

JOINT COMMISSION ON HEALTH CARE



2012 Annual Report of the Joint Commission on Health Care

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA



REPORT DOCUMENT 102

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RICHMOND
2013



COMMONWEALTH of VIRGINIA

Joint Commission on Health Care

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Chairman

Kim Snead
Executive Director

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May 21, 2013

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

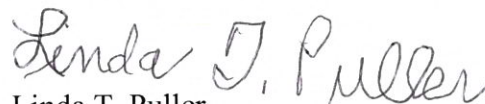
Members of the Virginia General Assembly
General Assembly Building
Richmond, Virginia 23219

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, 2012.

This report includes a summary of the Joint Commission's activities including legislative recommendations to the 2013 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,


Linda T. Puller

Joint Commission on Health Care

Membership



Senate of Virginia

The Honorable Linda T. Puller, Chair

The Honorable George L. Barker
The Honorable Harry B. Blevins
The Honorable Charles W. Carrico, Sr.
The Honorable L. Louise Lucas
The Honorable Stephen H. Martin
The Honorable Jeffrey L. McWaters
The Honorable Ralph S. Northam



Virginia House of Delegates

The Honorable John M. O'Bannon, III, Vice-Chair

The Honorable Robert H. Brink
The Honorable David L. Bulova
The Honorable Benjamin L. Cline
The Honorable Rosalyn R. Dance
The Honorable T. Scott Garrett
The Honorable Algie T. Howell, Jr.
The Honorable Riley E. Ingram
The Honorable Christopher K. Peace
The Honorable Christopher P. Stolle

The Honorable William A. Hazel, Jr.
Secretary of Health and Human Resources

Staff

Kim Snead
Executive Director

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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. In 2012, the Joint Commission welcomed five new members:



Senator Charles W. Carrico, Sr.
40th Senate District



Senator Stephen H. Martin
11th Senate District



Senator Jeffrey L. McWaters
8th Senate District



Delegate Riley E. Ingram
62nd House District



Delegate Christopher P. Stolle
83rd House District

During the JCHC meeting on June 6, 2012, Senator Linda T. Puller was elected Chair and Delegate John M. O’Bannon, III was elected Vice Chair of the Commission. Senator Puller subsequently appointed Senator L. Louise Lucas and Delegate Christopher P. Stolle to serve as co-chairs of the Behavioral Health Care Subcommittee and Senator Harry B. Blevins and Delegate Robert H. Brink as co-chairs of the Healthy Living/Health Services Subcommittee.

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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 authorized in approved work plans, the following presentations were made to the Joint Commission and its Subcommittees in 2012. The meeting presentations, documents, and minutes are posted on the Commission website (jchc.virginia.gov).

Joint Commission on Health Care

The Joint Commission held four meetings in 2012. During the meeting in September, Secretary William A. Hazel, Jr. discussed Virginia’s settlement agreement with the U.S. Department of Justice. Secretary Hazel listed the milestones that have been achieved as well as the remaining issues to be addressed in preparing the community-based system for individuals with intellectual and/or developmental disabilities.

During the meeting in October, Alfred D. Hinkle, Jr., President of the Board of Directors and Michael Lundberg of Virginia Health Information presented the organization’s *2012 Annual Report and Strategic Plan*.

Staff reports presented to the Joint Commission addressed the following topics:

JCHC 2012 MEETINGS
 June 6
 September 18
 October 16
 November 7

- Health Care Compact
- Regulation of Surgical Assistants and Surgical Technologists
- Cost Sharing and Specialty Tier Pricing of Prescription Medications
- Opt-Out Program for Organ, Eye, and Tissue Donation
- Rural Obstetrical Care in Virginia
- Interim Report: Fiscal Impact of Untreated Dental Disease
- Regulation of Naturopaths

Behavioral Health Care Subcommittee

Meetings of the Behavioral Health Care Subcommittee were held on June 28 and October 16. Inspector General Douglas Bevelacqua provided an overview of the work of the OIG for Behavioral Health and Developmental Services.

Commissioner James W. Stewart, III discussed the challenges faced by the behavioral health care system, and the 11 priority needs identified in the *Creating Opportunities* strategic plan.

Richard J. Bonnie, L.L.B. reviewed the issue of increasing the maximum time period of temporary detention orders from 48 to 72 hours and recommended

BHC Subcommittee Members

Co-Chairs
Senator L. Louise Lucas
Delegate Christopher P. Stolle

Senator George L. Barker
 Senator Charles W. Carrico, Sr.
 Senator Ralph S. Northam
 Senator Linda T. Puller

Delegate Robert H. Brink
 Delegate David L. Bulova
 Delegate Rosalyn R. Dance
 Delegate T. Scott Garrett
 Delegate Algie T. Howell, Jr.
 Delegate Riley E. Ingram
 Delegate John M. O’Bannon, III



making the change in statute. Two staff reports were presented to the Subcommittee addressing:

- Mandatory Outpatient Treatment for Chronic Substance Abuse Disorder
- Potential Expansion of the Health Practitioners’ Monitoring Program

Healthy Living/Health Services Subcommittee

The Healthy Living/Health Services Subcommittee met twice during 2012; on June 6 and September 18. Presentations heard by the Subcommittee included:

- A discussion of the Virginia Chamber of Commerce’s focus on health care by Bob Cramer.
- An update on the Virginia Health Information Exchange by Kimberly Barnes of VDH.
- A description of the University of Virginia’s interprofessional health education between nursing and medical students by Dorrie K. Fontaine, PhD, RN, FAAN, and Valentina Brashers, MD, FACP, FNAP.
- An update regarding the work of the UVA Center for Telehealth by Karen Rheuban, M.D.
- An update, by State Health Commissioner Karen Remley, regarding collaborative efforts to address the challenges faced by the AIDS Drug Assistance Program.
- A report by Robin Hills, with the VCU School of Nursing, on expedited partner therapy as an option in treating chlamydia and gonorrhea.
- An overview, by Beth Bortz, of the Virginia Center for Health Innovation which will be established as a nonprofit corporation governed by a Board of Directors.
- A presentation on the importance of providing respite services to support the family and friends who provide uncompensated care to their family members by Courtney Tierney, Director of the Prince William Area Agency on Aging.

HL/HS Subcommittee Members

Co-Chairs

Senator Harry B. Blevins
Delegate Robert H. Brink

Senator George L. Barker
Senator Ralph S. Northam
Senator Linda T. Puller

Delegate David L. Bulova
Delegate Rosalyn R. Dance
Delegate T. Scott Garrett
Delegate Riley E. Ingram
Delegate John M. O’Bannon, III
Delegate Christopher K. Peace
Delegate Christopher P. Stolle

Two staff reports were presented to the Healthy Living/Health Services Subcommittee:

- Why Is Respite Important for Caregivers?
- Fiscal Impact: Medicaid Eligibility and Uncompensated Asset Transfers

Staff Activities

In 2012, 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

All-Payer Claims Database Workgroup, Participant

Children’s Health Insurance Program Advisory Committee - Data Review Subcommittee

National Center for the Analysis of Healthcare Data, Advisory Board

Virginia Chamber of Commerce Employer Health Care Subcommittee, Advisor

Virginia Commonwealth University’s Department of Health Administration, Adjunct Professor

Virginia Health Innovation Plan, Improving Transparency and Availability of Data Innovation

Team, Advisor

Virginia Telehealth Network, Board Member



Staff also made presentations to:

Appalachian School of Pharmacy
Allied Health Caucus of the General Assembly
Randolph Macon College, Class within Sociology Department
Richmond/Central Virginia Community Forum
Virginia Bar Association, Cancer Research, Prevention and Care in Virginia and Health Care Section at their Annual Health Law Extravaganza
Virginia Chamber of Commerce Employer Health Care Subcommittee
Virginia Commonwealth University, classes within School of Allied Health Professions and School of Social Work
VCU Health Care Politics and Policy Class

JCHC staff attended:

Commonwealth of Virginia Process Innovation Workshop
Connect Virginia meetings
Mid-Atlantic Telehealth Resource Center Summit
Virginia Bar Association - Health Law Roundtable
Virginia Chamber of Commerce
Virginia Health Care Conference
Virginia Health Reform Initiative meetings
Virginia Oral Health Coalition - Oral Health Summit
Virginia Oral Health Coalition - Oral Health and Teledentistry Conference
Virginia State Bar Conference

In addition, one staff member graduated from the Virginia Executive Institute and another staff member gave an interview on eating disorders for Richmond's NBC Channel 8.





Executive Summaries

During 2012, 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 studies were completed.

Health Care Compact

House Bill 264, introduced by Delegate Christopher K. Peace during the 2012 General Assembly Session, sought to amend Title 32.1, Chapter 17 of the *Code of Virginia* to establish the Interstate Health Care Compact. Enacting HB 264 would allow Virginia to join other member states in requesting Congressional consent to regulate health care within state borders; suspend “the operation of any conflicting federal laws, rules, regulations, and orders within their states”; and secure federal funding. HB 264 was continued in the House Committee on Rules until 2013 and Delegate Peace requested that the Joint Commission on Health Care conduct an informational study regarding the Interstate Health Care Compact.

Findings

The Interstate Health Care Compact (HCC), which allows for expansive authority and responsibility for health care regulation by member states, would increase state political power and therefore requires Congressional approval. The HCC seeks to transfer primary responsibility for health care policy and funding to state governments. Under the HCC, except for federal military-related care, states would have the ability to override any federal law, regulation, or funding decision; and in turn, those states would accept responsibility for funding state and federal health care obligations and receive federal block grant funding. In consideration for accepting the funding responsibilities, the federal government would be expected to provide an annual block grant to each HCC-member state.

In 2010, advocates of the compact formed the Health Care Compact Alliance. The Alliance supports efforts to pass HCC-legislation in states.¹ As of December 2012, 25 states had considered joining the HCC with seven states enacting legislation.² The HCC envisions significant expansion of state power to regulate health care within that member state's borders. Unless superseded by state law, the obligation extends to all non-military, federal programs including Medicare, Medicaid, and the State Children's Health Insurance Program. The HCC stipulates that the federal government will provide funding to each state based on its total federal health care spending during federal fiscal year 2010 with annual adjustments for inflation and population.

There are concerns regarding the funding formula and whether its adjustment factors for inflation and population will allow states to fund their health care needs in the coming years. Although the HCC includes specific, operational provisions, there is significant uncertainty regarding actual implementation. Congress does not have to approve the compact as written and could

¹ See Health Care Compact Alliance website at <http://healthcarecompact.org>.

² Some States Pursue Health Care Compacts, *National Conference of State Legislatures* at <http://www.ncsl.org>.



require extensive changes during the Congressional consent process. Moreover, if the compact were to receive Congressional approval, there are still many unanswered questions. It is expected that a request for Congressional consideration of the HCC will only be made, if a relatively large number of states approve the compact.

Joint Commission Action

No policy options were developed by staff; Delegate Peace requested the study on an information-only basis.

Regulation of Surgical Assistants and Surgical Technologists

Senate Bill 313 introduced by Senator Harry B. Blevins was continued in Senate Education and Health until 2013 and referred to JCHC for study. Senate Bill 313 would establish requirements for the Board of Medicine to license surgical assistants and certify surgical technologists. Currently, there are no regulatory requirements placed on individuals who perform as surgical assistants or surgical technologists in Virginia.

Findings

In 2010, the Board of Health Professions initiated an exhaustive review as requested by surgical assistants and surgical technologists and as part of the Board's ongoing review regarding regulation of "emerging health professions." The Board's findings on degree of risk included:

- "The unregulated practice of **surgical assistants** poses a high risk of harm to patients which is directly attributable to the nature of the practice.... Although surgical assistants practice with surgeons, the nature of their work requires independent judgment, knowledge and competence. Therefore **licensure** is the least restrictive means of protecting the public and ensuring the minimum qualifications of surgical assistants."
- "The unregulated practice of **surgical technologists** poses a moderate potential harm....attributable to the nature of certain advanced tasks, and the inherent hazards and patient vulnerability associated with surgery and infection....While much of the work...is supervised...the nature of the risks and tasks require independent competence and judgment" such that **mandatory certification** should be required for surgical technologists. (*VA Board of Health Professions Study, July 2010, pp. iv-v.*)



The Board of Health Professions recommended, in part, that the Board of Medicine should:

- "establish a license for surgical assistants"
- "require mandatory certification for surgical technologists"
- "identify training programs and military occupational specialties that impart the necessary skills, knowledge and competence and allow military-trained surgical technologists and surgical assistants to practice in Virginia"

However, no legislative action was taken to adopt those recommendations.

Only two states (Illinois and Texas) and the District of Columbia license surgical assistants (although Texas exempts from licensure those surgical assistants who are employed by hospitals and practice under the delegated authority of a physician). Kentucky is the only state that has certification requirements for surgical assistants, although surgical assistants who are employed by hospitals and practice under the direct supervision of a registered nurse are exempt from the certification requirements. Colorado is the only state that requires surgical assistants to register. Six states (Illinois, Indiana, New Jersey, South Carolina, Tennessee, and Texas) have certification requirements for surgical technologists. Colorado and Washington require surgical technologists to register.

Joint Commission Action

JCHC provided a written report to the Senate Committee on Education and Health without taking further action.



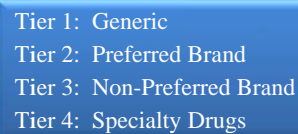
Cost Sharing and Specialty Tier Pricing of Prescription Medications

House Joint Resolution 579 (2011) introduced by Delegate John M. O'Bannon, III directed the Joint Commission on Health Care to conduct a two-year study to determine the impact of cost sharing, coinsurance and specialty tier pricing on access to prescription medications for chronic health disorders; and to identify and evaluate options for reducing any negative impacts of cost sharing, coinsurance and specialty tier pricing, including but not limited to statutory limitations on cost sharing obligations for prescription medications.

Findings

In the United States, 88 percent of workers covered by an employee-sponsored health insurance plan have a tiered cost-sharing formulary for their prescription drugs. Traditionally, formularies consisted of three tiers or less; however, an increasing number of plans have created a fourth tier of drug cost sharing, often referred to as a specialty tier, primarily for expensive drugs.

Originally developed as part of Medicare Part D, specialty tiers are now utilized by the majority of commercial health insurance plans.



Tier 1: Generic
Tier 2: Preferred Brand
Tier 3: Non-Preferred Brand
Tier 4: Specialty Drugs

Cost-sharing structures vary among health insurance plans, but most require enrollees to pay a set co-payment for drugs in tiers 1 through 3 and a percentage of the drug's cost (ranging from 10 to 40 percent) for those in the fourth/specialty tier. Individual insurers or payers determine whether a drug is placed on a specialty tier.

While no standard definition exists for specialty drugs, most are biologics (derived from living organisms, in contrast to being made from chemical compounds). Biologics are used to treat complex conditions; are administered by injection, infusion, inhalation, or orally; and are very expensive. On average, the monthly cost for a specialty drug is \$1200; and while specialty tier drugs are prescribed for only 1 percent of commercial health plan enrollees, they account for 12 to 16 percent of commercial pharmacy-benefit drug spending.

Examples of health conditions often treated by using specialty drugs include inflammatory conditions (such as rheumatoid arthritis and Crohn's disease), multiple sclerosis, cancer, HIV, blood disorders, and hepatitis C.



Although specialty drugs generally are quite expensive, other factors to consider include:

- The original intent of drug tiers, to provide incentives for consumers to consider costs when making health care decisions, is not applicable for specialty drugs for which there are no suitable, less expensive alternatives. Instead, drug tiering has created a structure where those who are most sick are required to pay more.
- Specialty tier pricing may not be cost effective for employers in the long run due to increased medical costs that can result from decreases in treatment adherence.
- The number of conditions that can be treated with specialty drugs—and thus the number of patients eligible for treatment with these high-cost drugs—are expected to increase significantly over the next ten years and beyond.



- Biosimilars (generic versions of biologic drugs) are expected to reduce drug costs, but their impact will not be seen for many years. Furthermore, biosimilars will not reduce drug costs as much as conventional generic drugs. Due to the complexity of the manufacturing process, biosimilars likely will still be far more expensive than most conventional drugs.

Joint Commission Action

Introduce legislation requiring qualified health plans to allow individuals who are expected to incur costs in excess of the cost-sharing limits set by the federal Affordable Care Act, the option of paying their capped out-of-pocket amount in 12 equal installments over the course of the year.

Legislative Action

Senate Bill 945 - Senator Linda T. Puller

House Bill 2030 - Delegate Christopher K. Peace

Amend *Code of Virginia* Title 38.2, to require that qualified health plans allow enrollees, who are expected to have annual prescription medication costs in excess of their expected cost-sharing obligation, to request and set up equal monthly payments to reach that obligation over the plan year.

Senate Bill 945 was tabled in the House Committee on Health, Welfare and Institutions

House Bill 2030 was left in the House Appropriations Committee

Opt-Out Program for Organ, Eye, and Tissue Donation

House Joint Resolution 19 (Delegate John M. O'Bannon, III) directed JCHC to study options for establishing an opt-out program for organ, eye, and tissue donation in the Commonwealth.

Findings

There is a need to increase the availability of organs for donation. According to Donate Life America:

- As of July 2012, there were 114,712 patients waiting for an organ donation.
- Every 10 minutes another name is added to the national organ transplant waiting list.
- Approximately 6,000 people die waiting for a transplant each year.
- While 90% of Americans say they support donation, only 30% know the essential steps to become a donor.

Virginia operates by an opt-in, or voluntary consent, organ donation process. In recognition of individual rights and voluntarism, the process is governed by the Uniform Anatomical Gift Act which provides:

- Any person older than 18 can make a gift, effective upon death, of all and any part of his/her body.
- When the deceased has not expressly made a gift or expressly objected to donation during his/her lifetime, the deceased's family can make a gift.
- Expressly allows gifts to be made by will, effective immediately upon death, or by donor card, and can be revoked at any time.



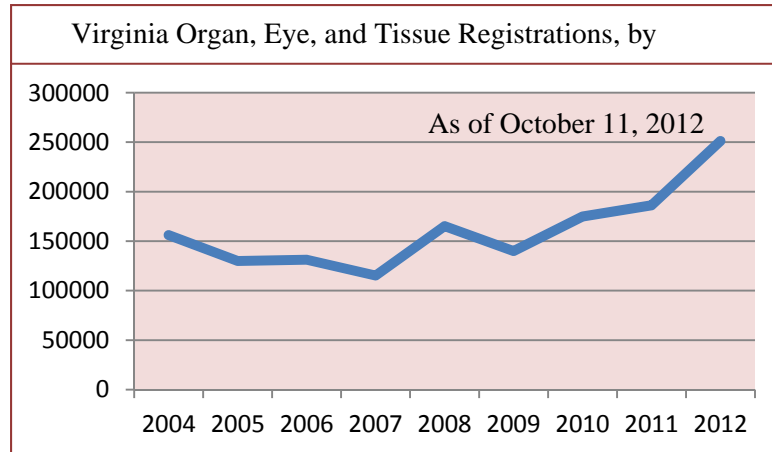
To be a donor in Virginia, an individual can either register to be an organ, eye, or tissue donor on the Virginia Registry – DonateLifeVirginia.org. or say “yes” to donation at the Department of Motor Vehicles which will place the individual on the DonateLifeVirginia.org registry. (To remain on the donor registry, individuals must check “yes” to donation every time they renew their driver’s licenses or state identification card).

Presumed Consent. Because the need for organ, eye, and tissue donations surpasses the supply, some argue for a presumed consent donation system which presumes a person has consented to organ, eye, and tissue recovery if he/she has not registered a refusal. Advocates indicate such a system would improve efficiency and increase supply; reflect the opinion of the vast majority who favors organ donation; and maintain individual autonomy in the ability to opt-out, while focusing more on the needs of those on the donation waiting list.

A number of European countries (Austria, Belgium, Denmark, France, and the Netherlands) have implemented a presumed consent system. After these countries implemented a presumed consent system, the supply of organs did increase; however, research is unclear as to whether other factors played a bigger role than the policy of presumed consent. For example, in many countries these laws are rarely enforced and family consent is always or often required before organs are extracted.



A recent study conducted by the Association of Organ Procurement Organizations indicates that the United States already has higher donation rates than any of the countries with presumed consent systems. Furthermore, organ, eye, and tissue registrations in the United States and specifically, in Virginia, continue to increase.



Opposition to Presumed Consent. If Virginia were to switch to a presumed consent system, it would be the first state in the country to do so. To date, presumed consent legislation, considered by other states (including Colorado, Delaware, Illinois, Pennsylvania, and New York) has not been enacted. Presumed consent donation efforts have been opposed by Donate Life California and other organizations whose primary goal is to increase organ donation and recovery rates. Opposition to presumed consent in the United States has been based on the opinion that the current system seems to be working well. Furthermore, because the majority of U.S. citizens favor individual autonomy, there is a fear that moving to a presumed consent system would result in a decrease in organ donations.

Joint Commission Action

JCHC members voted to take no action.

Rural Obstetrical Care in Virginia

By letter request, Delegate David A. Nutter and Senator Ralph S. Northam asked that JCHC update the recommendations from the Governor's 2004 Working Group on Rural Obstetric Care. The working group's objectives were to assess the level of maternal and infant health in rural populations, determine the factors influencing access to and utilization of obstetrical services in these areas, and identify programs with the potential to address barriers to access and utilization of obstetrical services in the State's rural areas.

Findings



The infant mortality rate in Virginia has decreased from 7.4 per 1000 live births in 2004 to 6.8 per 1000 in 2010. However, infant mortality rates, as well as low birth weight and prematurity rates, remain higher in rural areas of the State. Further, while 82 percent of pregnant women in Virginia begin receiving prenatal care in the first trimester of their pregnancy, fewer women in rural areas do so; Scott County (26.1%) and the city of Bristol (31.3%) have the lowest percentages. Late onset of prenatal care and poorer birth outcomes are associated with barriers to access and utilization in rural areas including: hospital obstetrical unit closures, OB/GYN health practitioner shortages, difficulty establishing and maintaining birth centers, and demographic factors (such as poverty and low education levels). There are a number of ways to address these barriers, such as enabling birth centers to be reimbursed by Medicaid, expanding the prenatal telehealth program at the University of Virginia (UVA), encouraging more health practitioners to practice in rural areas, and supporting prenatal education programs.

Birth Centers. A pilot project to establish birth centers in the Northern Neck and Emporia encountered difficulties primarily due to the inability to receive Medicaid reimbursement. The Northern Neck Family Maternity Center closed in 2011 after 14 months of operation and the opening of the Women's Health and Birthing Center in Emporia has been delayed indefinitely. To receive Medicaid reimbursement for the cost of operating the facility, the birth center must be licensed or recognized as being accredited by an approved national organization. If Virginia were to either license or recognize freestanding birth centers, it may improve the financial viability of centers in rural areas that rely heavily on Medicaid payments.



Perinatal Telehealth Program. In 2009, UVA established the High-Risk Obstetrics Telehealth Program to improve access to specialized prenatal care for women with high-risk pregnancies in communities that do not have a maternal-fetal medicine specialty unit. After three years of operation, the program has shown a range of positive outcomes, including a 25 percent reduction in preterm deliveries. Expanding the program to include Danville, Pittsylvania County and Washington County, and developing ultrasound services at the Culpeper and Staunton Health Department telemedicine sites would provide greater access to prenatal care for a larger number of women with high-risk pregnancies.



Scholarship/Loan Repayment Programs. Access to care can be increased by encouraging health care professionals to practice in underserved areas by providing additional funding or by expanding scholarship and loan repayment programs.

The Virginia State Loan Repayment Program which covers physicians, physician assistants, and nurse practitioners receives \$400,000 in federal funding each year. To access the funding, the non-profit clinic or hospital hiring the practitioner must provide a 50-percent match. Consequently, all available funds fail to be allocated every year; in FY 2012, one loan repayment grant was awarded and in FY 2013, there are seven applicants but grants had not been awarded as of the reporting of this study.

The Virginia Nurse Practitioner and Nurse Midwife Scholarship Program could be amended to include loan repayments to provide additional flexibility. Furthermore, additional funding could be provided specifically for nurse practitioners who specialize in OB/Women's Health and for nurse midwives. In FY 2012, five scholarships of \$5,000 were awarded and in FY 2013, three scholarship awards of \$5,000 have been recommended.

Prenatal Education Programs. Increased support could be provided to expand existing programs that provide prenatal health information for pregnant women and training for health care providers. For example, Virginia recently slipped from first to fifth in terms of the state with the highest utilization rates for Text4Baby primarily due to a lack of funding for customizing the texts and for advertising.

Joint Commission Action

JCHC members voted to introduce two budget amendments (described below) and authorized the following letters of the JCHC chair:

- Request that the Virginia Department of Health and the Department of Medical Assistance Services review the potential for licensing or recognition of freestanding birth centers, for the purpose of Medicaid facility reimbursement, and report to the Joint Commission by October 1, 2013.
- Request by letter of the Joint Commission Chair that, as part of the maternal and child health strategic plan, the Virginia Department of Health give due consideration to the Baby Basics curriculum as a tool to improve patient education and standardize health messages for pregnant women and mothers.

Legislative Action

Two budget amendments to increase funding for the Virginia Department of Health were introduced:

- Expand, through the UVA Center for Telehealth, the Perinatal Telehealth Network to include Danville, Pittsylvania County, and Washington County and initiate ultrasound services at the Culpeper and Staunton Health Department telemedicine sites.
\$867,000 GFs for FY 2014
- Allow for the customization and advertisement of the text4baby program.
\$75,000 GFs for FY 2014

The amendments were not included in the approved State budget.

Regulation of Naturopaths

House Bill 2487, introduced by Delegate Terry G. Kilgore, would have amended *Code of Virginia* Title 54.1 to require the Board of Medicine to license and regulate naturopaths as independent practitioners. HB 2487 was left in the House Committee of Health, Welfare and Institutions and referred to JCHC for study.

Findings

The practice of naturopathy is not a regulated health profession in Virginia. In general, there are two broad categories of naturopathic practice:

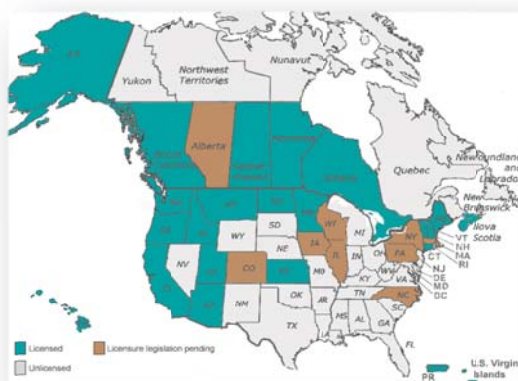
Traditional Naturopaths (TNs)

- No standard professional educational requirements.
- Training programs vary from non-degree certificate program to doctoral programs.
- Role is to educate and support the health of clients through non-invasive means.
 - TNs do not diagnose, treat conditions, or perform surgery.
- Titles used: Naturopath, Classical Naturopath, Nature Care Practitioner
- Number practicing in Virginia: 100s perhaps >1000

Naturopathic Physicians (NaPs)

- Graduates of a four-year, graduate-level naturopathic medical school accredited by an organization recognized by the U.S. Department of Education.
- Statutes in other states define NaP role in various ways ranging from primary care to promoting wellness.
- Titles used: Naturopath, Medical Naturopath, Naturopathic Doctor, or Doctor of Naturopathy
- Estimated number in Virginia: 24

NaP Regulation: 16 States License NaPs. Typical licensure requirements include graduating from an accredited four-year, residential naturopathic medical school and passing a postdoctoral board examination (NPLEX).



HB 2487 Provision Highlights

Naturopathic Physician requirements for licensure:

- Graduation from a naturopathic medical education program that offers graduate-level, full-time didactic and supervised clinical training
- Successful completion of a competency-based national naturopathic medicine licensing examination administered by an agency recognized by the Board.



Furthermore, HB 2487 restricts the practice of naturopathy to licensed NaPs; unlicensed practitioners would not be allowed to use the title “naturopath” and be limited to “providing information” about vitamins and herbs.

Proponent Arguments for Regulation	Opponent Arguments Against Regulation
<ul style="list-style-type: none"> ➤ NaPs can help remedy Virginia’s shortage of primary care physicians. ➤ NaPs complete a 4-year accredited medical school. ➤ NaPs emphasize prevention, which can be a cost-effective type of health care. ➤ Without regulation, NaPs are not allowed to practice up to their level of training. ➤ Naturopathy is unregulated in Virginia and any individual can present himself/herself as a “naturopath.” 	<ul style="list-style-type: none"> ➤ NaPs do not have the requisite education and training to provide the same level and quality of care as a physician to practice independently. <ul style="list-style-type: none"> ○ NaPs are not required to participate in a supervised residency program, like MDs and DOs. ➤ NaPs are not sufficiently trained to prescribe medications. ➤ Medical efficacies of the treatment modalities by NaPs are unproven. ➤ The practice of traditional naturopathy could become illegal without a NaP license. ➤ The term “naturopath” could be reserved only for NaPs. ➤ If NaPs are regulated, it may negatively impact the market that traditional naturopaths serve.

Virginia previously licensed naturopaths; but in 1980, the Board of Medicine repealed licensure provisions while grandfathering in the four naturopaths who had maintained their licensure. The last license expired in 2002; thereby, ending Virginia’s regulation of naturopathy. However, since 2005, five bills have been introduced to regulate naturopathic physicians in Virginia; none of the bills were reported out of the originating Committee. In 2005, the Board of Health Professions initiated an exhaustive review of the regulation of naturopaths and found that the “risk of harm” criterion for licensure was not met.

Joint Commission Action

JCHC members voted to take no action.



Mandatory Outpatient Treatment for Substance Use Disorder

A 2011 JCHC staff study examined the use of involuntary commitment procedures in treating chronic substance use disorder (HJR 682 – Delegate John M. O’Bannon, III). Study findings included:

- The *Code of Virginia* currently allows for the use of involuntary commitment procedures for persons in need of substance abuse treatment.
- Involuntary commitment procedures are not often used for this purpose for a variety of reasons.
- Involuntary commitment to inpatient treatment in most cases is better suited to compel treatment for mental illness; however, mandatory outpatient treatment is potentially a better disposition for persons with chronic substance use disorder.

JCHC members voted to include in the 2012 work plan, a study of whether mandatory outpatient treatment can be structured to address more effectively the needs of persons in need of substance abuse treatment.

Findings

In general, the option of mandatory outpatient treatment (MOT) is used infrequently (in less than 1% of involuntary commitment hearings in 2012) and very rarely used to address substance abuse. One exception to this general rule is the community services board (CSB) in Prince William County which has had success using MOT.

308 MOTs were issued from July 2008 – June 2012
78 MOTS (25.3%) in Prince William County

Approximately one-third of the clients, placed on MOT in Prince William County, were required to receive substance abuse treatment services as well as services for mental illness. 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. Prince William County CSB representatives indicated that two aspects of their civil commitment process made MOT more feasible:

- They waited a full 48 hours before initiating the involuntary commitment 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.

Representatives of the Department of Behavioral Health and Developmental Services and a number of CSBs noted that the success of court-mandated treatment for such criminal acts as driving under the influence as evidence that MOT can work. However, there are challenges including a common substance abuse assessment tool that has not been adopted, the participants would need to agree to treatment, and there are few penalties for noncompliance. Furthermore, limited treatment resources, including access to detoxification and residential treatment, compromises the continuum of care for those with substance use disorder and are significant factors limiting the use of MOT. However, MOT could be used more effectively if, at the least a common substance abuse assessment tool were adopted and used, and the temporary detention order (TDO) period could be increased to 72 hours, or at a minimum, allow at least 24 hours to pass before the involuntary commitment hearing is held.



Additional Discussion Regarding Temporary Detention Orders. Richard Bonnie of the UVA School of Law, in discussing the proposal to increase the maximum time for a TDO, made the following points:

- Virginia's 48-hour limitation is the shortest timeframe in the United States.
- Increasing the maximum timeframe was recommended by the Virginia Tech Review Committee, the Office of the Inspector General, and the Commission on Mental Health Law Reform.
- Legislation, introduced in 2010 (HB 307 - O'Bannon/SB 85 - Howell) in order to extend the maximum TDO period to 72 hours, was unsuccessful due to a projected fiscal impact of more than \$2.7 million per year.

A study, undertaken by Mr. Bonnie and Dr. Tanya Wanchek and published in *Psychiatric Services* examined 500 cases in which Medicaid paid for TDO hospitalizations and found that longer TDO periods were correlated with more dismissals, fewer involuntary commitments, fewer post-TDO hospitalizations, and shorter post-TDO hospital stays (when hospitalization was ordered).

Mr. Bonnie asserted that when these factors are considered the fiscal impact (on the involuntary commitment fund) of extending the maximum time period for a TDO to 72 hours actually would be modest. Based on conservative assumptions (e.g., that no hearing would be held after 72 hours), Mr. Bonnie estimated that the net number of additional days of hospitalization would be less than 1,000 (actual number is 873), resulting in a fiscal impact of no more than \$600,000. In addition, increasing the minimum period of time to at least 24 hours may offset the additional cost altogether, leading to a net savings. Mr. Bonnie also pointed out that the number of TDOs and hearings has decreased over the last two years and assuming this trend continues, this would further reduce the fiscal impact of increasing the maximum duration of the TDO period.

Joint Commission Action

JCHC members voted to take no action.



Potential Expansion of the Health Practitioners' Monitoring Program

Senate Bill 634 (Senator Jill Holtzman Vogel) and House Bill 1289 (Delegate S. Chris Jones) would amend Section 54.1-2515 of the *Code of Virginia* relating to the type of impairments qualifying a health practitioner for voluntary participation in the Health Practitioners' Monitoring Program (HPMP). Both bills were continued until 2013 and referred to JCHC for study.

Findings

The Health Practitioners' Monitoring Program was established in State statute in 1997 and provides confidential services (including intake, referrals for assessment and/or treatment, monitoring, and alcohol and drug toxicology screens) for the health practitioner who may be impaired by any physical or mental disability, or who suffers from chemical dependency. The program encourages early identification and referral to appropriate treatment, allows valuable professionals to return to practice following treatment with ongoing monitoring, and improves practitioners' prognosis for recovery. The Health Practitioners' Monitoring Program is operated by VCU's Department of Psychiatry under a Memorandum of Agreement with the Department of Health Professions. The program has an annual budget of \$1.8 million, funded by professional licensure fees; 579 practitioners were enrolled in September, 2012.

Senate Bill 634 and House Bill 1289 would amend the definition of impairment in *Code* § 54.1-2515 to include mismanagement of countertransference. Mismanagement of countertransference is when a patient unconsciously transfers feelings and attitudes from a person or situation in the past onto their therapist and the therapist responds to the patient's feelings inappropriately. The fiscal impact statement for the bills indicated:

“While there is no way to estimate the number of new practitioners that might enter HPMP based on this expanded definition of impairment; it is assumed that program costs would increase significantly. HPMP costs are allocated to the boards by which the participating practitioner is licensed. Therefore, as program participation increases, associated board costs go up and have to be covered by revenue generated from regulatory fees imposed on all of that board's licensees. The Department of Health Professions maintains that it is likely that the provisions of this bill would enable a significant number of new practitioners from all health regulatory boards to enter HPMP. Further, the cost associated with this increase will likely necessitate fee increases for all health regulatory boards.”

In addition to the anticipated fee increases, concerns regarding mismanagement of countertransference include that it cannot be objectively measured, is not a disorder in the DSM IV, and is considered an egregious violation of professional ethical code. Proponents of the bill indicate that the current system does not address adequately the problem of mismanagement of countertransference; allowing practitioners to participate in the HPMP would provide screening, oversight, and a systematic protocol for treatment.

Joint Commission Action

JCHC provided a written report to the Senate Committee on Education and Health and to the House Committee on Health, Welfare and Institutions, without taking further action.



Fiscal Impact: Medicaid Eligibility and Uncompensated Asset Transfers

House Bill 1090, introduced by Delegate John M. O’Bannon, III in 2012, sought to address problems related to the sale or transfer of real property in determining Medicaid eligibility for long-term care services. Delegate O’Bannon requested a fiscal impact review by JCHC after the substitute for his bill was left in the House Appropriations Committee.

Findings

Financial eligibility for Medicaid includes restrictions on income, resources, and assets (including stocks, bonds, vehicles, life-insurance, and non-exempt real property) as well as any uncompensated transfer of those financial “goods.” Regarding real property, an uncompensated transfer occurs when the property is sold for less than its locality-assessed property value for tax purposes. In light of the recent and significant decrease in housing values, HB 1090 sought to provide new exceptions for when an uncompensated transfer of real property is deemed to have occurred. Currently, if a Medicaid applicant sold his house for less than its tax-assessed value, a penalty period could be imposed making the applicant ineligible for Medicaid payments for a period of time.

Accurately understanding the consequences of changes in Medicaid eligibility for long-term care services is very important given the potential costs involved; in early 2013, 18 percent of enrollees received long-term care services while those services comprised 35 percent of all Medicaid expenditures. (Long-term care services include nursing facility care, community-based waiver programs, and end-of-life care.)

The JCHC study examined the impact of the proposed changes to Medicaid guidelines contained in the HB 1090 substitute. Potential implementation issues were identified including:

- Accepting private real estate appraisals could result in wide variation allowing for sale and transfer values that are beyond the bill’s intent.
- Validating that a sale or transfer actually involved an arm’s length transaction between two independent parties with no relation to each other could prove to be difficult for DMAS and social service agencies.
- Ensuring that the reason for a sale or transfer was made for reasons other than to be eligible for Medicaid assistance, could prove to be difficult for DMAS and social service agencies.

JCHC staff concurred with the likely short-term impact that HB 1090 would expand Medicaid long-term care eligibility with a projected fiscal impact of slightly less than \$1 million in FY 2013 and \$3 million in FY 2014 (as described in the fiscal impact statement completed by the Department of Planning and Budget). However, JCHC staff also emphasized that the long-term fiscal impact could be higher if proceeds from real property sales are used for anything other than the medical and nursing facility care that the Commonwealth would have paid for or if individuals change their handling of real property sales to preserve assets.

Joint Commission Action

No policy options were developed by staff as it was a fiscal impact review.



Selected Presentation Summaries

Quality Collaborative Care Through Interprofessional Education

Valentina Brashers, M.D., FACP, FNAP and Dorrie K. Fontaine, Ph.D., RN, FAAN with the University of Virginia provided an overview of UVA's interprofessional education initiative.

Findings

The importance of collaborative practice has been underscored by the Institute of Medicine in reports related to quality of care (including the landmark 1999 report, *To Err is Human: Building a Safer Health System*) and in establishing its five core competencies of health professionals. If health professionals do not learn to work together more effectively the results will be: poor patient outcomes; diagnostic, treatment, prevention, and communication errors; and higher costs and attrition.

The World Health Organization defines interprofessional education as when students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes and as preparing a "collaborative practice-ready" health workforce. The interprofessional education initiative at UVA builds on a foundation which includes simulation, telehealth, and global health partnerships; UVA is recognized as a national leader providing:

- Twenty-five interprofessional educational programs in undergraduate, graduate, and professional education.
- Numerous grants of more than \$800,000 in support of interprofessional education at UVA.
- National dissemination of scholarship and leadership related to interprofessional education, including presentations at national meetings.

While there is a great deal of interest in interprofessional education including inquiries from public and private medical programs, a survey of baccalaureate medical, nursing, and pharmacy programs in the Commonwealth was proposed to determine the levels of integration and interest as a first step in planning to facilitate further development.

Joint Commission Action

JCHC members voted to take no action.

Telehealth: A Tool for the 21st Century

Dr. Karen S. Rheuban, of the Center for Telehealth at the University of Virginia, addressed the Healthy Living/Health Services Subcommittee and offered the following remarks and policy options.

Findings

“Telemedicine” is the use of medical information exchanged from one site to another via electronic communications to support medical diagnosis, ongoing patient care, and remote patient monitoring. “Telehealth” encompasses a broader definition of remote health care (such as health-related distance learning) that does not always involve clinical services.



Public and private Virginia organizations have underscored the value of telehealth through research, partnering and funding commitments.

Telehealth seeks to benefit patients, health professionals, and communities.

- Patients are benefited through timely access to services that are unavailable locally, relief from the burden and cost of transportation, and improvement in quality of care.
- Health professionals working in shortage areas can access consultative services and continuing education, in some cases helping to increase the area’s provider community.
- Communities are benefited as 90 percent of patients remain in the local setting, expanding locally-available medical services; often enhancing a community’s health care and economic prospects.

Virginia is considered to be a leader in telehealth; the UVA telehealth program includes 40 different specialties which provided more than 27,000 encounters as of April 2013.

Joint Commission Action

JCHC members voted to take the following actions:

- Introduce a budget amendment (language and funding) for \$25,000 in State general funds to advance statewide education programs regarding emergency stroke care through the Virginia Stroke Systems Task Force.
- Include in the 2013 JCHC work plan for JCHC, a study of various avenues to expand access to mental health services through telemedicine, including potential public-private partnerships.
- By letter of the JCHC Chair, request that the Virginia Department of Health, Department of Medical Assistance Services, Department of Education, and the academic health centers collaborate regarding how to expand services for children in the Commonwealth.
- By letter of the JCHC Chair, request that the Department of Medical Assistance Services consider funding for chronic disease management programs in the home setting using remote patient monitoring and care coordination in the Medicaid program.

Legislative Action

A budget amendment for \$25,000 GFs was introduced to allow the Virginia Department of Health to advance statewide education programs via telehealth regarding emergency stroke care. The budget amendment was not included in the approved state budget.

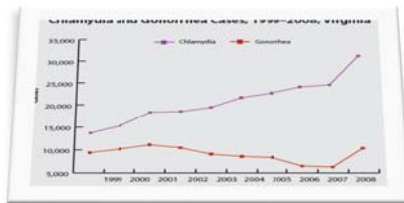
Expedited Partner Therapy: An Innovative Strategy

House Joint Resolution 147 (Delegate Charniele Herring) directed JCHC to study options for implementing expedited partner therapy in the Commonwealth. Although the resolution was laid on the table in the House Committee on Rules, JCHC members voted to complete a two-year study.

Becky Bowers-Lanier with B2L Consulting and Robin Hills (Clinical Assistant Professor with the School of Nursing at Virginia Commonwealth University) proposed making a presentation this year, possibly in lieu of further study by JCHC staff. The following remarks and policy proposals were included in Ms. Hills' presentation.

Findings

Chlamydia and gonorrhea are serious and often asymptomatic diseases that affect both men and women. While these diseases can cause permanent physiological damage resulting in infertility, tubal pregnancy, and chronic pelvic pain in women and gonorrhea can result in infertility in men, these negative effects are more closely linked to re-infection than to initial infection underscoring the importance of treating both partners with antibiotics to prevent re-exposure.



While incidence rates in Virginia for both chlamydia and gonorrhea are lower than the national average, the number of new cases of chlamydia continues to increase each year; and the incidence rates for gonorrhea (after decreasing from 2000 through 2007) are rising in the State. Given increasing incident rates and adherence problems with treatment, the Centers for Disease Control and Prevention recommended in 2006 that expedited partner therapy be used to facilitate partner management among heterosexual men and women.

Expedited partner therapy is the clinical practice of treating the sex partners by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner. Along with medication, the unexamined partner typically is sent information advising him/her to receive a medical examination. Expedited partner therapy is considered to be an additional strategy for partner management that is not intended to replace other strategies, such as standard patient referral, when available. However, studies have found this treatment often to be more effective than standard approaches.

Since 2006, the American Bar Association, American Medical Association, Society for Adolescent Health and Medicine, American Academy of Pediatrics, and American Congress of Obstetricians and Gynecologists have stated their support for expedited partner therapy as an option for treating chlamydia and gonorrhea and for reducing rates of infection. By 2012, expedited partner therapy was permitted in 32 states.

Joint Commission Action

JCHC members voted to ask staff to review a number of medical and legal concerns that were raised related to potential implementation of expedited partner therapy.



Why Is Respite Important for Caregivers?

Courtney Tierney with Prince William Area Agency on Aging made the following remarks regarding the importance of providing respite care for caregivers in a presentation to the Healthy Living/Health Services Subcommittee.

Findings

The majority of informal caregivers are “related by blood or marriage, but partners, friends, and neighbors are also caregivers.” Informal caregivers allow many Virginians to avoid or delay nursing facility care which saves millions in Medicaid costs. An AARP Public Policy Institute study estimated that in 2009, more than 1.1 billion hours of care had been provided in Virginia for a total value of \$11.7 million in public savings.³

While caregiving is often very meaningful and rewarding, it can be very stressful and socially isolating and it takes time from work and other family responsibilities. The health of caregivers often suffers over time; several studies have reported that family caregivers can suffer from serious depression and the type of extreme stress which has been shown to cause premature aging. Respite care includes such services as companionship and personal care services in the home, institutional respite care (overnight or for longer periods of time), and adult day health care. The provision of respite care enables someone else to provide care allowing the caregiver to relax or take care of personal, family, or work responsibilities.

The Virginia Respite Care Initiative was established in 1988 to provide care for Virginians who are elderly (60 and older) or suffer from Alzheimer’s disease or related dementias. To qualify for assistance, the applicant must have a 24-hour caregiver; respite care is limited to 35 hours per month. In FY 2012, 290 caregivers received respite care at a cost of \$456,209 in State GFs for an average of \$1,573 per client for the year. In requesting that the appropriation be doubled, Ms. Tierney indicated that the \$1 million would save State funding by delaying and in some cases avoiding nursing-facility admission and by supporting families so they can continue to provide care.

Joint Commission Action

JCHC members voted to introduce a budget amendment of \$543,791 GFs for FY 2014 (for the Virginia Department for Aging and Rehabilitative Services) to increase statewide funding for the Virginia Respite Care Initiative.

Legislative Action

The introduced budget amendment was not included in the approved State budget.

This presentation focused on the Virginia Respite Care Initiative. There is also a federal program, the National Family Caregiver Support Program (Title III-E), which was established in 2000. In 2011, Virginia received \$3.1 million in Title III-E funding (which required a match of \$2.3 million in local, State, and private funding); a variety of services were provided to 4,044 caregivers and 1,704 received respite care. Title III-E funding can be unpredictable as it is subject to sequestration and other federal budgetary actions.

³ Lynn Feinberg, Susan C. Reinhard, and Rita Choula, *Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving*, Insight on the Issues #51 (Washington, DC: AARP Public Policy Institute, June 2011).

Eating Disorders Follow-Up

A JCHC-staff study on eating disorders, requested by Senator Linda T. Puller in SJR 294 (2011), included several policy options that were approved by Joint Commission members. One option asked the Departments of Education and Health to determine the resources that are currently available in public schools and to collaborate with the National Eating Disorders Association in finding “an evidence-based eating disorder screening program for potential implementation in Virginia’s school systems.”



2012 Activities and Findings

Dr. Patricia Wright, the Superintendent of Public Schools, reported on work group findings in response to the JCHC letter-request. Work group members found that a number of resources are available to school personnel:

- Videos on eating disorders were distributed to school nurses several years ago.
- An eating disorder workshop for school nurses was offered at the Summer Institute for School Nursing this past year.
- DOE school health specialists who offer technical assistance for school nurses “will provide additional resources on eating disorders.”
- Eating disorder resources, aligned with Virginia’s standards of learning, are available on the Health Smart Virginia website <http://healthsmartva.pwnet.org> and will be “promoted to all school personnel.”
- Healthy eating habits and positive self-image are addressed in the school curricula and the NEDA toolkit for teachers.

“Less than 45% of affected individuals seek treatment...up to 20%...will die without treatment ...eating disorder on-set often occurs during middle to high school age.”

In addition, several screening instruments were examined by the work group and a recommendation was made to provide information on the SCOFF questionnaire, an “evidence-based, short screening interview,” to school nurses, psychologists, and social workers for use in determining whether to refer a student for additional services.

Joint Commission Action

JCHC members voted to encourage, by letter of the Joint Commission Chair, the Virginia Department of Health and the Virginia Department of Education to implement the work group recommendations to:

- Conduct training within the clinical community, such as to physicians and nurse practitioners, in recognizing and treating eating disorders since this is a complex disorder and is extremely sensitive and clinical in nature;
- Continue efforts to raise awareness of school personnel regarding the signs and symptoms of eating disorders and appropriate referral;
- Increase awareness of the Health Smart Virginia Website with ready-made lesson plans for healthy eating habits and positive body image aligned with Virginia SOL; and
- Provide information on the SCOFF questionnaire to school nurses, school psychologists, and school social workers for use in evaluating the need for referral to a health care provider.





Meeting Agenda Items

Joint Commission on Health Care

- June 6, 2012 Work Plan for JCHC and BHC – 2012
Kim Snead, Executive Director
- Work Plan for HL/HS – 2012
Stephen W. Bowman, Senior Staff Attorney/Methodologist
- September 18, 2012 Update: Settlement Agreement with the U.S. Department of Justice
The Honorable William A. Hazel, Jr.
Secretary of Health and Human Resources
- STAFF REPORTS:
Health Care Compact - HB 264 – Delegate Christopher K. Peace
Stephen W. Bowman
- Regulation of Surgical Assistants and Surgical Technologists
SB 313 – Senator Harry B. Blevins
Jaime H. Hoyle, Senior Staff Attorney/Health Policy Analyst
- Cost Sharing and Specialty Tier Pricing of Prescription Medications
HJR 579 (2011) – Delegate John M. O’Bannon, III
Michele L. Chesser, Ph.D., Senior Health Policy Analyst
- October 16, 2012 Summary of Public Comments/Follow-up on Eating Disorders Study
Kim Snead
- Virginia Health Information: 2012 Annual Report and Strategic Plan
Alfred D. Hinkle, Jr., President, VHI Board of Directors
Michael T. Lundberg, Executive Director
- STAFF REPORTS:
Opt-Out Program for Organ, Eye, and Tissue Donation
HJR 19 – Delegate John M. O’Bannon, III
Jaime H. Hoyle
- Rural Obstetrical Care in Virginia
Michele L. Chesser, Ph.D.
- Fiscal Impact of Untreated Dental Disease (Interim Report)
SJR 50 – Senator George L. Barker
Jaime H. Hoyle
- Regulation of Naturopaths
HB 2487 (2011) – Delegate Terry G. Kilgore
Stephen W. Bowman
- November 7, 2012 Decision Matrix: Review of Policy Options and Legislation for 2013
JCHC Staff

Behavioral Health Care Subcommittee

- June 28, 2012 Report from the Office of the Inspector General for BHDS
Inspector General G. Douglas Bevelacqua



Update: Department of Behavioral Health and Developmental Services
James W. Stewart, III, Commissioner

Discussion Regarding Temporary Detention Orders

Richard J. Bonnie, L.L.B., Professor of Public Policy
Harrison Foundation Professor of Law and Medicine
Director, Institute of Law, Psychiatry and Public Policy
University of Virginia School of Law

October 16 2012 Overview on Discussions with the Virginia Community College System
Kim Snead

STAFF REPORTS:

Mandatory Outpatient Treatment for Chronic Substance Abuse Disorder

Jaime H. Hoyle

Potential Expansion of the Health Practitioners' Monitoring Program

Michele L. Chesser, Ph.D.

Healthy Living/Health Services Subcommittee

June 6, 2012 Virginia Chamber's Focus on Health Care
Bob Cramer, Health Benefits Manager, Norfolk Southern Corporation
Chairman, Virginia Chamber of Commerce Healthcare Committee

Update: Virginia Health Information Exchange

Kimberly Barnes, Coordinator with the Office of Information Management and Health IT
Virginia Department of Health

Interprofessional Health Education between Nursing and Medical Students
Dorrie K. Fontaine, PhD, RN, FAAN, Sadie Heath Cabaniss, Professor of Nursing and Dean
UVA School of Nursing

Valentina Brashers, MD, FACP, FNAP, Professor of Nursing, Woodard Clinical Scholar,
UVA School of Nursing

Telehealth: A Tool for the 21st Century

Karen Rheuban, M.D., Medical Director
UVA Center for Telehealth

September 18, 2012 Update: AIDS Drug Assistance Program (ADAP)
Karen Remley, MD, MBA, FAAP, State Health Commissioner
Virginia Department of Health

Expedited Partner Therapy

Robin L. Hills, MS, WHNP-BC, CNE
Clinical Assistant Professor, VCU School of Nursing

Virginia Center for Health Innovation

Beth Bortz, President & CEO
Virginia Center for Health Innovation

Why Is Respite Important for Caregivers?

Courtney Tierney, Director
Prince William Area Agency on Aging

Fiscal Impact Review: Medicaid Eligibility and Uncompensated Asset Transfers

HB 1090 – Delegate John M. O'Bannon, III
Stephen W. Bowman



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](#).)



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