JOINT COMMISSION ON HEALTH CARE

COMMONWEALTH OF VIRGINIA
REPORT DOCUMENT 14

2009 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
2010

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
Richmond, Virginia 23218
804.786.5445
804.786.5538 fax

June 17, 2010

The Honorable Robert F. McDonnell
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 McDonnell 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, 2009.

This 2009 Annual Report includes a summary of the Joint Commission's activities and legislative recommendations to the 2010 Session of the General Assembly. In addition, staff studies are submitted as written reports, published, and made available on the General Assembly's website and the Joint Commission's website.

Respectfully submitted,

R. Edward Houck

Preface

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. *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." In July 2003, the definition of "health care" was expanded to include behavioral health care.

Membership

The Joint Commission on Health Care is comprised of 18 legislative members; eight members of the Senate appointed by the Senate Committee on Rules and 10 members of the House of Delegates appointed by the Speaker of the House.

The Joint Commission would like to recognize four departing members for their invaluable and dedicated service.

The Honorable Kenneth R. Melvin represented the 80th House District from 1986 to 2009. Delegate Melvin was one the original JCHC members appointed in 1992 when the Joint Commission was established. Delegate Melvin was elected to serve a two-year term as Chairman of the Joint Commission on Health Care in 1998.

The Honorable Franklin P. Hall represented the 69th House District from 1976 to 2009. Delegate Hall was appointed to the Joint Commission in 1996 and served as Chairman of JCHC's Long-Term Care Subcommittee from 2000 through 2002.

The Honorable Phillip A. Hamilton represented the 93rd House District from 1988 through 2009. Delegate Hamilton was appointed to the Joint Commission in 1998 and served as Chairman of the Long-Term Care Subcommittee from 2003 through 2005 before being elected to serve a two-year term as Chairman of the Joint Commission on Health Care in 2006.

The Honorable Marilyn Tavenner was appointed Secretary of Health and Human Resources by Governor Kaine in 2006 and served as an ex officio member of JCHC from 2006 through 2009. Secretary Tavenner was responsible for overseeing the operation of 12 agencies, including the Departments of Health, Behavioral Health and Developmental Services, Social Services, Health Professions and Medical Assistance Services.

While the contributions of these members are too numerous to detail, their wisdom and dedication will be missed.

Membership
2009

Senate of Virginia

The Honorable R. Edward Houck, Chairman

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

Virginia House of Delegates

The Honorable Phillip A. Hamilton, Vice-Chairman

The Honorable Clifford L. Athey, Jr.
The Honorable Robert H. Brink
The Honorable David L. Bulova
The Honorable Benjamin L. Cline
The Honorable Rosalyn R. Dance
The Honorable Algie T. Howell, Jr.
The Honorable Harvey B. Morgan
The Honorable David A. Nutter
The Honorable John M. O'Bannon, III

The Honorable Marilyn B. Tavenner
Secretary of Health and Human Resources

Staff

Kim Snead
Executive Director

Stephen W. Bowman
Senior Staff Attorney/Methodologist

Michele L. Chesser, Ph.D.
Senior Health Policy Analyst

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

Sylvia A. Reid
Publication/Operations Manager

Offices

Pocahontas Building
900 East Main Street
1st Floor West
P. O. Box 1322
Richmond, VA 23218
804.786.5445
804.786.5538 fax

Website: http://jchc.virginia.gov

Table of Contents

Activities	**1**
Executive Summaries	**3**
Analysis of Virginia's Health Workforce Pipelines	**3**
Opportunities for Early Identification and Preventive Care of Chronic Diseases	**7**
Improving Aging-at-Home Services and Support for Culture Change Initiatives	**11**
Notification for Breaches of Personal Health Records	**13**
Task Force on Adverse Medical Outcomes	**15**
Virginia's Long-Term Care Ombudsman Program	**19**
Review of Statutory Language on Barrier Crimes	**21**
Impact of Legislation on Virginia's Mental Health System	**23**
Meetings/Presentation Topics	**29**
Legislative Initiatives	**35**
Reports Received	**41**
Future Studies	**43**
Statutory Authority	**45**

Activities

In keeping with the 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 Joint Commission heard presentations on such topics as an overview of JLARC's report on *Services for Virginians with Autism Spectrum Disorders*, updates on the H1N1 flu outbreak, and a proposal for JCHC to provide oversight of a study of mental health issues in higher education.

JCHC Meetings
April 30
September 1
October 7
November 12

Staff reports were presented to address:

- Virginia's Healthcare Workforce Pipelines
- Early Identification and Preventive Care of Chronic Diseases
- Culture Change in Long-Term Care Facilities
- Interim Report on State Funding for Cancer Research
- Notification for Breaches of Personal Health Records
- Interim Report on Ensuring Care for Individuals with Life-Threatening Conditions
- Update on HJ 101 Task Force on Adverse Medical Outcomes

HL/HS Subcommittee Meetings
April 30
August 12
September 1
November 12

The Healthy Living / Health Services Subcommittee met four times and heard presentations on such matters as childhood obesity, infant mortality, HIV / AIDS, the impact of the economic downturn on safety net providers, and a staff report addressing Virginia's Long-Term Care Ombudsman Program.

The Behavioral Health Care Subcommittee met four times, considering reports on such topics as improvements in the delivery of behavioral health services, activities of the Commission on Mental Health Law Reform, the impetus for the Geriatric Mental Health Planning Partnership, and the conflict between Virginia's mental health parity laws and recently enacted federal law.

BHC Subcommittee Meetings
April 30
August 12
October 7
November 12

Two staff reports were presented:

- Minority Mental Health Needs and Treatment in Virginia
- Statutory Language on Barrier Crimes

Executive Summaries

During 2009, the Joint Commission on Health Care staff conducted studies in response to requests from the General Assembly or JCHC's membership. In keeping with the Joint Commission's statutory mandate the following study reports were completed.

Analysis of Virginia's Health Workforce Pipelines

Physicians, Psychiatrists, Dentists, Clinical Psychologists and Pharmacists

A 2007 presentation on the shortage of geriatricians led to a proposed study of the adequacy of Virginia's educational pipelines to meet the projected need for certain health care professionals. This is the final report of that two-year study, conducted by the Joint Commission on Health Care (JCHC). In 2009, an interim report was submitted and published as RD 118, and the final report was published in 2010 as RD 90.

Findings

Projections indicate that Virginia's population and percentage of older residents will increase over the next two decades, increasing further the demand for health care services. At this time, Virginia's most critical physician shortages are in primary care, geriatric care, psychiatry, emergency medicine, and general surgery. These shortages are exacerbated by the maldistribution of physician practices which tend to be located in Virginia's more urban localities. A need for additional dentists and mental health professionals also was identified.

There are a number of avenues Virginia could take to address shortages and maldistribution of health care professionals, including:

- providing increased funding for State-supported family medicine programs;
- funding State loan repayment programs (that were recently defunded);
- increasing Medicaid reimbursement rates;
- encouraging medical schools to enroll students more likely to provide services in underserved areas;

- Educating the physician workforce about geriatric care issues through physician groups and the Board of Medicine; and
- Expanding telemedicine services and payment for such services.

With these alternatives in mind, 19 policy options were presented for consideration.

Policy Options

Joint Commission members approved 16 policy options.

Eleven options involve making requests by letter of the JCHC chairman:

- Request the Department of Medical Assistance Services (DMAS) to develop and report on a methodology and cost estimate for providing enhanced Direct Medical Education (DME) and Indirect Medical Education (IME) payments to graduate medical programs in Virginia that train primary care, general surgery, emergency medicine physicians, and psychiatrists. Report to JCHC by August 30, 2011.
- Request that medical schools at Eastern Virginia Medical School, University of Virginia, Virginia Commonwealth University, Edward Via Virginia College of Osteopathic Medicine, and Virginia Tech Carilion School of Medicine and Research Institute make efforts to increase their enrollment of medical students from rural communities in Virginia and of individuals with an interest in serving underserved and minority populations.
- Request the Board of Medicine to include and promote geriatric care issues among its online educational resources and/or most appropriate venues.
- Request the Virginia Chapter of the American College of Physicians to include and promote geriatric care issues among its online educational resources and/or most appropriate venues.
- Request the Virginia Academy of Family Physicians to continue to promote geriatric training among its membership.
- Request the Special Advisory Commission on Mandated Health Insurance Benefits to support SB 1458 (Wampler) and HB 2191 (Philips) which require health insurers, health care subscription plans, and health maintenance organizations provide coverage for the cost of telemedicine services.
- Request the Department of Human Resource Management to consider and, if appropriate, conduct pilot programs for selected telemedicine-covered services within the State Employee Health Insurance program.

- Request the Department of Behavioral Health and Developmental Services (DBHDS) to report on the Department's current and historical utilization of telemedicine and telepsychiatry services, effectiveness of such services, locations offering such services, use of telemedicine by CSB providers, and impediments to greater adoption and usage by the Department and CSBs. Report to JCHC by August 30, 2010.
- Request the Department of Health Professions to improve the information collected and compiled about clinical psychologists that is retained in the Healthcare Workforce Data Center.
- Request the Department of Health Professions to improve the information collected and compiled about dentists that is retained in the Healthcare Workforce Data Center.
- Request the Virginia Pharmacists Association, the Virginia Department for the Aging, and local area agencies on Aging to collaborate to provide and disseminate information about Medicare's Medication Therapy Management (MTM) program to pharmacists, prescription counselors, and Medicare beneficiaries.

Five options involve considering a budget amendment when State revenue allows in order to:

- restore funding for the State Loan Repayment Program (SLRP) & Virginia Loan Repayment Program (VLRP);
- increase dedicated funding for the EVMS, UVA and VCU Family Practice Residency Programs;
- increase Medicaid reimbursement rates to match the level of Medicare reimbursement rates for primary care physicians;
- enable the Department of Health Professions (DHP) to develop a continuing medical education course, focusing on medication issues of geriatric patients that would be targeted for primary care physicians; and
- extend basic dental benefits to adults eligible for Medicaid.

Opportunities for Early Identification and Preventive Care of Chronic Diseases

Senate Joint Resolution 325, introduced by Senator Houck in 2009, directed JCHC to "(i) examine clinical and other studies concerning the manner in which early identification and preventive care can be utilized to halt or slow the evolution of such conditions as diabetes, hypertension, kidney disease, obesity, and pneumonia into chronic and terminal conditions; (ii) assess the means by which Virginia can address fragmentation of services across the health delivery system and the patient's community in order to enhance early identification and preventive care and care management for chronic disease, and to identify opportunities for providing more coordinated care management for individuals with multiple chronic diseases; and (iii) estimate the fiscal impact on the Commonwealth and private payers from such strategies."

The final report for this study was published as SD 4 (2010).

Findings

In the United States, chronic diseases are a leading cause of adult disability and account for 70% of all deaths. The costs for people with chronic diseases account for more than 75% of the nation's $2 trillion in health care expenditures. Expenses for chronic diseases are typically driven by the reoccurrence of acute events, such as emergency room (ER) visits, hospitalizations, or costly inpatient and outpatient treatment plans. People with chronic conditions typically have multiple health care providers, treatment plans and prescriptions written by different physicians who may be unaware of the other providers treating the individual, often resulting in unnecessary and costly ER and hospital admissions.

There is a spectrum of potential approaches to address chronic disease and the fragmentation of the health care system. This spectrum ranges from disease management programs which base care coordination around the identification of specific disease states rather than on the whole person, to programs that focus on all of the person's needs and the service delivery system, to those that focus on prevention and wellness.

Disease Management Programs. Disease management programs are designed to coordinate the delivery of care to patients, improve clinical outcomes, and reduce costs for participants living with specific chronic conditions that have high prevalence rates and/or expensive treatment costs. The programs typically involve combinations of enhanced screening, monitoring, self-management and education, and the coordination of care among providers.

In 2006, Virginia implemented a disease management program, "Healthy Returns," for its Medicaid fee-for-service recipients who have asthma, chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes. During the JCHC study, the potential for adding an integrated care model for chronic kidney disease (CKD) was discussed. CKD, a precursor to kidney failure, is a growing epidemic in the U.S. with almost two-thirds of CKD patients also having diabetes, hypertension or both. The integrated care model provides coordinated care to address these health care needs at dialysis centers.

Recent Budgetary Actions:

As part of Governor Kaine's September 2009 cost savings actions, the decision was made not to renew the DMAS contract for the Healthy Returns Disease Management program. As a result, effective October 31, 2009, the program was discontinued.

Chronic Care Management Models. Chronic care management models are more comprehensive, community-based approaches which focus on the needs of the whole person rather than only the disease. These models also use community resources to address the non-medical needs of the patient, understanding that many persons with chronic conditions have other needs that prevent them from getting care, such as transportation, child care, and housing. The Department of Medical Assistance Services (DMAS) released a request for proposal (RFP) in July 2008 to implement such a model for the Medicaid and FAMIS fee-for-service recipients at highest risk for high utilization and cost of services. DMAS subsequently withdrew the RFP due to a number of technical issues.

Patient-Centered Medical Homes. Patient-centered medical homes focus on the health care delivery system and use a team-based model of care led by a personal physician. The personal physician is responsible for the "whole person" and coordinates patient care across the health system and community to provide continuous care throughout a patient's lifetime to maximize health outcomes.

Prevention and Wellness Approaches. Other approaches recognize the growing body of evidence that earlier identification of chronic diseases coupled with preventive care can halt or slow the progression of chronic diseases, thereby improving patient health and well-being while reducing medical costs. For example, some employers are adding on-site medical clinics in an effort to save on health care costs and encourage employee wellness.

Wellness programs in general are a growing trend in the private sector which is mandating health testing and wellness programs in order to improve employee health and decrease costs. Well over half of large companies in the U.S. have launched such initiatives. There is anecdotal evidence of improved health; however, health care costs were often at least 3% higher in the first year of wellness programs due to increased health care utilization.

In July 2009, a pilot program for State employees in the Hampton Roads area was implemented to focus on wellness and preventive care. Optima Health was awarded a two-year contract for the pilot program designated as "COVA Connect." The program will cover 17,000 State employees and seek to reduce chronic conditions and control health care costs.

Policy Options

JCHC members approved the following two policy options:

- Request by letter of the chairman that the Department of Medical Assistance Services report to JCHC no later than August 2010 regarding recommended options for addressing the chronic care needs of Virginia's Medicaid and FAMIS enrollees. The options should consider at a minimum issues related to:
  - ◊ whether to retain a disease management program (perhaps incorporating additional diseases and an integrated care model for chronic kidney disease);
  - ◊ whether to reissue a proposal for chronic care management services; and
  - ◊ whether to initiate one or more demonstration projects for a patient-centered medical home.

- Request by letter of the chairman that the Department of Human Resource Management report to JCHC (after July 2010) regarding costs and benefits of the recently implemented COVA Connect pilot program.

Improving Aging-at-Home Services and Support for Culture Change Initiatives

This is the final report of a two-year JCHC study as requested by three resolutions introduced during the 2008 General Assembly Session:

- Senate Joint Resolution 102 (Senator Stosch) and House Joint Resolution 238 (Delegate Shannon) "to study support services for family caregivers of the frail elderly and disabled and community-based caregiver support organizations."
- House Joint Resolution 69 (Delegate Plum) to study alternative solutions to long-term care needs.

A number of ideas were examined in the course of the final study including approaches for utilizing existing resources to provide support for caregivers, streamlining the system for accessing community resources, increasing eligibility for community-based services, and strengthening culture change initiatives for Virginia's long-term care facilities.

Support for Family Caregivers

Family caregivers provide help with household chores, personal care, transportation, medication, companionship, paying bills, and coordinating services outside the home. Approximately 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 nearly 800 million hours of unpaid care, valued at a cost of $7.8 million a year.

Family caregivers allow many elderly or disabled individuals to remain in their homes. Providing support for these family caregivers may be one of the least expensive methods to enable more individuals to remain in and age at home thereby preventing or delaying the need for assisted living or nursing facility care. Fortunately, Virginia already has a significant number of public/private partnerships; such as the Virginia Caregiver Coalition, James Madison University's Caregivers Community Network, and the Virginia Center on Aging; providing needed resources for caregivers while requiring relatively little State funding. These organizations help make aging at home possible by offering caregiver training workshops, respite care, support services, and access to resources through coordinated referral systems. The organizations/partnerships have established relationships with each other, aging agencies, and other organizations interested in caregiver issues; and comprise an extensive network of professionals and volunteers. Moreover, James Madison University's Caregiver Community Network offers an award-winning model that could be replicated throughout the Commonwealth.

Support to Allow for Aging at Home

Aging at home also 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), Money Follows the Person, and Cash and Counseling programs; however, there are still challenges including limited reimbursement for in-home care, fragmented services and funding sources, and restrictive requirements for Medicaid waiver eligibility.

To qualify for an Elderly or Disabled with Consumer Direction (EDCD) Medicaid waiver, an individual must meet the requirements for nursing home eligibility including needing assistance with four of five activities of daily living. Although the EDCD waiver is designed to allow an elderly or disabled individual to live at home, the eligibility requirements prevent that individual from qualifying for waiver services while he is still healthy enough to not require nursing home care. The Medicaid Home and Community-Based Services State Plan Option (authorized by the Deficit Reduction Act of 2005 as a 1915(i) benefit) provides states greater flexibility in determining eligibility for home and community-based services. For example, Virginia could adjust eligibility in the State Plan Option to allow individuals requiring assistance with only three (rather than four) activities of daily living to be eligible for services.

While the State Plan Option would enable elderly or disabled individuals to receive home and community-based services earlier in order to prevent or delay the need for nursing facility care, some concerns were voiced by DMAS staff including:

- The services may be considered an entitlement which would require providing services to everyone who qualifies and requests home and community-based services.
- It is unknown whether Virginia's increased cost of providing services to currently ineligible individuals would be offset by preventing or delaying their need for Medicaid-funded nursing home care.
- It may be wise to wait for further clarification of the State Plan Option regulations.

Policy Options

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

- Introduce a joint resolution requesting that the Joint Legislative Audit and Review Commission study the costs and benefits of implementing a Home and Community -Based Services State Plan Option.
- Include in the JCHC 2010 work plan, a staff study of the feasibility of replicating James Madison University's Caregivers Community Network in other areas of the Commonwealth.

Notification for Breaches of Personal Health Records

Senate Bill 1229 (2009) introduced by Senator Barker, sought to provide additional protections for medical information by amending Virginia's Database Breach Law (*Code of Virginia* § 18.2-186.6) and Health Records Privacy Act (*Code* § 32.1-127.1:03). The Senate Courts of Justice Committee referred SB 1229 to the Joint Commission on Health Care and Joint Commission on Technology and Science (JCOTS) for study pursuant to Senate Rule 20(l).

Findings

Individually identifiable health information is collected or retained by numerous public and private entities. When the Health Insurance Portability and Accountability Act (HIPAA) was enacted, stringent standards were established to protect the privacy of health information maintained by health care providers, health insurers, and health care clearinghouses. Recently, new entities called personal health record (PHR) vendors have emerged and maintain sensitive identifiable health information provided by consumers. PHR vendors are not subject to HIPPA requirements. SB 1229 sought to add PHR vendors within the definition of health care providers that are subject to privacy provisions in *Code* § 32.1-127.1:03 and to create a notification requirement for breaches of individually identifiable health information within *Code* § 18.2-186.6.

Since the time that SB 1229 was referred to JCHC and JCOTS, a number of federal notification requirements have been enacted to address health information breach notifications. Effective September 2009, the Federal Trade Commission and the U.S. Department of Health and Human Services enacted new notification requirements for breaches of individually identifiable health information. These regulations were enacted pursuant to the Health Information Technology for Economic and Clinical Health (HITECH) Act (as part of the American Recovery and Reinvestment Act of 2009). These regulations cover PHR vendors; such as Google Health and Microsoft Vault, PHR business associates and third-party providers, and the entities that have historically been subject to HIPAA.

A joint JCHC/JCOTS Subcommittee met and determined that the HITECH Act had achieved the goals of SB 1229 and that no further action was needed regarding the bill. Of note, the HITECH Act does not require breach notification for all collections of individually identifiable health information maintained by Virginia's governmental entities, such as the Prescription Monitoring Program maintained by the Department of Health Professions.

Policy Option

JCHC members agreed to continue the study in the 2010 work plan, if the current JCOTS/JCHC review is not completed in time for 2010 Session. The second year of study would focus on electronic records of individually identifiable health information held by State and local government entities that are not required to notify individuals in the event of a breach.

Task Force on Adverse Medical Outcomes

House Joint Resolution 101, introduced by Delegate O'Bannon during the 2008 General Assembly, was left in the House Committee on Rules. However, Delegate O'Bannon requested by letter that the Joint Commission on Health Care 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.

After the completion of the first year of the study, JCHC recommended convening a Task Force consisting of representatives of the primary stakeholders including the Medical Society of Virginia; Virginia Hospital and Healthcare Association; Department of Health; Department of Health Professions; Board of Medicine; Virginia Trial Lawyers Association; Virginia Association of Defense Attorneys; the medical malpractice insurance industry; and broader physician, health care provider and consumer representation. The Task Force was charged 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;
- tracking results and developments in disclosure and resolution programs now operational in Virginia and other states, and federal developments in this area; and
- 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.

Findings

This was the second year that JCHC convened a group to study the use of disclosure, apologies, alternative dispute resolution and other measures in the case of adverse medical outcomes. The Phase 1 study report (RD 109 – 2008) recognized that the issues raised by this subject are numerous and can be complex. During Phase 2 of the study, staff continued to research other programs as well as federal developments, and formed a broad-based Task Force to focus on the development of a model program for disclosure programs. The essential challenge put to the Task Force was twofold: to identify what a pilot model program could look like in Virginia, and to

identify ways to incentivize its use so that the concept would be fairly tested. Draft legislation for a Pilot Project for Disclosure Programs was circulated to the Task Force in advance of its full day meeting in September, allowing for early preparation and comment. At that meeting, the Task Force agreed to ten elements of the Pilot Disclosure Program.

- Triggered by an injury to the patient
- Voluntary participation by health care providers in 5-year pilot program.
- Oversight by the Virginia Department of Health (VDH) with cooperation and support from the Virginia Board of Medicine.
- Guidelines or conditions of participation developed by VDH with advice and consultation from stakeholder groups.
- Encourage proactive, pre-claim responses and possible resolution of all size injuries at the discretion of the participating provider.
- Broad flexibility for programs to develop their protocols within agency parameters.
- Bifurcated process provided for disclosure and a resolution process for patient compensation that includes a right to counsel.
- A patient's opt-in (to enter into a resolution process) must be preceded by full explanation of the process, including notice of the right to be legally represented and giving the patient a reasonable period of time for consideration after the offer of process.
- Legal provision that liability carriers cannot take negative action (invoke cooperation clause or later deny coverage) to a participant.
- Requirement for participants to report their evaluation of experiences to VDH.

Privilege as set forth in the Pilot Project for Disclosure Program covers information developed, activity, and communications which occur in the disclosure program process, but does not privilege or prohibit use of "fact." It is not drafted to affect what may or may not be other privileged information concerning other activities outside of a participating Pilot Project Disclosure Program. Privilege also applies to the resolution process used, if one is used.

Representatives of the Virginia Trial Lawyers Association (VTLA) expressed that they could not support the privilege provision, but would continue to work with the remaining Task Force members on satisfactory language. Tension exists, and was duly

noted, between: (1) the concern on the part of the VTLA that a privilege should not be created that could allow an abuse of the privilege to harm or disadvantage an injured patient's exercise of his/her legal rights to achieve fair compensation; and on the other hand, (2) the fact that providers will be deterred from complying with the full disclosure required in a pilot program when they fear that they thus lay themselves open to perceived harsh and unfair punitive consequences other than a fair compensation of the patient. As described in the Phase 1 study report (RD 109), the end result of this tension is often that what a provider will view as a fair and appropriate disclosure may not meet the standards of those to whom disclosure is made. The point of this pilot would be to test what happens when a robust disclosure program with potential for ensuing resolution process is pursued.

Federal Developments

On September 9, 2009, President Obama announced a plan to provide $25 million in grants for states and health systems that carry out and evaluate evidence-based patient-safety and medical-liability demonstrations. The demonstration initiatives administered by the Agency for Health Care Research and Quality within the U.S. Department of Health and Human Services, are designed to "test models that meet the following goals:

- put patient safety first and work to reduce preventable injuries;
- foster better communication between doctors and their patients;
- ensure that patients are compensated in a fair and timely manner for medical injuries, while also reducing the incidence of frivolous lawsuits; and
- reduce liability premiums."

Three-year grants of up to $3 million will be available for applicants to implement and evaluate demonstration projects, and one-year grants of up to $300,000 and technical assistance will be available for states and organizations that want to plan demonstrations. Applications were accepted from December 20, 2009 through January 20, 2010.

Policy Options

JCHC members approved two policy options:

- Introduce legislation to amend the *Code of Virginia* by adding a § 8.01-581.20:2 to authorize a Disclosure Pilot Program as discussed in the Task Force's proposal.
- Request by letter of the Chairman that the Secretary of Health and Human Resources pursue federal grant funding for technical assistance or the implementation of a Disclosure Pilot Program or demonstration project, as outlined by the Agency for Health Care Research and Quality.

Virginia's Long-Term Care Ombudsman Program

A study of Virginia's Long-Term Care Ombudsman Program (LTCOP) was requested by AARP with cooperation from the program's State Long-Term Care Ombudsman Office in order to (i) examine the role of the long-term care ombudsman program in Virginia, (ii) determine whether State and federal mandates are being fulfilled, and (iii) examine the adequacy of program resources to meet current and future need for services.

The long-term care ombudsman program was established in 1978 in the federal Older Americans Act. The Act requires ombudsman programs to:

- identify, investigate, and resolve complaints of long-term care facility residents;
- protect the health, safety, welfare, and rights of facility residents;
- advocate for improvement in long-term care;
- provide information and consultation to residents and their families;
- publicize issues of importance to residents, families and the general public; and
- monitor, analyze and comment on federal, state, and local policies affecting residential long-term care (LTC) facilities.

Findings

In Virginia, the ombudsman program is headed by the Office of the State Long-Term Care Ombudsman. There are 20 local ombudsman offices located in area agencies on aging and employing 31 local ombudsman staff (16 of the 31 work full-time) and 109 volunteers. Funding for Virginia's LTCOP has steadily increased over time; however, funding has not kept up with inflation and growing demands on the program. The percentage of total funds allocated to the State office (relative to the local programs) has decreased over time.

Ombudsman staff provides a significant amount of systems advocacy, especially related to culture change in LTC facilities. Staff is very involved in reviewing complaints from residents of LTC facilities and in FY 2008 ombudsman staff conducted:

- 2,462 complaint investigations, of which 1,936 were resolved or partially resolved;
- 201 non-complaint related visits to nursing facilities;
- 196 non-complaint related visits to assisted living facilities;
- 13,456 consultations with individuals; and
- 1,372 consultations with LTC facility staff.

By contrast, the ombudsman program has very limited involvement with complaint handling in home and community-based care due to the lack of resources for additional staff, training, and marketing of ombudsman services.

Looking to the future, the ombudsman program does not have adequate resources to provide services to the growing elderly population. Addressing the needs of a growing elderly population and a shift toward community-based care would require:

- increasing staff and volunteer ombudsmen;
- additional training for staff and volunteer ombudsmen on the complex issues involved in providing LTC services in the home and community;
- a public information campaign to educate individuals about broadened scope of the program;
- reformatting the data collection system to include non-facility data;
- increased funding for the program; and
- maintaining services and support for the elderly in LTC facilities.


Long Term Care

Policy Option

JCHC members approved the policy option to introduce a joint resolution requesting that the Joint Legislative Audit and Review Commission:

- examine the need for additional State funding for the Office of the State Long-Term Care Ombudsman and local offices; and
- determine whether the Office of the State Ombudsman should have greater administrative control over resource allocation and other administrative decisions.

Senate Joint Resolution 51 (Senator Puller) was passed by indefinitely in the Senate Rules Committee.

Review of Statutory Language on Barrier Crimes

In 2008, House Bill 1203 (Delegate Melvin) and Senate Bill 381 (Senator Martin) were introduced on behalf of JCHC in order to ease a few employment restrictions to allow a person with a misdemeanor assault conviction to be assessed for employment in adult substance abuse or mental health treatment programs. To be considered for employment, the assessment would have to determine that the individual's offense was substantially related to his mental illness and that subsequently he had been successfully rehabilitated. (This type of assessment has been allowed for individuals seeking to work in adult substance abuse programs since 2001 – *Code of Virginia* §§ 37.2-416 and 506.)

As HB 1203 and SB 381 were considered by the House Committee on Health, Welfare and Institutions, both were supposed to be amended to remove the provision that would allow for a conviction of assault and battery against a family or household member. HB 1203 was amended appropriately. However, in SB 381, the provision was removed from *Code* § 37.2-416 (addressing employment by providers licensed by the Department of Behavioral Health and Developmental Services) but was not removed from *Code* § 37.2-506 (addressing employment by community services boards). The oversight was not discovered until after both bills were signed by the Governor, and since SB 381 was signed last, its provisions became law on July 1, 2008.

Actions Taken in 2009

During the 2009 General Assembly Session, two identical bills – HB 2288 (Delegate Cline) and SB 1228 (Senator Barker) – were introduced on behalf of JCHC to address the previously described oversight. Both bills were left in the Senate Committee for Education and Health to allow JCHC to reconsider the issue.

The original bills (HB 1203 and SB 381) as introduced in 2008, intended to include a misdemeanor conviction of assault and battery against a family or household member as one of the permissible offenses. The original JCHC study found that these assaults often occur when individuals are in crisis and going through an involuntary commitment process. There is no provision for reviewing the circumstances of the assault convictions, so even misdemeanor convictions prevent individuals from being employed in treatment programs. Furthermore, being employed is crucial to the individual's recovery and community services boards and many private providers would like to have the option of assessing individuals in recovery for employment in their adult treatment programs.

Policy Option

JCHC members voted to introduce legislation to amend the *Code of Virginia* § 37.2-416.C to allow an individual with a conviction of assault and battery against a family or household member to be assessed for employment by providers licensed by the Department of Behavioral Health and Developmental Services.

Senator Lucas introduced Senate Bill 260, on behalf of JCHC, to amend Code § 37.2-416 to allow an individual with a conviction of assault and battery against a family or household member to be considered for employment by providers licensed by the Department of Behavioral Health and Developmental Services.

Delegate Cline introduced House Bill 867 to address the oversight in 2008 to remove from Code § 37.2-506 the provision that allows an individual with a conviction of assault and battery against a family or household member to be considered for employment by community services boards.

SB 260 passed the Senate (40-0) but was amended to conform to HB 867 before passing in the House (71-27). The committee of conference was unable to reach agreement and SB 260 failed to pass. HB 867 was continued to 2011 in the Senate Committee for Education and Health and referred to JCHC pursuant to Rule 20 (l) of the Senate of Virginia. A written report is due to the bill patron and Senate committee chair by November 2, 2010.

Impact of Legislation on Virginia's Mental Health System

This is the final year of a two-year evaluation requested in Senate Joint Resolution 42, introduced by Senator Lucas in 2008. SJR 42 directed JCHC to evaluate "the impact of certain recommendations and legislation on the mental health system in the Commonwealth." Responsibility for the evaluation was assumed by JCHC's Behavioral Health Care Subcommittee. An interim report (SD 3 – 2009) and a final report (SD 3 – 2010) were published as legislative documents.

The following *Summary of Mental Health Reform Legislation* provides a brief explanation of the 20 mental health reform bills enacted during the 2009 General Assembly Session. The bills address such systemic matters as:

- crisis stabilization to divert individuals from the involuntary civil commitment system;
- alternatives to transportation by law enforcement for individuals subject to emergency custody orders, temporary detention orders, and involuntary commitment orders;
- expansion of advance medical directives to allow for decisions related to mental health treatment; and
- provision of mandatory outpatient treatment and voluntary admission for minors.

2009 Progress Report of the Commission on Mental Health Law Reform

Richard J. Bonnie, L.L.B., Chair of the Commission on Mental Health Law Reform reported on the major activities of the Commission and indicated that some of the key accomplishments include the:

- consensus developed among the many different parties who have been involved in the review through "habits of collaboration,";
- collection and analysis of data necessary for setting policy and providing oversight; and
- development of a "common understanding of problems…and key elements of the solutions."

The Reform Commission expects to continue to have significant work in the areas of emergency services and commitment reform and empowerment and self-determination. With regard to emergency services and commitment reform the Commission expects to:

- "Continue to enhance opportunities for intensive intervention services to prevent, ameliorate and stabilize crises without invoking commitment process or initiating criminal process;
- lengthen TDO period to facilitate thorough evaluation and stabilization before scheduled hearing;
- facilitate discharge or conversion to voluntary status in clinically appropriate cases;
- based on experience and available resources, identify most appropriate role for mandatory outpatient treatment (MOT);
- develop integrated, stand-alone "Psychiatric Treatment of Minors Act."; and
- continue to reduce reliance on law enforcement transportation through Alternative Transportation Orders."

With regard to empowerment and self-determination, the Reform Commission continues to work on the implementation and refinement of the Health Care Decisions Act, with special emphasis on the new advance directive provisions for mental health care.

Activities Planned for 2010

JCHC members voted in favor of a request to provide an "umbrella of oversight" for a proposed one-year study of mental health issues in higher education. The study will be "coordinated with the State Council on Higher Education and the Department of Education as well as the Commission on Mental Health Law Reform." Mr. Bonnie's memorandum describing the study follows on the next page.

UNIVERSITY OF VIRGINIA SCHOOL OF LAW
Richard J. Bonnie
Harrison Foundation Professor of Medicine and Law
Hunton & Williams Research Professor
Professor of Psychiatry and Neurobehavioral Sciences
Director of Institute of Law, Psychiatry and Public Policy

Memorandum

To: Senator R. Edward Houck, Chair, Joint Commission on Health Care
Re: Proposed JCHC Study of Mental Health Issues in Higher Education
Date: October 7, 2009

This memorandum supplements my memorandum to you dated August 31, 2009, in which I described a possible study of mental health issues in higher education under the auspices of the Joint Commission on Health Care. Conducting such a study would serve the interests of the people of the Commonwealth and would be timely in light of the opportunity for coordination with the Supreme Court's Commission on Mental Health Law Reform before the Commission completes its work in 2010. I am confident that the study can be carried out successfully within the next year without any JCHC financial support and without diverting staff attention from the Joint Commission's other priorities.

Steering Committee. The proposed study would be directed by a steering committee that I would chair. The members of the steering committee would include Chris Flynn, the director of the counseling service at Virginia Tech (who would chair a task force on access to mental health services); Jim Stewart, the Inspector General for Behavioral Health and Developmental Services), Professor John Monahan, my colleague at UVA who is an expert on empirical research in mental health law; Diane Strickland, a former Circuit Court judge and member of the Governor's Panel on the Virginia Tech Shootings; Jim Reinhard, Commissioner of Behavioral Health and Developmental Services; Ron Forehand, Deputy Attorney General; Susan Davis, an experienced lawyer who also serves as a student affairs officer at UVA (who would chair a task force on legal issues); and any others who may be suggested by the Joint Commission. Joanne Rome, a Staff Attorney in the Supreme Court, will serve as liaison from the Court, but not as a member.

Coordination with Other Agencies. The study would be formally coordinated with the State Council on Higher Education and the Department of Education as well as the Commission on Mental Health Law Reform, facilitating advice and collaboration throughout the process. The Commission will provide assistance and guidance, as needed, regarding data collection and outreach to relevant constituencies and agencies.

Task Forces. As outlined in my previous memorandum, the Steering Committee would oversee the activities of two task forces, one on Legal Issues in College Mental Health and a second on Access to Mental Health Services by College and University Students. Membership would be drawn from colleges and universities of varying sizes and locations, both public and private. The Steering Committee would develop a specific charge for each of the task forces. For the moment, it is perhaps sufficient to say that the task force on legal issues would be charged with addressing the roles and responsibilities of colleges in responding to possible student mental health crises, including notification and sharing of information, threat assessment, initiation and participation in commitment proceedings and follow-up. The task force on access to services would be charged with assessing the current need for mental health services among Virginia's college and university students, and the current availability of services to address these needs. Each task force would make recommendations for training, institutional policies and practices, and any legislative action that may be needed.

With the direction and guidance of the Steering Committee, the task forces would conduct surveys of colleges and universities in their respective domains, assemble available information regarding these issues, including experience in other states, and would prepare a report and recommendations for consideration by the Steering Committee, review and comment by the Commission on Mental Health Law Reform and other interested parties, and eventual submission to the Joint Commission.

Composition of Task Forces. Our tentative roster for the legal issues task force includes counseling center directors from George Mason and James Madison Universities, campus police officials from Virginia Tech and Christopher Newport, and student affairs officials from UVA, William and Mary, Randolph Macon, ODU, Bridgewater, VCU and Piedmont Community College. Our tentative roster for the access task force includes counseling center directors from Virginia Tech, Longwood University, VCU, Virginia Wesleyan, Virginia State University, Norfolk State, University of Richmond, Radford University, Christopher Newport University, and ODU; two officials from the community college system; and two officials from community services boards. The respective task forces will be advised by representatives of the General Counsel's offices from UVA (legal issues task force) and Virginia Tech (access task force). We will also seek to involve parent organizations and student peer counseling organizations and other stakeholders in the work of the two task forces.

Institutional Support. The legal issues task force will be headquartered at UVA and the access task force will be headquartered at Virginia Tech. I am grateful to each of these institutions for agreeing to provide the core infrastructure support for the study. The responsibility for organizing task force meetings, summarizing deliberations, conducting and analyzing the surveys and drafting and circulating reports would be borne by the respective chairs and by other willing task force members, with the support of their own institutions and agencies. The costs of attending meetings, communications and logistics, and photocopying materials generated by and circulated to task force members will be borne by their respective institutions.

Schedule. If the Joint Commission is willing to provide an umbrella of oversight for the proposed study, the target date for formal appointment of the Task Forces would be the end of October, 2009. Progress reports to the Steering Committee and the Joint Commission Council would be expected in April, 2010 and July, 2010, with the final reports being due in October, 2010.

Summary of Mental Health Reform Legislation Enacted in 2009

	Crisis Stabilization Teams
SB 1294 (Edwards)	The Department of Criminal Justice Services and the Department of Behavioral Health and Developmental Services (DBHDS) using available federal or state funding are to "support the development and establishment of crisis stabilization team programs in areas throughout the Commonwealth
	Transportation
HB 2460 (O'Bannon) **SB 823** (Cuccinelli)	Allows a family member, friend, CSB representative or "other alternative transportation provider" with trained staff to transport a person subject to an emergency custody order, temporary detention order, or involuntary commitment order.
	Emergency Custody and Involuntary Commitment Processes
HB 2486 (Ward) **SB 1079** (Howell)	Authorizes a law-enforcement officer to take into emergency custody, a person being transported following his consent to voluntary admission, if that person revokes consent but meets requirements for emergency custody.
HB 1948 (Shuler)	Adds marriage and family therapists as professionals allowed to "conduct independent examinations of persons who are subject to a hearing for involuntary commitment."
	Advance Medical Directives and Voluntary Admission
HB 2396 (Bell) **SB 1142** (Whipple)	Revises the Health Care Decisions Act to add conditions under which an incapacitated person with mental illness could be admitted to a facility for treatment.
HB 2257 (Albo)	Provides that a person's compliance/noncompliance with treatment will be considered in determining whether to allow him to consent to voluntary admission.
	Notification and Disclosure
HB 2459 (O'Bannon) **SB 1076** (Howell)	Allows a consumer in a mental health facility to identify a person to be notified of "his general condition, location, and transfer to another facility."
HB 2461 (O'Bannon) **SB 1077** (Howell)	Authorizes disclosure to a family member or friend regarding certain information (such as location and general condition) about a person subject to an emergency custody order, temporary detention order, or involuntary commitment order.

	Technical and Administrative Changes
HB 2060 (Hamilton) **SB 1083** (Howell)	Clarifies a number of technical "issues resulting from the overhaul of mental health laws during the 2008 Session."
SB 1081 (Howell)	Clarifies that "a special justice serves at the pleasure of the chief justice of the judicial circuit in which he serves, rather than the specific chief justice that makes the original appointment."
SB 1078 (Howell)	Allows "special justices, retired judges, or district court substitute judges presiding over involuntary commitment hearings" to receive reimbursement for associated mileage, parking, tolls (and postage).
SB 1082 (Howell)	Clarifies the responsibilities for the Office of the Executive Secretary of the Supreme Court and DBHDS with regard to preparing various documents.
	Psychiatric Inpatient Treatment of Minors Act
HB 2061 (Hamilton) **SB 1122** (Lucas)	Allows for mandatory outpatient treatment and voluntary admission for treatment of minors for mental illness; clarifies when a "qualified evaluator" must attend the minor's hearing and the circumstances in which the evaluator's report would be admissible.

Meetings/Presentation Topics

April 30, 2009

Update on H1N1 Flu Outbreak
Karen Remley, M.D., M.B.A.
State Health Commissioner

Proposed Work Plan for 2009
Kim Snead, Executive Director

September 1, 2009

Staff Reports:
Virginia's Healthcare Workforce: Present & Future Need
Stephen W. Bowman, Senior Staff Attorney/Methodologist

Opportunities for Early Identification and Preventive Care of Chronic Diseases
Jaime H. Hoyle, Senior Staff Attorney/Health Policy Analyst

Culture Change in Long-Term Care Facilities
Michele L. Chesser, Ph.D., Senior Health Policy Analyst

Update on JLARC Report on Services for Virginians with Autism Spectrum Disorders
Kim Snead

October 7, 2009

Update on H1N1 Flu
Karen Remley, M.D., M.B.A.
State Health Commissioner

Virginia Cancer Plan Update
Kirsten Edmiston, M.D., FACS, CPAC Advisory Board Co-chair
Virginia State Chair, Commission on Cancer, American College of Surgeons
Medical Director, Inova Cancer Services, Inova Health System
Clinical Assistant Professor of Surgery, Virginia Commonwealth University

Diane Cole, MPH, CPAC Co-chair
Manager, Education and Support Services
University of Virginia Cancer Center

Staff Reports:
State Funding for Cancer Research (Interim Report)
Michele L. Chesser, Ph.D

Notification for Breaches of Personal Health Records
Stephen W. Bowman

Ensuring Care for Individuals with Life-Threatening Conditions (Interim Report)
Jaime H. Hoyle

HJ 101 Task Force on Adverse Medical Outcomes
Jaime H. Hoyle

Proposal for JCHC Study of Mental Health Issues in Higher Education
Richard J. Bonnie, L.L.B., Chair
Commission on Mental Health Law Reform

November 12, 2009

Review of Decision Matrix
Tour - Massey Cancer Center - Virginia Commonwealth University

Behavioral Health Care Subcommittee

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.

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

Senator R. Edward Houck (ex-officio)

April 30, 2009

Proposed Work Plan for 2009
Kim Snead

Staff Report: Minority Mental Health Needs and Treatment in Virginia
Michele L. Chesser, Ph.D.

August 12, 2009

Geriatric Mental Health Planning Partnership
Stephen M. Herrick, Chair
Geriatric Mental Health Planning Partnership

Julie Young Bayly, Administrator
Riverside Convalescent Center – Saluda

NAMI's Grading of the States 2009
Mira Signer, Executive Director
NAMI-Virginia

System Update
James S. Reinhard, M.D., Commissioner
Department of Behavioral Health and Developmental Services

Mental Health Coverage - Overview of State Law and Federal Mental Health Parity Act
Jacqueline A. Cunningham, Deputy Commissioner
Life and Health Division, Bureau of Insurance
State Corporation Commission

Bonnie S. Salzman, Associate General Counsel
Bureau of Insurance
State Corporation Commission

October 7, 2009

Commission on Mental Health Law Reform: Current and Planned Activities
Richard J. Bonnie, L.L.B., Commission Chair

Development of Comprehensive Plan for Behavioral Health Services for Children, Adolescents and their Families
Ray Ratke, Special Advisor on Children's Services

Mental Health First Aid Program
Meena Dayak, Vice President of Marketing and Communications

Susan Partain, Outreach Associate
National Council for Community Behavioral Healthcare

Staff Report: Review of Statutory Language on Barrier Crimes
Jaime H. Hoyle

November 12, 2009

Review of Decision Matrix

Healthy Living/Health Services Subcommittee

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)

April 30, 2009

Proposed Work Plan for 2009
Stephen W. Bowman

August 12, 2009

Trauma Center Fund Update
Stephen W. Bowman

Childhood Obesity
Lynn Fellin, Associate Director
Office of School Nutrition Programs, Virginia Department of Education

Heidi Hertz, Obesity-Prevention Coordinator
Division of WIC & Community Nutrition Services, Virginia Department of Health

Marty Kilgore, Executive Director
Virginia Foundation for Healthy Youth

HIV/AIDS in Virginia
Kathy Hafford, Director
Division of Disease Prevention, Virginia Department of Health

Sue Rowland, Executive Director
Virginia Organizations Responding to AIDS

Infant Mortality in Virginia
Dr. David Suttle, Director, Office of Family Health Services
Virginia Department of Health

Virginia's State Rural Health Plan
Beth O'Connor, Executive Director
Virginia Rural Health Association

November 12, 2009

Review of Decision Matrix

Legislative Initiatives
2010

HB 306 **Patron: Delegate John M. O'Bannon, III**
Purpose: Disclosure of adverse medical outcomes; pilot program.
Final Action: Continued to 2011 in House Courts of Justice

SB 260 **Patron: Senator L. Louise Lucas**
Purpose: Mental health and substance abuse providers; background checks.
Final action: Passed the Senate (40-0) but was amended to conform to HB 867 before passing in the House (71-27). The committee of conference was unable to reach agreement, so SB 260 failed to pass.
(HB 867 was continued to 2011 in Senate Education and Health.)

SB 706 **Patron: Senator R. Edward Houck**
Purpose: Health insurance; coverage for mental health and substance abuse services.
Final Action: Passed both Chambers on unanimous votes.

HJ 83 **Patron: Delegate Robert H. Brink**
Purpose: JLARC study of the costs and benefits of implementing the Home and Community-Based Services State Plan Option; report.
Final action: Left in House Rules

HJ 56 **Patron: Delegate Rosalyn R. Dance**
Purpose: Virginia Cancer Plan; report.
Final action: Passed both Chambers on unanimous votes.

SJ 51 **Patron: Senator Linda T. Puller**
Purpose: JLARC study of the Office of the State Long-Term Care Ombudsman.
Final action: Passed by indefinitely in Senate Rules.

Three budget amendments introduced on behalf of JCHC, addressed:

- Funding to offer coverage to legal immigrants who are Medicaid-eligible pregnant women (labor and delivery costs are covered already as emergency services).
- Funding to offer coverage to legal immigrants who are FAMIS-eligible pregnant women.
- Language directing the Department of Medical Assistance Services to develop, to the extent that it is budget neutral or likely to result in cost savings, express lane eligibility provisions and other administrative procedures to simplify child health enrollment and improve retention.

None of the amendments were included in the budget approved by the General Assembly.

House Bill 306
Delegate John M. O'Bannon, III

Disclosure of adverse medical outcomes; pilot program. Creates a pilot program to assess the creation of disclosure programs in health care facilities designed to facilitate disclosures of adverse medical outcomes between health care providers and patients. The Department of Health shall adopt guidelines concerning the standards for such disclosure programs. Participating health care facilities are required to assess any such program and make reports to the Department of Health. The pilot program sunsets on December 31, 2015.

Full text:

01/11/10 House: Prefiled and ordered printed; offered 01/13/10 10103528D

pdf | impact statement

Status:

01/11/10 House: Prefiled and ordered printed; offered 01/13/10 10103528D

01/11/10 House: Referred to Committee on Health, Welfare and Institutions

01/21/10 House: Referred from Health, Welfare and Institutions by voice vote

01/21/10 House: Referred to Committee for Courts of Justice

01/22/10 House: Assigned Courts sub: Civil

02/01/10 House: Subcommittee recommends continuing to 2011 by voice vote

02/03/10 House: Continued to 2011 in Courts of Justice by voice vote

Senate Bill 260
Senator L. Louise Lucas

Mental health and substance abuse providers; background checks. Allows private providers licensed by the Department of Behavioral Health and Developmental Services to hire as a direct care employee in adult substance abuse or mental health treatment programs a person who has been convicted of a misdemeanor violation relating to assault and battery against a family or household member as long as such offense was substantially related to substance abuse or mental illness and the applicant has been rehabilitated. Alternatively, the bill authorizes private providers to hire as a direct care employee persons who have been convicted of not more than one misdemeanor violation relating to assault and battery against a family or household member if 10 years have elapsed since the conviction, unless the person committed the offense while employed in a direct consumer care position.

The bill also makes a technical change that clarifies the existing law that (i) community service boards and private providers may hire as a direct care employee persons who have been convicted of not more than one misdemeanor violation relating to assault and battery and (ii) community service boards may hire as a direct care employee persons who have been convicted of not more than one misdemeanor violation relating to assault and battery of a family or household member, provided, however, that in the case of any conviction referenced in clause (i) or (ii), 10 years have elapsed since the conviction, and the person did no commit the offense while employed in a direct consumer care position.

(SB 260 continued)

Full text:
01/12/10 Senate: Prefiled and ordered printed; offered 01/13/10 10100800D pdf
02/18/10 House: Committee substitute printed 10105474D-H1 pdf
Status:
01/12/10 Senate: Prefiled and ordered printed; offered 01/13/10 10100800D
01/12/10 Senate: Referred to Committee on Education and Health
01/21/10 Senate: Reported from Education and Health (15-Y 0-N)
01/22/10 Senate: Constitutional reading dispensed (39-Y 0-N)
01/25/10 Senate: Read second time and engrossed
01/26/10 Senate: Read third time and passed Senate (40-Y 0-N)
02/03/10 House: Placed on Calendar
02/03/10 House: Read first time
02/03/10 House: Referred to Committee on Health, Welfare and Institutions
02/18/10 House: Reported from Health, Welfare and Institutions with substitute (13-Y 9-N)
02/18/10 House: Committee substitute printed 10105474D-H1
02/19/10 House: Read second time
02/22/10 House: Read third time
02/22/10 House: Committee substitute agreed to 10105474D-H1
02/22/10 House: Engrossed by House - committee substitute SB260H1
02/22/10 House: Passed House with substitute (71-Y 27-N)
02/22/10 House: VOTE: --- PASSAGE (71-Y 27-N)
02/24/10 Senate: House substitute rejected by Senate (1-Y 39-N)
02/25/10 House: House insisted on substitute
02/25/10 House: House requested conference committee
03/01/10 Senate: Senate acceded to request (40-Y 0-N)
03/01/10 Senate: Conferees appointed by Senate
03/01/10 Senate: Senators: Lucas, Locke, Quayle
03/03/10 House: Conferees appointed by House
03/03/10 House: Delegates: Cline, Cleaveland, Englin
03/14/10 Senate: No further action taken
03/14/10 Senate: Failed to pass in Senate

Senate Bill 706
Senator R. Edward Houck

Health insurance; coverage for mental health and substance abuse services. Requires that group health insurance coverage issued to large employers provide mental health and substance use disorder benefits in parity with the medical and surgical benefits contained in the coverage, in accordance with the Mental Health Parity and Addiction Equity Act of 2008.

Full text:
01/22/10 Senate: Presented and ordered printed 10100804D pdf | impact statement
02/04/10 Senate: Printed as engrossed 10100804D-E pdf | impact statement
03/05/10 Senate: Bill text as passed Senate and House (SB706ER) pdf | impact statement
04/12/10 Governor: Acts of Assembly Chapter text (CHAP0693) pdf

Amendments:
Senate amendments
Status:
01/22/10 Senate: Presented and ordered printed 10100804D
01/22/10 Senate: Referred to Committee on Commerce and Labor
02/01/10 Senate: Reported from Commerce and Labor with amendments (15-Y 0-N)
02/03/10 Senate: Constitutional reading dispensed (39-Y 0-N)
02/04/10 Senate: Read second time
02/04/10 Senate: Reading of amendments waived
02/04/10 Senate: Committee amendments agreed to
02/04/10 Senate: Engrossed by Senate as amended SB706E
02/04/10 Senate: Printed as engrossed 10100804D-E
02/08/10 Senate: Read third time and passed Senate (40-Y 0-N)
02/16/10 House: Placed on Calendar
02/16/10 House: Read first time
02/16/10 House: Referred to Committee on Commerce and Labor
02/23/10 House: Reported from Commerce and Labor (22-Y 0-N)
02/25/10 House: Read second time
02/26/10 House: Read third time
02/26/10 House: Passed House BLOCK VOTE (96-Y 0-N)
02/26/10 House: VOTE: BLOCK VOTE PASSAGE (96-Y 0-N)
03/05/10 Senate: Enrolled
03/05/10 Senate: Bill text as passed Senate and House (SB706ER)
03/05/10 House: Signed by Speaker
03/08/10 Senate: Signed by President
04/12/10 Governor: Approved by Governor-Chapter 693 (effective 7/1/10)
04/12/10 Governor: Acts of Assembly Chapter text (CHAP0693)

House Joint Resolution 83
Delegate Robert H. Brink

JLARC; study the costs and benefits of implementing the Home and Community-Based Services State Plan Option; report. Directs the Joint Legislative Audit and Review Commission to study the costs and benefits of implementing the Home and Community-Based Services State Plan Option.

Full text:
01/12/10 House: Prefiled and ordered printed; offered 01/13/10 10103455D pdf

Status:
01/12/10 House: Prefiled and ordered printed; offered 01/13/10 10103455D
01/12/10 House: Referred to Committee on Rules
01/18/10 House: Assigned Rules sub: #3 Studies
01/21/10 House: Subcommittee recommends laying on the table by voice vote
02/16/10 House: Left in Rules

Senate Joint Resolution 51
Senator Linda T. Puller

Study; Joint Legislative Audit and Review Commission; State Office of the State Long-Term Care Ombudsman. Requests the Joint Legislative Audit and Review Commission to examine the need for additional state funding for the Office of the State Long-Term Care Ombudsman and the local offices and whether the state Office should have greater administrative control over resource allocation and other administrative decisions.

Full text:
01/12/10 Senate: Prefiled and ordered printed; offered 01/13/10 10103859D pdf

Status:
01/12/10 Senate: Prefiled and ordered printed; offered 01/13/10 10103859D
01/12/10 Senate: Referred to Committee on Rules
01/18/10 Senate: Assigned Rules sub: Studies
02/12/10 Senate: Passed by indefinitely in Rules by voice vote

House Joint Resolution 56
Delegate Rosalyn R. Dance

Virginia Cancer Plan; report. Requests the Virginia Cancer Plan Action Coalition to report on changes to the Virginia Cancer Plan to the Governor, the General Assembly, and the Joint Commission on Health Care in each year that changes are made to the Virginia Cancer Plan.

Full text:
01/11/10 House: Prefiled and ordered printed; offered 01/13/10 10100796D pdf
02/08/10 House: Printed as engrossed 10100796D-E pdf
03/05/10 House: Bill text as passed House and Senate (HJ56ER) pdf

Amendments:
House amendments

Status:
01/11/10 House: Prefiled and ordered printed; offered 01/13/10 10100796D
01/11/10 House: Referred to Committee on Rules
01/18/10 House: Assigned Rules sub: #3 Studies
01/21/10 House: Subcommittee recommends reporting with amendment(s) (6-Y 0-N)
02/02/10 House: Reported from Rules with amendments (14-Y 0-N)
02/08/10 House: Taken up
02/08/10 House: Committee amendments agreed to
02/08/10 House: Engrossed by House as amended HJ56E
02/08/10 House: Printed as engrossed 10100796D-E
02/08/10 House: Agreed to by House BLOCK VOTE (95-Y 0-N)
02/08/10 House: VOTE: BLOCK VOTE PASSAGE (95-Y 0-N)
02/09/10 Senate: Reading waived
02/09/10 Senate: Referred to Committee on Rules
02/19/10 Senate: Assigned Rules sub: #1
02/26/10 Senate: Reported from Rules by voice vote
03/01/10 Senate: Reading waived (40-Y 0-N)
03/02/10 Senate: Read third time
03/02/10 Senate: Agreed to by Senate by voice vote
03/05/10 House: Bill text as passed House and Senate (HJ56ER)

Reports Received

Specialty Drug Program
Report Document No. 287
Department of Medical Assistance Services

Annual Report on the Preferred Drug List Program
Report Document No. 288
Department of Medical Assistance Services

Novel Influenza A (H1N1) Briefing
Dr. Karen Remley – State Health Commissioner

Comprehensive State Plan 2010- 2016
Virginia Department of Behavioral Health and Developmental Services

Community-Based Jail Diversion Programs
Report Document No. 340
Virginia Department of Behavioral Health and Developmental Services

Crisis Intervention Team Program Assessment
Report Document No. 420
Department of Criminal Justice Services

Medicaid Autism Services Outreach Plan
Department of Medical Assistance Services

Annual Report on the Status of the Family Access to Medical Insurance Security (FAMIS) Plan Trust Fund
Report Document No. 412
Department of Medical Assistance Services

Future Studies

Resolutions Referred

HJ 27 Delegate Harry R. Purkey

Directs the Joint Commission on Health Care to (i) determine the volume of indigent health care provided by private, specialty, and not-for-profit hospitals in the Commonwealth; (ii) determine the financial cost of indigent health care to private, specialty, and not-for-profit hospitals in the Commonwealth; and (iii) identify and analyze potential tax and other incentives that may be offered to private and specialty hospitals and other health care providers to encourage the provision of care to indigent individuals.

HJ 82 Delegate Patrick A. Hope

Review available information including information about chronic health care home systems in other states to develop recommendations related to the development of a system of chronic health care homes in the Commonwealth.

HJ 99 Delegate Christopher P. Stolle

Study catastrophic health insurance coverage options. In conducting its study, the Commission shall (i) determine the availability and usage of catastrophic health insurance policies in the Commonwealth, (ii) examine the results of efforts in other states to increase the use of catastrophic health insurance policies, and (iii) evaluate the potential benefits and risks of facilitating the offering within the Commonwealth of health insurance policies or plans that provide catastrophic coverage only.

Senate and House Bills Referred

SB 266 Senator Mary Margaret Whipple

Bill Summary: Changes the eligibility for the Family Access to Medical Insurance Security Plan from children in families with an income at or below 200 percent of the federal poverty level to those with an income at or below 225 percent of the federal poverty level.

HB 512 Delegate Thomas D. Rust

Bill Summary: Allows a licensed physician to prescribe, administer, or dispense long-term antibiotic therapy to a patient diagnosed with Lyme disease. Also specifies that the Board of Medicine shall not initiate a disciplinary action against a licensed physician solely for prescribing, administering, or dispensing long-term antibiotic therapy to a patient clinically diagnosed with Lyme disease, provided such clinical diagnosis and treatment has been documented in the patient's medical record by such licensed physician.

HB 867 Delegate Benjamin L. Cline
Bill Summary: 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 operated by a community services board.

Studies Continued from 2009

SJ 339 Senator George L. Barker
Directs the Joint Commission on Health Care to study ways to ensure that individuals with life-threatening conditions receive the care they need, regardless of resources. In conducting its study, the Commission shall (i) identify existing resources to help those without private insurance who don't qualify for Medicaid in emergency situations and ways to publicize any such resources, (ii) determine approximately how many such cases occur in the Commonwealth each year, (iii) examine programs in other states to provide assistance in such situations, and (iv) recommend effective solutions for addressing this problem in the Commonwealth. Provision of care for life-threatening conditions

SJ 292 Senator Stephen H. Martin
Directs the Joint Commission on Health Care to study the benefits to the Commonwealth of appropriating additional funds for cancer research. The joint subcommittee shall (i) examine the sufficiency of current funding sources for both the Massey Cancer Center and the University of Virginia Cancer Center; (ii) review history and successes of cancer research at each center; (iii) explore benefits to the Commonwealth of expanding state support of both centers; and (iv) research additional funding opportunities for both centers.

Reviews

Review the feasibility of replicating James Madison University's Caregivers Community Network in other areas of the Commonwealth (approved policy option). Another approved policy option was to examine Virginia's HIV Prevention and Treatment Programs.

The Behavioral Health Care Subcommittee will consider the survey and report findings of a steering committee on mental health issues and higher education. (See letter from Richard Bonnie on pp. 25-26).

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. (Expires July 1, 2012) Sunset.
The provisions of this chapter shall expire on July 1, 2012.
(1992, cc. 799, 818, § 9-316; 1996, c. 772; 2001, cc. 187, 844; 2006, cc. 113, 178; 2009, c. 707.)

Joint Commission on Health Care
900 East Main Street, 1st Floor West
P. O. Box 1322
Richmond, VA 23218