fred Birnbaum, Idaho Freedom Foundation (9.28.16)
21. Gregg Pfister, Foundation for Government Accountability (9.28.16)
22. Heidi Traylor, Terry Reilly Health Services (8.11.16)
23. Ingrid Brudenell (9.28.16)
24. James Baugh, Consortium for Idahoans with Disabilities (9.28.16)
25. Jared Tatro, Legislative Services Office (8.29.16)
26. Jeremy Monroe (9.28.16)
27. Jesus Blanco (9.28.16)
28. Jim Brook (8.29.16)
29. John Livingston, Idaho Freedom Foundation (9.28.16)
30. Jon Miller (9.28.16)
31. Katharine McNeery (9.28.16)
32. Lauren Necochea, Idaho Voices for Children (8.11.16)
33. Leanne Rousseau (9.28.16)
34. Lorin Nielsen, Bannock County Sheriff (9.28.16)
35. Luke Cavener, American Cancer Society Cancer Action Network (9.28.16)
36. Marilena Delgado (9.28.16)

37. Marshall Priest, Idaho Heart Association (9.28.16)
38. Mary Barinaga (9.28.16)
39. Matt Forge (9.28.16)
40. Melody Hayden (9.28.16)
41. Mike Foutz (9.28.16)
42. Mindy Hong (9.28.16)
43. Neva Santos (9.28.16)
44. Richard Armstrong, Department of Health and Welfare (7.20.16)
45. Samantha Joseph (9.28.16)
46. Scott Dunn (9.28.16)
47. Scott Shurtleff, Project Access Northwest (8.29.16)
48. Steven Kohtz (9.28.16)
49. Stewart Lawrence (9.28.16)
50. Susan Souvenir (9.28.16)
51. Ted Epperly, Family Medicine Residency of Idaho (8.11.16)
52. Tim Heinze, Close the Gap Coalition (9.28.16)
53. Tina DeBoer (9.28.16)
54. Travis Applebaum (9.28.16)
55. Xenia Williams (9.28.16)
56. Yvonne Ketchum-Ward, Idaho Primary Care Association (8.11.16)

Option 3.5: A Blend of Managed Care/Private Insurance



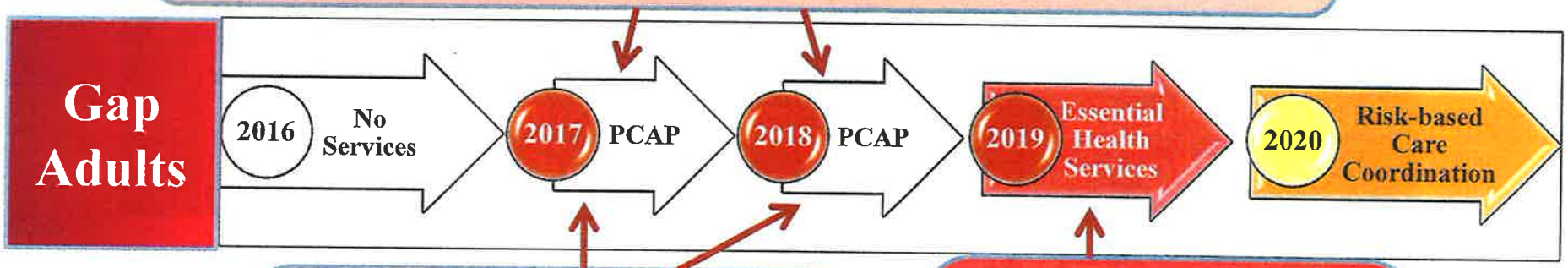
- During the next 10 years, state and local offsets totaling $915.4 million cover the recommendation's costs and result in a state/local tax savings of $173.4 million.
- Provides 103,000 people with access to healthcare coverage
- Supported by CMS

IDAHO DEPARTMENT OF HEALTH & WELFARE

2015-2016: Primary Care Access Program

PCAP sets foundation for successful transition to all essential health services

Primary Care Access Program (PCAP): State funded effort connects adults in Gap to coordinated preventive and primary care, setting the foundation for easy transition to all essential health services.



- Sliding income based fee
- Care coordination for chronic conditions
- Discounted pharmacy, office-based basic behavioral health
- Does not include hospitals, specialists

Access to coordinated, essential health services:

- **Preventive & primary care**
- **Hospitals**
- **Specialists**
- **Full pharmacy**
- **Behavioral health**

Transforming Idaho Healthcare

IDAHO DEPARTMENT OF HEALTH & WELFARE

1

STATE HEALTHCARE INNOVATION PLAN (SHIP)

- Convert Idaho primary care practices to Patient-centered Medical Home Mode
- 7 Regional Collaboratives
- Align payment mechanisms to focus on quality
- Improve care coordination through electronic health records

2

IDAHO MEDICAID

- Moving providers to PCMH
- Paying for quality
- Transforming to episodic payment
- Share savings when quality achieved

3

GAP ADULTS

- PCAP sets foundation
- Improve access to essential health services

4

RISK-BASED CARE COORDINATION

- Healthcare delivered through PCMH model
- Everyone has access to essential health benefits
- Payment systems reimburse for quality
- Providers and taxpayers share savings

Where Are We Now?

IDAHO DEPARTMENT OF HEALTH & WELFARE

Risk Base Care Coordination for Medicaid

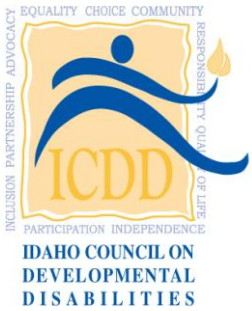
- Begin payment change 2017
- Significant transformation 2018

Gap Sub-Populations

- $12M with 10,000 people indigent/CAT
  - 35% cycle -- multiple times
  - Each time increased costs per episode

- $10.5M with 5,600 people in Probation/Parole

(Based on information from WICHE Justice Reinvestment Analysis on Behavioral Health)



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C. L. "Butch" Otter
Governor

Debra Parsons
Chair

Christine Pisani
Executive Director

March 9, 2017

Senator Lee Heider, Chairman
Senate Health and Welfare Committee
Statehouse
Boise, ID 83720

RE: Senate Bill 1142

Chairman Heider and Committee Members:

The Council on Developmental Disabilities is authorized by federal and state law to monitor systems and policies and to advocate for improved and enhanced services that enable Idahoans with developmental disabilities to live meaningful lives, included in their communities. The Council is comprised of 23 volunteers appointed by the Governor.

The Council applauds the efforts and commitment of Senator Hagedorn for working diligently to resolve the lack of health insurance coverage. The leadership of Chairman Wood and Senator Hagedorn on health care coverage for Idahoans is recognized and appreciated.

It is never a bad idea to provide funding to the primary care clinics. However, Senate Bill 1142 does not resolve the coverage gap crisis. There will be no significant impact on the issues faced by 12-13,000 Idahoans who experience serious and persistent mental illness in Idaho. This population is currently served through the Department of Health and Welfare, funded entirely by state general funds. The services available are limited to people in serious crisis who are deemed either a risk to themselves or others. The services do not provide for rehabilitative services or community based supports to maintain a person's mental health to prevent a relapse or crisis. However, passing legislation to close the coverage gap this session would drastically improve our state's inadequate and broken mental health system.

The funding made available through this legislation will fund primary care, which is not the same as comprehensive health care coverage. Primary care takes place on a first come first serve basis and only covers certain types of prescriptions, mainly antibiotics, but has limited ability to cover ongoing high cost prescriptions needed by individuals with severe and persistent mental illness and chronic health conditions. Many people require health care that includes frequent routine visits that may include specialized treatments and medications.

If comprehensive health care is not passed this year, we will continue to pay for emergency care for the uninsured in an inefficient and expensive way - through our property taxes, state funds, and higher health care premiums, since the cost of caring for the uninsured is often passed on to those that are insured. When we do not provide preventative health care and pay only for care when people are in crisis or at the end of their lives it costs the taxpayers of Idaho millions of dollars.

If you could do one thing to significantly improve the mental health system and the health of people with chronic health conditions in Idaho it would be to pass comprehensive health care coverage. 78,000 uninsured Idahoans should not have to wait another year.

Christine Pisani
Executive Director

Testimony to the Senate Health & Welfare Committee on SB 1142

Lauren Necochea, Director of Idaho Voices for Children

March 9, 2017

Good Afternoon, Chairman Heider, and members of the Committee. I am Lauren Necochea, director of Idaho Voices for Children.

Thank you for working toward a solution for our fellow Idahoans -- Idahoans who are working to climb the economic ladder, but get knocked down by illnesses and hospitalizations that could be manageable with comprehensive coverage. Families facing a dreadful medical emergency worry simultaneously about the potential financial ruin.

I am particularly grateful to the bill's sponsors, whom I admire and respect, for rolling up their sleeves to solve an important problem. Healthcare was one of Idahoans' top priorities in a recent Boise State opinion survey. Thank you for making it your priority.

I stand before you as a voice for children and families and in Idaho. Therefore, it is my job to say that this legislation does not go far enough. Until we leverage the dollars available for Idaho to expand coverage, we can't solve a major problem in our state's health care system.

It feels like we've been sitting at a train station and for four years, the train has pulled up to the station and Idaho has let it go by. While families are facing the grave consequences of these delays, there's been another problem with waiting. The trains coming in the future may not take us as far as we'd like to go. They may be less cost-effective for our state. That makes all the more urgent to act today.

We can't say for certain what the next wave of national healthcare reform will look like. But there is a consistent theme in the debate that Congress is having: a strong preference given to states that have expanded Medicaid.

The bill released this week by the House GOP demonstrates this preference, as it keeps the expansion's enhanced match in place through 2019. It is also clear this is the floor for how the Medicaid expansion will be treated. A number of Republican senators have expressed that the House bill doesn't do enough for expansion states, and they hope to make improvements if it is passed out of the House.

Our wait-and-see approach put us in a low-priority position in the first serious proposal to reform the Affordable Care Act. To continue to wait-and-see is the riskiest approach today, from both a fiscal standpoint and when you think about the lives of Idahoans that are on the line.

If we get on the train today, we can always get off the farther down the line. We can opt out or back-track if the math doesn't work out. Expanding coverage today will allow us to

experiment with managed care and value-based purchasing to maximize health outcomes for our dollar.

I urge you to consider how we can amend this bill to best protect Idaho's healthcare future during this session. It's time for Idaho to get on the train. It might be the last one.

Good afternoon Mr. Chairman and members of the committee. My name is Kelli Brassfield and I represent the Idaho Association of Counties. Thank you As you all know, our counties have a large role in the healthcare of those who fall under 138% of the federal poverty level. We see all types of individuals from those who have to have their gall bladders out (but are otherwise healthy) to those who have chronic issues and everything in-between.

The Idaho Association of Counties took a position in September to support a complete, Idaho Based Solution, that provides essential healthcare coverage to the 78,000 Idahoans living in the insurance coverage gap by leveraging federal and state dollars, managing care, controlling costs, and eliminating inefficient public programs.

Our association understands the complexities around providing healthcare to the citizens in our state. We believe this bill is a good ~~first~~ step to providing healthcare to our citizens; however, we know there is still a lot of work to be done to come to the more comprehensive care we are looking for. I am ~~We are~~ not here today to neither support nor oppose this bill but would like to offer our continued support in this effort to find an Idaho Based Solution. I would like to thank all of those who have worked very hard on the proposals that have been brought forward and I look forward to continuing to work with them.

Thank you Mr. Chairman and I would stand for any questions.

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March 9, 2017

To: Sen. Patti Ann Lodge, Chairman
Sen. Abby Lee, Vice Chairmen
Members of the Senate, Judiciary & Rules Committee

From: Sylvia Chariton, President
AAUW Boise Area Branch

Re: Testimony Against SB 1142 – Not a Good Alternative to Closing the Gap

Chairman ~~Lodge~~ Winder and Committee Members,

My name is Sylvia Chariton and I am submitting testimony against SB 1142 on behalf of the American Association of University Women (AAUW) of Idaho. I currently serve as president of the AAUW Boise Area Branch.

AAUW believes that SB1142 will not solve the coverage gap crisis. While the window of opportunity is still available, Idaho needs a bill that provides the gap population with comprehensive coverage. Since AAUW largely represents women, this brief testimony will be mainly female specific.

According to recent Idaho statistics, females are 55 percent of the Medicaid Gap population. Because women are more likely than men to be covered as dependents, a woman is at a greater risk of losing her insurance if she becomes widowed or divorced, if her spouse loses his job, or her spouse's employer drops family coverage or increases premiums and out-of-pocket costs to unaffordable levels.

Based on a recent Kaiser Study, the gap in private sector and publicly funded programs left 18% of Idaho women uninsured. Many Idaho low income women, many of whom labor daily as low wage workers have been the needless victims of bad healthcare policy and shortsighted decisions. Living in fear of medical catastrophes or untreated conditions, these women live lives of quiet desperation.

Although this legislation may attempt to provide eligible participants with regular preventive primary care and care management for chronic conditions; what happens when an accident occurs or an asymptomatic condition erupts into a major medical event?

According to Kaiser, these marginalized women are two to three times as likely to forgo medical services due to cost. When these disenfranchised folks end up in our Emergency Departments, Idahoans already pay for their bills either through cost shifting at the hospitals or through their county's Catastrophic Fund using our tax payer dollars. These unfortunate circumstances create an unquantifiable risk factor that hurts everyone. Although well-intentioned, the limitations of this proposed legislation creates another short-sighted decision.

Finally and unfortunately, Idaho has developed in indifference to rural poverty. Some Idaho communities have fallen so far through the cracks that it feels like the rest of the state has left them behind. Decades go by, yet in some of these poor rural communities, it is like time has stood still. The inequity in rural vs urban life in Idaho is most pronounced in the health care delivery system. Many of the rural and critical access hospitals can barely keep their doors open. Please close the Gap in 2017 before it's too late, keep the doors open in these remote facilities and give our rural communities a life line to modern medicine and better lives.

IDAHO INTERFAITH ROUNDTABLE AGAINST HUNGER
P.O. Box 7343, Boise, ID 83707 www.IIRAH.org

March 9, 2017

In too many Idaho households, medical expenses compete with food for scarce family dollars. The Idaho Interfaith Roundtable Against Hunger (IIRAH) has a strong interest, therefore, in the success of efforts to address the medical insurance coverage gap.

We appreciate the intention of Senate Bill 1142, to subsidize basic and preventive health care to a limited number of citizens with very low incomes. It has good features, and it is a good place to start.

However, primary care does not substitute for health insurance, nor would this bill guarantee even primary care to all comers who may be eligible. We know you understand that the plight of the uninsured is not adequately addressed by this proposal. Your committee today will have to determine whether S 1142 would be the best use of the available funds, in the light of that reality.

IIRAH continues to call for a comprehensive Idaho solution of medical insurance that does not ask citizens to join a waiting list for primary care and does not throw them back on their own resources when they face a major emergency.

Thank you.

Darcy James

Darcy James, Chair, and the IIRAH Board of Conveners

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

2:00 P.M.
Room WW54
Monday, March 13, 2017

SUBJECT	DESCRIPTION	PRESENTER
S 1139	Relating to Health Care	Morgan Howard, Intern for Senator Johnson
H 222	Relating to the Secure Treatment Facility Act	Cameron Gilliland, Deputy Administrator, Division of Family & Community Services

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Monday, March 13, 2017
TIME:	2:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Anthon, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 2:07 p.m.

S 1139

Relating to Health Care. Morgan Howard introduced herself to the Committee as an intern for Senator Johnson to present **S 1139**. **Ms. Howard** explained the bill clarifies admitting privileges for advanced practice nurses and physician assistants. Idaho Code is unclear as to whether these practitioners have the right to admit patients to hospitals. The issue was brought to light by rural hospitals with fewer physicians than larger hospitals.

Ms. Howard also presented some proposed amendments to the bill that were drafted by the Department of Health and Welfare (Department). The first is a rewrite of new Idaho Code § 39-1396 providing guidelines for hospitals granting admission privileges. The amendments to sections two and three of the bill include a reference to the new Idaho Code § 39-1396. The amendment to section 4 provides practitioners must be licensed and granted privileges by the facility's bylaws, and the facility must practice oversight of those admitted. Finally, there is a correction to title. **Ms. Howard** requested the bill be sent to the Fourteenth Order for possible amendment.

Vice Chairman Souza asked if Ms. Howard could review the amendments, explain the amendment language compared to the original bill, and state whether or not Ms. Howard agrees with the amendments. **Ms. Howard** explained the amendment to section 1 adds guidelines for admitting privileges. It specifies the practitioner granted privileges must be recommended by the medical staff and approved by the governing board of the hospital, and the practice must be within the scope of the practitioner's license. **Ms. Howard** said the amendments seem reasonable and there is no reason to grant privileges if not recommended by hospital staff. She supports the changes.

Ms. Howard commented sections 2 and 3 replace the language "or other persons specified in the bylaws" with a reference to Idaho Code § 39-1396 to streamline the bill. She is in agreement with the changes. The amendment to section 4 specifies the practitioners must be licensed and granted privileges in accordance with the facility's bylaws. The language is to protect the hospital from legal liability, and she supports these changes as well.

Senator Anthon referred to the word "through" at the beginning of line 2 on page 2 of the amendments and asked if that is the correct word. **Ms. Howard** responded it is grammatically correct to her knowledge. The bill drafters in the Legislative Services Office prepared the language to be consistent with Idaho Code.

Senator Lee inquired if the amendments are acceptable to the hospital association and if there is concern about hospital accreditation if the bill passes. **Ms. Howard** replied she is not aware of any objections to the amendments by the Idaho Hospital Association or Idaho Medical Association. **Senator Lee** asked if Toni Lawson of the Idaho Hospital Association could be recognized to respond to the question.

Toni Lawson introduced herself to the Committee as vice president of government relations for the Idaho Hospital Association. She has not seen or reviewed the amendments and cannot comment at this time. Hospitals have run into some issues in this area, and her association wants to work with the Department this summer to clarify some areas, hopefully without having to bring new legislation.

MOTION: **Senator Martin** moved to send **S 1139** to the floor with a recommendation that it be referred to the Fourteenth Order for possible amendment. **Senator Lee** seconded the motion. The motion carried by **voice vote.**

H 222 **Relating to the Secure Treatment Facility Act. Cameron Gilliland** introduced himself as the Deputy Administrator for the Division of Family and Community Services at the Department. He oversees the Southwest Idaho Treatment Center (SWITC) and the State's crisis services for individuals with developmental disabilities.

Mr. Gilliland explained **H 222** authorizes the Department to establish, operate, and maintain a secure treatment facility for individuals with developmental disabilities who pose a threat to the safety of others. The facility would be located at the SWITC campus with a maximum of four beds. Currently, the SWITC is asked to serve some dangerous clients who have come through the court system and is not adequately equipped to do so. Courts are understandably reluctant to place someone in jail who is intellectually disabled or has severe autism but must assess if the client is competent to stand trial while assuring safety of the public and the client. Many of these clients who commit dangerous crimes such as murder, rape, and felony assault are placed at the SWITC instead of in jail while the court sorts out the issues. **Mr. Gilliland** displayed two items taken from clients, a spoon and a stick both fashioned into weapons, that might be used against other clients or staff. SWITC staff have collected dozens of such handmade weapons over the past couple of years.

Mr. Gilliland said the SWITC's licensure requirements do not allow for the center to be secure. Clients are free to move about the complex and the community as well as have access to personal and household items that they may use as weapons. The mix of little control and dangerous clients has resulted in significant worker's compensation claims and attacks on clients, staff, and the community, as well as multiple calls to law enforcement. During calendar year 2016, SWITC experienced a 29 percent rate of worker's compensation claims, meaning nearly one of three workers at the SWITC filed an injury claim, and 70 percent of those claims were the result of intentional attacks by clients. Last year, there were 784 assaults at the SWITC. Employee turnover at the SWITC is about twice that of the rest of the Department. During the past five years, there have been 12 medical layoffs. Workers have experienced traumatic brain injury, puncture wounds, human bites, and sexual assault, including injuries causing permanent disability.

Mr. Gilliland informed the Committee dangerous clients have also left campus and attacked members of the public. A woman who stopped to assist one of the runaway clients was assaulted by the client when she opened her car door to ask him if he needed help. Another client attacked and injured a child at the Walmart off Garrity Road. The need for secure facilities is ongoing and immediate. There is currently a SWITC client who attacks female employees without warning by grabbing their hair near the scalp. The client attempts to slam the employees' heads into her knee while shouting, "I will kill you." Only well trained staff and vigilance have prevented serious injury. This particular client had been in the Canyon County Jail and the Idaho Department of Corrections (IDOC) prior to coming to the SWITC. Due to the severity of danger posed by these clients, an emergency exists, and the Department is requesting authority to implement secure features as soon as the bill is signed into law.

Mr. Gilliland stated the bill contains safeguards to assure appropriate treatment and outside oversight. Idaho courts will provide oversight by determining who will come to the facility. A court must commit a client to the Department, and the court would have to find the client is appropriate to be confined to the State's secure treatment facility. In addition to court oversight, the Director of the Department will make the decision regarding placement. Additional outside oversight will be provided through licensure and rules to be developed after passage of the bill. Licensure will require an annual survey similar to the process currently utilized for the SWITC. Another form of oversight will be provided by the client's attorneys and DisAbility Rights Idaho, and both will have unfettered access to the clients in the secure facility.

Mr. Gilliland commented the bill does not result in a fiscal impact at this time. If the bill passes, some secure features such as locks, cameras, alarms, and possibly fencing of the current campus can be completed this year. Safety can be improved quickly, while the Department continues to explore the costs and benefits of constructing a new facility or remodeling an existing building. The cost of a new facility has been estimated at $1.7 million, while remodeling a building would cost considerably less. The Department will work with the Governor's office and the Legislature to determine the best way to cover necessary costs in future years.

Mr. Gilliland said he bill represents significant collaboration and negotiation among several stakeholders, including the Administrative Office of the Idaho Supreme Court, DisAbility Rights Idaho, the Idaho Council on Development Disabilities, the American Civil Liberties Union, Canyon County Sheriff's Office and Prosecutor's Office, and the Idaho Sheriff's Association. At the final House hearing, no stakeholders spoke against the bill. Passage will allow the Department to more safely serve clients while protecting clients and the public.

Chairman Heider asked for a status update on a proposed plan to turn a facility in Eastern Idaho into a secure facility. **Mr. Gilliland** responded there are two facilities working their way through the process this year, and Chairman Heider may be thinking of the secure mental health facility for adolescents that has been discussed for Eastern Idaho. The secure facility contemplated under **H 222** is for the narrow population of individuals with developmental disabilities and possibly also mental health issues.

Senator Martin inquired about the source of funds to perform the security upgrades. **Mr. Gilliland** replied existing funds will be used this fiscal year. There are many buildings at the SWITC, and there is one building in current use that was built with stronger windows and doors that can accept locks. Fencing and a time-out room are also under consideration. No additional funding will be requested this year. **Senator Martin** further inquired how the new building or major renovation would be funded. **Mr. Gilliland** answered at one time it was contemplated to move the entire SWITC campus and sell the land. An architect drew up some plans for a new secure facility, and that was the source of the cost estimate. However, the Department is reviewing other options. Some secure features can be put on the existing building, but it may not turn out to be the best permanent situation. **Senator Martin** asked if there will be a request next year for additional money to enhance an interim facility. **Mr. Gilliland** replied he can't say for sure.

Senator Lee referred to page 1, line 29 of the bill that says, "when a person is the subject of a court order pursuant to Idaho Code § 56-1404 for admission to a secure facility, the department may disposition to the facility or another appropriate placement." She asked how that is language differs from current practice, and she further inquired what discretion is afforded the Department, since the court has determined the person should be at a secure facility. **Mr. Gilliland** responded if a person with developmental disabilities commits a crime and the court deems the person incompetent to stand trial, the court will commit the person to the Department, and this population is generally already going to the SWITC. The bill would give the Department a more secure option in the facility, and he does not foresee an increase in the number of clients coming to the Department. The Department's psychiatrist and clinicians make a recommendation to the Director whether a client goes to the secure treatment facility or is placed in the general SWITC population. Generally, the person would go to the secure facility while the Department assesses risk. If determined to be unsafe, the client would stay in the secure facility until it was possible to transition to the general population.

Senator Lee inquired whether this in any way will relieve the pressures on the county jails or IDOC facilities. **Mr. Gilliland** answered it will relieve the county jails to the extent it will be an easier choice for the court to send the person to the SWITC rather than to jail. However, the developmental disabilities population represents a narrow segment of the larger mental health population.

Senator Foreman asked whether there was any thought given to simply asking for emergency authority to put locks on the existing building and make it secure for the time being. That would allow time to get bids and finalize plans to either build a new building or convert an existing building, and the Department could come back later with a new bill to implement the final plan. **Chairman Heider** commented the SWITC property was going to be sold and the facility shut down, and the Department would have had a significant amount of money for different options. That is not going to happen now so the Department is looking to add security features now and possibly build a different facility later. **Mr. Gilliland** added this bill contains an emergency clause because some legislators suggested it is important to implement these provisions now due to the existing dangerous clients.

Senator Anthon referred to page 2 and the criteria for admission starting on line 38 and stated the criteria involves the court make a finding that the criteria have been met. He inquired what is the result if the court finds based on competent medical testimony there is a developmental disability but the Department disagrees. **Mr. Gilliland** answered the Court can commit and determine a developmental disability regardless of whether the Department agrees. However, the Department works with the court to make that determination. There have been cases where the Department disagreed, but the Department still gets the client, and the client will probably be sent to the SWITC.

Vice Chairman Souza asked if the Department will want a trailer bill to finance the $1.7 million for this year. She further inquired how the Department will determine the true cost of the new facility. **Mr. Gilliland** responded the Department will not request additional funding this year. Costs for a permanent facility will be developed only if it is determined a different facility is required. Currently, there is one client to place in the secure facility, and in the past there has been a maximum of three clients at a time. The Department's primary concern is to develop some immediately safety measures, and it is possible no additional funding will be requested if the initial measures work. Primary treatment needs to be clinical and not based on walls and doors.

Senator Lee referred to page 3, line 1 of the bill that says the court shall order the person to be appropriate for admission to the facility. However, the bill goes on to say in the next section that admission to the facility will be determined solely by the director or the director's designee. **Senator Lee** asked if it is a policy change to give so much discretion to the Director. She is concerned there is no one else who can determine the client can be reassigned to a less restrictive facility. **Mr. Gilliland** asked for clarification on Senator Lee's question. **Senator Lee** gave the example of a person in a halfway house who takes a rod off the wall and beats someone to death. If the court finds this person is not competent to stand trial, the law says the person will be committed to the Department. The court may find the person is a terrible danger to others and order the person to a secure center, but the Department may or may not have a place to put the person. The bill would allow the Department to use its assessment to place the person in a lesser facility. In some cases, it results in placing people in the county jail or IDOC. **Mr. Gilliland** replied the current statute pertaining to persons with developmental disabilities says the Director and his designee have the authority to determine where someone is placed. Sometimes the courts will overemphasize the danger of a developmentally disabled individual, so the Department makes its own analysis based on years of experience. At present, everyone who comes to the Department from the court is able to walk off the SWITC campus and do harm to other people. The bill would not solve the problem described, but it solves a problem for the Department in that there is currently no secure facility, and the Department sometimes gets dangerous clients.

TESTIMONY: **Christine Pisani** introduced herself to the Committee on behalf of the Idaho Council on Development Disabilities (ICDD) and stated the ICDD has agreed not to oppose the bill after it was changed from initial versions. **Ms. Pisani** testified in accordance with Attachment 1. She expressed concern regarding cuts in funding for psychiatric rehabilitation treatment services and disagreed with the characterization that violent behavior has increased in the developmental disabilities population. She urged the Department to work with stakeholders to develop plans for services designed to prevent violent behavior and reduce incarceration, and to provide these services in home communities.

Senator Lee asked whether Ms. Pisani believes there is a need for a place to securely house dangerous individuals away from others. **Ms. Pisani** responded the community has suffered greatly at the loss of mental health services to meet the needs of the developmental disabilities population. Additional mental health services would likely prevent this type of placement.

TESTIMONY: **Jim Baugh** introduced himself to the Committee as the Executive Director of DisAbility Rights Idaho (DRI), which is the protection and advocacy system referred to in the statutes. His organization provides free legal and advocacy services, including public policy analysis for Idahoans with disabilities, and has unique federal authority to investigate instances of abuse and neglect in the disability population.

Mr. Baugh stated DRI is not unconcerned about the safety of residents, and resident to resident abuse is one of the types of situations DRI investigates. He understands the need to design a physical setting that is a safer environment allowing for better observation and interventions to prevent injuries. **Mr. Baugh** complimented the Department for working through several versions of the bill and negotiating with stakeholders.

Mr. Baugh reiterated Ms. Pisani's comments that developmental disabilities haven't fundamentally changed, but what has changed is people with developmental disabilities are not getting adequate mental health treatment services because Idaho has not developed its mental health facilities with that specialty in mind. This is a small sub-population, and while people with developmental disabilities are more likely to have or develop a mental illness, it is a difficult sub-population to treat. Standard mental health treatments require patients to provide feedback and manage medications, and that is more difficult for a person who has limited communication or may not understand abstract concepts. It is an area for improvement, and in other states it has been shown that specialized treatment can prevent people from becoming violent.

Mr. Baugh commented the language about the Department making decisions about moving someone in and out of the secure facility pertains to moving the person between the secure building and the general SWITC population. Those decisions are more competently made by the clinical staff and the Department, as opposed to the court. The statute does not give the Director of the Department the authority to place a person in the jail. That placement would have to be done by the court.

TESTIMONY: **Kieran Donahue** introduced himself as the Canyon County Sheriff and also on behalf of the Idaho Sheriff's Association. He said this bill is about the safety of the client as well as the public and other clients.

Sheriff Donahue stated the Canyon County jail currently has a unique individual at the jail who was taken on by the Department about ten years ago and is now in her mid-20s. This client has been deemed to be a dangerously mentally ill person and was found incompetent to stand trial by a district judge. The client has been housed at the Canyon County jail intermittently over the last two years, and in that time she has injured nine jail staff. Three of the nine injured jail employees were seriously injured, and one nearly lost her arm. Jail staff are not trained mental health professionals, and the jail is not built to house such mentally ill persons.

Sheriff Donahue explained the client has been charged with 17 felonies in Canyon County, and there was no place to house her. IDOC was asked to take her and she was housed in the penitentiary on two occasions but never convicted of a crime. She is so incredibly strong, she must be restrained with belly chains and leg irons. This is someone's daughter and sister, and his staff see her that way. The staff sings to the person because she has the mental capacity of a seven year old and it calms her down. Because she has a tendency to slam her head on concrete floors and walls when she doesn't get her way, the client wears a helmet at almost all times. A few months ago, her restraints were removed, and one day she took her helmet off and tore it in two with her bare hands. Idaho, the courts, and the Department must have a place to secure these mentally ill patients with developmental disabilities who have been found incompetent to stand trial, both for their own safety and the safety of others.

Mr. Gilliland returned to the podium to summarize the presentation of the bill. The Department is asking for another tool to serve individuals with developmental disabilities and mental health issues. The Department has worked hard to collaborate with providers and other stakeholders and came up with the best bill possible. It doesn't solve some of the general issues around mental health, but it offers the stakeholders another option to provide more safety for all clients and staff. The SWITC is the best place for this individual, and the SWITC staff is properly trained and has had some success with this individual for the past month.

Senator Anthon stated he supports the general policy idea but he still has concerns. In a situation where a person who is charged with a crime, the magistrate judge will make a legal determination as to whether the person has a developmental disability. This bill says unless the Department agrees with the judge, the judge will not have this tool available for the person charged with the crime. **Mr. Gilliland** answered if the person has a developmental disability, it is a rare occasion that the Department would not agree. In guardianship and competency cases, the judge gives notice to the Department, and the Department refers the matter to an evaluation committee, including a doctor, psychologist and social worker. The evaluation report goes to the court saying whether or not the person has a developmental disability. The judge would still commit the person to the Department. In those cases, the Department still has the person, and the person would likely be at the SWITC anyway. They would all be the Department's issue.

Senator Anthon stated at the end of the proceeding, it is the judge who decides who is developmentally disabled, and he asked why this language was inserted in the bill to authorize the Department to make that decision instead of the judge. **Mr. Gilliland** responded he is not sure. The Department wants to be involved in making the determinations.

Brent King introduced himself to the Committee as Deputy Attorney General for the Department. The Department's determination that developmental disability is the primary diagnosis has two functions. The first is to determine the nature of the incompetency, whether because of a developmental disability or a mental illness. The determination also prevents conflicting results between Department personnel or programs and allows the Department to place the person in the most appropriate program. The legislation deals specifically with the situation described by Mr. Baugh, which is the Department's ability to move a person back and forth between the secure facility and the general population, whether it's the SWITC or some other mental health program. The Department is not trying to supplant a judicial decision of any sort, and if a judge commits someone to the Department, the Department will have that person.

MOTION: **Senator Lee** moved to send **H 222** to the floor with a **do pass** recommendation. **Vice Chairman Souza** seconded the motion.

DISCUSSION: **Senator Lee** expressed appreciation to the Department for working so hard to bring forward another tool. There are still a few concerns but she will support the bill because these options are needed. She looks forward to implementing other preventative issues and collaboration to review how this has worked and make any needed changes.

Chairman Heider commented this is a tool to help the Department carry out its obligations and it is needed.

Senator Anthon said he has some concerns about the bill but he will support the motion. These matters involve a crime and committing someone to State care, and someone's fundamental rights are being taken. At some point, there must be a very good judicial process. This kind of discretion in the Department is concerning, and he hopes there will not be problems as a result.

The motion carried by **voice vote**. **Senator Foreman** requested he be recorded as voting nay.

Chairman Heider announced the House Health and Welfare Committee would meet on March 14, 2017 at 9:00 a.m. to hear about issues with the Veyo contract.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 3:17 p.m.

_____

Senator Heider
Chair

_____

Jeanne Jackson-Heim
Secretary

IDAHO COUNCIL ON
DEVELOPMENTAL
DISABILITIES

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C. L. "Butch" Otter
Governor

Debra Parsons
Chair

Christine Pisani
Executive Director

March 13, 2017

Senator Lee Heider, Chairman
Senate Health and Welfare Committee
Statehouse
Boise, ID 83720

RE: HB 222 Secure Treatment Facility

Chairman Heider and Committee Members:

The Council on Developmental Disabilities is authorized by federal and state law to monitor systems and policies and to advocate for improved and enhanced services that enable Idahoans with developmental disabilities to live meaningful lives, included in their communities. The Council is comprised of 23 volunteers appointed by the Governor.

In exchange for some changes to this bill, the Council has agreed to not oppose this legislation. The Council on Developmental Disabilities, Disability Rights Idaho, and the State Independent Living Council weighed in heavily on the House Bills (H44, H187, and H222) presented to the House Health & Welfare committee establishing a new state "secure treatment facility" for people with a dual diagnosis, a co-occurring intellectual or developmental disability and a mental health diagnosis.

During committee hearings a powerful narrative was presented about "deranged" patients with superhuman strength attacking jail and Southwest Idaho Treatment Center (SWITC) personnel and causing severe injuries. The idea that people with mental illness are for some reason becoming more violent, more criminal and less susceptible to treatment was also presented. The Department of Health & Welfare presented plans to create a secure facility at Southwest Idaho Treatment Center. Law enforcement personnel also testified about an increased number (this wave) of violent and criminal inmates with mental illness and developmental disabilities. The media reinforced this message by emphasizing the violent behavior of one individual in the Treasure Valley.

In 2009 - 2011, when the budget for services provided through the Department of Health & Welfare was cut, the consequences were many; ACT teams lost 80 participants, regional mental health centers were drastically reduced, and there was a significant loss of community based mental health services. At that time the Council on Developmental Disabilities and Disability Rights Idaho predicted an increase in incarceration, increased emergency room visits, and a rise in crisis response, as a result of these cuts.

In 2011, the Legislature passed House Bill 260 further reducing Psychosocial Rehabilitation (PSR) services and prohibiting people with an intellectual or developmental disability from having access to both developmental disability and PSR services. Advocates were optimistic in 2012 when we successfully advocated for House Bill 609 which states "mental health providers may not provide training for skills included in the individual's developmental disability plan, but may provide services related to the individual's mental illness that requires specialized expertise of mental health

professionals, such as management of mental health symptoms, teaching coping skills related to mental health diagnosis, assisting with psychiatric medical appointments and educating individuals about their diagnosis and treatment." Our optimism was short lived when the Department of Health & Welfare implemented a contract with Optum Idaho in 2013 that created a similar restriction on psychiatric rehabilitation services through managed care.

The Council is once again highlighting the desperate need for community based mental health services for people who experience a developmental disability and a mental illness. There is no intentional plan in place to develop Medicaid billable mental health services for people with developmental disabilities. Instead the Department of Health & Welfare is proposing the establishment of a secure treatment facility for people whose mental health needs are going unmet in the community and thus opening the door for further increases in violent behaviors, we feel could be reduced with appropriate and adequate community services. The Council on Developmental Disabilities has proposed a plan for the Department of Health & Welfare to consider. The proposed plan would bring key stakeholders together to work with the National Association of Dual Diagnosis (NADD), North America's leading experts in the field of DD/MI dual diagnosis to work on plans for services designed to prevent violent behavior and reduce incarceration.

The Council is encouraged at the work the Division of Family and Community services is beginning to do with the assistance of the National Association of Dually Diagnosed (NADD). The mission of NADD is to advance mental wellness for persons with developmental disabilities through the promotion of excellence in mental health care. NADD provides extensive training in best practices in assessment, treatment, and program models. It is recognized as the leading expert in providing professionals, educators, policy makers, and families with education, training, and information on mental health issues relating to persons with intellectual or developmental disabilities.

The Council is acutely aware of the challenges that individuals with a dual diagnosis experience. It is always preferable to provide services to maintain people's mental health in their home communities so that the proposed secure facility will not expand beyond the proposed 4 bed capacity. We see huge potential for our state to raise the bar on community based mental health services with highly trained staff, appropriate and accessible services, and a result of people maintaining their mental health while experiencing a meaningful life in their home community.

Christine Pisani
Executive Director

NADD

An association for persons with developmental disabilities and mental health needs.

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CHIEF EXECUTIVE OFFICER

Robert J. Fletcher, D.S.W., NADD-CC

To: Chairman Heider and Members of the Health & Welfare Committee
From: Robert J. Fletcher, DSW, ACSW, NADD-CC, Founder & CEO of NADD
Re: House Bill 222
Date: March 3, 2017

I am writing to express my concern about the proposed House Bill 222. There is extensive and growing evidence that individuals with intellectual disability and co-occurring mental illness – including those individuals who display severe aggression -- can be safely maintained in the community, provided that all levels of staff are properly trained, that appropriate services are wrapped around the individual, and that appropriate and effective crisis prevention and intervention services are available 24 hours a day, 7 days a week. Trained staff, appropriate services wrapped around the individual, and available crisis prevention and intervention services dramatically reduce the costly need for emergency room visits and hospitalization in this population. As you know, the trend across the country is away from institutionalization and toward community-based options. By creating a secure treatment facility at this time, Idaho is going against the tide of history and directing financial resources away from where they would better serve this vulnerable population, specifically training and appropriate services.

For over thirty years, NADD has been committed to improving the lives of individuals who have intellectual and developmental disabilities co-occurring with mental illness. The mission of NADD is to advance mental wellness for persons with developmental disabilities through the promotion of excellence in mental health care. NADD has provided extensive training in best practices in assessment, treatment, and program models. NADD is recognized as the leading North American expert in providing professionals, educators, policy makers, and families with education, training, and information on mental health issues relating to persons with intellectual or developmental disabilities. Over the past thirty years, we have seen vast improvements for individuals with intellectual disability co-occurring with mental illness, a significant portion related directly to being incorporated into and supported in the community. NADD has worked to raise the bar concerning the quality of services provided – through education and training and through the NADD Competency-Based Certification Program for clinicians, Direct Support Professionals, and case managers. We are very aware of the challenges that individuals with co-occurring mental illness and intellectual disability face, and of the potential for trained staff, appropriate services, and available crisis services to provide a meaningful life within the community.

I urge you to not support the proposed House Bill 222.

Respectfully submitted,

Robert J. Fletcher, DSW, ACSW, NADD-CC

132 Fair Street, Kingston, NY 12401-4802 (845) 331-4336 (800) 331-5362 Fax: (845) 331-4569 info@thenadd.org www.thenadd.org

AGENDA

SENATE HEALTH & WELFARE COMMITTEE

2:00 P.M.
Room WW54
Tuesday, March 14, 2017

SUBJECT	DESCRIPTION	PRESENTER
Page Graduation	Farewell to Committee Page Bridger Cardon	Chairman Heider
H 212	Relating to Psychologists	Kris Ellis, Idaho Psychological Association
H 213	Relating to Behavioral Health Services	Treena Clark, Program Manager

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Tuesday, March 14, 2017
TIME:	2:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	Senator Anthon
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 2:05 p.m.
PAGE GRADUATION:	**Chairman Heider** recognized and thanked Bridger Cardon for his service as the Committee page for the second half of the First Session of the 64th Legislature. **Mr. Cardon** commented he enjoyed himself and liked hearing the discussions. He plans to attend college in the fall and major in business and finance to help his father run the family car wash business in the future. He also intends to serve a mission for his church. **Senator Martin** inquired the origin of Mr. Cardon's first name. **Mr. Cardon** replied he has no idea but it may have to do with Jim Bridger. **Senator Jordan** asked what surprised Mr. Cardon most about serving as a page. **Mr. Cardon** responded it is interesting how every senator has different ideas and perspectives. He appreciates that senators represent a group of people and they vote as their constituents want, rather than how the senators might personally choose to vote. **Chairman Heider** presented Mr. Cardon with a gift from the Committee.
H 212	**Relating to Psychologists. Kris Ellis** introduced herself to the Committee on behalf of the Idaho Psychological Association (IPA). **Ms. Ellis** stated **H 212** is the result of three years of negotiations with interested stakeholders. The bill would allow doctoral level psychologists to prescribe medications relevant to the practice of psychology upon completion of a master's degree in psychopharmacology from an accredited institution and two years of practice under the supervision of a medical doctor. The bill also specifies education requirements and supervision provisions, and it establishes an advisory panel of medical doctors and pharmacists to assist in the rulemaking process. **Ms. Ellis** recognized several participants who were instrumental in developing the legislation: the Board of Psychologists; attorneys at the Bureau of Occupational Licenses; Alex Adams of the Board of Pharmacy; Ken McClure with the Idaho Psychiatric Association who spent many hours working on concepts and language; and Idaho State University. The Region 7 Mental Health Board has also indicated its support. **Ms. Ellis** informed the Committee that psychologists with training in psychopharmacology have been licensed in other states and trained by the U.S. military for more than 20 years with an exceptionally safe record. The bill will help improve mental health care in Idaho by allowing those who provide therapy to assess and prescribe current mental health medications.

TESTIMONY: **Dr. Page Haviland** introduced herself to the Committee as the President of the IPA to speak in support of **H 212**. She is a licensed clinical psychologist in private practice in Meridian, Idaho and a Navy veteran. During her time as a Navy psychologist at the National Naval Medical Center in Bethesda, Maryland, she worked with Dr. Morgan Sammons, who completed the Department of Defense psychologist training program to prescribe medications. Her experience inspired her to pursue the same training. **Dr. Haviland** commented her first duty station after finishing her degree was as the only Navy psychologist serving 15,000 beneficiaries at the Naval Air Warfare Center in Maryland. Had she been able to prescribe, service members and their families would not have experienced long wait times to get comprehensive mental health care and in serious cases would not have had to drive one hour each way to the nearest psychiatrist at Walter Reed Army Medical Center.

Dr. Haviland commented she is very interested in obtaining the new training. Wait times for psychiatric intervention now range from two to four months. Her patients who are active duty service members would be able to attend one appointment instead of two, with virtually no wait time. She already works closely with several physicians who refer clients to her, and there would be no change in the way she consults with the doctors. **Dr. Haviland** said she contacted Commander Rabinowitz, a prescribing psychologist and the Navy's specialty advisor for psychopharmacologically trained psychologists. Dr. Rabinowitz is responsible for helping select and send psychologists to post-doctoral fellowships in psychopharmacology. The Navy is interested in using Idaho State University (ISU) as a potential site for the Navy's post-doctoral fellowship program (see Attachments 1 and 2). The bill would provide an opportunity to set a high standard for training psychologists to prescribe and at the same time provide a flagship program for the Navy and possibly other branches of the armed services. She urged the Committee to support the bill.

TESTIMONY: **Michael McGrane** introduced himself on behalf of the Idaho Nurses Association and Nurse Leaders of Idaho to speak in support of the bill. Among his groups' members are a number of family nurse practitioners who practice in rural Idaho. He has heard about the dire need for psychiatric resources for back-up and coordination of care. The availability of psychiatric care in Idaho is sparse. The bill requires coordination between the primary care providers and the psychologists, and it will open up desperately needed access.

TESTIMONY: **Dr. Lyn McArthur** introduced herself to the Committee as a psychologist from Inkom, Idaho. She is the behavioral health director for a community health center called Health West, and she works in Lava Hot Springs and the Pocatello area. Approximately one-third of Health West patients are uninsured. **Dr. McArthur** reported in Pocatello, there is one adult-focused psychiatrist, and the wait for an appointment is very long. There are two child psychiatrists, and the waits are about three months for an initial visit. Jails are full and are being renovated to make space in Pocatello. Most current inmates have concurrent mental health and substance abuse issues. State Hospital South in Blackfoot has about a three-week wait. Currently, inpatients are being diverted to Boise or Twin Falls. The Eastern Idaho area has experienced an increase in mental health care needs. The Idaho suicide rate is high and the shortage of providers is real and dangerous. Many providers are doing their best, but many are untrained or undertrained to handle mental health concerns.

Dr. McArthur advised she has seen the effects of too few psychiatrists in her professional life, and she has also experienced it personally. A few years ago, someone came into her home. Her husband saw the person standing in the hallway by their children's rooms, and the person ran away when confronted. The police arrived and conducted a search, and Dr. McArthur's neighbor called a few hours later and told them the neighbor's son had recently been diagnosed with schizophrenia. It was the neighbor's son who had come into their home because he was wandering and confused. A few weeks later, **Dr. McArthur** saw on the news that her neighbor's son had mugged a woman and assaulted the police officer who tried to arrest him. Perhaps this person would not have entered the legal system if services had been available. Psychologists can address mental health with therapy, behavioral strategies, or medications. They can also help patients get off medications. **H 212** would help keep Idahoans safe and save money.

TESTIMONY: **Ken McClure** introduced himself on behalf of the Idaho Medical Association and the Idaho Psychiatric Association. His clients have appeared before the Committee several times this session to express concerns about scope of practice legislation based on how public health will be affected. In years past, his clients have opposed this legislation in its previous forms.

Mr. McClure thanked Ms. Ellis and the Idaho Psychological Association for the time spent to build safeguards into this legislation to protect the public health. Education is the key to privileging and credentialing. **H 213** has an educational standard that can work, although it depends in part on how ISU develops the program. He hopes to work with ISU on the program and that this legislation will help Idaho citizens. This bill is the first of its kind in the nation. A psychologist will obtain an education that is the equivalent of a nurse practitioner degree, or approximately two years of classroom study.

Mr. McClure mentioned in prior drafts of the legislation, the education component was inadequate because it was initially patterned after a New Mexico program consisting of only a series of weekend courses. In the psychology doctoral programs, a person can get a doctorate with studying only very little hard science curriculum. A deep understanding of biology and chemistry is necessary prior to prescribing medication.

Mr. McClure stated a clinical experience requirement was also lacking in previous versions of the bill. Doctors learn through a hands-on residency experience, and **H 213** would require psychologists to spend a period of time working under the supervision of a psychiatrist. At the end of the period, the psychiatrist must sign off that the psychologist has the requisite experience to conduct a safe prescribing practice. **Mr. McClure** said the changes are material, and he is pleased the IPA chose to adopt them.

Vice Chairman Souza asked about the cost and length of the training, assuming a psychologist already has a doctorate and has been practicing for some period of time. **Mr. McClure** replied the education is a two-year full-time program, followed by two years practicing under the supervision of a psychiatrist, as well as a national exam. This program will most likely be pursued by someone just entering a career, but there is nothing preventing someone in mid-career from completing the training and practice requirements.

Vice Chairman Souza commented she is concerned about the proposal because one of the goals is to increase a patient's ability to access a prescribing psychologist in a reasonably fast way. She inquired how someone who is working to support a family will be able to commit to two years of full-time study. **Mr. McClure** answered that is likely the reason someone in mid-career might not want to commit to the program. A prescription pad should only be given to someone with sufficient education and training. Psychology undergraduate and doctoral programs can have no or very little science curriculum. To learn that material in order to prescribe safely does take some time. At the end of the process, the person will be capable of prescribing accurately and safely without any kind of supervision. Two years is a cost, but it is a price well paid to ensure well trained and competent providers.

Vice Chairman Souza said she obtained her masters in health education over a two-year period while attending school part-time and working full-time. She asked if this type of program could be structured so a person could maintain a daily occupation and attend school part-time. **Mr. McClure** responded that would be possible, but the education must be a two-year equivalent, so it might take longer than two years to complete the program if only attending part-time. Psychology does not have the same foundation and educational criteria as nursing. Someone with a nursing degree could likely obtain an advanced degree in a shorter period of time. The foundation to build a prescribing practice was the issue that took the most time for the parties to address in the legislation.

Ms. Ellis was recognized to summarize the presentation. It will be possible to attend the program full-time while working and raising a family, and members of the IPA who plan to pursue this training intend to complete it in conjunction with their current profession. After the two years of classroom study, the two years of supervised practice would be incorporated into the psychologist's regular practice. The cost of the program is unknown at this time. ISU estimates ten students would be a break-even point, so it would likely be the same tuition as for an ISU nursing program.

MOTION: **Vice Chairman Souza** moved to send **H 212** to the floor with a **do pass** recommendation. **Senator Martin** seconded the motion.

Senator Lee stated she supports the bill and she appreciates the hard work of all the stakeholders. She heard no one got exactly what they wanted, but this is a good first step and there is an opportunity to make improvements going forward.

The motion carried by **voice vote.**

H 213 **Relating to Behavioral Health Services. Treena Clark**, Program Manager with the Department's Division of Behavioral Health (Division), introduced herself to present **H 213**. The bill amends definitions of peer services and updates provisions relating to the composition and duties of the State Behavioral Health Planning Council and Regional Behavioral Health Boards.

Ms. Clark explained the Regional Behavioral Health Services Act (RBHSA) was passed in 2014 and established initial and ongoing composition of the committee with authority to appoint members to the Regional Behavioral Health Boards. The proposed language would add a county commissioner to each Regional Behavioral Health Board and provide for the method of selection of a county commissioner to serve. It would also expand the categories of membership for both the State Behavioral Health Planning Council and the Regional Behavioral Health Boards to include representatives from the field of "prevention."

Ms. Clark advised the RBHSA allows for development and provision of community recovery and family support services. One method of community support that has proven to be effective is for a peer or family member who has lived experience to use that experience to assist individuals with behavioral health issues. The bill would add definitions of "family support partner," "peer support specialist," and "supportive services" to the statute to support the development and implementation of peer services in Idaho. There is no anticipated fiscal impact.

Vice Chairman Souza stated she has heard from some constituents who are concerned with the definition of "family support partner" and asked if it will limit family members or relatives from being involved. **Ms. Clark** answered the stakeholders worked very hard to develop these definitions. The definition of "family support partner" requires the service to be provided by a parent or family member with experience raising a child with a severe emotional disturbance because that experience is invaluable to a family navigating the multiple systems and agencies. Not having the experience would prevent someone from becoming a family support partner under the definition. **Vice Chairman Souza** asked if the family member would have to complete the prescribed training in order to work with their own family members or relatives as a family support partner. **Ms. Clark** replied the person would be required to complete the training if desiring certification as a family support partner. If the person wants only to support the family or provide services without seeking reimbursement, the person does not have to be certified.

MOTION: **Senator Harris** moved to send **H 213** to the floor with a **do pass** recommendation. **Senator Jordan** seconded the motion. The motion carried by **voice vote**. **Senator Foreman** requested he be recorded as voting nay.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 2:40 p.m.

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Senator Heider
Chair

_____

Jeanne Jackson-Heim
Secretary

Idaho State
UNIVERSITY

Kasiska Division of Health Sciences
Vice President for Health Sciences
921 South 8th Avenue, Stop 8055 • Pocatello, Idaho 83209-8055

March 2, 2017

Honorable Fred Wood
Chairman, House Health and Welfare Committee
Idaho Legislature
State Capitol
P.O. Box 83720
Boise, Idaho 83720

Dear Representative Dr. Wood:
I appreciate the opportunity to comment on legislation proposed by the Idaho Psychological Association to allow qualifying psychologists a provisional certificate of prescriptive authority. At Idaho State University, our role is to provide leadership in the delivery of health care by educating caring and competent professionals across all dimensions of health and to promote collaborative research and practice in the health sciences. Clearly, the delivery of mental health care services in Idaho is a critical need; every square inch of the state is a mental health Health Professional Shortage Area according to workforce data.

However, the needs for mental health services extend beyond the border of our state. We have had conversations with Dr. Yaron (Ron) Rabinowitz, senior prescribing psychologist in the Navy and specialty advisor for prescribing psychologists in the military. We look forward to working with him on a program that would meet the needs of our military as well as those in private practice.

I have reviewed the proposed legislation including the curricular requirements of the clinical psychopharmacology program. Idaho State University is optimally positioned to provide this type of training. We have faculty with tremendous expertise in neuroscience, psychopharmacology, psychology, anatomy, pathophysiology, physical assessment, research methods and ethics. Of course, any new program requires approvals by both the University and the State Board of Education. This process takes several months, but is not anticipated to be a barrier given the incredible need for enhancing the delivery of mental health services and our campus-wide mission. Should the legislature choose to enact this privilege, ISU will endeavor to take a proposal to the State Board of Education for approval with the goal of offering classes as soon as fall of 2018.

Phone: (208) 282-3848 • Fax (208) 282-4487 • isu.edu/healthsciences

Our expertise and mission places ISU in a prime position to provide the training program required to prepare psychologists for meeting the standards necessary to qualify for a certificate of prescriptive authority in psychopharmacology. We look forward to passage of this legislation in order to help meet the critical health care needs of Idaho.

Sincerely,

Rex W. Force, PharmD, BCPS, FCCP
Vice President of Health Sciences

cc: Deborah Katz, Executive Director, IPA
Kris Ellis, IPA Legislative Liaison
Page Haviland, PhD, President, IPA
Paul Cady, PhD, Dean, ISU College of Pharmacy

UNITED STATES MARINE CORPS
U.S. MARINE CORPS FORCES
SPECIAL OPERATIONS COMMAND
MARINE SPECIAL OPERATIONS SCHOOL
PSC BOX 20185
CAMP LEJEUNE, NC 28542-0185

IN REPLY REFER TO:
5300
PSYCH
20 FEB 17

From: LCDR Yaron G. Rabinowitz, MSC, USN
To: Fred Wood M.D., Chairman House Health and Welfare Committee

Subj: Idaho RxP Legislation and Training Program

Dear Chairman Wood:

I am Yaron Rabinowitz PhD, Lieutenant Commander, United States Navy. I am a prescribing psychologist and the Navy's Psychopharmacology Subspecialty Leader. In that capacity, I oversee the training and development of all prescribing psychologists in the Navy. A primary aspect of my job is to identify and cultivate appropriate training programs for Navy Psychologists.

The Navy is interested in sending psychologists to a two-year, full-time training program in Clinical Psychopharmacology. The rigorous training proposed in your prescriptive authority legislation appears to meet our needs.

Should the legislation become law, the Navy will make the Boise campus a primary training ground. It is possible that other branches of the military would be interested in such a rigorous program as well.

Please let me know if there are any questions I can answer or issues I can address.

Y. G. RABINOWITZ, PhD, ABPP, ABMP
LCDR, US NAVY

AMENDED AGENDA #1

SENATE HEALTH & WELFARE COMMITTEE

1:00 P.M.
Room WW54
Friday, March 17, 2017

SUBJECT	DESCRIPTION	PRESENTER
S 1191	Relating to Dietitians	Anne Lawler, Executive Director, Board of Medicine
Approval of Minutes	Minutes of the March 9, 2017 Meeting Minutes of the March 13, 2017 Meeting	

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Souza
Sen Martin
Sen Lee
Sen Harris
Sen Anthon
Sen Agenbroad
Sen Foreman
Sen Jordan

COMMITTEE SECRETARY

Jeanne Jackson-Heim
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Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Friday, March 17, 2017
TIME:	1:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Souza, Senators Martin, Lee, Harris, Agenbroad, Foreman, and Jordan
ABSENT/ EXCUSED:	Senator Anthon
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED:	**Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 12:56 p.m.
APPROVAL OF MINUTES:	**Vice Chairman Souza** moved to approve the Minutes of the March 9, 2017 meeting. **Senator Martin** seconded the motion. The motion carried by **voice vote.**
	Senator Martin moved to approve the Minutes of the March 13, 2017 meeting. **Vice Chairman Souza** seconded the motion. The motion carried by **voice vote.**
S 1191	In anticipation of the referral of **S 1191**, the Committee held a hearing. **Relating to Dietitians. Anne Lawler**, Executive Director of the Board of Medicine (Board), introduced herself to the Committee. The purpose of the bill is to update the Dietetic Practice Act. A concern arose in Senate floor debate about a previous version of the bill that allowed the Board to assess costs and attorney's fees to a licensee in a disciplinary proceeding. After meeting with some Senators who expressed that concern, the Board made changes, and this bill is the result.
	Ms. Lawler explained language was deleted pertaining to "driving under the influence," along with provisions authorizing the Board of Medicine to impose a fine and assess costs and attorney's fees against a dietitian for a disciplinary action. Those provisions had originally been added to be consistent with the Medical Practice Act. However, the Board believes that updating the scope of practice for the dietitians is more important than retaining that language.
	Senator Jordan referred to page 9, Idaho Code § 54-3511 pertaining to penalties. She inquired if Ms. Lawler had discussed this provision with any of the Senators and if the language is consistent with other medical practice legislation. **Ms. Lawler** replied that topic did not come up in her discussions, but it is consistent with the other medical acts. In addition, that provision only applies to a criminal violation, and it would generally pertain to unauthorized use of the term "dietitian" or unlicensed practice. The Board is required to report such violations to the county prosecutor.
	Vice Chairman Souza moved to send **S 1191** to the floor with a **do pass** recommendation. **Senator Martin** seconded the motion. The motion carried by **voice vote.**
ADJOURNED:	There being no further business at this time, **Chairman Heider** adjourned the meeting at 1:05 p.m.

ADDENDUM: Following the referral of **S 1191** on March 20, 2017, the bill was buck slipped.

Senator Heider
Chair

Jeanne Jackson-Heim
Secretary