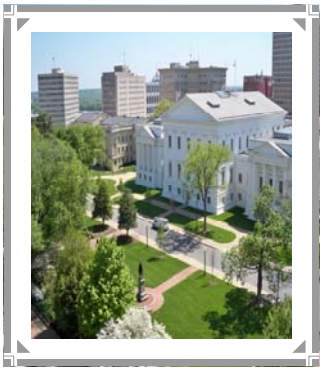
# Joint Commission on Health Care

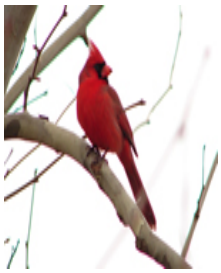
## 2008 Annual Report



Virginia
House of Delegates

Senate of
Virginia

Behavioral Health
Care Subcommittee



Long-Term Care/
Medicaid Reform
Subcommittee

# 2008 Annual Report of the

# Joint Commission on Health Care

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA


## REPORT DOCUMENT 14

COMMONWEALTH OF VIRGINIA
RICHMOND
2009

# COMMONWEALTH of VIRGINIA

## Joint Commission on Health Care

Senator R. Edward Houck
Chairman

Kim Snead
Executive Director

900 E. Main Street, 1st Floor
P.O. Box 1322
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804.786.5445
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August 19, 2009

The Honorable Timothy M. Kaine
Governor of Virginia
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, VA 23219

Members of the Virginia General Assembly
General Assembly Building
Richmond, VA 23219

Dear Governor Kaine and Members of the General Assembly:

Pursuant to the provisions of the *Code of Virginia* (Title 30, Chapter 18, §§ 30-168 through 30-170) establishing the Joint Commission on Health Care and setting forth its purpose, I have the honor of submitting herewith the Annual Report for the calendar year ending December 31, 2008.

This 2008 Annual Report includes a summary of the Joint Commission's activities and legislative recommendations to the 2009 Session of the General Assembly. In addition, executive summaries of the studies completed in 2008 are included. The final reports of the completed studies were published and made available on the General Assembly website. All reports may be accessed from the Joint Commission's website.

Respectfully submitted,

R. Edward Houck
Chairman

# Membership
## 2008

### Senate of Virginia
R. Edward Houck, Chairman

George L. Barker
Harry B. Blevins
L. Louise Lucas
Ralph S. Northam
Linda T. Puller
Patricia S. Ticer
William C. Wampler, Jr

### Virginia House of Delegates
Phillip A. Hamilton, Vice-Chairman

Clifford L. Athey, Jr.
Robert H. Brink
David L. Bulova
Benjamin L. Cline
Franklin P. Hall
Kenneth R. Melvin
Harvey B. Morgan
David A. Nutter
John M. O'Bannon, III

In addition, the Secretary of Health and Human Resources, Marilyn B. Tavenner serves as an ex officio member of the Commission

# Staff

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Executive Director

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Senior Staff Attorney/Methodologist

Michele L. Chesser, Ph.D.
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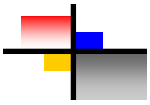
# Introduction

## 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*, 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, in July 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 2008, the Joint Commission on Health Care staff conducted studies in response to legislative requests. In keeping with the Joint Commission's statutory mandate the following study reports were completed.

## Section 125 Plans/Health Insurance Exchanges

### Introduction

In 2006, Senate Joint Resolution 4 directed JCHC to study (i) the factors leading to rising health care costs in the Commonwealth (ii) the derivative effects of increases in health care costs including increases in health insurance premiums and denial of coverage and, (iii) ways to reduce health care costs.... "A written report was issued in 2007 and in 2008 JCHC recommended continuing the study to review the advisability of encouraging Section 125 Plans and establishing a Virginia health insurance exchange for small businesses.

### Employer-Sponsored Health Insurance and Section 125 Plans

Employer-sponsored health insurance is the primary source of health insurance for the non-elderly in the United States. More than 150 million Americans currently receive their health insurance through their employers. Employer adoption of a Section 125 Plan can help to make health insurance more affordable for employees.


Section 125 Plans commonly known as "cafeteria plans" are detailed documents created by or for employers to enable employees to purchase health insurance policies with pre-tax dollars. (These Plans are designed in conformance with requirements of Section 125 of the U.S. Internal Revenue Code and apply to group insurance plans.) The use of pre-tax dollars reduces federal and

state income and social security tax liabilities for participating employees. For these employees, the "experienced" cost of their health insurance coverage is reduced, typically resulting in savings of 25 to 40 percent. An example of the potential savings is shown below.

**Individual Earning $50,000 Annually with Single Health Insurance Policy**

| | | |
|---|---|---|
| VA Small Group avg. monthly premium (2006) | | $ 246 |
| Payroll deduction amount (through 125 plan) | | $ 246 |
| Reduction in FICA tax → | 7.65% | $ 19 |
| Reduction in federal tax liability → | 18% | $ 44 |
| Reduction in VA state tax liability → | 5.2% | $ 13 |
| Net premium cost to employee | | $ 170 |
| **Total Monthly Tax Savings →** | **31%** | **$ 76** |

In addition, the adoption of Section 125 Plans may reduce the payroll taxes owed by employers. The Internal Revenue Code specifies certain limitations for Section125 Plans including:

- Plans cannot be set up to cover self-employed individuals, partners in a partnership, and directors and limited partners in a limited liability corporation.
- Employers that do not offer health insurance or that pay 100 percent of their employees' health premiums would realize no reduction in their payroll tax liability by establishing a Plan.
- While Section 125 Plans can significantly decrease the cost of health insurance for many employees, it does not make insurance inexpensive so many employed Virginians would still be unable to afford health insurance.

## Section 125 Plans in Virginia

Although Section 125 Plans can result in significant cost savings for employers and employees, many businesses in Virginia, particularly smaller businesses,

have not adopted a Plan. According to the Agency for Healthcare Research and Quality, many of the over 400,000 Virginians with employer-sponsored health coverage cannot pay health insurance premiums with pre-tax monies.

There are a number of reasons that Section 125 Plans have not been adopted more broadly. The primary reason is a general lack of employer knowledge about such Plans. In addition, there is a perception that establishing a Plan would result in a significant increased administrative burden, as well as questions regarding the cost and time it would take to understand and develop the Plan. However, when Section 125 Plans are understood, the challenges associated in creating them are generally minor while the benefits are significant.

Sixty-eight percent of the small businesses in Virginia that offer health insurance do not offer a Section 125 Plan. These small businesses (defined as having fewer than 50 employees) employ approximately 291,000.

In contrast, only eight percent of the larger businesses in Virginia that offer health insurance do not offer a Section 125 Plan. These larger businesses (with 50 or more employees) employ approximately 139,000.

## Health Insurance Exchanges

Heath insurance exchanges are designed to promote competition between health insurers, to provide consumers a single access point for high-quality health insurance products, and to provide insurance product information in an understandable way. Exchanges may be operated by a public or private entity and may address individual and/or small group insurance markets. This review determined that in Virginia, significant resources would be needed to create and operate an exchange while it is unlikely that having an exchange would improve market efficiency or lower health insurance premiums significantly.

In addition, the study ascertained that there is no consistent resource to assist employers in determining all of the health insurance options available in their area. To help address this need, a listing of available health insurers by locality could be developed and added to the health insurance section of the Virginia Health Information (VHI) website.

## Policy Options

Four of the ten policy options presented were approved by the Joint Commission. These four policy options involved a letter request from the chairman:

- The Department of Human Resources Management, in consultation with the Department of Business Assistance (VDBA), was asked to create a detailed electronic document highlighting Section 125 benefits; requirements for adoption; COBRA, ERISA, and HIPPA implications; and a simple Section 125 Plan form to post on the VDBA website and on Virginia's business portal website.
- The Virginia Chamber of Commerce was asked to inform its membership of Section 125 Plans and associated benefits through its newsletter.
- The National Federation of Independent Businesses/Virginia was asked to include information on Section 125 Plans as part of the Federation's Area Action Council meetings with small businesses.

In addition, the Joint Commission members voted to convene a workgroup in 2009 to compile information needed for an informational website on health insurers to be hosted by Virginia Health Information with appropriate linkages on other State websites and to address other health insurance issues as appropriate.

# Interim Analysis of Health Workforce Pipeline

## Introduction

The demand for health care services is expected to increase as Virginia's population increases (and as the percentage of older residents increases) over the next few decades. Consequently, it will be important to anticipate future workforce shortages among health care professionals and to take action to prevent or minimize any shortages. In 2007, JCHC members requested a two-year study of Virginia's workforce pipelines for physicians, dentists, clinical psychologists, and pharmacists.

## First Year Analysis

The first-year analysis reviewed the current number of licensed physicians, dentists, clinical psychologists, and pharmacists and characteristics of the related higher education programs in Virginia (see Table below).

HC Professional Educational Program

| | # Licensed in Virginia | Type of Institution Offering Degree Program | # Degree Programs | 2008-09 Enrollment | 2008 Graduates | 2007-08 General Fund Appropriation *in millions* |
|---|---|---|---|---|---|---|
| Physicians | 16,191 | Public | 3 | 1745 | 418 | $50.6 |
| | | *Private* | *1* | *680* | *139* | *$0.0* |
| Dentists | 4,995 | Public | 1 | 374 | 92 | $6.6 |
| | | *Private* | *0* | *0* | *0* | *$0.0* |
| Clinical Psychologists | 2,434 | Public | 8 | 317 | 38 | *** |
| | | *Private* | *3* | *536* | *75* | *$0.0* |
| Pharmacists | 9,636 | Public | 1 | 512 | 115 | $4.1 |
| | | *Private* | *3* | *745* | *187* | *$0.0* |

In the course of conducting this analysis it was determined that the Board of Medicine does not save an annual historical copy of the Doctor's Profile Database. The database contains such information as practice locations, primary specialty, educational background, and dates of training. Making an archive copy of this database on an annual basis would allow for more accurate trend analyses and projections of future physician supply.

## Second Year Analysis

During the second year analysis, study activities will determine current supply and demand for each health care profession being reviewed (by geographic region in Virginia) and estimate future supply and demand for services. In addition, the financial cost of operating a medical school will be examined (as requested and approved during a JCHC meeting held in November 2008). In completing the second year analysis, JCHC staff will collaborate with the National Center for the Analysis of Healthcare Data within the Edward Via Virginia College of Osteopathic Medicine. This collaboration will enhance the comprehensiveness of the workforce data that can be collected and analyzed.

## Policy Options

Two of the three policy options presented, were approved by the Joint Commission:

- The JCHC Chairman was authorized to request by letter that the Board of Medicine save an electronic copy of its Doctor's Profile Database on an annual basis.
- JCHC staff was authorized to collaborate with the National Center for the Analysis of Healthcare Data (within the Edward Via Virginia College of Osteopathic Medicine) in completing the study.

(Note: Option 1 to take no action was rejected.)

# Support for Family Caregivers and Alternatives to Long Term Care

## Introduction

Senate Joint Resolution 102 (Senator Stosch) and House Joint Resolution 238 (Delegate Shannon) directed the Joint Commission on Health Care to study support services for family caregivers of the frail elderly and disabled and community-based caregiver support organizations. SJR 102 was agreed to by both houses of the General Assembly.

House Joint Resolution 69 (Delegate Plum) directed the Joint Commission on Health Care to study alternative solutions to long-term care needs including identifying and reviewing alternatives to traditional long-term care facilities such as intentional communities of clustered homes. The resolution was left in the House Committee on Rules, however the study was completed upon request by Delegate Hamilton.

## Support for Family Caregivers

Family caregivers provide help with household chores, personal care, transportation, medication, companionship, paying bills, and coordinating services outside the home. In the U.S., 44 million Americans (1 in 5 adults) provide unpaid care, valued at a cost of $350 billion a year. In Virginia, 740,402 caregivers provide 793 million hours of unpaid care, valued at a cost of $7.8 million a year.

Many family caregivers have unmet needs and stress factors such as unrelieved caregiver burden, exhaustion, financial pressures, health risks, emotional strain, mental health problems, workplace issues, retirement insecurity, lost opportunities, and legal concerns. Very often, the result of these stressors is early placement of loved ones into nursing homes. In order to reduce the burden experienced in the caregiver role, caregivers need greater emotional support, access to information and resources, guidance in the decision-making process, support from employers, and relief from the financial burden of caregiving. Primary funding sources for family caregiver support in Virginia are the

National Family Caregiver Support Program, Virginia Caregivers Grant (which was eliminated from the 2008-2010 state budget), Virginia Respite Care Initiative Grant, and Medicaid home and community-based care waivers.

### Model Caregiver Support Programs

Currently there are several programs in other states that can be used as a model for Virginia to provide better support to family caregivers. Key elements of these programs that could be replicated in Virginia are:

- Single coordinating organization for all services
- Central point of entry to caregiver resources and information
  - On-line resource center
  - Standardized call center
- Caregiver assessment
- Consumer-directed services
- Family caregiver education and training programs.

## Alternatives to Long-Term Care

The traditional long-term care model is not designed to help elders age at home. Instead, it is based on the use of large institutional facilities operated according to a medical model that emphasizes efficiency, a hierarchical management structure, rules, routines, and requirements. The great majority of individuals prefer to live at home as long as possible and, when it is time, to live in a facility that offers a more personal, home-like environment. Many state governments are enacting new programs and/or changing the way their aging agencies are structured to help older individuals stay in their homes longer (e.g. increasing the availability of services and adopting consumer-directed programs); and the culture change movement has resulted in widespread changes in nursing and assisted living facilities nationally and in Virginia. Initial research has shown that culture change increases the quality of life for residents and the work environment for staff, lowers turnover rates, and that many improvements can be accomplished without substantially increasing operating costs.

## The Green House Model

The Green House model represents the most transformational culture change currently used. Six to 10 elders live together in a house with a central hearth, kitchen, and dining area where all elders and staff interact in a more familial manner. The work structure is less hierarchical and staff members are empowered to make decisions as a collective, with elder input. Challenges to The Green House model include high capital costs, low Medicaid rates, and the obstacles involved in moving Green House homes off of campuses and into communities "where people live and homes belong." To address these problems and facilitate the creation of more Green House homes, the project's director recommends the following:

- Create programs to offset development costs for low-income projects
  - Tax credit equity programs, targeted grants, and interest rate reductions
- Work with states to enhance Medicaid reimbursement rates for person-centered models of care
- Support fast-track review process for state plan amendments that relate to payment rate changes for Green House providers

## Aging at Home

Aging at home requires the ability to obtain needed services at home such as nursing, companion and chore services, support for caregivers, and technology. Virginia is moving in the right direction with the creation of No Wrong Door, Virginia Easy Access, Program of All-Inclusive Care for the Elderly (PACE), and the Money Follows the Person program; however, there are still challenges such as:

- Limited reimbursement for in-home care
- Fragmented services and funding sources
- Personal in-home care under the Medicaid Elderly or Disabled with Consumer Direction (EDCD) waiver is restricted to individuals who meet Virginia's stringent criteria for admission into a nursing facility (assistance with 4 of 5 activities of daily living).

### Cash and Counseling Program and Intentional Communities

Two innovative approaches to helping elders age at home are the Cash and Counseling Program and Intentional Communities.

- The Cash and Counseling Program is a consumer-directed model that allows elderly and disabled consumers who receive personal assistance services through Medicaid to direct their own care through a flexible budget they control. Participants can use their allotted budget to hire personal care aides, purchase items or services (including home modifications), and/or pay a family caregiver. The program also includes a counseling component to provide assistance in planning budgets, handling employee wages and tax paperwork, and accounting for expenditures.
- Intentional communities are non-profit organizations founded by residents that provide support to residents who wish to stay in their homes as they grow older. Members email or call a single telephone number to arrange for assistance or to participate in a variety of activities. Services that typically are provided include transportation, home maintenance, assistance with paperwork, occasional meal preparation and companionship, and weekly grocery shopping. Intentional communities provide programs and services more cost-effectively than most conventional retirement communities.

## Policy Options

Three policy options were approved:

- Continue study for one additional year to research options for improving "aging at home" services and support for culture change initiatives in Virginia.
- Restore funding for the Virginia Caregivers Grant when the state budget allows.
- Assist local Chambers of Commerce in enlightening Virginia business owners about caregiver workforce issues and in encouraging owners to provide caregiver support programs.

# Various Responses to Medical Errors

## Introduction

HJR 101 of the 2008 General Assembly directed the Joint Commission on Health Care to study, in the case of medical errors and adverse medical outcomes, the use of disclosure, apologies, alternative dispute resolution and other measures. JCHC was also directed to study the impact of such measures on the cost and quality of care, patient confidence and the medical malpractice system. A workgroup – the 101 Study Committee – was formed by the Virginia Bar Association and the Joint Commission on Health Care to complete the study.

## Study Findings

When there is medical error, needs and concerns arise for both the patient and the Health Care Provider (HCP). The injured patient may need but not receive: an explanation of what happened or an apology; adequate compensation; or reassurance that steps have been taken to assure that the error is not repeated. The HCP may feel powerless to talk openly with the injured patient about what happened and to express an apology. It may be difficult for the HCP to determine how to balance ethical and legal responsibilities with personal, professional and financial liability when deciding what and how to disclose.

Several disincentives exist to disclosure of medical errors:

- Government investigations triggered by Federal and state reporting requirements
- Raised malpractice insurance premiums and discontinued coverage
- Possible waiver of peer review privileges
- Possibility that defense costs could actually rise due to an increased number of claims
- Loss of professional reputation
- Fear of a lawsuit.

Fear of lawsuits and loss of reputation remain the biggest barriers to disclosure of medical errors.

However, studies suggest that a majority of patients sue, not because of injury but because they believe they are not treated with respect, not told the truth, or the HCP has not taken responsibility for his/her actions. The silence of the "deny and defend" culture breeds anger, and is a major determining factor in a patient's decision to sue.

Incentives for disclosure of medical error include:

- Rebuilding trust and solidifying the provider/patient relationship, thereby decreasing malpractice litigation and reducing overall costs.
- Creating a culture of transparency and accountability that fosters an environment where medical errors are identified and corrected, thereby buttressing the patient safety movement.
- Acknowledging an error giving an institution the freedom to correct the mistakes and theoretically prevent future harm and improve patient safety.
- Increasing patient confidence in the integrity of the health care system.
- Encouraging care to be patient-centered, not based on the protection of the organization.

A movement promoting disclosure programs in the medical setting is taking root nationwide. Across the country, including in Virginia, hospitals have been voluntarily implementing disclosure/early resolution programs. Each program has a unique approach but some consistent characteristics include:

- Focusing on early resolution (pre-claim) of the issues.
- Having transparency and accountability as the intended purpose for implementation, not a decrease in medial malpractice costs.
- Having procedures in place to determine, before a disclosure conversation is initiated, if and how an adverse event occurred.

- Having clear policies as to who makes the initial disclosure, as well as future disclosure conversations.
- Employing a strong education/training/support element for all involved.

The 101 Study Committee indicated it was unable to conclude at this time that Virginia should take action to mandate or foster disclosure conversation programs or alternative programs for compensation resolutions; more information and work is needed.

## Policy Options

The committee recommended and JCHC members approved the following policy option:

The JCHC should convene a Task Force consisting of representatives of the primary stakeholders in this subject area – to include the Medical Society of Virginia; the Virginia Hospital and Healthcare Association; the Department of Health; Department of Health Professions; Board of Medicine; the Virginia Trial Lawyers Association; the Virginia Association of Defense Attorneys; the medical malpractice insurance industry; and broader physician, health care provider and consumer representation.

The committee recommended that the JCHC charge this task force with:

- building upon the work already done by the 101 Study Committee;
- developing agreed-upon working definitions of key terms such as adverse outcome, medical error, and disclosures, to facilitate discussions in Virginia of the issues;
- tracking results and developments in disclosure and resolution programs now operational in Virginia and other states, and federal developments in this area;
- Crafting a model or models for disclosure and early resolution programs that could be offered to Virginia health care providers, insurers, and attorneys for their use;

- should such a model or models be developed, considering ways to incentivize health care providers to try use of such models and to report outcomes of their use with regard to several factors, including cost, claims experience, impact on quality/patient safety efforts, and reported patient/ provider satisfaction; and
- should the Task Force decide not to offer such model(s), explaining the reasons.

# Overview of Underage Drinking

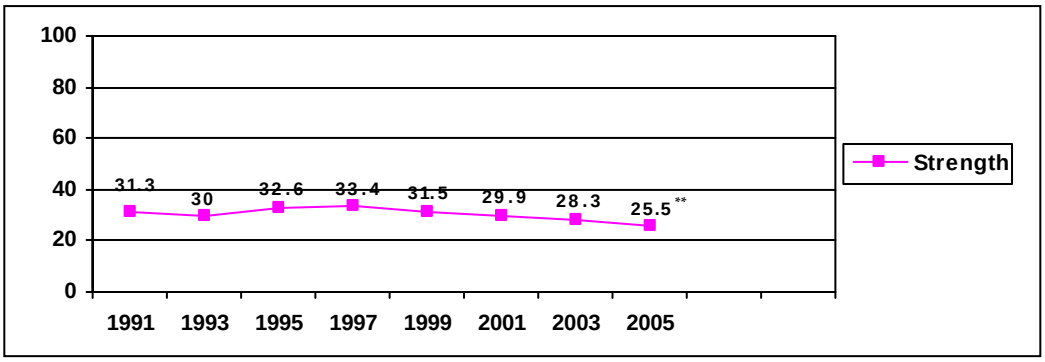
## Introduction

Underage drinking continues to be a problem in the U.S. Alcohol is easy to obtain, drinking tends to begin early (prior to the age of 13 years), and heavy/ binge drinking is prevalent among high school (25.5%) and college students (43%). Those who drink regularly before the age of 15 years are four times more likely to develop alcoholism during their lifetime.

Underage drinking is linked to increases in:

- Driving accidents
- Developmental problems
- Academic problems
- Suicide
- Other risky behavior
  - Unintended sex, injury to self and others, and memory loss.

Percentage of High School Students Who Reported Episodic Heavy Drinking,* 1991 - 2005




* Had 5 drinks of alcohol in a row (i.e., within a couple of hours) on 1 of the 30 days preceding the survey.
** Significant linear decrease and quadratic change, $P < .05$ *National Youth Risk Behavior Surveys, 1991 – 2005.*

## Prevention Strategies

Reduce availability by promoting responsible adult behavior and holding adults accountable when they provide alcohol to minors.

- "Parents Who Host Lose the Most" program
- Keg registration laws

Increase enforcement of current laws especially related to alcohol-free school campuses, tale of alcohol to minors, and drinking and driving.

Change social norms by supporting marketing programs to inform students that most of their peers do not drink to lower drinking rates, limit advertising of alcohol to youth, and educate parents and community on the effects of alcohol on the development of adolescents and to change "Right of Passage" norms.

## Policy Options

JCHC members approved one of three policy options. The approved option involved introducing legislation (Senate Bill 1341 and House Bill 2087) to amend the Alcoholic Beverage Control Act (Title 4.1) to make hosting a party in which underage drinking is allowed a Class 3 misdemeanor. The legislation would have prohibited knowingly permitting anyone under the age of 21 to consume alcohol on one's private property or failing to make reasonable efforts to halt such consumption. This law would not have applied to alcohol use by family and guests, including guests under 21 if accompanied by a parent, guardian, or spouse who is at least 21 years of age.

Questions and concerns were raised about the bills' provisions; SB 1341 was stricken from the docket of Senate Courts of Justice at the request of the patron and HB 2087 was left in House Courts of Justice.

# Mental Health Reform

## Introduction

Senate Joint Resolution 42, introduced by Senator L. Louise Lucas during the 2008 General Assembly Session, was amended to request that the Joint Commission on Health Care (JCHC) complete a two-year study regarding "the impact of certain recommendations and legislation on the mental health system in the Commonwealth." JCHC was directed to complete an interim report during the first year of study.

Numerous studies and reports dating as far back as 1949, have found Virginia's mental health system to be critically lacking in community-based services. A national study, *Grading the States: A Report on America's Health Care System for Serious Mental Illness* (2006) by the National Alliance on Mental Illness (NAMI) gave Virginia an overall grade of "D" for its public mental health system. While the NAMI report considered Virginia's efforts to increase funding and promote recovery-based policies to be positive steps, the report also noted: "Beneath the excitement and hope… lies the reality that Virginia's public system has suffered from years of deep cuts that fell disproportionately on the community system." (Source: *Grading the States: A Report on America's Health Care System for Serious Mental Illness*, p. 171.)

The tragic Virginia Tech incident in April 2007 brought further attention to weaknesses in Virginia's mental health system. A number of investigations of the incident were undertaken, numerous hearings and meetings were held, and the Commission on Mental Health Law Reform accelerated its timetable to examine issues related to the civil commitment process. In response to the findings of these investigations and studies, significant new funding and statutory changes were introduced during the 2008 General Assembly Session.

## Behavioral Health Care Subcommittee Review

The two-year study of changes to Virginia's mental health system was assumed by JCHC's Behavioral Health Care Subcommittee. Presentations

on behalf of the Commission on Mental Health Law Reform; the Department of Mental Health, Mental Retardation and Substance Abuse Services; community services boards; special justices; sheriffs; and hospitals were heard by the Subcommittee during meetings held in 2008.

## Consideration of Mental Health Reform Legislation

Mental health reform legislation enacted during the 2008 General Assembly Session included substantive changes in:

- Commitment criteria by removing "imminent" from the dangerousness criteria.
  - Virginia was 1 of only 5 states that still included "imminent" danger in its requirement for commitment.
- Information/evidence considered for emergency custody orders and temporary detention orders, including treating physician's recommendation and relevant hearsay evidence.
- Involuntary commitment process such as the information to be considered by the special justice, including the pre-admission screening report and independent examiner's report.
- Requirements for independent examiner and treating physician to attend commitment hearing or be available for questioning; in addition CSB representative must attend the hearing or participate via telephone or "two-way electronic video and audio communication system…."
- Mandatory outpatient treatment plans which are to include the "specific services to be provided" as well as who will provide each service and the CSB responsible for the plan and for reporting "any material noncompliance to the court."
- Psychiatric inpatient treatment of minors by extending the maximum period of temporary detention from 72 to 96 hours and allowing a parent or legal custodian to authorize inpatient treatment for minors 14 and older who are "incapable of making an informed decision…."

Figure 1: Summarizes mental health reform bills that were expected to be considered during the 2009 General Assembly Session.

# FIGURE 1

## Summary of Potential 2009 Mental Health Reform Legislation

### TASK FORCE ON FUTURE COMMITMENT REFORM

**Legislation Carried Over from 2008**

**HB 735** (Caputo)
Allowing 3rd year law students to represent petitioners in commitment hearings

**SB 274** (Cuccinelli)
Transfer to outpatient treatment

**SB 177** (Marsh)
Assisted outpatient treatment

**Bills Referred to Mental Health Law Reform Commission**

**HB 267** (Albo)
Appointment of counsel for indigent petitioners in commitment hearings

**HB 938** (Gilbert)
Petitioner right of appeal

**SB 102** (Cuccinelli)
3-tier transportation system

**SB 106** (Cuccinelli)
Substantial deterioration outpatient commitment criteria

**SB 143** (Edwards)
Extension of TDO to 96 hours

**SB 214** (Edwards)
Mandated special justice training

**SB 333** (Cuccinelli)
Independent examiner authorization to release detained persons

**SB 335** (Cuccinelli) Offer of voluntary outpatient treatment to detained person; conditions

### TASK FORCE ON ADVANCE DIRECTIVES

**Legislation Carried Over from 2008**

**HB 1004** (Bell)
Advance mental health directives

**Bills Referred to Mental Health Law Reform Commission**

**SB 47** (Whipple/Lucas)
Advance mental health directives

## TASK FORCE ON ACCESS TO SERVICES

**Legislation Carried Over from 2008**

**SB 16** (Edwards)
Crisis intervention teams

**SB 18** (Edwards)
Pilot mental health courts

**SB 65** (Howell)
MH representation on community criminal justice boards

**SB 138** (Puller)
DOC to identify medical and psychiatric benefits for prisoners

**SB 275** (Cuccinelli)
Emergency psychiatric treatment for inmates

**SB 440** (McEachin)
Emergency psychiatric treatment for inmates

**Bills Referred to Mental Health Law Reform Commission**

**SB 64** (Howell)
Mandated CSB core services

## COMMISSION FOR SPECIAL COLLABORATIVE STUDY WITH SCHEV

**HB 751** (Peace)
Providing mental health information to colleges and universities

**HB 752** (Peace)
Medical record release information

**POTENTIAL MENTAL HEALTH LAW REFORM COMMISSION LEGISLATION**

**Transportation**
Allow for a 3-tier transportation system to:

Allow persons and entities other than law enforcement to transport for ECOs/TDOs

Delete provision providing for cost of transportation to be paid by Commo wealth from jail funds, permitting law enforcement to bill Medicaid

**Privacy Proposal**
Permit health care providers to notify family members or personal representative of person's location and general condition

**Health Care Decisions Act**
Would permit health care agent designated by person in advance directive or guardian authorized by circuit court order to admit person who is determined incapacitated to mental health facility for up to 7 days

**Independent Examiner Training Proposal**
Psychiatrists and psychologists should also be required to complete DMMRSAS certification program

Would provide training on requirements of VA law on commitment and health records privacy

**Rights of Persons in Commitment Process**
Provide person opportunity to have family member, friend or personal representative notified of hospitalization and transfer

Add to events that permit set aside of default judgment for person involuntarily detained or admitted to mental health facility

**Additional Legislation**
Allow for extension of TDO to 4 or 5 days

Allow for mandatory outpatient treatment after inpatient commitment

Allow for mandatory outpatient treatment to prevent inpatient hospitalization

Legislation carried over from 2008 and proposed during the 2009 Session will be reviewed by the BHC Subcommittee during the second year of the study. The final report will detail the Subcommittee's work in 2009, including any legislative options proposed for consideration during the 2010 General Assembly.

# Activities

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.

## Joint Commission on Health Care

Four JCHC meetings were held in 2008:

May 28
July 29
September 4
November 24

Minutes for each meeting can be found on the Commission's website.

The Joint Commission heard presentations on such topics as the priorities and initiatives of the newly-appointed Commissioner of Health, descriptions of the Mental Retardation and the Individual and Family Developmental Disability Support waivers, and an implementation plan for a lead agency for autism and developmental disability services.

Staff reports were presented to address:

- Initiatives to improve the accessibility and availability of health insurance
- Support for family caregivers and long-term care alternatives
- Potential responses to medical errors and adverse medical outcomes
- Virginia's efforts to recruit and retain psychiatrists
- Analysis of the educational pipelines for certain health care professionals.

## Long-Term Care/Medicaid Reform Subcommittee

JCHC's Long-Term Care/Medicaid Reform Subcommittee heard presentations on such matters as the priorities and initiatives of the Commissioner of the Department for the Aging; Medicare's new policy to Provide no payment for treating "preventable" conditions, mistakes and infections acquired during a hospital stay; and an update on Virginia's Medicaid reform and long-term care initiatives.

Long-Term Care/ Medicaid Reform Subcommittee met three times in 2008:

August 12
September 4
November 24

## Behavioral Health Care Subcommittee

The Behavioral Health Care Sub-committee met four times during 2008:

July 29
August 12
October 23
November 24

JCHC's Behavioral Health Care Subcommittee heard staff reports addressing underage drinking and the role of psychiatrists and psychologists in the civil commitment process. (The staff report on minority access to mental health services was distributed, although it will not be heard in Subcommittee until 2009.) Furthermore, presentations were given by other agencies and organizations on such issues as services provided by community services boards for children and adolescents; legislation introduced in 2008 to reform Virginia's mental health system; and recent activities of the Commission on Mental Health Law Reform.

# Meeting Dates and Presentation Topics
# Joint Commission on Health Care

## May 28, 2008

**Election of Officers**
Delegate Phillip A. Hamilton, Chairman

**Overview of Legislation and Proposed Studies**
Kim Snead, Executive Director

## July 29, 2008

**Proposed Workplan**
Kim Snead

## September 4, 2009

**Initiatives and Priorities of the Virginia Department of Health**
Karen Remley, M.D., M.B.A., Commissioner

**Initiatives of Virginia Health Information**
Michael Lundberg, Executive Director

**Discussion: Mental Retardation Waiver and the Individual & Family Developmental Disability Supports Waiver**
James S. Reinhard, M.D., Commissioner, DMHMRSAS
Terry A. Smith, Director, Division of Long-Term Care, DMAS
Mary Ann Bergeron, Virginia Association of Community Services Boards
Jennifer Fidura, Virginia Network of Private Providers
Howard Cullum, President, The Arc of Virginia
Sara Ruh, The Arc of Hanover
Katherine Montgomery, The Arc of Northern Virginia
Sandy Hermann, Parent & Care Connection for Children, CHKD
Dana Kavanagh, Ability Unleashed
Jill Jacobs, Parent and Alliance for Cross-disability Empowerment
Joshua Wilson
Kim Lett, Parent and disAbility Resource Center

**Staff Report: Section 125 Plans/Virginia Health Insurance Exchange**
Stephen W. Bowman, Senior Staff Attorney/Methodologist

## October 23, 2008

**Review of Public Comments and Submitted Reports**
Kim Snead

**Update: Virginia's Public Guardian and Conservator Board**
Paul F. Aravich, Ph.D., Chair
Virginia Public Guardian & Conservator Advisory Board

**Lead State Agency for Autism & Developmental Disabilities Services**
Heidi Dix, Deputy Secretary
Office of the Secretary of Health and Human Resources

**Updates: JCHC Study Recommendations on Tracking Services for Preterm/Low-Birth Weight Infants & the Virginia Stroke Systems Task Force**
David E. Suttle, M.D., Director, Office of Family Services
Virginia Department of Health

Mary Ann Discenza, Part C Coordinator, Office of Child & Family Services
Department of Mental Health Mental Retardation & Substance Abuse Services

**Staff Report: Support for Family Caregivers & Long-Term Care Alternatives**
Michele L. Chesser, Ph.D., Senior Health Policy Analyst

**Staff Report: Various Responses to Medical Errors**
Jaime H. Hoyle, Senior Staff Attorney/Health Policy Analyst

**Staff Report: Commonwealth's Efforts to Recruit and Retain Psychiatrists**
Jaime H. Hoyle

**Interim Staff Report: Analysis of Health Workforce Pipelines**
Stephen W. Bowman

## November 24, 2008

**Decision Matrix**

# Behavioral Health Care Subcommittee

## Membership

Senator L. Louise Lucas, Co-Chair
Delegate Harvey B. Morgan, Co-chair

Senator George L. Barker
Senator Ralph S. Northam
Senator Linda T. Puller
Senator Patricia S. Ticer
Senator William C. Wampler, Jr.

Senator R. Edward Houck (ex-officio)

Delegate Robert H. Brink
Delegate David L. Bulova
Delegate Franklin P. Hall
Delegate Phillip A. Hamilton
Delegate David A. Nutter
Delegate John M. O'Bannon, III

### July 29, 2008

**Proposed Workplan**
Kim Snead

**Review of CSB Child & Adolescent Services**
James W. Stewart, III, Inspector General , Office of the Inspector General
DMHMRSAS

**JLARC Study: Mitigating the Cost of Substance Abuse in Virginia**
Kim Snead

**Staff Report : Overview of Underage Drinking**
Michele L. Chesser, Ph.D.

### August 12, 2008

**Staff Report: Role of Psychiatrists and Psychologists in Emergency Custody Orders, Temporary Detention Orders and Involuntary Civil Commitment**
Jaime H. Hoyle

**Overview of 2008 General Assembly Action**
Jane D. Hickey, Office of the Attorney General

**Commission on Mental Health Law Reform: Progress Report**
Richard J. Bonnie, L.L.B., Chair
Commission on Mental Health Law Reform

**October 23, 2008**
**Discussion: Effect of Mental Health Reform Changes**
James S. Reinhard, M.D., Commissioner, DMHMRSAS
George Braunstein, Public Policy Chair, VACSB
Nancy L. Quinn, Esquire, Special Justice
Sheriff Steve Draper, President, VSA/City of Martinsville
Sheriff Beth Arthur, Arlington County
Sheriff Tommy Whitt, Montgomery County
Gary S. Kavit M.D., FACEP, Riverside Regional Medical Center, Newport News

**Commission on Mental Health Law Reform:**
**Current and Planned Activities**
Richard J. Bonnie, L.L.B., Chair , Commission on Mental Health Law Reform
The Honorable Stephen D. Rosenthal, Esquire
Troutman Sanders LLP
Jane D. Hickey, Office of the Attorney General

**Staff Report**: **Minority Access to Mental Health Services in Virginia**
Michele L. Chesser, Ph.D.

**November 24, 2008**
**Decision Matrix**

# Long-Term Care/Medicaid Reform Subcommittee Membership

Senator Linda T. Puller, Co-Chair
Delegate John M. O'Bannon, III, Co-Chair

Senator George L. Barker
Senator Harry B. Blevins
Senator Ralph S. Northam
Senator Patricia S. Ticer

Delegate Robert H. Brink
Delegate Benjamin L. Cline
Delegate Franklin P. Hall
Delegate Phillip A. Hamilton
Delegate Harvey B. Morgan
Delegate David A. Nutter

Senator R. Edward Houck (ex-officio)

**July 29, 2008**
**Proposed Workplan**
Stephen W. Bowman

**August 12, 2008**
**Virginia Department for the Aging Initiatives**
Linda L. Nablo, Commissioner

**Update on FAMIS & FAMIS Plus**
Judith Cash, Chair
Children's Health Insurance Program Advisory Committee

**CMS Progress Towards Value Based Purchasing Hospital Acquired Conditions**

Thelma M. Baker, Senior Director
Virginia Health Quality Center

**Virginia Medicaid Policies: Implications for Health System Performance, Care Integration/Improvement and Communities**
Chris Bailey, Senior Vice President , Virginia Hospital & Healthcare Association
Scott Burnette, President/CEO, Community Memorial Healthcenter
Stephen Morrisette, President, Virginia Health Care Association

**September 4, 2008**

**Update: Medicaid Reform & Long-Term Care Initiatives**
Patrick Finnerty, Director
Department of Medical Assistance Services

**Status of Compliance: State Employees' LTC Insurance Plan with LTC Partnership Requirements**
Sharon Finn, Program Manager, Office of Health Benefits
Department of Human Resource Management

**Anthem 360° Health Program Value in Virginia**
Shannon Stepp, Sales Account Executive
Health Management Corp.

**November 24, 2008**

**Decision Matrix**

**In addition to staff presentations, the Commission heard from representatives from other organizations:**

Ability Unleashed
Arc of Virginia - Arc of Hanover - Arc of Northern Virginia
Children's Health Insurance Program Advisory Committee
Commission on Mental Health Law Reform
Community Memorial Healthcenter
Department of Human Resource Management
Department of Medical Assistance Services
Health Management Corporation
Office of the Attorney General
Office of the Inspector General for Department of Mental Health, Mental Retardation and Substance Abuse Services
Office of the Secretary of Health and Human Resources
Parent & Care Connection for Children
Parent and Alliance for Cross-disability Empowerment
Parent and disAbility Resource Center
Riverside Regional Medical Center
Troutman Sanders LLP
Virginia Association of Community Services Boards
Virginia Department of Health
Virginia Department for the Aging
Virginia Health Care Association
Virginia Health Information
Virginia Health Quality Center
Virginia Hospital & Healthcare Association
Virginia Network of Private Providers
Virginia Public Guardian & Conservator Advisory Board
Virginia Sheriffs' Association

**The following reports were received.**

**Auxiliary Grant Portability**
**A Plan to Restructure Auxiliary Grants for Certain CSB Case Management Consumers**

**Current Medical Developmental Disabilities Waiver Diagnoses**

**Developmental Disabilities Waiver and Mental Retardation Waiver**
**Chart**

**Department of Medical Assistance Services**
**Enhanced Benefits Accounts Report**

**Department of Medical Assistance Services**
**Letter**

**Department of Mental Health, Mental Retardation and Substance Abuse Services**
**Jail Diversion Initiatives**

**Mental Health Law Reform**
**Preliminary Report**

**Mental Health Law Reform**
**Progress Report**

**Ombudsman Activities and Services, Fiscal Year 2008**

**Part C Services**
**Transition Letter**

**Report on the Status of the Family Access to Medical Insurance Security (FAMIS) Plan Trust Fund - FY2008**

**Virginia Association of Community Service Boards**
**Memo**

**Virginia's Conversion Health Foundations**
**2007 Report**

**Virginia Department of Health**
**HPV Vaccine Information**

# Legislative Initiatives

## Actions Taken on 2009 Legislative Proposals

**Senate Bill 1060/House Bill 1952**

Chief Patrons: Senator Puller and Delegate O'Bannon

*Purpose:*

To repeal the sunset date for the Joint Commission on Health Care.

*Final Action:*

Both bills were amended to extend the sunset date from July 1, 2010 to July 1, 2012.

**Senate Bill 1341/House Bill 2087**

Chief Patrons: Senator Lucas and Delegate Melvin

*Purpose:*

To amend the Alcoholic Beverage Control Act (Title 4.1) to make hosting a party in which underage drinking is allowed to be a specific crime punishable as a Class 3 misdemeanor.

*Final Action:*

Each bill was stricken at the request of the chief patron due to issues identified during Committee discussions. The BHC Subcommittee will consider the option of addressing the identified issues including whether legislation should be introduced in 2010.

**Senate Bill 1228/House Bill 2288**

Chief Patrons: Senator Barker and Delegate Cline

*Purpose:*

To correct a mistake from the 2007 Session when two JCHC bills were amended (and consequently passed) in slightly different ways.

*Final Action:*

Both bills were left in the Senate Education and Health Committee. The BHC Subcommittee will consider the option of addressing the identified issues including whether legislation should be introduced in 2010.

**Senate Bill 1060 — Senator Linda T. Puller**
**House Bill 1952 — Delegate John M. O'Bannon, Jr.**
**Repeal § 30-170 of the *Code of Virginia***

*Summary as introduced:*
**Joint Commission on Health Care.** Repeals provision sunsetting the Commission on July 1, 2010.

*Full text:*
01/13/09 Senate: Prefiled and ordered printed; offered 01/14/09 094346840 **(impact statement)**
02/17/09 House: Committee substitute printed 097327304-H1 **(impact statement)**

*Status:*
01/13/09 Senate: Prefiled and ordered printed; offered 01/14/09 094346840
01/13/09 Senate: Referred to Committee on Rules
02/02/09 Senate: Assigned Rules sub: Studies
02/06/09 Senate: Reported from Rules (17-Y 0-N)
02/09/09 Senate: Constitutional reading dispensed (40-Y 0-N)
02/10/09 Senate: Read second time and engrossed
02/10/09 Senate: Constitutional reading dispensed (40-Y 0-N)
02/10/09 Senate: Passed Senate (40-Y 0-N)
02/13/09 House: Placed on Calendar
02/13/09 House: Read first time
02/13/09 House: Referred to Committee on Rules
02/17/09 House: Reported from Rules with substitute (15-Y 0-N)
02/17/09 House: Committee substitute printed 097327304-H1
02/19/09 House: Read second time
02/20/09 House: Passed by for the day
02/23/09 House: Passed by for the day
02/24/09 House: Read third time
02/24/09 House: Committee substitute agreed to 097327304-H1
02/24/09 House: Engrossed by House - committee substitute SB1060H1
02/24/09 House: Passed House with substitute (96-Y 2-N)
02/24/09 House: VOTE: --- PASSAGE (96-Y 2-N)
02/25/09 Senate: House substitute agreed to by Senate (38-Y 0-N)
02/25/09 Senate: Title replaced 097327304-H1

**Senate Bill 1341 — Senator L. Louise Lucas**
**House Bill 2087 — Delegate Kenneth R. Melvin — Patron**
**Amend the *Code of Virginia* by adding § 4.1-305.1**

*Summary as introduced:*
**Alcoholic beverages; underage consumption.** Provides that anyone who knowingly permits underage consumption of alcoholic beverages in his dwelling or on his private real property, or who knows that such behavior is occurring but fails to make reasonable efforts to halt it, is guilty of a Class 3 misdemeanor.

*Full text:*
01/14/09 Senate: Prefiled and ordered printed; offered 01/14/09 091527840

*Status:*
01/14/09 Senate: Prefiled and ordered printed; offered 01/14/09 091527840
01/14/09 Senate: Referred to Committee on Rehabilitation and Social Services
01/23/09 Senate: Rereferred from Rehabilitation and Social Services (15-Y 0-N)
01/23/09 Senate: Rereferred to Courts of Justice
01/27/09 Senate: Assigned Courts sub: Criminal
02/04/09 Senate: Stricken at the request of Patron in Courts of Justice (14-Y 0-N)

*Full text:*
01/13/09 House: Prefiled and ordered printed; offered 01/14/09 091524840 **(impact statement)**

*Status:*
01/13/09 House: Prefiled and ordered printed; offered 01/14/09 091524840
01/13/09 House: Referred to Committee for Courts of Justice
01/20/09 House: Assigned Courts sub: Criminal
01/28/09 House: Subcommittee recommends striking from the docket
02/10/09 House: Left in Courts of Justice

**Senate Bill 1228 — Senator George L. Barker**
**House Bill 2288 — Delegate Benjamin L. Cline**
**Amend and reenact § 37.2-506 of the *Code of Virginia***

*Summary as introduced:*
**Eligibility for employment with community services board; removes provision allowing employment of person convicted of assault and battery of a family member.** Eliminates provision authorizing employment of a person convicted of assault and battery of a family member at an adult substance abuse or adult mental health treatment program by a community services board.

*Full text:*
01/13/09 Senate: Prefiled and ordered printed; offered 01/14/09 091145840 **(impact statement)**

*Status:*
01/13/09 Senate: Prefiled and ordered printed; offered 01/14/09 091145840
01/13/09 Senate: Referred to Committee on Education and Health
01/19/09 Senate: Assigned Education sub: Health Care
02/05/09 Senate: Left in Education and Health (13-Y 0-N)

*Full text:*
01/14/09 House: Prefiled and ordered printed; offered 01/14/09 091146840 **(impact statement)**

*Status:*
01/14/09 House: Prefiled and ordered printed; offered 01/14/09 091146840
01/14/09 House: Referred to Committee on Health, Welfare and Institutions
01/27/09 House: Reported from Health, Welfare and Institutions (22-Y 0-N)
01/28/09 House: Read first time
01/29/09 House: Read second time and engrossed
01/30/09 House: Read third time and passed House BLOCK VOTE (97-Y 0-N)
01/30/09 House: VOTE: BLOCK VOTE PASSAGE (97-Y 0-N)
02/02/09 Senate: Constitutional reading dispensed
02/02/09 Senate: Referred to Committee on Education and Health
02/19/09 Senate: Left in Education and Health

# 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.**

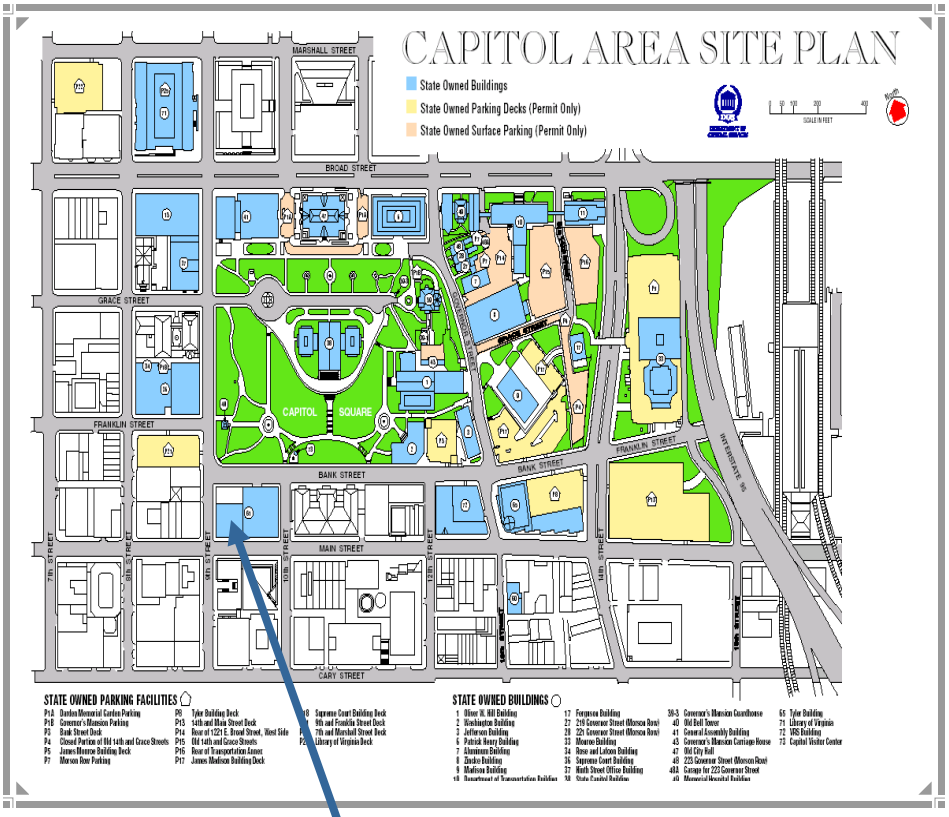
Repealed by Acts 2003, c. 633, cl. 2.

**§ 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