2007 Annual Report

Joint Commission on Health Care

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Joint Commission on Health Care

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INTRODUCTION

Commission Profile

The Joint Commission on Health Care (JCHC), a standing Commission of the General Assembly, was established in 1992 to continue the work of the Commission on Health Care for All Virginians. The statutory authority for JCHC in *Code of Virginia* § 30-168, Title 30, Chapter 18, states in part: "The purpose of the Commission is to study, report, and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services." Moreover, as of July 1, 2003, JCHC assumed the responsibilities of the Joint Commission on Behavioral Health Care.

Membership

The Joint Commission on Health Care is comprised of eighteen legislative members. Eight members of the Senate are appointed by the Senate Committee on Rules and ten members from the House of Delegates, "of whom three shall be members of the House Committee on Health, Welfare and Institutions, to be appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates."

Commission members' appointment terms coincide with their terms in office, although members may be reappointed to the Commission.

A chairman and vice-chairman are elected from the Commission's membership and a majority of Commission members constitutes a quorum.

EXECUTIVE SUMMARIES

During 2007, the Joint Commission on Health Care, its Behavioral Health Care Subcommittee, and the Long-Term Care/Medicaid Reform Subcommittee conducted studies in response to legislative requests. In keeping with its statutory mandate the Joint Commission completed the following study reports.

Follow-Up Care and Tracking Systems for Preterm and Low-Birth Weight Infants

The Joint Commission on Health Care was briefed by Dr. Susan Brown in October 2005, regarding the importance of providing follow-up services for preterm (premature) and low-birth weight (LBW) infants. JCHC subsequently voted to request a study in 2006 to determine the availability and adequacy of follow-up services and the potential need for a tracking system for preterm and LBW infants.

The National Center for Health Statistics defines premature and low-birth weight infants as:

Premature birth
Delivery occurring at less than 37 completed weeks of gestation (full term = 38 to 42 weeks).

Low - Birth Weight
Less than 2,500 grams or 5.5 pounds; very low birth weight < 1,500 grams or 3.25 pounds.

Historical data suggests a strong correlation between these two birth indicators.

National and Virginia data indicate that the percentage of preterm and LBW infants increased from 1994 to 2004. According to the Virginia Department of Health, of the 11,261 live births in 2004, 8,587 were preterm and LBW.

Importance of Follow-Up Care

Early intervention services in the first years of life are crucial for preterm and LBW infants. During the first years of a child's life, the brain is especially receptive to the positive effects of intervention services. The provision of follow-up services to preterm and LBW babies soon after their birth frequently results in increased developmental scores. Studies have found

that long-term public savings may be achieved if follow-up services are provided early in a child's life. These savings result from decreased grade repetition and spending in special education, welfare, and juvenile justice programs; and ultimately from increased tax revenues and enhanced productivity.

Many developmental delays may not be obvious to parents and may not be recognized until their child enters school. If early intervention services are not provided the child will be at an increased risk of academic failure, behavioral problems, and socio-emotional disturbance. The developmental delays typically involve communication, social, motor skills and problem solving. The optimal time for providing services for the most benefit is 0 to 5 years of age.

JCHC Study Activities

A JCHC—convened workgroup cited anecdotal evidence that families are having difficulty accessing services for their preterm and low-birth weight infants, with contributory factors including a general lack of understanding regarding the importance of follow-up services, the cost of services particularly since reimbursement for services is low, and the restrictive eligibility criteria for public programs.

In 2007, the workgroup addressed three areas of concern:

1. Which State data systems identify young children and could those systems provide for improved tracking of preterm and LBW infants?
2. What services are provided for children born preterm or LBW, which organizations provide these services and to what extent can (or do) these organizations track service utilization for these children?
3. To what extent are outcomes associated with the provision of services tracked, and is the tracking specific to children who were born preterm and LBW?

The workgroup verified that no State data system specifically identifies and tracks children who were preterm/low-birth weight at birth. While a number of State programs serve some of these children, no program consistently identifies specifically which of the children served were preterm/ low-birth weight. Obstacles to instituting this type of tracking include the lack of common identifiers across agencies, the need for a coordinated interagency approach to tracking children across agencies, and the restrictions contained in the privacy provisions of the federal Family Educational Rights and Privacy Act.

JCHC Chairman's Letter Requests

JCHC members authorized the Chairman to make a number of letter requests which are first steps in determining the State's ability to address the aforementioned obstacles. The letters requested the following actions:

- The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) make preterm and low-birth weight information mandatory data fields when local partners electronically submit Part C early intervention information.
- The Virginia Department of Health (VDH) report to JCHC in 2008 regarding service information collected through the Pregnancy Risk Assessment Monitoring System survey.
- VDH and DMHMRSAS report to JCHC in 2008 on the status of using the same unique identifier for children served by two programs the agencies administer (Virginia Infant Screening and Infant Tracking System and the Infant and Toddler Connection) and on the feasibility of studying outcome data on preterm and low-birth weight infants who receive Part C services.
- VDH report to JCHC in 2008 on the status of the pilot linking birth certificate information to certain children's records maintained by the Department of Medical Assistance Services.
- VDH, with assistance from DMHMRSAS, report to JCHC in 2008 on the feasibility of studying outcome data on preterm and low-birth weight infants that receive Part C services. (Restrictions on VDH's ability to access educational records protected by the Family Educational Rights and Privacy Act are the primary obstacle.)

Higher Rates of Cervical Cancer among Minority Women

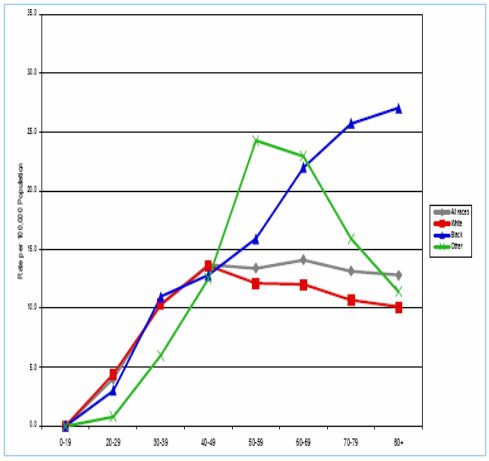
In January 2005, Governor Mark R. Warner issued Executive Directive 5, creating a task force to study the problem of cervical cancer among women in the Commonwealth.

Jane H. Woods, Secretary of Health and Human Resources, chaired the task force which consisted of 20 individuals including physicians, college professors, and Virginia Department of Health (VDH) staff.

The task force report was issued in November 2005, and included five recommendations. One of the recommendations was to "request the Joint Commission on Health Care to further study racial, ethnic, and cultural disparities in cervical cancer incidence to identify causes and develop a plan to address findings."

Rates of cervical cancer, though decreasing for women of all racial/ethnic groups, are still higher for minority women. The incidence of cervical cancer continues to increase with age for minority women whereas the incidence of cervical cancer for White women peaks in the mid forties. Further, Black women in Virginia are more likely to be diagnosed at an advanced stage of disease and have twice the mortality rate from cervical cancer compared to White women.

Age Adjusted Incidences of Cervical Cancer by Race



Gray line: All Races Blue line: Black
Red line: White Green line: Other
Source: Report of Governor's Task Force on Cervical Cancer. 2005

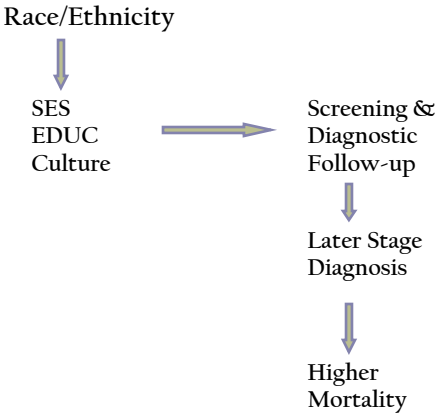
Higher rates of cervical cancer and mortality are primarily a result of racial and ethnic minorities being more likely to have lower socioeconomic status, lower levels of education, and, for some minority groups, a higher likelihood of cultural norms that discourage women from having regular Pap tests and pelvic exams. The result is a lower probability of initial screening and diagnostic follow-up which can lead to higher incidences of cervical cancer, a later stage of diagnosis, and ultimately the increased likelihood of mortality. Forty-six to 56 percent of women diagnosed with cervical cancer had not had a Pap test within three years of the diagnosis and minority women with cervical cancer are less likely to have been screened by a Pap test than White

women with the disease. Even when women are screened, the screening must be followed by prompt notification of test results, adequate patient follow-up, and appropriate and timely treatment in order to be effective. For minority women, this process is more likely to be incomplete.

Some cultures, especially Vietnamese and Korean, discourage women from having pelvic exams and Pap tests due to norms that prohibit or strongly discourage exposure of women's bodies to anyone other than the husband. For women of other minority groups (e.g. Black and Hispanic) the lack of screening is more likely to be an economic problem. Due to past and present discrimination and inequality, minorities are more likely to live below the poverty line, have lower-paying jobs, and/or lack health insurance. All of these economic conditions make it less probable that a woman will have a designated primary care physician/ gynecologist and a yearly gynecological exam. Because of the lack of consistent screening, minority women tend to have cervical cancer diagnosed at a later, more life-threatening, stage.

Diagnostic follow-up also is a factor that varies by racial/ethnic group. In large part, the lower rates of follow-up among minority women are a result of having no insurance, low income, and/or being underinsured. However, education also is an important factor. When the results of a Pap test show an abnormality, many women do not fully understand the meaning of these results, underestimate their importance, and unfortunately delay returning to the physician for a follow-up exam. As is the case of the lack of screening, poor follow-up of abnormal Pap test results can lead to cervical cancer being treated at a later stage, increasing the likelihood of mortality.

Causes of Higher Cervical Cancer Rates among Minorities



Strategies which could significantly reduce these disparities include the school mandate for the human papillomavirus (HPV) vaccination, educational programs designed to be culturally appropriate for specific minority communities, and greater access to screening and treatment through such programs as Virginia's "Every Woman's Life." With the availability of HPV vaccines, in combination with annual screening procedures, cervical cancer is a disease that can be stopped. As one physician stated,

"Cervical cancer is now a preventable disease and any woman presenting with invasive cervical cancer should be viewed as a failure of screening."

Legislation

Four Policy Options were presented, JCHC members voted to take no action at this time.

Stroke Prevention and Care

House Joint Resolution 635 (2007), introduced by Delegate John M. O'Bannon III, directed the Joint Commission on Health Care to study and develop strategies to address "stroke prevention and care across the Commonwealth" and to identify and propose solutions to barriers for optimal stroke care, such as:

- Public awareness initiatives
- Emergency response protocols
- Primordial, primary and secondary prevention of stroke
- Rehabilitation of stroke patients
- Continuous quality improvement initiatives, and
- Availability of public support to treat indigent and uninsured stroke victims.

Although HJR 635 was left in the House Committee on Rules, JCHC included the study in its work plan.

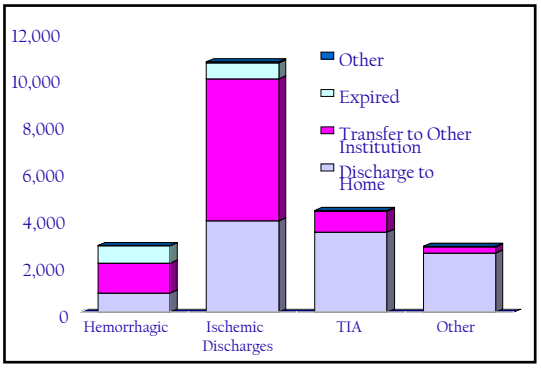
Stroke in Virginia

Stroke is the third leading cause of death in the Commonwealth according to a 2006, report from the Virginia Department of Health (VDH) . The Virginia Health Information hospital discharge dataset reported that in 2004, 3,681 Virginians died from a stroke.

Further, VDH 2004 statistics indicated for every 100,000 Virginians, 54 died from a stroke and for every 100,000 black Virginians, 79 died from a stroke.

In 2006, Virginia hospitals had 20,674 stroke patient discharges. The table below shows patient discharges from Virginia hospitals for the different types of stroke.

Patient Discharges



Virginia's most common type of stroke is ischemic and the most likely to be fatal is hemorrhagic. Ischemic strokes also represent the highest level of discharge to a nursing facility and rehabilitation center.

JCHC – Convened Workgroup

When JCHC undertook the study, a workgroup was convened with members that had diverse interests and expertise regarding strokes. The JCHC-convened workgroup met four times in 2007 (June 8, July 11, July 27, and August 14). Discussions and presentations addressed background information and stroke prevalence, as well

as a review of the stroke systems in place related to prevention, emergency and continuing care, rehabilitation, and ongoing improvement efforts. After much deliberation, the workgroup developed and recommended eight options (including the option to take no action) for JCHC consideration.

Workgroup Participants

A neurologist

A neuroradiologist

An emergency care physician

A licensed nurse

A general practice physician

An emergency care physician

Pharmacologist

An administrator of a small rural hospital

An administrator of a Primary Stroke Center

An administrator of an accredited stroke rehabilitation facility

Representatives of:

VDH Division of Chronic Disease Prevention

VDH Emergency Medical Services

American Stroke Association

In response to the findings and workgroup recommendations of this study, six options were adopted by the Commission. The following five options involved requests by letter of the Chairman:

1. Virginia Department of Health to convene a standing Stroke Systems Task Force.
2. Virginia Hospital and Healthcare Association to assist in encouraging all hospitals to establish a protocol for the rapid evaluation and subsequent admission or transfer of the stroke patient.
3. VDH Office of Emergency Medical Services to report to JCHC regarding progress in developing a centralized data collection system for electronic medical records.
4. Department of Medical Assistance Services (DMAS) to investigate the option for care coordination service payments for those who have had a stroke.
5. Department of Social Services (DSS) and DMAS to investigate an expedited Medicaid determination review for acute stroke patients.

The sixth approved option involved introducing legislation to amend the *Code of Virginia* to require each regional EMS Council to create a uniform destination plan for pre-hospital stroke patients.

Senate Bill 344
Senator Blevins
Acts of Assembly Chapter 567

House Bill 479
Delegate Hamilton
Acts of Assembly Chapter 66

Review of Health Care Costs

Senate Joint Resolution 4 (2006), introduced by Senator Roscoe W. Reynolds, directed JCHC to examine (i) factors leading to rising health care costs in the Commonwealth, (ii) the derivative effects of rising health care costs including increases in health insurance premiums and denial of coverage, and (iii) ways to reduce health care costs in the Commonwealth and alleviate the burdens associated with the rising cost of health care." A report was presented to JCHC in 2006; however, specific findings and recommendations were delayed until 2007.

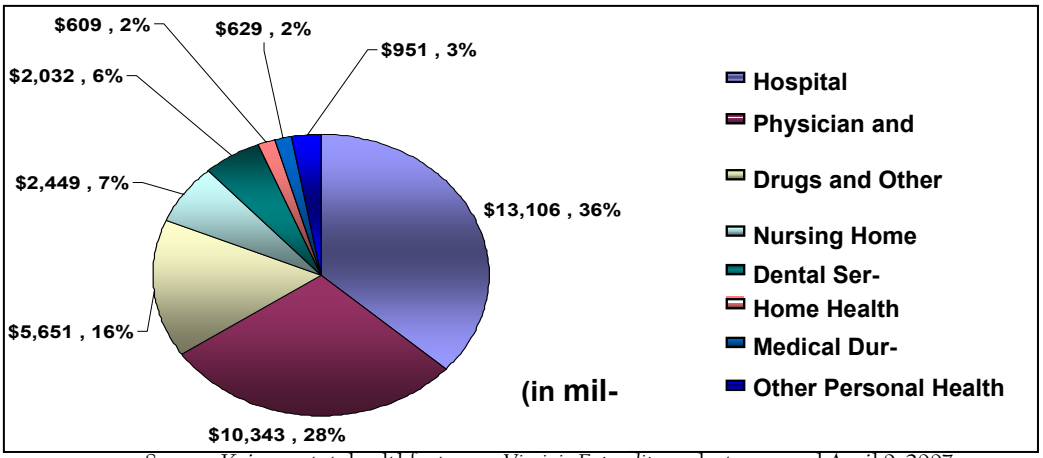
Health Care Costs

The rising cost of health care is a significant concern in the United States. According to a report by the Kaiser Family Foundation and Health Research and Educational Trust, health care spending has increased at an average annual rate of 9.8 percent since 1970, thereby increasing national health care expenditures from $75 billion in 1970 to $2.0 trillion in 2005. In Virginia, an estimated $35.8 billion was spent on health care in 2004. As shown in the chart below, spending related to hospital and physician/ other professional services accounted for almost two-thirds of Virginia's 2004 health care spending.

Not all businesses offer health insurance to its employees. In fact, the likelihood of a business offering health insurance to its employees is highly correlated with the size of the business. Only 45 percent of the smallest businesses offered health insurance in 2007, whereas 99 percent of businesses with 200 or more employees offered health insurance.

Virginia Reports on Health Care Costs

During this study, many reports were reviewed including two Virginia-specific reports: the JLARC study *Options for Extending Health Insurance to Uninsured Virginians* and *Roadmap for Virginia's Health: A Report of the Governor's Health Reform Commission.*



Source: Kaiser - statehealthfacts.org, *Virginia Expenditures*, last accessed April 9, 2007

Some of the health insurance options and findings discussed in JLARC's study.

- Allowing small employers to utilize State employee or Local Choice health plans, which could make providing insurance more affordable and attractive by reducing premium and administrative costs but lead to higher premiums for State and Local Choice employees, increased administrative burden and costs for the State.
- Establishing a market exchange that small employers could designate as their employer plan, which could encourage more small employers to offer health insurance by providing the opportunity to offer pre-tax employer contribution without any administrative responsibilities. However, eliminating the administrative burden may not provide sufficient incentive to offer health insurance.
- Expanding Medicaid/FAMIS eligibility, which would allow Virginia to cover more low-income individuals and expand the use of federal matching funds but add costs to the State.
- Providing direct subsidies to low-income individuals to purchase health insurance, which could fill the gap between what some individuals can afford and the price of insurance but would require substantial subsidy for individuals to engage and add costs to State.
- Providing subsidies to small employers, which could be provided through tax incentive or direct payment, and could require that employers contribute to employees' health insurance. This option would require substantial subsidy to be attractive for small employers, and would add costs to State.

Roadmap for Virginia's Health: A Report of the Governor's Health Reform Commission also provides options that would affect health care costs. One option is to create a private health insurance product for working uninsured Virginians and small businesses who have limited access to other health insurance options. The product is expected to cost the Commonwealth an estimated $20,000,000 per year and include a monthly premium estimated to be $135 for a health care insurance policy capped at $50,000 in claims per year.

Premiums for individuals whose income is less than 200 percent of the Federal Poverty Level would be paid:

Employer 1/3
Employee 1/3
Commonwealth 1/3

Legislation

Although no legislation was introduced related to this study, JCHC members voted to continue the examination of health care costs within the 2008 JCHC work plan.

The 2008 study will examine the advisability of:
i) establishing a Virginia health insurance exchange targeted for small businesses,

ii) assisting employer adoption of Section 125 (cafeteria) plans, and

iii) examining any other health insurance issues as deemed appropriate.

Increasing the Availability of Health Insurance Providers in Rural Areas

House Bill 1324 introduced by Delegate David A. Nutter during the 2006 General Assembly Session directed the Commissioner of Insurance to prepare a plan to double the level of competition among providers of health insurance products in the Commonwealth's rural areas. HB 1324 was passed by in the House Commerce and Labor Committee in favor of a letter to the Joint Commission on Health Care requesting a study of the issues contained in the bill.

Differences Between Rural and Non-Rural Localities in Virginia

Some distinct differences are observed when the socio-economic well-being of rural and non-rural localities in Virginia are compared (Rural is defined in this report as having fewer than 120 people per square mile). The most notable difference is seen in family income as the average income in rural localities was nearly $13,000 less than in non-rural localities. Moreover, families living in rural areas were more likely to have incomes at or below 200 percent of the federal poverty level, experience unemployment, and lack health insurance.

Rural and Non-Rural Localities Have Distinct Differences

		Rural Localities	Non-rural Localities
2000 Localities' Persons per square mile*	Average	61	1,106
	Median	*56*	*326*
2004-05 Median Family Income**	Average	$38,596	$51,341
	Median	*$36,375*	*$46,890*
2004-05 Rate of Population 200% or Below the Federal Poverty Level (FPL)**	Average	32.1%	24.2%
	Median	*32.0%*	*21.5%*
2004-05 Unemployment rate**	Average	4.4%	3.8%
	Median	*4.4%*	*3.3%*
2004-05 Uninsured Rate**	Average	14.8%	13.4%
	Median	*14.8%*	*12.9%*

Employer—Offered Health Insurance

Employer-offered health insurance is very important as most non-elderly Virginians, like most non-elderly Americans, have health insurance coverage through their employers. As reported in *Options to Extend Health Insurance Coverage to Virginia's Uninsured Population*, a study by the Joint Legislative Audit and Review Commission (JLARC), almost 80 percent of the non-elderly Virginians who have health insurance coverage are insured through their employers.

Small businesses (those least likely to offer their employees health insurance coverage) are disproportionately located in rural areas.

Consequently, it was not surprising to find that these socio-economic factors contributed to accessibility and affordability problems faced by individuals seeking health insurance coverage in rural localities. Conversely, the availability of health insurers was not substantially lower in rural localities when compared with non-rural localities. A review of State-licensed manage care insurers indicated that while rural areas have the lowest number of insurers, all Virginia localities had at least 35 insurers that offer health insurance plans.

Several options were suggested to address accessibility and availability of health insurance:

Average # of Licensed and Certified HMOs
- Rural Localities – 9
- Non-Rural Localities – 12

Average # of Licensed and Certified PPOs
- Rural Localities – 34
- Non-Rural Localities – 35

Allow Mandate-Free Health Insurance Products in Rural Areas. The ability to offer a health insurance product which is not required to include mandated benefits has the potential to allow for lower-cost plans.

Provide Tax Incentives for Health Insurers in Rural Areas. Providing a State tax-credit or deduction for the development of new product lines or policies offered in targeted rural areas might be an effective incentive to develop lower-cost health insurance plans.

Provide Subsidies for Employers who Offer Health Insurance for Employees. Small employers, operating in targeted rural areas, that add health insurance as an employee benefit, could have some of the cost incurred reimbursed through direct subsidy or changes in tax policy.

Legislation

Although no legislation was introduced related to this study in 2008, JCHC members voted to endorse the general concept of subsidizing a health insurance product for uninsured Virginians.

Minority Access to Mental Health Services

Senate Joint Resolution 25 introduced by Senator Henry L. Marsh, III in the 2004 Session of the General Assembly directed the Joint Commission on Health Care to conduct a two-year study of "the mental health needs and treatment of young minority adults in the Commonwealth." The resolution requested the Commission to:

- Estimate the "number of mentally disabled young adults by gender, age, and racial and ethnic classification, in the geographic regions of the Commonwealth."
- Identify the "prevailing mental health and emotional disorders and their etiology among minority young adults [and]…the mental health needs of minority citizens, particularly minority young adults in Virginia."
- Determine the "number of racial and ethnic minority persons who receive mental health treatment…and the facilities providing such care."
- Ascertain whether "mental health providers are trained to provide culturally competent mental health treatment" and the level of need for such treatment in Virginia.
- Review "federal and state laws and regulations…and identify the…extent to which medical records information may be disclosed to parents and family members to assist them in obtaining health, social services, and mental health treatment for mentally disabled young adults" and recommend ways to provide information to allow family members to obtain services and treatment without resorting to involuntary commitment.

Access to Treatment

The majority of people with diagnosable mental disorders, regardless of race or ethnicity, do not receive treatment. This is often the result of cost, lack of insurance, unavailability or fragmentation of services, a belief that the problem does not require medical attention, a lack of knowledge about mental illness, or the fear of stigma. Stigma prevents many people from seeking treatment in large part because our society still does not recognize mental illness as being a real health condition like diabetes or heart disease. The good news is that for those who do seek help there is an array of effective treatments available for most kinds of mental illness. However, not all individuals have the same likelihood of receiving treatment. In addition to the barriers that exist for all Americans, others like mistrust and fear of treatment, racism and discrimination, and language and cultural differences further deter racial and

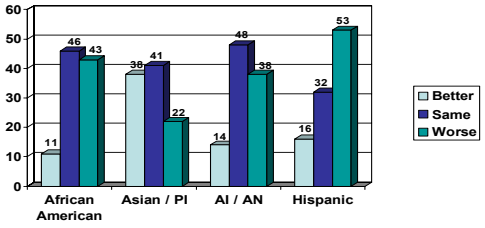
ethnic minorities from seeking care. Minorities also tend to be over-represented in high-need or at-risk populations that have less access to treatment.

Quality of Care

Research has found that minorities do not receive the same quality of care as whites in general. As the Surgeon General reported in 1999, the higher level of burden from mental illness experienced by minority groups "stems from minorities receiving less care and poorer quality of care, rather than from their illnesses being inherently more severe or prevalent in the community."

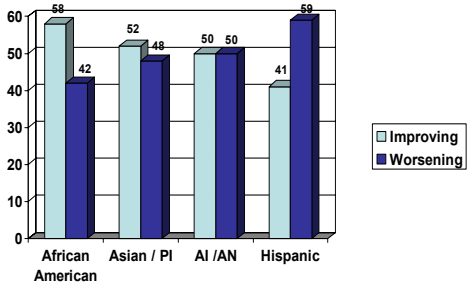
Conducted by the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality, the 2005 National Healthcare Disparities Report (NHDR) is a national survey that tracks the quality of healthcare using 46 core performance measures (http://www.ahrq.gov/qual/nhdr05/nhdr05.htm). As can be seen on the tables, a significant percentage of minorities receive poorer quality of care, compared to Whites. "For African Americans, quality of care was poorer than that for Whites for 20 out of 46 measures (43%), while care was better quality than Whites for just 5 out of 46 measures (11%). Among the 38 measures that were available for Hispanics, 20 (53%) showed that they received poorer quality than non-Hispanic Whites, and just 6 (16%) showed better quality than non-Hispanic Whites. Of the 21 measures available for American Indians/Alaska Natives, 8 (38%) showed poorer quality than Whites and just 3 (14%) showed better quality than Whites. Asians and Pacific Islanders had better quality than Whites for 12 of the 32 available measures (38%) but still had poorer quality for 7 out of 32 measures (22%) (Source: Kaiser Family Foundation)

Comparison of Quality of Care Measures for Minority Population Groups vs. Whites (%)



Source: AHRQ, National Healthcare Disparities Report, 2005

Changes in Quality of Care Disparities Over Time: Summary by Race/Ethnicity (%)



Source: AHRQ, National Healthcare Disparities Report, 2005

For many minorities, the quality of care is getting worse. Almost half of the core quality measures for Asians and Pacific Islanders (48%) and for American Indians/ Alaska Natives (50%) were worsening and roughly half were improving (48% and 50%,

respectively). For African Americans, 42% of the core quality measures were getting worse and 58% were improving. The trend in quality of care for Hispanics is even more problematic: 41% of their core indicators showed an improvement in quality of care, while 59% indicated a worsening of conditions.

In addition to receiving poorer quality care, African Americans also tend to be over-represented in admissions to public mental hospitals which tend to be less preferable than community-based sources of treatment. While consisting of only 19.6% of the Commonwealth's total population, 35.5% of admissions to public hospitals in Virginia are for African Americans. These results indicate that more effort needs to be placed on increasing the quality of care received by minorities for both public and private mental health service providers and a coordinated and comprehensive service delivery system is needed – especially for high-need populations.

Cultural Competency and Workforce Shortages

Racial/ethnic disparities, at least in part, can be alleviated by increasing the level of cultural competency of all practitioners and addressing workforce issues including practitioner shortages in underserved areas and the lack of racial/ethnic minority health practitioners.

Cultural Competence

The Virginia Department of Health is making improvements in the area of cultural competence through the Culturally and Linguistically Appropriate Health Services (CLAS) Act Initiative; however, cultural competency training needs to be recognized as an important component of all practitioners' training and knowledge. Currently students majoring in the health care professions are not required to demonstrate competency in cross-cultural knowledge or in culturally appropriate care in order to graduate from Virginia's colleges and universities.

Workforce Shortages

To address workforce shortages, various programs provide incentives for health care practitioners to serve in under-served regions of the State, but only one program focuses specifically on the mental health field (child psychology/psychiatry internships). Moreover, no program is dedicated solely to increasing the number of racial and ethnic minority mental health care providers (with the possible exception of the Virginia College of Osteopathic Medicine where students are trained to treat the individual as a whole and,

therefore, have at least basic mental health knowledge and it is likely that some students choose to specialize in the mental health
field). This critical shortage needs to be addressed in order to reduce disparities in minority employment opportunities and to provide more culturally appropriate care for minority populations.

Legislation

Based on the study findings, JCHC voted to request by Chairman's letter that the State Council of Higher Education for Virginia (SCHEV) examine the issue of requiring cultural competence training as part of college curriculum for health profession majors.

Background Checks for Medical Practitioners

In 2007, House Bill 1944 introduced by Delegate Harry R. Purkey was passed by in the Health Welfare and Institutions Committee, but was referred by letter to the Joint Commission on Health Care (JCHC) as a study. HB 1944, as introduced, would have: (i) required criminal history background checks for all individuals seeking initial licenses to practice medicine, osteopathic medicine, chiropractic, or podiatry; (ii) authorized the Board of Medicine (Board), at its discretion, to require background checks of individuals seeking to renew licenses; and (iii) set forth approximately 30 crimes that conviction of which would prevent the Board from granting or renewing a license

Virginia Law

Under Virginia law, there is no requirement that an individual undergo a criminal background check before receiving a license to practice medicine. There is also no requirement that an individual undergo a criminal background check as a requirement for license renewal or continued competency. However, every licensee must apply for renewal of his license biennially, and furnish information, such as any convictions, to the Board (*Code of Virginia* § 54.1-2904).

Additionally, there are is no barrier crime law that specifically prohibits a person who has committed certain crimes from practicing medicine. The Virginia Board of Medicine can refuse to admit an individual for examination, refuse to issue a license or certificate, or suspend or revoke a license or certificate for certain unprofessional conduct, including, for example:

- Violating any statute or regulation "relating to the manufacture, distribution, dispensing or administration of drugs;"
- Being convicted in any jurisdiction of any felony, or of a misdemeanor involving moral turpitude; or,
- Having had a certificate or license revoked or suspended without having that certificate or license to practice reinstated in another jurisdiction (*Code of Virginia* § 54.1-2915).

Hospitals must report disciplinary action to the Board (*Code of Virginia* § 54.1-2400.6). Additionally, the clerk of court in "which conviction of a felony or adjudication of incompetence or incapacity was made, who has knowledge that a practitioner has been convicted or found to be incapacitated or incompetent," shall have a duty to report these findings promptly to the Board" of Medicine (*Code of Virginia* §54.1-2917).

Upon notice, the Board must suspend the license or certificate. However, according to staff at the Department of Health Professions (DHP), the practice of reporting such findings never occurs.

Other States

Twenty-eight states have the statutory authority to run criminal background checks as a condition of licensure. Most of the states that now require background checks instituted the requirement in recent years, so there is little information about the long-term benefits. Texas began checking backgrounds in 2005 and has found that they are time-consuming and are not revealing many problems. In Arizona, background checks are completed, but the findings are not necessarily used to disqualify someone from being licensed. Kentucky requires a criminal background check of all persons applying for initial licensure and at other times as requested by the Board when good cause is shown. Nevada requires all new medical doctor applicants to be fingerprinted. Additionally, if a formal complaint is filed on a currently licensed physician, he/she will be required to be fingerprinted.

Virginia Department of Health Professions Efforts

To determine what has been missed by not completing background checks, DHP wanted to complete background checks on a random sample of physicians. However, since DHP would need probable cause to conduct a background check, DHP decided instead to check 280,000 licensees (of all types) against the Virginia Sex Offender Registry. Five licensees were found on the registry; four were licensed by the Board of Nursing and one was licensed by the Board of Social Work (*Code of Virginia* § 54.1-3011). Both the Board of Nursing and the Board of Social Work have the discretion to suspend or revoke a license as a result of a felony conviction (*Code of Virginia* § 54.1-3007). The four nursing licensees had disclosed their convictions.

Legislation

Five policy Options were presented for consideration by JCHC, who approved the option to request by letter of the Chairman that the Executive Secretary of the Supreme Court of Virginia and the Compensation Board look into, and if necessary, address the extent to which clerks are adhering to the requirements of *Code of Virginia* § 54.1-2917.

Impact of Barrier Crime Laws on Social Service and Health Care Employers

Senate Joint Resolution 106 introduced by Senator Jeannemarie A. Devolites-Davis during the 2006 General Assembly Session directed the Joint Commission on Health Care "to study the impact of barrier crime laws on social service and health care employers, prospective employees, consumers, residents, patients and clients" and present its findings to the Governor and the 2008 General Assembly.

Barrier Crime Laws

Barrier crime laws prohibit persons convicted of certain statutorily-defined crimes from obtaining employment with employers specializing in the care of vulnerable populations, such as children, the elderly, and those with mental disabilities. The *Code of Virginia* § 63.2-1719 and § 37.2-314 list 89 felonies and 21 misdemeanors as barrier crimes relating to social services and health care employers.

JCHC Workgroup

The research findings and testimony of workgroup stakeholders revealed that persons with a history of mental illness and/or substance abuse problems often have criminal backgrounds related to their illness or substance abuse problems, and consequently have difficulty obtaining employment, making rehabilitation more difficult. Moreover, some employers, particularly health and social service providers, also have difficulty obtaining a qualified workforce.

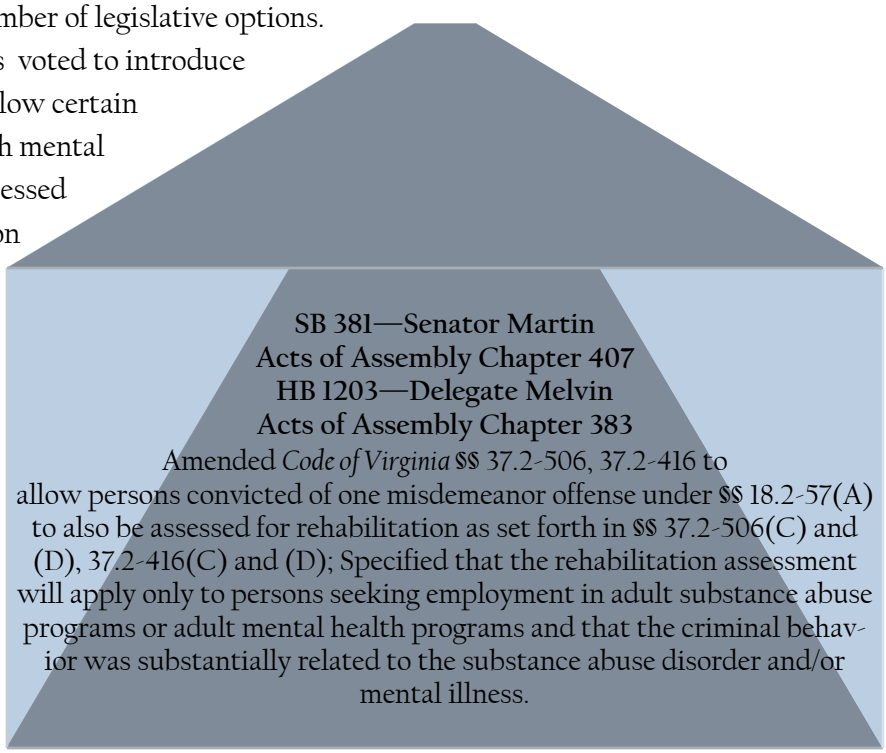
Although workforce shortages affect many of the health and social service providers in Virginia, most of the workgroup participants indicated they were not interested in changing the barrier crime laws affecting their services. However, this was not the sentiment expressed by representatives of community services boards (CSBs). CSB representatives suggested removing the current barrier crimes provisions pertaining to employment in adult substance abuse and adult mental health treatment programs and allowing consideration of an individual's entire criminal record. They also suggested providing for a rehabilitation assessment for employment of individuals with serious mental illness similar to the assessment allowed for individuals with substance use disorder.

Virginia law allows individuals with substance abuse disorder, with certain barrier crimes on their records, to be assessed for rehabilitation and therefore become eligible to work in direct care within an adult substance use program. There is no similar provision in Virginia law to assess individuals with mental illness and certain barrier crimes on their records to

qualify for rehabilitation assessment for employment. Individuals with serious mental illness who have assault records typically are ineligible to be employed even as peer counselors. Often, these assaults involved a family member or a law enforcement officer during the emergency custody or temporary detention process. Many mental health service consumers could benefit from peer contact, similar to the benefits enjoyed by consumers with substance use disorder. CSBs estimate that more than 40 individuals would qualify for employment, if they could be assessed for rehabilitation in the same manner as allowed for substance use disorders.

Legislation

Based on the two-year study, JCHC staff developed a number of legislative options. JCHC members voted to introduce legislation to allow certain individuals with mental illness to be assessed for rehabilitation for potential employment in adult substance abuse and adult mental health treatment programs.



Treatment Needs of Individuals Found Not Guilty by Reason of Insanity

Senate Joint Resolution 324 introduced by Senator Linda T. Puller during the 2005 General Assembly Session was amended to direct the Joint Commission on Health Care (JCHC), through its Behavioral Health Care Subcommittee, to study the needs of patients found not guilty by reason of insanity (NGRI) and persons found incompetent to stand trial.

Three-Year Study by BHC Subcommittee

This is the third and final JCHC report in response to this study resolution. Legislation based on the study findings was introduced by JCHC and enacted by the General Assembly during the 2006, 2007 and 2008 Sessions. (Study findings and the actions taken by JCHC during the first two years of the study are detailed in Senate Document 5 – 2006 and Report Document 78 – 2007.)

An initial review of Virginia' NGRI system, (reported to the BHC Subcommittee in 2005) found that the number of NGRI acquittees has increased in recent years. Furthermore, a lack of sufficient community services resulted in some acquittees remaining in State hospitals longer than necessary. The length of stay, as measured by the amount of time spent in the State hospital before the first conditional release (for releases that occurred during fiscal years 2001 through 2005) was reported by DMHMRSAS to be:

Type of Charge	Average Length of Hospitalization	Median Length of Hospitalization	Number of Acquittees Released
Misdemeanor	34 months	12.7 months	46
Felony	41 months	35.7 months	136

Source: DMHMRSAS Excel Spreadsheet dated September 12, 2005

DMHMRSAS reported as of September 7, 2007, there were 221 NGRI acquittees in a State hospital. Two hundred and sixteen had of the 221 acquittees, had felony charges including:

- 31 homicide
- 28 attempted murder or sex offense
- 117 other felony against person
- 31 felony against property
- 6 substance abuse or weapons offense
- 3 other felony minor offenses.

"The number of NGRI admissions has been increasing which decreases the number of short-term acute beds available given longer lengths of stay than most civilly committed individuals." The number of individuals arrested and found to be incompetent to stand trial as well as individuals found not guilty by reason of insanity could be reduced substantially by:

- Providing appropriate care in the community
- Diverting individuals who are mentally ill from the criminal justice system whenever possible, and
- Reforming the civil commitment system.

Legislation

The legislative options approved by JCHC for introduction during the 2008 General Assembly included to:

- Introduce legislation to amend *Code of Virginia* § 19.2-169.3.B to limit to 45 days the treatment provided to restore competency for a defendant charged with a minor, nonviolent misdemeanor offense.
- Introduce a budget amendment to provide funding of $410,000 GFs for each year of the biennium for DMHMRSAS to fund outpatient restorations for adults (including $20,000 to train additional CSB/BHA staff in completing competency restoration.).
- Introduce legislation to move language clarifying that voluntary admission to a State hospital should not automatically result in revocation of the acquittee's conditional release. Language would be removed from *Code of Virginia* §§ 19.2-182.8 and 19.2-182.9 to § 19.2-182.7.

House Bill 480 (Delegate Brink) tabled.

Senate Bill 380—Senator Martin
Acts of Assembly Chapter 406

House Bill 1186—Delegate Melvin
Acts of Assembly Chapter 796

Senate Bill 345—Senator Blevins
Acts of Assembly Chapter 810

Lead Agency to Serve Individuals with Autism Spectrum Disorders

> *"Autism spectrum disorders (ASDs) are a group of developmental disabilities defined by significant impairments in social interaction and communication and the presence of unusual behaviors and interests….The thinking and learning abilities of people with ASDs can vary – from gifted to severely challenged. ASD begins before the age of 3 and lasts throughout a person's life. It occurs in all racial, ethnic, and socioeconomic groups and is four times more likely to occur in boys than girls."* ***Source:*** *Autism Information Center, Centers for Disease Control and Prevention Website.*

Estimates regarding the prevalence of ASD have increased exponentially in recent years with the current estimate being 1 child in every 150 in the United States. The Commonwealth of Virginia, like many states, is struggling to address the ever-increasing need for educational and support services for children and adults with ASDs.

Three - Year Study by BHC Subcommittee

This is the third year that the Behavioral Health Care (BHC) Subcommittee of the Joint Commission on Health Care has reviewed a subject related to ASDs. The Subcommittee began its review of issues in 2005. The Subcommittee learned of the significant educational and support needs of persons with ASDs and the critical need for one State agency to have primary responsibility for planning and service provision. Legislation and budget amendments, introduced on behalf of JCHC, sought to address some of the most pressing needs. HJR 96 and SJR 125 (2006) were identical resolutions which asked:

- The Department of Education to continue to implement initiatives to strengthen teacher qualifications related to the needs of children with ASDs; and
- The Department of Mental Health, Mental Retardation and Substance Abuse Services to assist in expanding "training opportunities that include approaches specifically addressing the needs of children with autism spectrum disorders...."

HJR 96 and SJR 125 were adopted unanimously by the 2006 General Assembly.

The BHC Subcommittee voted to continue its review of educational and support services for ASDs in its 2006 work plan. Susan Williams, Ph.D. of VCU's Virginia Treatment Center for Children, Dr. Patricia Abrams of DOE, and Carol Schall, Ph.D. of the Virginia Autism Resource Center gave presentations regarding resources in Virginia. The need for a lead State agency for ASD was identified as a significant issue as there is no centralized responsibility for

or coordination of policy and services across the lifespan for individuals with ASD in Virginia.

During the 2007 General Assembly Session, a budget amendment of $288,500 for VCU was introduced on behalf of JCHC. The budget amendment was designed to support a variety of training and technical assistance activities related to working with individuals with ASD. The requested funding was not included in the approved State budget.

In 2007, the BHC Subcommittee voted to convene a work group to develop a consensus regarding which State agency should be established or designated as the lead agency for ASD services. The absence of a State home has meant that no one agency has the responsibility or legislative mandate to develop policy, to plan and coordinate service delivery, to request funding or to undertake strategic planning for the needs of the ever-increasing number of Virginians with an ASD. JCHC staff convened work group meetings on June 26th, July 13th, August 20th and October 29th.

Although 10 Options for establishing a new agency or redesigning an agency to serve as the lead agency to serve individuals with an ASD or other developmental disability were discussed by the workgroup, no broad consensus was reach.

Consequently, during the 2008 Session, JCHC introduced a budget amendment requesting that the Secretary of Health and Human Resources develop and report on an Implementation Plan to determine the State agency that should be responsible for serving individuals with autism spectrum disorders.

Although the suggested language was not included in the approved budget, a letter was sent by the Chairman of JCHC asking the Secretary of Health and Human Resources to develop and report on an Implementation Plan by October 1, 2008.

2008 Legislative Initiatives

The Commission's legislative package included four bills and ten budget amendments (which were introduced in both the House and Senate chambers).

Senate Bill 380 — Senator Stephen H. Martin (Passed)
House Bill 1186 — Delegate Kenneth R. Melvin (Passed)
Amend *Code of Virginia* § 19.2-169.3 to limit to 45 days the timeframe for treatment provided to restore competency for a defendant charged with certain minor, nonviolent misdemeanor offenses.

Senate Bill 345 — Senator Harry B. Blevins (Passed)
House Bill 480 — Delegate Robert H. Brink (Tabled)
Amend *Code of Virginia* to move language from §§ 19.2-182.8 and 19.2-182.9 to § 19.2-182.7 in order to clarify that voluntary admission to a State hospital should not automatically result in revocation of the acquittee's conditional release.

Senate Bill 381 — Senator Stephen H. Martin (Passed)
House Bill 1203 — Delegate Kenneth R. Melvin (Passed)
Amend *Code of Virginia* §§ 37.2-506 and 37.2-416 to allow community services boards and providers licensed by DMHMRSAS to hire as a direct care employee in adult substance abuse or mental health treatment programs someone with certain misdemeanor assault and battery convictions, as long as such offences are substantially related to the applicant's substance abuse or mental illness and the applicant has been rehabilitated.

Senate Bill 344 — Senator Harry B. Blevins (Passed)
House Bill 479 — Delegate Phillip A. Hamilton (Passed)
Amend *Code of Virginia* § 32.1-111.11 to require delineation of a uniform destination plan for pre-hospital stroke patients.

Introduced Budget Amendments

Chief Patron: Brink		Item 316 # 10h	
Chief Patron: Puller		Item 316 # 13s	
Health and Human Resources	**FY 08-09**	**FY09-10**	
Grants To Localities	$410,000	$410,000	GF

Explanation:
(This amendment provides $410,000 from the general fund each year to fund outpatient competency restoration of adults. Title 19.2, Chapter 11, *Code of Virginia*, requires restoration of competency to be completed on an outpatient basis unless inpatient treatment is required, but no funding is provided. Funding is provided for juvenile outpatient restoration. Outpatient restoration services are typically provided by staff of community services boards. The Joint Commission on Health Care has found that the lack of funding results in mentally ill adults remaining in jails longer awaiting restoration services, particularly as the number of competency restoration orders received by CSBs has increased significantly in the last few years.)

Chief Patron: Brink		Item 306 # 19h	
Chief Patron: Blevins		Item 306 # 8s	
Health and Human Resources	**FY 08-09**	**FY09-10**	
Department of Medical Assistance	$17,310,750	$34,833,000	GF
Services	$17,310,750	$34,833,000	NGF

Explanation:
(This amendment provides $17.3 million the first year and $34.8 million the second year from the general fund and an equal amount of federal Medicaid matching funds to increase services provided under the mental retardation (MR) waiver program by 1,000 slots over the biennium. Language is modified in the Department of Medical Assistance Services to reflect the total appropriations available in the biennium for the MR waiver program. The introduced budget provides 75 MR waiver slots in the second year. The additional slots will help to address the urgent care waiting list for the MR waiver which included 1,845 individuals in November 2007. This is a recommendation of the Joint Commission on Health Care.)
The approved budget included funding to phase in 600 additional waiver slots.

Chief Patron: Morgan			Item 284 # 8h
Chief Patron: Houck			Item 284 # 1s
Health and Human Resources	**FY 08-09**	**FY09-10**	
Department For The Aging	$200,000	$200,000	GF

Explanation:
(This amendment provides funding for the Respite Care Initiative grant which enables a caregiver of an individual with dementia to have a temporary rest from the caregiver role. At present, there are 264 families on the waiting list for services. The requested funding would allow approximately 80 additional families to benefit from the Respite Care Initiative. This is a recommendation of the Joint Commission on Health Care.)

Chief Patron: Nutter	Item 282 # 2h
Chief Patron: Martin	Item 282 # 3s
Health and Human Resources	
Secretary Of Health And Human Resources	Language

Explanation:
(This amendment requires the Secretary of Health and Human Resources to develop an implementation plan for serving individuals with autism spectrum disorders and report its findings to the Governor and Chairmen of House Appropriations and Senate Finance committees by October 1, 2008.)

Chief Patron: O'Bannon			Item 201# 1h
Chief Patron: Martin			Item 201 # 1s
Health and Human Resources	FY 08-09	FY09-10	
University Of Virginia Medical Center	$100,000	$100,000	GF

Explanation:
(This amendment requests general fund support to expand services provided by the Richard Dart ALS Clinic.)

Commission Activities in 2007

In keeping with its statutory mandate, the Joint Commission completed studies; considered the comments of advocates, industry representatives, and other interested parties; and introduced legislation to advance the quality of health care, long-term care and behavioral health care in the Commonwealth. The following reports and presentations were made to the Joint Commission and its two Subcommittees in 2007.

May 10, 2007
Long-Term Care and Medicaid Reform Subcommittee

Proposed Work Plan for 2007	Michele L. Chesser, Ph.D. Senior Health Policy Analyst
Overview of 2007 Legislation	Stephen W. Bowman Senior Staff Attorney/Methodologist

May 10, 2007
Joint Commission on Health Care

Proposed Work Plan for 2007	Kim Snead, Executive Director

Behavioral Health Care Subcommittee
May 10, 2007

Proposed Work Plan for 2007 Overview of Legislation	Kim Snead

June 13, 2007
Behavioral Health Care Subcommittee

Comprehensive Services for At-Risk Youth & Families	Kim McGaughey Executive Director Office of Comprehensive Services for At Risk Youth & Families
Custody Relinquishment and the Comprehensive Services Act	Nathalie Molliet-Ribet Chief Legislative Analyst JLARC
Local Government Concerns Relative to Mental Health Funding for Children & Adolescents	Janet C. Areson Director of Policy Development Virginia Municipal League
	Dean Lynch CAE, Director of Intergovernmental Affairs Virginia Association of Counties Substance Abuse Outpatient Services for Adults
Review of CSB Substance Abuse Outpatient Services for Adults	James W. Stewart, III, Inspector General Office of the Inspector General for MHMRSAS

June 13, 2007
Joint Commission on Health Care

Update on Screening of Newborns in Virginia	Kim Snead
Update on Regulation of Assisted Living	The Honorable Marilyn B. Tavenner Secretary of Health and Human Resources
Preliminary Findings of the Governor's Health Reform Commission	Heidi Dix Assistant Secretary of Health & Human Resources Aryana Khalid Assistant Secretary of Health & Human Resources
Overview of Mental Retardation Services in Virginia	Raymond R. Ratke, Deputy Commissioner DMHMRSAS
Effect of Improved Glucose Control in Hospitalized Patients	Timothy D. Meakem, M.D., Chief Medical Officer Medical Automation Systems
Virginia Healthcare Emergency Management Program and Response System	Steve Ennis, Technical Advisor HRSA Hospital Preparedness Program Virginia Hospital and Healthcare Association Bill Berthrong Hospital Preparedness Program Coordinator Emergency Preparedness & Response Programs Virginia Department of Health
Staff Report: Accuracy of Discard Dates of Prescription Drugs	Michele L. Chesser, Ph.D.

August 16, 2007
Behavioral Health Care Subcommittee

Forensic Mental Health Initiatives	James J. Morris, Ph.D Director, Forensic Services DMHMRSAS
Pre and Post Diversion Initiatives	Victoria Huber-Cochran, J.D. New River Valley Jail Diversion Programs Facilitator
Transition Services for Adolescent Offenders	Joanne Smith, President Virginia Council on Juvenile Detention
Virginia's Community-Based Juvenile Competency Restoration Services	Jeanette DuVal, Director Juvenile Competency Services DMHMRSAS
Integrated Policy & Plan to Provide & Improve Access to MHMRSAS	Ray Ratke, Deputy Commissioner DMHMRSAS

August 16, 2007
Long-Term Care and Medicaid Reform Subcommittee

Update: Medicaid Reform and Long-Term Care Partnership	Steve Ford, Director of Policy and Research Department of Medical Assistance Services
Update: Integration of Acute & Long-Term Care and Expansion of PACE	Cindi Jones, Chief Deputy Director Department of Medical Assist Services
Update: "No Wrong Door" System and Departmental Actions Due to HB 2032	Debbie Burcham, Chief Deputy Commissioner Virginia Department for the Aging
Virginia Alzheimer's Disease and Related Disorders Commission 2007 Report: Focus on Respite Care	Dr. Russell H. Swerdlow, Chair Alzheimer's Disease and Related Disorders Commission

September 19, 2007
Behavioral Health Care Subcommittee

Report on the Virginia Tech Tragedy	James W. Stewart, III, Inspector General Office of the Inspector General for DMHMRSAS
Staff Update: Work of Groups Examining Virginia Tech Tragedy	Jaime H. Hoyle Senior Staff Attorney/Health Policy Analyst
Demonstration of Prototype of Acute Psychiatric Bed-Reporting System	Michael Lundberg, Director Virginia Healthcare Information
Staff Report: Workgroup Examining Services for Individuals with Autism	Kim Snead
Staff Report: Reentry Assistance for Offenders with Behavioral Health Care Needs	Kim Snead
Staff Report: Treatment Needs of Individuals Found Not Guilty by Reason of Insanity	Kim Snead

September 19, 2007
Joint Commission on Health Care

Amyotrophic Lateral Sclerosis (ALS)	Colleen McGuire, Director of Patient Services ALS Association
Review of Brain Injury Services in Virginia	Eric H. Messick, Principal Legislative Analyst JLARC Annie McDonnell, MPA, OTR/L, Executive Director Brain Injury Association of Virginia
Virginia Healthcare Information Annual Report	Michael Lundberg, Director Virginia Healthcare Information

September 19th — JCHC continued

Strategies to Improve Health Care Quality in Virginia	Ed Susank, Chair Health Care Quality & Safety Task Force AARP Scott Johnson, General Counsel Medical Society of Virginia
HPV Vaccination of Women Age 16 – 26 in Virginia	Jennifer L. Young, MD. Fellow Gynecologic Oncology University of Virginia
Staff Report: Higher Rates of Cervical Cancer in Minority Women	Michele L. Chesser, Ph.D.
Staff Report: Tracking System for Preterm/ Low-Birth Weight Infants	Stephen W. Bowman

October 17, 2007
Long-Term Care and Medicaid Reform Subcommittee

Impact of Aging on State Agencies	Ashley S. Colvin, Project Leader JLARC
Final Report: Impact of Assisted Living Regulations	Walter L. Smiley, Section Manager JLARC
Virginia Quality Improvement Program	Terry A. Smith, Director Division of Long-Term Care DMAS
Shortage of Geriatricians in Virginia	Jonathan M. Evans, Associate Professor, Chief of the Section of Geriatric Medicine University of Virginia School of Medicine
States' Health Care Reform Initiatives	Stephen W. Bowman

October 17, 2008
Joint Commission on Health Care

Public Comments Received on Preterm Infant and Autism Studies	Kim Snead
Sickle Cell Disease: An Overview of Current Services and Emerging Needs in the Commonwealth	Dr. Michael Royster, Director Office of Minority Health & Public Health Policy Virginia Department of Health Jean Radcliffe-Shipman Sickle Cell Program Manager Virginia Department of Health
Needs Related to Sickle Cell Disease	George Carter, Administrator Statewide Sickle Cell Chapters of Virginia Judy Anderson Sickle Cell Association

October 17th — JCHC continued

Report of the Edward Via Virginia College of Osteopathic Medicine	Dixie Tooke-Rawlins, D.O., Dean
Report on HPV Vaccine	Carl W. Armstrong, M.D. Director of the Office of Epidemiology Virginia Department of Health
Review of CSB Mental Retardation Case Management Services	James W. Stewart, III, Inspector General Office of the Inspector General for DMHMRSAS
Review of Mental Retardation Service System	Raymond R. Ratke, Deputy Commissioner DMHMRSAS
Staff Report: Virginia Stroke Systems	Stephen W. Bowman

October 26, 2007
Behavioral Health Care Subcommittee

Availability and Cost of Licensed Psychiatric Services in Virginia	Ashley S. Colvin, Project Leader JLARC
Discussion: Potential Mental Health Issues Related to Virginia Tech Tragedy	Kim Snead Jaime H. Hoyle

October 26, 2007
Joint Commission on Health Care

Briefing: Governor's Health Reform Commission	Heidi Dix, Assistant Secretary Health and Human Resources Aryana Khalid, Assistant Secretary Health and Human Resources
Staff Report: Impact of Barrier Crime Laws	Jaime H. Hoyle
Staff Report: Background Checks for Medical Practitioners	Jaime H. Hoyle
Staff Report: Minority Access to Mental Health Services	Michele L. Chesser, Ph.D.
Staff Report: Housing Opportunities for Persons with Mental Illness	Michele L. Chesser, Ph.D.
Staff Report: Increasing the Availability of Health Insurance Providers in Rural Areas	Stephen W. Bowman
Staff Report: Health Care Cost	Stephen W. Bowman

November 8, 2007
Behavioral Health Care Subcommittee

Review of Subcommittee Decision Matrix	JCHC Staff

November 8, 2007
Long-Term Care and Medicaid Reform Subcommittee

Review of Subcommittee Decision Matrix	JCHC Staff

November 8, 2007
Joint Commission on Health Care

Review of Subcommittee Decision Matrix	JCHC Staff

December 9, 2007
Joint Commission on Health Care

Review of Potential Legislation	Kim Snead
Review of Approved Budget Amendments	Kim Snead
Identification of Chief Patrons & Bill Signing	Delegate Phillip A. Hamilton

Statutory Authority

§ 30-168. (Effective until July 1, 2010) Joint Commission on Health Care; purpose.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care.

For the purposes of this chapter, "health care" shall include behavioral health care. (1992, cc. 799, 818, §§ 9-311, 9-312, 9-314; 2001, c. 844; 2003, c. 633.)

§ 30-168.1. (Effective until July 1, 2010) Membership; terms; vacancies; chairman and vice-chairman; quorum; meetings.

The Commission shall consist of 18 legislative members. Members shall be appointed as follows: eight members of the Senate, to be appointed by the Senate Committee on Rules; and 10 members of the House of Delegates, of whom three shall be members of the House Committee on Health, Welfare and Institutions, to be appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates.

Members of the Commission shall serve terms coincident with their terms of office. Members may be reappointed. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments.

The Commission shall elect a chairman and vice-chairman from among its membership. A majority of the members shall constitute a quorum. The meetings of the Commission shall be held at the call of the chairman or whenever the majority of the members so request.

No recommendation of the Commission shall be adopted if a majority of the Senate

members or a majority of the House members appointed to the Commission (i) vote against the recommendation and (ii) vote for the recommendation to fail notwithstanding the majority vote of the Commission.
(2003, c. 633; 2005, c. 758.)

§ 30-168.2. (Effective until July 1, 2010) Compensation; expenses.
Members of the Commission shall receive such compensation as provided in § 30-19.12. All members shall be reimbursed for reasonable and necessary expenses incurred in the performance of their duties as provided in §§ 2.2-2813 and 2.2-2825. Funding for the costs of compensation and expenses of the members shall be provided by the Joint Commission on Health Care.
(2003, c. 633.)

§ 30-168.3. (Effective until July 1, 2010) Powers and duties of the Commission.
The Commission shall have the following powers and duties:
1. To study and gather information and data to accomplish its purposes as set forth in § 30-168;
2. To study the operations, management, jurisdiction, powers and interrelationships of any department, board, bureau, commission, authority or other agency with any direct responsibility for the provision and delivery of health care in the Commonwealth;
3. To examine matters relating to health care services in other states and to consult and exchange information with officers and agencies of other states with respect to health service problems of mutual concern;
4. To maintain offices and hold meetings and functions at any place within the Commonwealth that it deems necessary;
5. To invite other interested parties to sit with the Commission and participate in its deliberations;
6. To appoint a special task force from among the members of the Commission to study and make recommendations on issues related to behavioral health care to the full Commission; and
7. To report its recommendations to the General Assembly and the Governor annually and to make such interim reports as it deems advisable or as may be required by the General Assembly and the Governor.
(2003, c. 633.)

§ 30-168.4. (Effective until July 1, 2010) Staffing.
The Commission may appoint, employ, and remove an executive director and such other persons as it deems necessary, and determine their duties and fix their salaries or compensation within the amounts appropriated therefor. The Commission may also employ experts who have special knowledge of the issues before it. All agencies of the Commonwealth shall provide assistance to the Commission, upon request.

§ 30-168.5. **(Effective until July 1, 2010) Chairman's executive summary of activity and work of the Commission.**
The chairman of the Commission shall submit to the General Assembly and the Governor an annual executive summary of the interim activity and work of the Commission no later than the first day of each regular session of the General Assembly. The executive summary shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.
(2003, c. 633.)

§ 30-169.
Repealed by Acts 2003, c. 633, cl. 2.

§ 30-169.1. **(Effective until July 1, 2010) Cooperation of other state agencies and political subdivisions.**
The Commission may request and shall receive from every department, division, board, bureau, commission, authority or other agency created by the Commonwealth, or to which the Commonwealth is party, or from any political subdivision of the Commonwealth, cooperation and assistance in the performance of its duties.
(2004, c. 296.)

§ 30-170. **(Effective until July 1, 2010) Sunset.**
The provisions of this chapter shall expire on July 1, 2010.
(1992, cc. 799, 818, § 9-316; 1996, c. 772; 2001, cc. 187, 844; 2006, cc. 113, 178.)

Joint Commission on Health Care
Location: Pocahontas Building
900 East Main Street, 1st Floor West
Richmond, VA 23219