#29

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Q1

What is your name and Candidate Committee name?

First and Last Name:	**Jackie Grimes**
Candidate Committee:	**Elect Jackie Grimes**
House/Senate District:	**Senate District 10**
Preferred Email:	**jacqueline@electjackiegrimes.org**

Q2

What is the role of state government in healthcare issues in Wyoming? Describe your top three priorities for improving the healthcare delivery system in the state?

1.	**Increasing access – building and supporting rural hospitals, FQHCs and CHCs. Ensuring other services such as transportation are available and servicing these facilities**
2.	**Improving affordability – a. Expanding the Medicaid programs like most other states have. b. Ensuring that legislation supports, rather than discourages, private insurance companies from entering our commercial market. c. Subsidizing the costs for individuals and families who don't qualify for Medicaid, are not covered by employer sponsored benefits, and don't have the financial means to completely afford private coverage. I think being able to receive health care is a basic human right and government should do what it can to ensure we all can afford it. While I don't believe the health care system should make tremendous profit from the poor, I also don't believe it is their responsibility to subsidize the cost. That's the responsibility of the community through government funding to ensure reimbursement levels are appropriate and sustainable.**
3.	**Improving systems for telehealth. Wyoming (and the rest of the country) has a shortage of qualified healthcare providers that will not increase fast enough to meet the demands of an aging population, especially if we increase access to health insurance for all. The state needs to assist in creating systems to support telehealth, like the infrastructure to connect rural hospitals and clinics to specialists in our urban areas. We need all allied health professionals working at the top of their license and being part of a health care team that can reach into our underserved areas, whether that be rural, or impoverished and under served urban areas.**

Q3

According to 2020 data, Wyoming's tobacco tax rate of $.60 per pack ranks 44th in the nation. The national average is $1.82 per pack. Given the state's declining revenue and Wyoming's low tobacco tax, is increasing the tobacco tax a subject you feel worthy of consideration? If you do support the tax increase is it primarily based in an interest to generate state revenue or as a method to de-incentivize tobacco use, or both?

Yes I support increasing the tobacco tax.,
Please Explain:
Yes, increasing tobacco tax is worthy of consideration. I view taxation of tobacco mainly as a means of modifying behavior, but I also think it is appropriate not only for discouraging consumption but also as a response to increased health care and other costs associated with tobacco and related products. I support increasing the tobacco tax as detailed in House Bill 0205, including "electronic smoking device[s]". I would also support sequestering these excise taxes and using them for smoking cessation and other health related programs. The revenue from the users of the products would help fund the treatments and contribute to lower health care costs and improved quality of life for many.

Q4

With 30 percent of Wyoming's population being covered by public payers (Medicare and Medicaid), and current projected budget shortfalls, how would you prioritize reimbursement from state Medicaid to physicians? Please explain.

While 30 percent of Wyoming's population may be covered by public payers, Medicare is administered and funded by the federal government or a Medicare Advantage plan and not the state. Medicaid, on the other hand, is administered by the state with co-funding from the federal government. Medicaid/CHIP covers about 13% of Wyoming's population even though 26% of the population is low income.
It is my belief that health care is a basic human right and although Wyoming may be facing a budget shortfall, it has been setting money aside in its rainy day fund for years. In fact, Wyoming is ranked number one in rainy day fund size with approximately 109% of its annual budget set aside. For comparison, Alaska at #2 has 52.6% and North Dakota at #3 has 30%. With respect to our adjoining states the highest (besides North Dakota) is South Dakota at 11.1% and the lowest is Montana at 4.6%. So Wyoming is well positioned to weather the budget shortfall while it works on longer-term solutions so that all Wyomingites who are eligible for Medicaid can continue to be covered and physicians can continue to be paid in a timely manner. That is what I would fight for.
However, I realize that one state senator's vote doesn't resolve a political issue. If it is not politically possible to continuing current funding with rainy day funds, the state will basically have two options: continue current benefits with the currently covered population until the funds run out; or change the programs benefits and eligibility so that the funding will last the complete fiscal year. I am not in favor of running out of funds before the end of the fiscal year and leaving health care providers unpaid. I prefer to design the program so that both providers and beneficiaries know who is covered and for what services and that the state covers those obligations with timely payments.
The federal government mandates that state Medicaid programs include 15 services such as inpatient and outpatient hospital services; EPSDT; physician services; FQHCs; rural health clinics; and other services. In addition, Medicaid programs can cover more than two dozen optional benefits at the state's discretion such as prescription drugs; physical therapy; podiatry; optometry; dental; chiropractic; hospice; and other services. There are also income eligibility requirements that can vary. For example, while the federal government requires that children at or below 133% of the federal poverty level be eligible for Medicaid, Wyoming covers children up to 205%; pregnant women to 159%; parents to 54%; and seniors and people with disabilities to 74%.
I prefer that Wyoming move towards Medicaid expansion where it's been estimated that the state is leaving $1.3 billion on the table over the next decade. However, for our immediate needs I advocate that we use the rainy day fund to continue the program as is. But if we politically have no choice but to make cuts, I'd rather do it up front by examining the optional benefits or adjusting the income eligibility so that providers and beneficiaries are confident that the program will pay for the services they provide/receive in a timely manner.

Q5

WMS supports physician-led healthcare teams with each licensed provider practicing at the top of their scope. Do you support licensed healthcare professionals expanding their scope of practice or increasing the specific tasks they can perform, such as psychologists prescribing or optometrists performing eye surgery, through rule making or legislation without proof of adequate expanded education, training and curriculum changes?

No, healthcare providers should only expand scope of practice when done through increased education, curriculum changes in training programs and stringent testing to determine proficiency.

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Please explain:

As a mental health professional, I support evidence-based approaches to delivering care. Likewise, I think legislating should be evidenced-based. Too often unqualified legislators use their anecdotal opinions to create legislation in areas outside of their expertise. That's generally when we get into trouble through overreach. As I noted above, the first role of government is to protect the public and part of that role is ensuring that health care providers are properly trained and credentialed to provide quality care within their scope of practice. I don't support expanding the scope of practice through rule making or legislation without tying it to the completion of certified courses sufficient to ensure the clinicians proficiency and to protect the public in the area of scope expansion

Q6

The demand for mental health services in Wyoming is on the with suicide rates remaining a top concern with Wyoming ranking as the third-highest state in the nation. Given this growing increase in demand for state mental health services, what do you believe can be done to positively impact this space through policy? Please explain.

There are several areas of policy that would be beneficial for Wyoming. Wyoming took the first step when it enacted policy that requires 2hrs a year or 8 hours in a 4 year period of suicide prevention training for educational staff. This is great education, however, it falls woefully short of what is needed in the state. First, this initial legislation needs to be expanded to include direct student instruction in mental health needs and suicide. In addition, parents need direct training in mental health and suicide prevention for their own children. This could be accomplished in a partnership with school districts to provide this training during times parents frequently access buildings such as during parent-teacher conferences or open houses. Expanding outside of school districts, there needs to be a statewide community engagement and educational campaign to educate the public at large about suicide and normalize receiving health; acknowledging that mental health is part of healthcare. Doctor's offices screening for mental health concerns; this has effectively been done in screening for postpartum depression. Further, the state needs to invest in a suicide crisis hotline to be link with the national program; as it stands now, when someone from Wyoming calls the national hotline, they are put on hold until someone from another state is available. This does no good getting help where it is needed. We need to expand teletherapy practices to reach rural populations and ranchers who may be too uncomfortable to travel to an office. Right now the most important thing we can do for mental health, is prevent further cuts. The Governor is anticipating cutting mental health services and supports by 20% during a time when mental health needs are at an all time high; we have to protect funding needed to get services and supports for families. Lastly, legislation is needed that prevents individuals who seek out help from being punished for doing so. This is particularly true for individuals who are afraid to ask for help due to fear of losing their jobs, losing custody of children, being evicted, or being charged with a crime (e.g., substance users). We have got to put protections in place to prevent retaliatory and discriminatory practices for those who seek help.

Q7

Would you support legislation to resolve the professional liability crisis in Wyoming? Specifically, would you support a cap on non-economic damages? Would you support other remedies such as adoption of the English rule, no-fault medical liability insurance or other such reforms?

I support capping non-economic damages	**Disagree**
I do not support capping non-economic damages	**Agree**
I support investigating all avenues to bringing meaningful liability reform to the state including capping non-economic damages.	**Disagree**
I support investigating alternative means to achieving liability reform but do not support capping non-economic damages.	**Agree**
I do not support any efforts to bring liability reform to the state as I do not see there is a current need or crisis.	**Disagree**

Please explain:

1. Cap on non-economic damages. Most laws are balancing acts between the interests of different groups within society. Laws protecting the public are necessary. But abuse of the system can occur and defendants have rights too. While we don’t want laws that discourage patients from seeking legitimate compensation for physical and mental harm they needlessly suffer, we also don’t want to allow them to abuse the system with frivolous or malicious lawsuits or unreasonable awards that end up impacting costs to others through higher malpractice insurance costs and overall higher health care costs. Caps on malpractice awards have to respect that balancing act and several states have had their legislation ruled unconstitutional. However, 30 states do have caps that have survived constitutional challenge. They fall into three types: caps on just pain and suffering; an absolute cap; and states that have just a hard cap. Without specifying what the cap should be in Wyoming (I believe this should be determined by a panel of experts familiar with the unique needs of Wyoming to guide the legislation) I do support equal protections for both litigants and defendants and recognize that malpractice lawsuits have the potential for abuse and unreasonable harm to defendants. 2. English rule. The English Rule where doctors have to prove that they have been arrested or have had their property seized in order for them to recover damages is unduly burdensome and unfair to the health care provider. I favor the American Rule followed by most states that does not require arrest of the person or seizure of property, but still requires the doctor prove that the underlying lawsuit was filed without justification and maliciously, and that the doctor won the original malpractice lawsuit. That’s still a substantial burden of proof placed on the health care provider and yet is a reasonable deterrent for frivolous and malicious malpractice lawsuits. 3. No-fault medical liability insurance. There are both positive and negative outcomes associated with medical malpractice awards. Not only do they compensate victims of malpractice but they also lead to higher malpractice insurance costs for health care providers and higher overall health care costs through the need for “defensive medicine”. The fear of malpractice litigation can lead providers to overprescribed diagnostic tests, medications and medical treatments that can affect patient safety and overall health care costs. There are many states that are experimenting with a no-fault medical liability system. I find the New Zealand system, which has been evolving since 1974, to be among the most promising (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5198606/). They created a publicly funded system that provides assistance with the cost of treatment and rehabilitation for all personal injury, regardless of fault, in exchange for banning patients suing for compensatory damages. Consequently, there is no culture of suing doctors for

damages and doctors pay comparatively low medical malpractice rates. Doctors are held accountable under a separate process that deals with a doctor's competence and fitness to practice, an independent patient complaints system, and a separate disciplinary process. There are increased costs under both our current system and the New Zealand system but the researchers found: "New Zealand's system of no-fault compensation for treatment injury provides more equitable access to compensation more efficiently than a malpractice system. It also generates novel patient safety data for learning, although these have yet to translate into improvement in patient safety. Despite widespread interest in malpractice reform as a means of slowing the rate of growth of healthcare costs, this analysis suggests such reform is likely to be unrewarding. Separating accountability from compensation does not make all that much difference to doctors. Processes to hold doctors to account are important in any medical regulatory structure, but they can instill fear and drive behavior regardless of the system of compensation. Nonetheless, the absence of a culture of suing in New Zealand does support the development of an atmosphere more conducive to thriving professional values and norms, although policies that foster professionalism remain elusive."

Q8

WMS advocates for physicians to practice evidence-based medicine grounded in the latest research and safety standards. WMS opposes any legislation that attempts to unnecessarily insert government within the relationship between physicians and their patients as it hinders the ability for doctors to administer the most recent, evidence based, practices in medicine. Do you oppose legislation that unnecessarily inserts government between a physician and a patient?

Yes, I oppose state legislation that inserts government between a physician and a patient.

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Please explain:

This question is difficult to answer. While I do oppose legislation that “unnecessarily” inserts government between a physician and a patient, your bulleted choice removes the word “unnecessarily”. There are scenarios where government might be a necessary player in the relationship between health care consumers and health care providers and I’m hesitant to give a blanket statement that precludes them all. On the other hand, I don’t believe that government has a “strong role to play in guiding how physicians practice medicine” – government does not always have the necessary knowledge and experience to play that role. I also have reservations about evidence-based medicine being the panacea for the problems of a complex adaptive world. While the Institute of Medicine has set a goal that 90 percent of health care decisions be evidence-based by 2020, we are a long way from achieving that. The accepted current view of evidence-based medicine is that it makes decision-making more thoughtful and more transparent. It imposes a new code of conduct on decision makers, which, at times, can be laborious and which makes it harder to justify certain kinds of interventions. And evidence-based medicine increases, rather than diminishes, professional responsibility and authority, because it provides a much more secure basis for decision making. However, EBM has its limitations. Some practical limitations include the absence of the support structures needed for sustained evidence-based decision making. There is a lack of commitment to its due process, insufficient evidence for too many problems, and insufficient local skills for interpreting evidence-based information. And there still are gaping holes in evidence on many common clinical topics and about high-risk populations. The recent fiasco at the Cochran Collaboration Board unleased legitimate concerns about the differences between the prevailing scientific method arising from the linear cause-and-effect assumption and the complex adaptive systems science methods that arise from observations that most phenomena emerge from nonlinearity in networked systems. Most medical conditions are characterized by necessary features that by themselves are not sufficient to explain their nature and behavior. Such nonlinear phenomena require modelling approaches rather than linear statistical and/or meta-analysis approaches to be understood. These considerations also highlight that research is largely stuck at the data and information levels of understanding which fails clinicians who depend on knowledge—the synthesis of information—to apply in an adaptive way in the clinical encounter. The point is,

evidence-based medicine is not yet mature enough to simply say that if the profession follows it there is no need for any government oversight or consumer protections. There is still an enormous knowledge imbalance between the patient and the doctor to not have systems in place to ensure patients are receiving the best evidence-based care and not being harmed. I think the two options given are a false choice and there is an in-between solution that keeps government out of routine interactions between the health care provider and the patient but recognizes that not all health care is, or can be, completely evidenced based and that some protections are still needed for less informed patients as well as to make allowances for clinicians that are dealing with complex problems for which the “evidence-based” treatment recommendation is insufficient.

Q9

Do you support expanding Medicaid to provide state-based insurance to uninsured Wyomingites for 10% of the cost to the State of Wyoming?

Yes,
Please explain:
Because Wyoming has not adopted Medicaid Expansion we have a significant number of people without insurance. 59,970 Number of people covered by Medicaid/CHIP as of July 2018 27,000 Number of people who would be covered if the state accepted expansion 6,000 Number of people who have no realistic access to health insurance without Medicaid expansion $1.3 billion Money the state is leaving on the table over the next decade by not expanding Medicaid

Q10

Please send me additional information about the following topics:

Would appreciate additional information the medical community is experiencing and ways the legislature can help.

Q11

Does your candidate committee accept Political Action Committee (PAC) contributions?

Yes