JOINT COMMISSION ON HEALTH CARE

COMMONWEALTH OF VIRGINIA
REPORT DOCUMENT 109 (2012)

2011 Annual Report of the Joint Commission on Health Care

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT 109

COMMONWEALTH OF VIRGINIA
RICHMOND
2012

COMMONWEALTH of VIRGINIA
Joint Commission on Health Care

Delegate Benjamin L. Cline
Chairman

Kim Snead
Executive Director

900 E. Main Street, 1st Floor
P.O. Box 1322
Richmond, Virginia 23218
804.786.5445
804.786.5538 (facsimile)

April 25, 2012

The Honorable Robert F. McDonnell
Governor of Virginia
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

Members of the Virginia General Assembly
General Assembly Building
Richmond, Virginia 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, 2011.

This report includes a summary of the Joint Commission's activities including legislative recommendations to the 2012 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,

Benjamin L. Cline

Joint Commission on Health Care

Membership

Virginia House of Delegates

The Honorable Benjamin L. Cline, Chair

The Honorable Robert H. Brink
The Honorable David L. Bulova
The Honorable Rosalyn R. Dance
The Honorable T. Scott Garrett
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 Christopher K. Peace

Senate of Virginia

The Honorable Linda T. Puller, Vice-Chair

The Honorable George L. Barker
The Honorable Harry B. Blevins
The Honorable R. Edward Houck
The Honorable L. Louise Lucas
The Honorable Ralph S. Northam
The Honorable Patricia S. Ticer
The Honorable William C. Wampler, Jr.

The Honorable William A. Hazel, Jr.
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

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

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 Commission would like to recognize the distinguished service of five departing members.

The Honorable R. Edward Houck represented the 17th Senate District from 1984 to 2011. Senator Houck was appointed to the Joint Commission by the Senate Committee on Privileges and Election in 2003. He served as chairman from 2008 – 2010.

The Honorable Harvey B. Morgan represented the 98th House District from 1980 to 2011. Delegate Morgan was one of the original JCHC members appointed in 1992, when the Commission was established. He served as chairman from 2002 – 2005.

The Honorable David A. Nutter represented the 7th House District from 2002 to 2011. Delegate Nutter was appointed by the Speaker of the House of Delegates to serve on the Joint Commission in 2006.

The Honorable Patricia S. Ticer represented the 30th Senate District from 1996 to 2011. Senator Ticer was appointed to JCHC by the Senate Committee on Rules in 2008.

The Honorable William C. Wampler, Jr. represented the 40th Senate District from 1988 to 2011. Senator Wampler was appointed to serve on the Joint Commission by the Senate Committee on Privileges and Election Commission in 2001.

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Activities

In keeping with its statutory mandate, the Joint Commission completed studies; received reports and considered comments from public and private organizations, 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.

As established by JCHC work plans approved in 2011, the following reports and presentations were made to the Joint Commission and its two Subcommittees. Minutes for each of the meetings can be found on the website (jchc.virginia.gov).

Joint Commission on Health Care Meetings

JCHC Meetings
May 17th
June 14th
September 19th
October 17th
November 22nd

JCHC members heard from Secretary Hazel concerning the Virginia Health Reform Initiative and from Michael Cannon, with the Cato Institute, on whether Virginia should create a Health Insurance Exchange. Additional presentations included: a summation of the work of the Joint Subcommittee Studying Strategies and Models for the Prevention and Treatment of Substance Abuse and an explanation of nurse staffing requirements as they apply to nursing facilities.

JCHC staff reports presented to the Commission addressed:

- Replicating the JMU Caregivers Community Network
- All-Payer Claims Databases
- Involuntary Admission of Persons in Need of Substance Abuse Treatment
- Potential Regulation Changes for the Board of Pharmacy
- Shaken Baby Syndrome and Abusive Head Trauma
- Pseudoephedrine as a Schedule III Controlled Substance
- Involvement of Virginia's Cancer Centers in Research and Treatment
- Interim Report on Access to Oral Chemotherapy Medications

Behavioral Health Care Subcommittee Meetings

The Behavioral Health Care Subcommittee met twice in 2011. During the May 17th meeting, the Subcommittee heard presentations from Deputy Secretary Keith Hare regarding the Department of Justice (DOJ) investigation of the Central Virginia Training Center and Virginia's compliance with the Americans with Disabilities Act; Heidi Dix and Dr. Olivia Garland on expanding community capacity for individuals

Behavioral Health Care Subcommittee

Co-Chairs
Delegate Harvey B. Morgan
Senator L. Louise Lucas

Delegate Robert H. Brink
Delegate David L. Bulova
Delegate Rosalyn R. Dance
Delegate Algie T. Howell, Jr.
Delegate David A. Nutter
Delegate John M. O'Bannon, III
Delegate Benjamin L. Cline (ex officio)

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

with intellectual disability and recent actions by the Centers for Medicare and Medicaid Services; Jennifer Fidura with the Virginia Network for Private Providers on related challenges faced by the Commonwealth in response to the DOJ report; and Howard Cullum of Arc of Virginia on systems reform for persons with intellectual disabilities.

On October 17th, the Behavioral Health Care Subcommittee heard presentations including an Interim Progress Report on Temporary Detention Order Barriers, an explanation of how community facilities which provide behavioral health care services are licensed, and the priorities of the Campaign for Children's Mental Health.

Healthy Living/Health Services Subcommittee Meetings

Healthy Living/Health Services Subcommittee

Co-Chairs
Delegate John M. O'Bannon, III
Senator Patricia S. Ticer

Delegate Robert H. Brink
Delegate Rosalyn R. Dance
Delegate T. Scott Garrett
Delegate Harvey B. Morgan
Delegate David A. Nutter
Delegate Christopher K. Peace
Delegate Benjamin L. Cline (ex officio

Senator George L. Barker
Senator Harry B. Blevins
Senator R. Edward Houck
Senator Ralph S. Northam
Senator Linda T. Puller

The Healthy Living/Health Services Subcommittee held three meetings in 2011. During the September 19th meeting, the Subcommittee heard from Dr. Keri Hall regarding findings and recommendations of the Governor's Lyme Disease Task Force and from William Lessard on Enhancing Medicaid Direct and Indirect Medical Education Payments.

In addition, three staff reports were presented addressing:

- Eating Disorders in the Commonwealth
- Public Access to Vital Records
- Chronic Health Care Homes

On October 3, the Healthy Living/Health Services Subcommittee met to allow for additional discussion related to establishing an all-payer claims database in Virginia. Presentations were made by the Virginia Hospital and Healthcare Association, Virginia Association of Health Plans, and Virginia Health Information. Discussions followed regarding important decisions that would need to be made if Virginia were to establish an APCD including: governance structure, voluntary or mandatory submission of data, payers that would be required to submit data, rules for release and for public dissemination of data, and funding sources to support the database. JCHC staff was directed to develop policy options regarding those decisions.

The final 2011 meeting of the Healthy Living/Health Services Subcommittee was held November 22. Secretary Hazel discussed the recommendations of the Virginia Health Reform Initiative's Advisory Council with regard to the structure and operation of a health benefits exchange in Virginia. Susan M. Davis and Richard J. Bonnie presented the *Virginia College Mental Health Study: Legislative Recommendations* and Mr. Bonnie presented the final report of the Commission on Mental Health Law Reform. The mental health topics

were originally scheduled to be heard during the Behavioral Health Care Subcommittee meeting in October.

Staff Activities

In 2011, JCHC staff served as members of the following organizations:

- Age Wave Plan for Greater Richmond
  - Leadership Committee, Well Communities Subcommittee, and Data Advisory Work Group
- Children's Health Insurance Program Advisory Committee (CHIPAC)
  - CHIPAC Data Review Subcommittee
- National Center for the Analysis of Health Care Data – Advisory Board
- Virginia Oral Health Coalition, Advisory Board

Staff also made presentations to:

- Central Virginia Health Underwriters
- Henrico Business Leaders
- Virginia Bar Association
- Virginia Commonwealth University
  - Class within School of Allied Health Professions
  - Class within School of Social Work
- Virginia Quality Healthcare Network
- Virginia Telehealth Summit

In addition, JCHC staff attended on-going meetings of the Governor's Lyme Disease Task Force.

Executive Summaries

During 2011, Joint Commission staff conducted studies in response to requests from the General Assembly or from JCHC membership. In keeping with the Commission's statutory mandate, the following staff reports were completed.

Adding Pseudoephedrine as a Schedule III Controlled Substance

Senate Bill 878, introduced by Senator William Roscoe Reynolds, proposed legislation to amend *Code of Virginia* § 54.1-3450 to add pseudoephedrine to Schedule III of Virginia's Drug Control Act which would prohibit the sale of the drug without a prescription. The bill was passed by indefinitely in the Senate Education and Health Committee to allow for review by JCHC.

Findings

Pseudoephedrine is an active ingredient in many cold and allergy medications and a precursor chemical that can be used in the production of methamphetamine. The proposal to make pseudoephedrine a Schedule III drug was reviewed as well as other means to reduce the use of pseudoephedrine (and ephedrine) to produce methamphetamine.

Results of the JCHC study indicate that there is a correlation between making pseudoephedrine a prescription medication and the number of methamphetamine labs in a state. After Oregon passed legislation requiring a prescription for pseudoephedrine, methamphetamine lab production fell from a high of 525 in 2002 to 13 in 2010.

In Mississippi which adopted a prescription-only law in 2009, methamphetamine lab seizures dropped by nearly 70 percent. However, for consumers, requiring a prescription would result in the added inconvenience and cost of having medical appointments with a physician in order to receive and renew prescriptions. Individuals without health insurance or who live in medically-underserved areas may have to delay or forgo cold/allergy symptom relief. It also is possible that the law would increase health care system costs and reduce the level of State tax revenue generated by over-the-counter pseudoephedrine sales.

Additional ways to restrict illegal access to pseudoephedrine include addressing "smurfing" (the process by which lab producers pay individuals to purchase legal amounts of pseudoephedrine at multiple stores) and the purchasing of relatively small amounts of pseudoephedrine (2-5 boxes) for the production of methamphetamine for personal use.

Joint Commission Action

JCHC members voted to introduce legislation to amend the *Code of Virginia* § 18.2-248.8 to require that the log, currently required to be maintained by sellers of products containing ephedrine, or pseudoephedrine must be kept by a State level law enforcement agency in electronic format, utilizing the National Precursor Log Exchange (NPLEx).

Legislative Action

House Bill 1161 – Delegate Benjamin L. Cline/**Senate Bill 294** – Senator L. Louise Lucas
Requires the Department of State Police to enter into a memorandum of understanding to establish the Commonwealth's participation in a real-time electronic recordkeeping and monitoring system for the nonprescription sale of ephedrine or related compounds. Most pharmacies and retail distributors will be required to enter nonprescription sales of ephedrine or related compounds into the electronic system. The bill retains the existing sales limit of no more than 3.6 grams of ephedrine or related compounds per day per individual retail customer and no more than 9 grams per 30-day period. The bill provisions will become effective January 1, 2013.

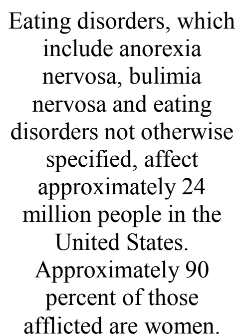
HB 1161 and SB 294 passed both Chambers on unanimous votes; *Acts of Assembly*, Chapters 252 and 160 respectively.

Eating Disorders in the Commonwealth

Senate Joint Resolution 294, introduced by Senator Linda T. Puller, directed the Joint Commission on Health Care to study eating disorders in the Commonwealth. The study was left in the House Rules Committee; however, JCHC members voted to complete the study.

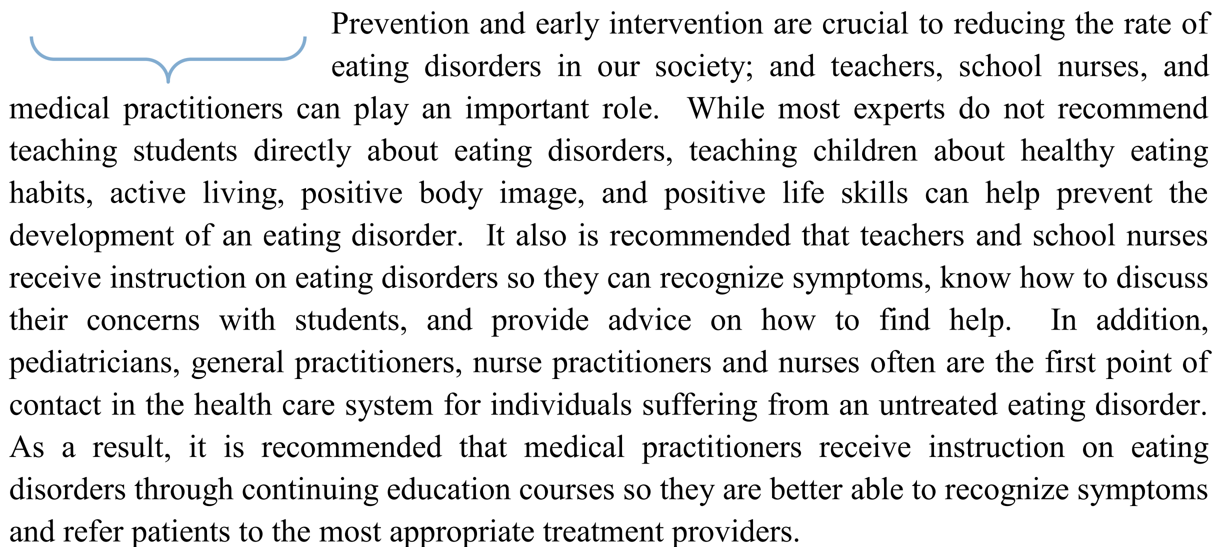
Findings

Although eating disorders can affect people of all ages, 86 percent of individuals with an eating disorder report that it began before the age of 20, and the age of onset has decreased dramatically in recent years. In addition, the occurrence of eating disorders among college-age women is approaching epidemic levels with between 19 and 30 percent of this age group displaying bulimic behavior.



Eating disorders, which include anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified, affect approximately 24 million people in the United States. Approximately 90 percent of those afflicted are women.

Eating disorders are potentially life-threatening mental illnesses that are difficult to treat. Anorexia nervosa has the highest mortality rate of all psychiatric illnesses; the mortality rate is 12 times higher than the mortality rate of all other causes of death for females 15 - 24 years of age with cardiac failure and arrhythmias, starvation and suicide being the leading associated causes of death. Due to the secretive nature of eating disorders, stigma, and lack of access to care, only one-third of people with anorexia nervosa and six percent of people with bulimia nervosa receive mental health treatment.



Prevention and early intervention are crucial to reducing the rate of eating disorders in our society; and teachers, school nurses, and medical practitioners can play an important role. While most experts do not recommend teaching students directly about eating disorders, teaching children about healthy eating habits, active living, positive body image, and positive life skills can help prevent the development of an eating disorder. It also is recommended that teachers and school nurses receive instruction on eating disorders so they can recognize symptoms, know how to discuss their concerns with students, and provide advice on how to find help. In addition, pediatricians, general practitioners, nurse practitioners and nurses often are the first point of contact in the health care system for individuals suffering from an untreated eating disorder. As a result, it is recommended that medical practitioners receive instruction on eating disorders through continuing education courses so they are better able to recognize symptoms and refer patients to the most appropriate treatment providers.

Joint Commission Actions

JCHC members approved three policy options:

- Request by letter of the JCHC Chairman that the Virginia Department of Education encourage grade schools, middle schools, and high schools to provide homeroom teachers and school nurses with instruction or information approved by the American Medical Association or the National Eating Disorders Association on how to recognize eating disorders and how to help youth who may be affected get the care they need.

- Request by letter of the JCHC Chairman that the Virginia Department of Education encourage schools to provide instruction or information approved by the American Medical Association or the National Eating Disorders Association on healthy eating habits and positive body image to students at some point during the fourth, fifth, or sixth grade.

- Request by letter of the JCHC Chairman that the Virginia Department of Health and the Virginia Department of Education collaborate with the National Eating Disorders Association, and other interested stakeholders, to study an evidence-based eating disorder screening program for potential implementation in Virginia's school systems. (JCHC staff will report back to the JCHC in 2012 regarding progress and staff recommendations for potential legislative implementation.)

Replicating James Madison University's Caregivers Community Network

In 2009, the Joint Commission conducted the study, *Improving Aging-at-Home Services and Support for Culture Change Initiatives*. JCHC members subsequently approved a policy option to include a staff study of the feasibility of replicating James Madison University's Caregivers Community Network in other areas of the Commonwealth. Since it was determined that one of the proposed policy options would be to introduce a budget amendment to fund demonstration grants for a two-year period presentation of the study was delayed until 2011 to correspond with the beginning of a two-year budget cycle.

Findings

The Caregivers Community Network is a cost-effective and award-winning program initiated in 2001 to address the need for affordable caregiver services by partnering with James Madison University (JMU). Services, such as personalized in-home companion care and errand running are provided for frail elders and their caregivers on a sliding fee scale; however, 71 percent of the clients are low-income and receive services free of charge. JMU students, as part of an elective course, and community volunteers are trained and assigned to families that have requested services; most of the program's budget needs are provided in-kind by JMU.

To encourage other universities and colleges in Virginia to establish their own Caregiver Community Network programs, it was recommended that two or three demonstration grants to provide two years of funding be awarded via a competitive process. The funding was expected to provide the university or college adequate time to develop and implement the program; after two years, the program was expected to be sustained using a combination of grants, student tuition, fundraising, and care-recipient fees.

Joint Commission Action

JCHC members voted not to take any action at this time.

Shaken Baby Syndrome/Abusive Head Trauma

House Joint Resolution 632, introduced by Delegate Glen Oder, was approved during the 2011 Session of the General Assembly. The resolution directed JCHC "to study the cost of Shaken Baby Syndrome and abusive head trauma in Virginia and identify best practices in reducing the incidence" of this type of intentional injury to children.

Findings

The National Center on Shaken Baby Syndrome defines shaken baby syndrome/abusive head trauma as "a term to describe the constellation of signs and symptoms resulting from violent shaking or shaking and impacting of the head of an infant or small child." Shaken baby syndrome (SBS) usually occurs in children under the age of two, but has been seen in children up to the age of five. Shaking typically happens when an angry parent or caregiver shakes a child to punish or quiet him/her during a period of inconsolable crying. The perpetrators are most often males and often are not the victim's father.

The majority of infants who survive severe shaking will have some form of neurological or intellectual disability; many will require lifelong medical care. Studies have shown that a number of victims of less severe shaking develop serious behavioral problems and may be placed in the foster care or juvenile justice systems.

JCHC staff worked primarily with the Virginia Department of Health, Virginia Department of Social Services, the Office of the Chief Medical Examiner and the Department of Medical Assistance Services in collecting statewide data on the incidence and costs of SBS to the Commonwealth. Mary Kay Goldschmidt, a graduate student at the University of Virginia, completed a complementary review that involved reviewing case studies and developing estimates of the costs associated with caring for specific SBS victims.

Incidence calculations vary between agencies as well as individual institutions and there is no universally accepted method or terminology used in calculating incidence. As such, our preliminary findings support the research of others that the incidence of SBS is under-reported. Additionally, the costs to the Commonwealth of caring for survivors of SBS are substantial and under-reported. As part of Ms. Goldschmidt's research, she reviewed the costs involved in assisting one SBS survivor who lived for two and a half years and found the actual cost to the Commonwealth was almost $240,000.

There are a number of established prevention programs, most of which seek to teach new parents how to handle their frustration when their infant cries for long periods of time.

These prevention programs typically have a hospital-based component which includes educational activities such as discussions with new parents, pamphlets, and videos describing the consequences of SBS and alternative ways to deal with frustration. While the hospital-based form of prevention is vital, additional prevention activities designed to reach men who are not the children's fathers and informal caregivers are needed also.

Joint Commission Actions

JCHC members approved two policy options:

- Request by letter of the chairman that the Departments of Health, Social Services, Behavioral Health and Developmental Services, Rehabilitative Services, and Education collaborate with other public and private sector stakeholders to identify current best practices, state-wide programs, surveillance and data, initiatives and interventions dedicated to addressing infant mortality in Virginia, including those efforts dedicated with specific attention to Shaken Baby Syndrome as a cause of infant mortality. The Virginia Department of Health, by July 1, 2013 and in collaboration with other agencies and stakeholders, shall submit a report to the Joint Commission on Health Care and the Virginia Disability Commission detailing these efforts with recommendations for improving public awareness and professional intervention and collaborative practices, and future program and policy development, supported by appropriate evaluation and outcome measures.

- Introduce a joint resolution to establish the third week of April as Shaken Baby Awareness Week in Virginia. The resolution would be in memory of Jared and the many other victims of Shaken Baby Syndrome in Virginia.

Legislative Action

House Joint Resolution 128 – Delegate Robert H. Brink

Designates the third week in April, in 2013 and in each succeeding year, as Shaken Baby Syndrome Awareness Week in Virginia.

HJR 128 was approved by both Chambers.

Involuntary Admission of Persons in Need of Substance Abuse Treatment

House Joint Resolution 682, introduced by Delegate John M. O'Bannon, III, directed JCHC to "(i) determine whether procedures for emergency custody, involuntary temporary detention, and involuntary admission for treatment are currently being used to commit persons with substance abuse or addiction disorders whose substance use creates a substantial likelihood that the person will cause serious physical harm to himself or others or suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs; (ii) if involuntary admission procedures are not being used for such purpose, determine whether individuals with substance abuse or addiction disorders might benefit from use of emergency custody, involuntary temporary detention, and involuntary admission procedures when statutory criteria are met; and (iii) if use of involuntary commitment procedures are found to offer potential benefits for persons with substance abuse or addiction disorders, provide recommendations for increasing the use of such procedures to protect the health and safety of individuals with substance abuse or addiction disorders and other residents of the Commonwealth." HJR 682 was left in the House Rules Committee with the understanding that JCHC members could choose to complete the review.

Findings

Although the *Code of Virginia* allows for its use, involuntary commitment for individuals in need of substance abuse treatment is not often used because the individual's behavior typically does not meet the commitment standard of imminent dangerousness. However, mandatory outpatient treatment (MOT) is potentially a better disposition for helping individuals with substance abuse disorder. The Commission on Mental Health Law Reform has discussed the merits of a "preventive MOT" to address the needs of individuals who do not meet the standard for involuntary commitment at that moment, but would without intervention. A preventive MOT might be particularly useful for individuals who have a serious substance abuse disorder.

In 2008, the Virginia General Assembly adopted civil commitment reforms that included changes designed to make MOT a more effective component of the process. While the use of MOTs generally decreased since the law came into effect, the community services board (CSB) in Prince William County actually increased its use of MOT:

> In general, MOT was used when the client was either "likely to harm self" or "lacking the capacity to protect self or provide for basic human needs." <u>Approximately one-third of the clients placed on MOT were required to receive substance abuse treatment services as well as services for mental illness.</u> CSB

representatives indicated that two aspects of their civil commitment process made MOT more feasible: they waited a full 48 hours before initiating the temporary detention hearing to give clients more time to consider and agree to treatment on an outpatient basis; and a second evaluation was completed immediately prior to the hearing to give the client another opportunity to express a willingness to participate in outpatient treatment. The MOT was found to meet the needs of clients who "fall somewhere in between inpatient care and dismissal" and the clients generally were very cooperative with treatment.

Joint Commission Actions

JCHC members voted to include in the 2012 work plan for the Behavioral Health Care Subcommittee, a study of whether mandatory outpatient treatment can be structured to address more effectively the needs of persons with substance abuse treatment. In addition, by letter of the Chairman, to request that representatives of the Department of Behavioral Health and Developmental Services, community services boards, and other interested parties participate in the study.

Regulation Changes for the Board of Pharmacy

Two bills, introduced by Delegate Thomas D. Rust to make changes in Board of Pharmacy regulations, were referred to JCHC by the Chairman of the House Committee on Health, Welfare and Institutions for further study of the issues addressed in the bills. HB 1961 would require the Board of Pharmacy "to promulgate regulations including the criteria for recusal of individual Board members from participation in any disciplinary proceeding involving a pharmacy, pharmacist or pharmacy technician with whom the Board member works, or by whom the member is employed." HB 1966 would allow "anyone to report to the Board of Pharmacy any information on a pharmacist, pharmacy intern, or pharmacy technician who may have substance abuse or mental health issues that render him a danger to himself or others."

Findings

Issues related to Board of Pharmacy regulations were brought to Delegate Rust's attention by a constituent whose infant was given an overdose of prescription medication because the prescription bottle was mislabeled. (Fortunately, it appears the infant suffered no permanent, long-term harm.) The constituent filed a complaint with the Board or Pharmacy. Since the complaint was resolved confidentially and the constituent was not informed of how the complaint was resolved, she was left feeling uncertain of whether a conflict of interest with a Board member could have existed.

HB 1961: *Recusal Required if Board Member Works for Same Pharmacy. A 2011 Survey of Pharmacy Law* found that no state requires a regulatory board member to recuse or otherwise disqualify himself based on being employed by the same pharmacy as the subject of a complaint. In fact, only Virginia had any language involving recusal in statute:

> The *Code of Virginia* § 54.1-110.B requires a member of any of the Boards within the Department of Health Professions to disqualify himself and "withdraw from any case in which he cannot accord fair and impartial consideration."

The current disciplinary process includes several opportunities for Board staff and members to identify conflicts of interest. Board of Pharmacy representatives indicated members tend to be overly cautious, very few complaints regarding conflict of interest and recusal have been made, and that more prescriptive language in statute would not be useful. However, the

Board of Pharmacy could improve its documentation by recording in the minutes of formal disciplinary hearings, a statement regarding any known conflict of interest or recusal of a Board member participating in the hearing. There are also opportunities for the Board to keep complainants informed of Board activities that are being undertaken to address their complaints. It is especially important to inform complainants that some actions taken by the Board that are confidential and consequently are not made public.

HB 1966: *Reporting on Substance Abuse or Mental Health Issues*. Current law (*Code* § 54.1-2400.8) already allows any person to report to the Board of Pharmacy or Department of Health Professions on any health care practitioner regarding unprofessional conduct or competency with immunity "unless such person acted in bad faith or with malicious intent." The Board of Pharmacy went further in 2008 by voting to support legislation requiring mandatory reporting for pharmacies and pharmacists that mirrored the requirements in place for hospitals.

The Board received public comment from the National Association of Chain Drug Stores opposing the legislative proposal; the comment stated, in part:

> "A preferable approach…is to make reporting known and suspected problems *voluntary*, and to provide a safe harbor from board disciplinary actions if the licensee experiencing the problem voluntarily reports to the board and agrees to undergo treatment under the Virginia Department of Health's Health Practitioners' Intervention Program."

Legislation to expand this type of mandatory reporting to pharmacies and pharmacists has not been introduced.

Joint Commission Action

Commission members voted to provide a written report of the study findings to the Chairman of the House Committee on Health, Welfare and Institutions and the bill patron without taking any other action.

Chronic Health Care Homes

House Joint Resolution 82 was introduced during the 2010 General Assembly by Delegate Patrick A. Hope. The resolution directed JCHC to complete a two-year study of "the feasibility of developing chronic health care homes in the Commonwealth."

Findings

Chronic diseases are the most prevalent, most costly and most preventable of illnesses. According to the Centers for Disease Control and Prevention, chronic diseases are a leading cause of adult disability and death in the U.S.; accounting for 70 percent of all deaths and more than 75 percent of the nation's $2 trillion in medical care costs. The fragmented way in which medical care is typically delivered means patients with multiple chronic conditions usually receive care from multiple providers working independently and therefore in a less effective, more costly manner. By contrast, "optimal care for people with chronic disease involves coordinated, continuous treatment by a multidisciplinary team." (Ann Tynan and Debra A. Draper, "Getting What We Pay For: Innovations Lacking in Provider Payment Reform for Chronic Disease Care" by *Health System Change* Research Brief No. 6 June 2008). The patient-centered medical home (PCMH) involves a team-based model of care in which a personal physician leads a team of providers responsible for planning and delivering ongoing care for the "whole person."

Patient-Centered Medical Home Initiatives. When HJR 82 was introduced in 2010, the concept of a PCMH was just beginning to gain attention. Since that time, there has been substantial growth in the development PCMH pilot programs, indicating that medical homes may become a useful, sustainable model. A number of initiatives are underway in the Commonwealth.

National Academy of State Health Policy Grants. In September 2009, the National Academy of State Health Policy (NASHP) awarded eight states, including Virginia, with a grant from The Commonwealth Fund to develop and implement policies that increase Medicaid and CHIP program participants' access to high performing medical homes. DMAS partnered with Southwest Virginia Community Health Systems, Community Care Network of Virginia, and Carillion to determine whether a Medicaid primary care case management program in southwestern Virginia could transition into a medical home pilot. The medical home pilot would provide primary care, behavioral health, disease and case management, and other services with a targeted population that would include the aged, blind and disabled as well as low-income families with children. As of November 2011, DMAS had modified its managed care contract language to support managed care participation in a PCMH pilot.

Virginia Innovation Center. A Virginia Innovation Center, established as a nonprofit center hosted by the Virginia Chamber of Commerce "will serve as a resource in Virginia by:

- Researching and disseminating knowledge about innovative models of health promotion and health care to Virginia employers, consumers, providers, health plans, public purchasers, and communities;
- Developing multi-stakeholder demonstration projects aimed at testing innovative models of health promotion and health care; and,
- Helping Virginia employers, providers, purchasers, health plans, and communities accelerate their pace of innovation for the benefit of Virginians." (Description sent to JCHC staff by Health and Human Resources Secretariat staff in August 2010.)

Virginia Primary Care Physicians. Medical home initiatives are being undertaken by physician practices across Virginia. The Family Medicine Group in Vinton was the first practice in Virginia to be certified as a PCMH. Now, 18 Carillion physician practices in the Roanoke and New River Valley areas are recognized as NCQA Level-3 (highest) PCMHs. Additionally, an increasing number of practices in the Hampton Roads area are transforming themselves into PCMHs. Physicians and faculty of Eastern Virginia Medical School and several Sentara practices are in the application process for recognition as a medical home.

Joint Commission Action

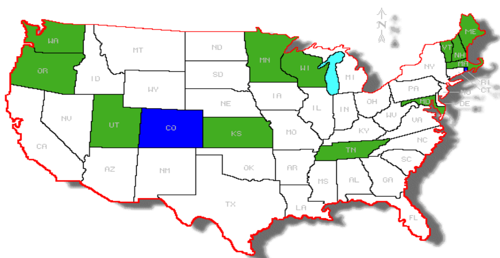
Commission members voted to continue monitoring the progress of primary care medical homes and other health care innovations in Virginia by including reports on initiatives in the 2012 work plan of the Healthy Living/Health Services Subcommittee.

All-Payer Claims Databases

A Joint Commission on Health Care report, *Catastrophic Health Insurance* House Document No. 3 (2011), included a policy option to review establishing an All-Payer Claims Database in Virginia. The Joint Commission study was undertaken in 2011.

Findings

All-Payer Claims Databases (APCDs) are large-scale databases that manage systematically-collected health care claims data. Examples of information that may be collected from private (health insurance) and public (Medicare, Medicaid, Veterans Administration) payers include: medical, pharmacy, and dental claims as well as eligibility and provider information.



Twelve states currently have an APCD and two states are in the process of implementing such databases.

The JCHC study revealed that data analyses, using the information collected within All-Payer Claims Databases, can provide useful information in such areas as health care costs, quality, and efficiency; geographic differences related to access and utilization; and overall system utilization.

Some of the specific ways that APCD-supported analyses have been used in other states include:[1]

- Helping employers understand variations in the cost and utilization of services by geographic area and in different provider settings (Maine, New Hampshire).
- Exploring value (cost and quality) for services provided (New Hampshire).
- Informing design and evaluation plans for payment reform models (New Hampshire, Vermont).
- Evaluating the effect of health reforms on the cost, quality, and access to care in a state (Maryland, Vermont).
- Comparing utilization patterns across payers to inform state purchasing decisions for Medicaid (New Hampshire) and identifying successful cost containment strategies (New Hampshire, Vermont).

Joint Commission Action

Commission members voted to introduce legislation to create an All-Payer Claims Database while specifying that the governance-structure should be housed within the nonprofit

[1] Patrick Miller, Denise Love, Emily Sullivan, Jo Porter and Amy Costello, *All-Payer Claims Databases: An Overview for Policymakers*, Academy Health & State Coverage Initiatives, May 2010.

organization, Virginia Health Information; that data collection should adhere to national reporting standards for medical claims; and that reporting of health insurance claims data should be made on a mandatory rather than voluntary basis.

Legislative Action

House Bill 343 – Delegate John M. O'Bannon, III/**Senate Bill 135** – Senator Linda T. Puller
Amend *Code of Virginia* Title 32.1, Chapter 7.2 to expand health data collected in order to develop an All-Payer Claims Database.

Both bills were amended several times: the Senate substitute for HB 343 was approved by both Chambers. SB 135 was eventually referred to a committee of conference and the conference report was agreed to by both Chambers; *Acts of Assembly*, Chapter 693 and 709 respectively.

Public Access to Vital Records

Senate Bill 865, introduced by Senator Harry B. Blevins, sought to make genealogical records in Virginia more accessible to the public by amending the *Code of Virginia* § 32.1-271(D) to require the State Registrar to make birth, death, marriage, and divorce records available to the public when statutory timeframes for privacy expire. (Currently the *Code* reads that the records may become public information.) SB 865 was passed by indefinitely in the Senate Committee on Education and Health and a letter was sent to the Joint Commission on Health Care requesting the submission of a written report to the Chair of the Senate Education and Health Committee, the bill patron, and the Senate Clerk's Office.

Findings

The Office of Vital Records, which is housed in the Virginia Department of Health and supervised by the State Registrar, is the primary repository of vital records in the Commonwealth. *Code of Virginia* § 32.1-271(D) establishes the following timeframes for the public release of records maintained by the State Registrar:

Birth records – 100 years after the date of birth
Death, marriage, and divorce records – 50 years after the date of occurrence

State statute and regulations provide that certain family members are allowed to access vital records prior to their public release by presenting valid identification and paying a $12 processing fee. Specifically immediate family may access all types of records, grandparents may request birth records by presenting evidence of need, and grandchildren and great grandchildren may access death records.

In addition, the Library of Virginia maintains birth, death, and marriage registers for 1853-1896 which may be accessed by the public, while local circuit courts maintain marriage and divorce records which are open for public inspection.

Concerns Related to Public Access

Allowing public access to vital records is a policy decision which requires balancing the competing priorities of the privacy of an individual's records and public access to those records. Concerns related to allowing increased public access include: identity theft, the privacy of personal and family records, and potential loss of revenue for the Office of Vital Records.

Identity Theft. Considering that so much personal information is available already through Internet searches, the primary concern relates to the fact that vital records often include

Social Security numbers. To some extent, Social Security numbers are available online and within Virginia court records. Furthermore, Social Security numbers may be redacted from records and indexes.

Privacy of Personal and Family Records. Although a great deal of personal information is already available via Internet search, there are instances such as highly-publicized events (such as the 9-11 attack or Virginia Tech shootings) or causes of death that families might prefer remain private.

Potential Loss of Revenue for the Office of Vital Records. The Office's operations are funded by fees collected when searches and copies of vital records are requested; in FY 2010, $4.4 million in fees was collected. It is unclear what the financial impact of increasing public access to vital records would be; however, the demand for official birth, marriage, divorce, annulment, and death records is likely to continue.

Potential Operational Enhancements. The Office of Vital Records does not have a complete index or digitized copies of all its vital records. Constructing an index and digitized records would be time-consuming and costly for the Office to undertake, but would allow records to be published online. There are alternatives to the Office directly completing the necessary tasks; for instance, Ancestry.com officials have indicated a willingness to create an index and/or digitized records at no expense to the Commonwealth.

Joint Commission Actions

The Commission members approved policy options to introduce legislation to change the time period that marriage, divorce, and annulment records and the time that death records "in the custody of the State Registrar may become public information" from 50 years to 25 years.

Legislative Action

Senate Bill 309 – Senator Harry B. Blevins
Amend *Code of Virginia* § 32.1-271(D) to reduce the period of time that must pass before records related to marriages and divorces may become public information from 50 years to 25 years and provides that annulments may become public information after 25 years.

Senate Bill 310 – Senator Harry B. Blevins
Amend *Code of Virginia* § 32.1-271(D) to reduce the period of time that must pass before death records may become public information from 50 years to 25 years.

House Bill 272 – Delegate Christopher K. Peace
Amend *Code of Virginia* § 32.1-271(D) to reduce the period of time that must pass before records related to deaths, marriages, and divorces may become public information from 50

years to 25 years and provides that annulments may become public information after 25 years.

HB 272 passed both Chambers on unanimous votes. *Acts of Assembly*, Chapter 16

SBs 309 and 310 were tabled by voice vote in the House Committee on Health, Welfare and Institutions.

Senate Bill 660 (Blevins) which included the provisions of SBs 309 and 310, as well as additional provisions, passed the House of Delegates 94-4 and the Senate 40-0; *Acts of Assembly*, Chapter 356.

Meeting Presentations and Documents

Joint Commission on Health Care

May 17, 2011	Proposed JCHC Work Plan/2011 Kim Snead, Executive Director
	Proposed BHC Subcommittee Work Plan/2011 Kim Snead
	Proposed HL/HS Subcommittee Work Plan/2011 Stephen W. Bowman , Senior Staff Attorney/Methodologist
	Staff Report: Replicating JMU Caregivers Community Network Michele L. Chesser, Ph.D., Senior Health Policy Analyst
June 14, 2011	2011 Plans for the Virginia Health Reform Initiative The Honorable William A. Hazel, Jr. Secretary of Health and Human Resources
	Should Virginia Create a Health Insurance Exchange? Michael F. Cannon, Director of Health Policy Studies Cato Institute
	Joint Subcommittee Studying Strategies and Models for the Prevention and Treatment of Substance Abuse Sarah E.B. Stanton, Senior Staff Attorney Virginia Division of Legislative Services
	Staff Report: All-Payer Claims Databases Stephen W. Bowman
September 19, 2011	Nurse Staffing Requirements in Virginia's Nursing Facilities Marissa J. Levine, M.D., MPH, Deputy Commissioner for Public Health and Preparedness Virginia Department of Health
	Staff Reports: Involuntary Admission of Persons in Need of Substance Abuse Treatment (HJR 682) Jaime H. Hoyle, Senior Staff Attorney/Health Policy Analyst
	Adding Pseudoephedrine as a Schedule III Controlled Substance (SB 878) Michele L. Chesser, Ph.D.
	Potential Regulation Changes for the Board of Pharmacy (HB 1961 & HB 1966) Jaime H. Hoyle

October 17, 2011	VHI 2011 Annual Report & Strategic Plan Update David D. Adams, President of Board of Directors Michael T. Lundberg, Executive Director Virginia Health Information
	Staff Reports: Study of Shaken Baby Syndrome and Abusive Head Trauma (HJR 632) Jaime H. Hoyle
	Mary Kay Goldschmidt, RN, BSN, CCM, CLCP, UVA School of Nursing Graduate Student, Public Health Nursing Leadership
	Update on All-Payer Claims Databases Stephen W. Bowman
	Involvement of Virginia's Cancer Centers in Research and Treatment Michele L. Chesser, Ph.D.
	Interim Report: Access to Oral Chemotherapy Medications (HJR 566) Jaime H. Hoyle
November 22, 2011	Decision Matrix: Review of Policy Options and Legislation for 2012 JCHC Staff

Behavioral Health Care Subcommittee

May 17, 2011	Update: Department of Justice Investigation Keith Hare, Deputy Secretary Health and Human Resources
	Department of Behavioral Health and Developmental Services Updates: Community Capacity Expansion for Individuals with Intellectual Disability Heidi R. Dix, Assistant Commissioner of Developmental Services
	Recent Centers for Medicare and Medicaid Services (CMS) Actions Olivia J. Garland, Ph.D., Deputy Commissioner
	Commentary on Behalf of the Virginia Network of Private Providers Jennifer Fidura
October 17, 2011	Interim Progress Report: Temporary Detention Order Barriers G. Douglas Bevelacqua, Inspector General Office of the Inspector General for Behavioral Health and Developmental Services
	Licensing of Community Facilities Providing Behavioral Health Care Services Dr. Les Saltzberg, Director of Licensure Department of Behavioral Health and Developmental Services
	The Campaign for Children's Mental Health Margaret Nimmo Crowe, Coordinator Campaign for Children's Mental Health

Healthy Living/Health Services Subcommittee

September 19, 2011	Governor's Lyme Disease Task Force: Review and Summary Keri Hall, M.D., M.S., Director of Epidemiology Virginia Department of Health
	Enhancing Medicaid Direct and Indirect Education Payments William J. Lessard, Jr., Director, Provider Reimbursement Department of Medical Assistance Services
	Staff Reports: Study of Eating Disorders in the Commonwealth (SJR 294) Michele L. Chesser, Ph.D.
	Public Access to Vital Records (SB 865) Stephen W. Bowman
	Chronic Health Care Homes (HJR 82- 2010) Jaime H. Hoyle
November 22, 2011	Virginia Health Reform Initiative: Response to HB 2434 The Honorable William A. Hazel, Jr. Secretary of Health and Human Resources
	The following presentations were originally scheduled to be heard in the Behavioral Health Care Subcommittee:
	Virginia College Mental Health Law Study: Legislative Recommendations Susan M. Davis, Associate Vice President for Student Affairs University of Virginia
	Progress Report on Mental Health Law Reform Richard J. Bonnie, L.L.B., Chair Commission on Mental Health Law Reform

Statutory Authority

§ 30-168. (Expires July 1, 2015) 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. (Expires July 1, 2015) 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. (Expires July 1, 2015) 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. (Expires July 1, 2015) 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. (Expires July 1, 2015) 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.
(2003, c. 633.)

§ 30-168.5. (Expires July 1, 2015) 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. (Expires July 1, 2015) 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, c296.)

§ 30-170. Expires July 1, 2015) Sunset.
The provisions of this chapter shall expire on July 1, 2015.
(1992, cc. 799, 818, § 9-316; 1996, c. 772; 2001, cc. 187, 844; 2006, cc. 113, 178; 2009, c. 707; 2011, cc. 501, 607.)

Joint Commission on Health Care

900 East Main Street, 1st Floor West

P O Box 1322

Richmond, VA 23218

804.786.5445

jchc.virginia.gov