

JOINT COMMISSION ON HEALTH CARE



2014 Annual Report of the Joint Commission on Health Care

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA



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RICHMOND
2015



JOINT COMMISSION ON HEALTH CARE

Delegate John M. O'Bannon III, Chair

Senator L. Louise Lucas, Vice Chair

May 28, 2015

The Honorable Terence R. McAuliffe
Governor of Virginia
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

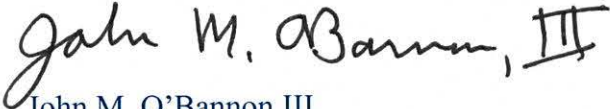
Members of the Virginia General Assembly
General Assembly Building
Richmond, Virginia 23219

Dear Governor McAuliffe and Members of the General Assembly:

Pursuant to the provisions of the *Code of Virginia* Title 30, Chapter 18 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, 2014.

This report includes a summary of the Joint Commission's activities including legislative recommendations to the 2015 Session of the General Assembly. In addition, staff studies are submitted as written reports and made available on the Reports to the General Assembly and the Joint Commission on Health Care websites.

Respectfully submitted,


John M. O'Bannon III

Joint Commission on Health Care Membership



Virginia House of Delegates

The Honorable John M. O'Bannon III, Chair

The Honorable David L. Bulova
The Honorable Benjamin L. Cline
The Honorable Rosalyn R. Dance
The Honorable T. Scott Garrett
The Honorable Patrick A. Hope
The Honorable Riley E. Ingram
The Honorable Kaye Kory
The Honorable Christopher K. Peace
The Honorable Christopher P. Stolle



Senate of Virginia

The Honorable L. Louise Lucas, Vice Chair

The Honorable George L. Barker
The Honorable Charles W. Carrico, Sr.
The Honorable John S. Edwards
The Honorable Stephen H. Martin
The Honorable Jeffrey L. McWaters
The Honorable John C. Miller
The Honorable Linda T. Puller

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

Staff

Kim Snead
Executive Director

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Senior Staff Attorney/Methodologist

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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.” The Joint Commission’s sunset date was extended to July 1, 2018 during the 2014 General Assembly Session (Senate Bill 60 and House Bill 680).

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. Four new Commission members were appointed in 2014 including Delegate Patrick A. Hope, Delegate Kaye Kory, Senator John S. Edwards, and Senator John C. Miller.

Delegate John M. O’Bannon III was elected to serve as Chair and Senator L. Louise Lucas was elected to serve as Vice Chair for 2014 and 2015. Delegate O’Bannon appointed Delegate Christopher P. Stolle and Senator John C. Miller to serve as co-chairs of the Behavioral Health Care Subcommittee and Delegate T. Scott Garrett and Senator George L. Barker to serve as co-chairs of the Healthy Living/Health Services Subcommittee.

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



Delegate Robert H. Brink, who represented the 48th district in the Virginia House of Delegates for 17 years, was appointed to JCHC in 1998. Delegate Brink introduced a number of JCHC-approved bills to enhance services for senior citizens and individuals with mental illness, to allow public and private entities to continue to form health partnership authorities, and to extend the sunset date for JCHC. Delegate Brink served as co-chair of JCHC’s Healthy Living/Health Services Subcommittee in 2012 and 2013.

The Honorable Robert H. Brink was appointed Deputy Commissioner of the Department for Aging and Rehabilitative Services in June 2014.



Delegate Rosalyn R. Dance was elected to represent the 63rd House district in 2005 and appointed to the Joint Commission in 2009. Delegate Dance served on JCHC’s Behavioral Health Care and Healthy Living/Health Services Subcommittees and introduced legislation which requires health insurers to provide 30-days prior notice to affected subscribers that a prescription drug is being moved to a formulary tier with higher cost-sharing requirements and a resolution ensuring that each five-year update of *The Virginia Cancer Plan* will be considered by JCHC and published as a legislative document.

The Honorable Rosalyn R. Dance was elected to serve the 16th Senatorial District on November 4, 2014.



Delegate Algie T. Howell, Jr. represented the 90th district in the Virginia House of Delegates for 10 years and was appointed to JCHC in 2009. In keeping with his keen interest in ensuring mental health and substance abuse services are made available, particularly for young people and individuals who come into contact with the criminal justice system, Delegate Howell was an active member on JCHC's Behavioral Health Care Subcommittee.

The Honorable Algie T. Howell, Jr. was appointed Vice Chair of the Virginia Parole Board in July 2014.

In addition, we would like to acknowledge the many contributions of Stephen W. Bowman who served as staff to the General Assembly for nearly 15 years; Stephen began his legislative career with the Virginia State Crime Commission before joining the staff of the Joint Commission in 2006 serving as Senior Staff Attorney and Methodologist. Stephen, an exceptional young man, will be missed by his devoted family, colleagues, and numerous friends.



October 13, 1973- December 3, 2014

Table of Contents

ACTIVITIES	
Joint Commission on Health Care	1
Additional Staff Endeavors	3
EXECUTIVE SUMMARIES	
Viral Hepatitis in the Commonwealth	4
Progress in Expanding Access to Brain Injury Services	7
Minor Consent Requirements for Voluntary Inpatient Psychiatric Treatment	10
Dental Safety Net Capacity and Opportunities for Improving Oral Health	14
Scope of Practice Exemptions in Approved Hospitals	18
Grand Aides and Similar Models of Health Care Delivery	20
Annual Reporting by Virginia's Health Conversion Foundations	22
MEETING AGENDA 2014	25
Policy on Remote Participation Due to Emergency or Personal Reasons	28
STATUTORY AUTHORITY	29

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.

Joint Commission on Health Care

Four Joint Commission meetings as well as two meetings of each subcommittee were held. The 2014 meeting agendas are shown on pages 25 through 27 of this report; meeting materials including presentations, handouts, and minutes are posted on the website at <http://jchc.virginia.gov>.

Staff reports presented addressed:

- Viral Hepatitis in the Commonwealth
- Interim Report on Progress in Expanding Access to Brain Injury Services
- Minor Consent Requirement for Voluntary Inpatient Psychiatric Treatment
- Dental Safety Net Capacity and Opportunities for Improving Oral Health
- Scope of Practice Exemptions in Approved Hospitals

In addition, JCHC-members heard from invited guest speakers. Jeanne Zeidler, of the Williamsburg Health Foundation, asked that the requirement for joint annual reports by the Virginia Consortium of Health Philanthropy be reconsidered. The requirement was established in House Joint Resolution 179 which was introduced on behalf of JCHC in 1998. Michael T. Lundberg, of Virginia Health Information, presented VHI's *2014 Annual Report and Strategic Plan Update*.

Barbara Wirth, Program Manager with the National Academy for State Health Policy, discussed *Medical Homes: Building Blocks to Health System Reform*.

Debra K. Ferguson, Commissioner of the Department of Behavioral Health and Developmental Services, gave an update on the work of the SB 627 Work Group on Training Center Closures.

BEHAVIORAL HEALTH CARE SUBCOMMITTEE

BHC Subcommittee Members

Delegate Christopher P. Stolle
 Senator John C. Miller
 Delegate David L. Bulova
 Delegate Rosalyn R. Dance
 Delegate T. Scott Garrett
 Delegate Patrick A. Hope
 Delegate Riley E. Ingram
 Delegate Kaye Kory
 Delegate John M. O'Bannon III
 Senator George L. Barker
 Senator Charles W. Carrico, Sr.
 Senator John S. Edwards
 Senator L. Louise Lucas
 Senator Linda T. Puller

The BHC Subcommittee held two meetings in 2014, on August 20 and October 8. During the BHC Subcommittee meeting in August:

Commissioner Ferguson provided an update and description of priorities for the Department of Behavioral Health and Developmental Services.

State Inspector General June W. Jennings described the core responsibilities of the newly-formed Office of the State Inspector General (OSIG) and summarized the findings of the OSIG *Review of Mental Health Services in Local and Regional Jails*.

Sheriff Gabriel A. Morgan of Newport News and Sheriff Brian K. Roberts of Brunswick County discussed the challenges of addressing the mental health needs of inmates held in jail. Stephany Melton Hardison representing the National Alliance on Mental Illness of Virginia, Jennifer Faison representing the Virginia Association of Community Services Boards, and Ashley Everette representing Voices for Virginia's Children spoke regarding the provision of mental health services in the Commonwealth.

During the meeting in October:

Robyn de Socio, Executive Secretary of the Compensation Board discussed the findings of the Board's 2013 Report on Mental Illness in Jails.

Jack Quigley, Special Projects Manager with the Department of Medical Assistance Services, and Fred Schilling, Myra Smith, and Teresa Harvey with the Department of Corrections discussed the new program to make Medicaid payments for eligible inmates of State prisons who are hospitalized in the community.

Holly Coy, Policy Director of the Office of the Lieutenant Governor, presented recommendations of the *Governor's Taskforce on Improving Mental Health Services and Crisis Response* and Jennifer S. Lee, M.D., Deputy Secretary of Health and Human Resources provided an overview of the Governor's plan, *A Healthy Virginia*.

HEALTHY LIVING/HEALTH SERVICES SUBCOMMITTEE

HL/HS Subcommittee Members

Delegate T. Scott Garrett
Senator George L. Barker
Delegate David L. Bulova
Delegate Rosalyn R. Dance
Delegate Patrick A. Hope
Delegate Riley E. Ingram
Delegate Kaye Kory
Delegate John M. O'Bannon III
Delegate Christopher K. Peace
Delegate Christopher P. Stolle
Senator John S. Edwards
Senator Stephen H. Martin
Senator John C. Miller
Senator Linda T. Puller

The HL/HS Subcommittee met twice in 2014, on August 20 and September 15. During the HL/HS Subcommittee meeting in August:

Dr. Raymond Scheppach, of the Miller Center and the School of Leadership and Public Policy at the University of Virginia, provided an overview of *Cracking the Code on Health Care Costs* and Dr. Peter Cunningham with Virginia Commonwealth University's Department of Health Care Policy and Research discussed trends related to the financial burden of health care spending has had on families.

Dr. Michele Chesser presented the staff report, *Grand Aides and Similar Models of Health Care Delivery*.

During the meeting in September:

Elizabeth A. Carter, Ph.D., described the work of the Department of Health Professions (DHP) on military credentialing and of the Veterans' Licensure and Certification Policy Academy convened by the National Governors Association.

State Health Commissioner Levine provided an overview of current goals and initiatives of the Virginia Department of Health.

Dr. David E. Brown D.C., DHP Director presented an agency overview including a description of the Prescription Monitoring Program and the Healthcare Workforce Data Center.

Additional Staff Endeavors

Served as member of the following organizations:

Age Wave Plan for Greater Richmond – Leadership Committee
Age Wave Plan for Greater Richmond - Data Subcommittee, Chair
Children’s Health Insurance Program Advisory Committee (CHIPAC)
Consulting Editorial Board Member for the journal *Social Work*, a publication of the National Association of Social Workers
Council on Disability and Persons with Disabilities of the Commission for Diversity and Social and Economic Justice
Lt. Governor’s Commonwealth Council on Childhood Success, Child Health and Well Being Workgroup

Taught course, presented report, or participated in panel discussion:

VCU Department of Health Administration – *Health Care Politics and Policy*
VCU Department of Health Care Policy and Research – *Introduction to Health Policy*
Virginia Bar Association – 16th Annual Virginia Health Law Legislative Update and Extravaganza
Virginia Brain Injury Council
Virginia Quality Healthcare Network – Breakfast with the Experts

Attended the following conferences and work group meetings:

Antitrust Law Spring Meeting
American Bar Association Conference
Health Law Conference – University of Virginia
Mid-Atlantic Telehealth Resource Summit
McGuire Veterans Administration Medical Center – Community Mental Health Summit

Published the following articles:

O’Connor, M.K., Netting, F.E., **Cole, P.L.**, Hopkins, K., Jones, J.L. Kim, Y., Mulroy, E., Rotabi, K.S., Thomas, M.L., Weil, M.O., & Wike, T. (2015). Voice and Community in the Corporate Academy: A Collective Biography. *Affilia*, 30(1), 9-25.

Netting, F.E., O’Connor, M.K., **Cole, P.L.**, Hopkins, K., Jones, J.L., Kim, Y., Mulroy, E., Rotabi, K.S., Thomas, M.L., Weil, M.O., & Wike, T. (in press). Reclaiming and Reimagining Macro Social Work Education: A Collective Biography. *Journal of Social Work Education*.

Cole, P.L., & Margolin Cecka, D. (2014). Traumatic Brain Injury and the Americans with Disabilities Act: Implications for the Social Work Profession. *Social Work*, 59(3), 261-269.

EXECUTIVE SUMMARIES



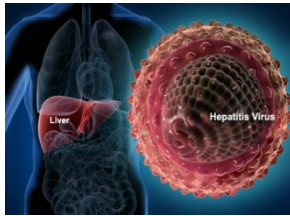
During 2014, Commission staff conducted studies in response to requests from the General Assembly or from Joint Commission members.

In keeping with the Commission's statutory mandate, the following studies were completed.

Viral Hepatitis in the Commonwealth

During the 2014 General Assembly Session, House Joint Resolution 68 (Delegate M. Keith Hodges and Delegate John M. O'Bannon III) directed the Joint Commission on Health Care to conduct a two-year study of viral hepatitis in the Commonwealth. The study objectives were to identify available resources as well as any factors that limit the testing, treatment, and prevention of viral hepatitis and to identify opportunities for integration of viral hepatitis treatment within new or existing HIV treatment programs.

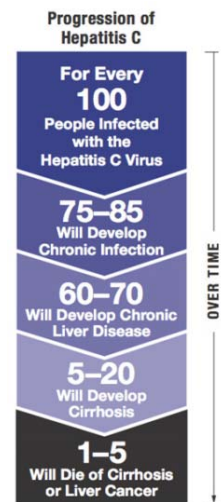
Viral hepatitis, which is an inflammation of the liver caused by a virus, claims the lives of 12,000 to 18,000 Americans each year. It is estimated that between 3.2 and 5.3 million



Americans are living with viral hepatitis and up to 75 percent do not know they are infected. In 2007, annual deaths in the U.S. due to viral hepatitis outpaced deaths due to HIV for the first time. While a number of viruses can cause hepatitis, hepatitis A (HAV), hepatitis B (HBV) and hepatitis C (HCV) are the most common in the United States. Hepatitis B and C may result in chronic hepatitis, potentially causing cirrhosis, liver failure and liver cancer. In fact, chronic hepatitis is the most common cause of liver cancer and liver transplants in America.

HEPATITIS A AND B

Each year, there are 17,000 new hepatitis A infections and 18,800 new hepatitis B infections in the United States. A vaccine is available for both hepatitis A and B and while hepatitis A usually clears on its own without treatment, hepatitis B can result in a chronic infection with the likelihood of progression from acute to chronic hepatitis B (typically based on the age at which the virus was acquired). Hepatitis B becomes chronic in over 90 percent of infants, 25 to 50 percent of children one to five years of age and six to ten percent of older children and adults. For the 90 percent of newborns infected with hepatitis B who develop chronic infection, up to 25 percent will die of cirrhosis, liver failure or liver cancer later in life. However, the standard of care for pregnant women now includes hepatitis B testing during pregnancy since interventions are now available to prevent transmission to the infant during birth.





HEPATITIS C

There are approximately 20,000 new hepatitis C infections each year in the United States; and for every 100 people who are infected, 75 to 80 will develop a chronic infection, 60 to 70 will develop chronic liver disease, 5 to 20 will develop cirrhosis, and 1 to 5 will die of cirrhosis or liver cancer. The Centers for Disease Control and Prevention (CDC) and the U.S. Preventive Services Task Force (USPSTF) recommend that all high-risk adults be screened for hepatitis C, which includes current or former drug users, recipients of clotting factor concentrates before 1987, recipients of blood transfusions or donated organs before July 1992, long-term hemodialysis patients, health care and public safety workers at risk of percutaneous blood exposure, HIV-infected persons and infants born to infected mothers. Given that 75 percent of hepatitis C cases are baby boomers, primarily due to the lack of blood supply screening prior to 1987, the CDC and USPSTF also recommend that health care professionals offer one-time screening to adults born in 1945 to 1965.

While there is no vaccine for hepatitis C, treatment is available.¹ Prior to 2013, HCV was treated with an interferon-based anti-viral regimen with long treatment durations (lasting up to one year), significant side effects, complicated dosing schedules and modest cure rates. Given these treatment problems and the fact that it can take years for chronic hepatitis to result in liver damage, many infected individuals chose to delay treatment until better medication was available. This has resulted in significant pent-up demand. In 2013, two new drugs sofosbuvir (Sovaldi) and simeprevir (Olysio) were approved by the Food and Drug Administration (FDA) as part of a combination anti-viral treatment regimen. These drugs must be taken with at least one of the traditionally used anti-virals that can cause side effects; however, both sofosbuvir- and simeprevir-based treatment regimens offer significantly higher cure rates than traditional regimens and a shorter treatment duration of 12 to 24 weeks.² Treatment costs of regimens utilizing the new medications are significant. A 12-week supply is \$84,000 for Sovaldi and \$66,360 for Olysio. Combined with the cost of the other drugs used in the regimen, a 12-week treatment for hepatitis C can cost as much as \$116,910. In October 2014, the FDA approved a new drug (Harvoni) for the treatment of Hepatitis C. It is the first all-oral regimen and is expected to cost \$95,000 for a 12-week treatment.

Factors Limiting the Prevention and Care of Viral Hepatitis in Virginia. The Office of Epidemiology within the Virginia Department of Health (VDH) includes a number of programs that focus on viral hepatitis prevention, immunization and/or surveillance, thereby providing important viral hepatitis tracking and care services. However, addressing the lack of dedicated funding streams for testing and the limitations of the State's surveillance system would allow VDH to be more effective in preventing the spread of viral hepatitis in the Commonwealth.

Lack of Dedicated Funding for Testing. In Virginia, the only HCV testing-specific funds came from a grant of \$240,000 for testing and care linkage for injection drug users which ended March 31, 2015; the funding could not be used for HCV testing of persons in other populations. State agencies do not receive categorical federal funding to support HCV

¹ A vaccine currently is in development and may be available as early as next year.

² It is important to note that there is some debate regarding the accuracy and range of cure rates for sofosbuvir and simeprevir based regimens.

testing. As a result, much of the leveraged funding is not available from year to year and is pulled from other program areas like HIV prevention. In Virginia, approximately \$86,000 of HIV prevention program funds are used for HCV testing each year.

Limitations of the State Surveillance System. VDH surveillance data is used to track the incidence of infection and guide development and evaluation of programs and policies designed to prevent viral hepatitis and minimize the public health impact of the disease. Currently, VDH receives no federal or State funding for viral hepatitis surveillance and investigation activities and, as a result, there is insufficient surveillance at the local and State levels. With limited resources for the investigation/quality checking of infection reports by providers and for the data entry of cases, many reports received by the agency lack information on linkage to care, risk data and demographic information. Of the incidence reports received by VDH, thousands have not been entered into a database due to a lack of dedicated data entry staff. This inability to fully investigate and document reports has resulted in the undercounting of cases and, in general, poor data quality. As a result, it is currently impossible to estimate the true burden of disease caused by viral hepatitis in Virginia.

ACTION BY THE JOINT COMMISSION ON HEALTH CARE
JCHC members voted to take no action.

Progress in Expanding Access to Brain Injury Services

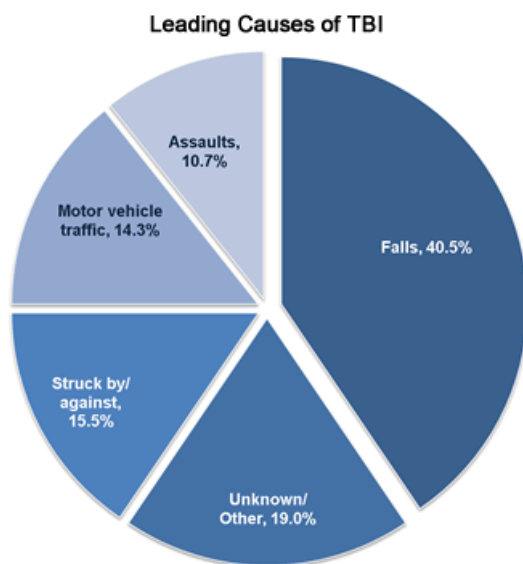
Senate Joint Resolution 80, introduced by Senator Frank M. Ruff, Jr. in 2014, required the Joint Legislative Audit and Review Commission to review progress made in the implementation of recommendations contained in the 2007 JLARC report as well as to make additional “recommendations for increasing access to brain injury services” in the Commonwealth.

Senate Rules Committee members requested that JCHC complete the review and Senate Joint Resolution 80 was continued by voice vote.

TRAUMATIC BRAIN INJURY

Traumatic brain injury (TBI) “is caused by a bump, blow, or jolt to the head or a penetrating head injury that disrupts the normal function of the brain. Not all blows or jolts to the head result in a TBI. The severity of a TBI may range from ‘mild’ (i.e., such as a brief change in mental status or consciousness) to ‘severe’ (i.e., an extended period of unconsciousness or memory loss after the injury). Most TBIs that occur each year are mild, commonly called ‘concussions.’”³

Estimated Incidence of TBIs. The Centers for Disease Control and Prevention (CDC) estimate that 1.7 million people in the U.S. sustain a TBI per year and that at least 5.3 million children and adults live with a permanent disability as a result of a TBI.



Source: CDC web page
http://www.cdc.gov/traumaticbraininjury/get_the_facts.html.

In Virginia, an estimated 28,000 sustain a TBI; approximately 1,400 die and 5,000 are hospitalized (estimates provided by the Brain Injury Association of Virginia).

Funding for Services. States use a combination of funding streams to support an array of services including state revenue, dedicated funding usually from traffic fines, vocational rehabilitation funding, federal grants, and Medicaid funding.

In Virginia, services are primarily funded through State general funds and such non-general fund sources as the Brain Injury Direct Services Fund and the Commonwealth Neurotrauma Initiative Trust Fund.

³ Centers for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control. *Report to Congress on mild traumatic brain injury in the United States: steps to prevent a serious public health problem.* Atlanta (GA). Centers for Disease Control and Prevention; 2003.

JLARC 2007 REVIEW

The 2007 JLARC review of brain injury services provided by the Department of Rehabilitative Services (DRS) found that access to services was limited. Although State funding for case management and clubhouse/day programs had been increased, allowing twice as many individuals with brain injury to receive those services (as compared to in FY 2002), access to services was very limited in some sections of the State, particularly in Southside Virginia, the Northern Neck, and “along the Interstate 81 corridor between Winchester and Lexington.”⁴ The JLARC review also indicated that such services as intensive neurobehavioral treatment programs, cognitive rehabilitation, supportive housing, and transportation were needed.

At the time of the JLARC report, DRS had not been combined with the Department for the Aging to create the Department for Aging and Rehabilitative Services (DARS), which occurred in 2012. Consequently, DRS and DARS will be used as appropriate throughout this section.

In addition, problems were reported with the management of the DRS brain injury registry. “Virginia’s brain injury registry was established to collect individual-level data...(1) to provide everyone reported to the registry with brain injury information, and (2) to assist with planning and programming...The registry is not as comprehensive as intended because at least two Level 1 Trauma Centers are not reporting to it due to database issues at DRS...Fewer than two percent of those sent an initial outreach mailer seek additional information...Furthermore, hospitals are required to report the same information” to VDH’s Virginia Statewide Trauma Registry that has different reporting requirements than the brain injury registry.⁵

DARS-REPORTED ACTIONS TAKEN TO ADDRESS JLARC RECOMMENDATIONS

In completing an interim report, JCHC staff asked that representatives of the Department for Aging and Rehabilitative Services provide an update of actions taken to address the recommendations made in the 2007 JLARC staff report. The update-responses are summarized on the next page.

ACTION BY THE JOINT COMMISSION ON HEALTH CARE

No action was taken; policy options will be included in the final report to be presented in 2015.

⁴ Report of the Joint Legislative Audit and Review Commission, *Access to State-Funded Brain Injury Services in Virginia* Senate Document No. 15, 2007, pp. iii-iv.

⁵ *Ibid.*, p. vii.



JLARC Recommendation	DARS Response
1. Relevant State entities should develop a plan “to address coordination and access to brain injury services by active and retired military”	The Virginia Wounded Warrior Program was statutorily established in 2008 to provide a mental health and rehabilitative program for veterans within the Department of Veterans Services in cooperation with DMHMRSAS and DRS.
2. DRS “should perform or contract with a third party to annually perform program evaluations of at least two State-contracted brain injury providers”	Since FY 2008, the required number of programs evaluated per year has, on average been met or exceeded. In FY 2013, DARS staff conducted 8 program evaluations and 2 fiscal audits; in FY 2014, 5 program evaluations and 2 fiscal audits will be conducted.
3. “Brain Injury and Spinal Cord Injury Services unit should include language in all State- funded contracts...requiring each program to submit the annual independent audit that is conducted of each program...[for DARS review and to share with the] Internal Audit Division to ensure appropriate use of State and federal funds.”	The requirement for an annual independent financial audit is included in all State-funded brain injury services program contracts. The audits are shared with the Community Based Services Division fiscal audit specialist who uses the reports when conducting fiscal evaluations of the programs
4. Amend <i>Code of VA</i> § 32.1-116.1 to require all licensed hospitals providing emergency medical services to report to the Virginia Statewide Trauma Registry (VSTR) patient-level information on all persons diagnosed with a brain and/or spinal cord injury, sustained other than through disease and to require that VDH transmit the information to DRS.	SB 197, enacted in 2008, required VDH to make available and share all information contained in the Virginia Statewide Trauma Registry with DRS to allow for the development and implementation of programs and services for persons suffering from brain injuries
5. Amend <i>Code of VA</i> “to eliminate statutory language requiring hospital reporting to the brain injury registry” and “to direct DRS to obtain the brain and/or spinal cord injury data collected by the Virginia Statewide Trauma Registry.”	SB197, enacted in 2008, eliminated the statutory language requiring hospital reporting to the brain injury registry by repealing § 51.5-11. The unintended consequence is that information is no longer reported to DARS on patients sustaining mild brain injury/concussions who are not hospitalized.
6. DRS should convene a work group “to identify the appropriate data elements needed from the VSTR and the most appropriate electronic format for transmitting that information.”	DRS worked with VDH to identify data elements needed to conduct outreach and to develop an electronic format for transmitting information from VSTR to DRS which conducts outreach via a contract with a statewide advocacy organization.
7. DRS “should require all State-funded brain injury service programs to provide ... information required by [<i>Code</i>] §51.5-11(B). The information should be reported each time a provider is contracted or makes contact with a new person with brain injury.”	This “recommendation was not implemented primarily because it would be a duplication of effort for the state-funded Brain Injury Services Programs...if an individual is already being served...there is no need for DARS to receive name/address information...”
8. DRS “should integrate the brain injury information it collects into the department’s program, policy, and fiscal planning.”	DARS “uses information obtained through its outreach activities in reporting incidence (number of people admitted to the hospital for treatment) and in identifying needs/barriers/gaps in services.”

Minor Consent Requirements for Voluntary Inpatient Psychiatric Treatment

During the 2014 General Assembly Session, Senate Bill 184 (Senator Jeffrey L. McWaters) and House Bill 1097 (Delegate James M. LeMunyon) were introduced to amend the minor consent requirement for inpatient psychiatric treatment. While the bills differed in approach, both would eliminate the requirement for a minor who is 14 years of age or older to consent to voluntary inpatient psychiatric treatment. SB 184 was passed by indefinitely by the Senate Committee on Courts of Justice with a letter from the Clerk of the Senate referring the bill's subject matter to JCHC for review. HB 1097 was left in the House Committee on Courts of Justice and referred to JCHC by letter of the Committee Chair for review.

INPATIENT PSYCHIATRIC TREATMENT AND AVAILABLE BEDS

Parental admission of minors for inpatient psychiatric treatment involves interests of parents, children, and government. *Code of Virginia* §§ 16.1-338 and 16.1-339 provide procedures for parental admission of minor children for inpatient treatment in psychiatric inpatient facilities and for certain residential treatment services. In terms of a continuum of treatment alternatives, residential and inpatient psychiatric treatment are the most intensive, costly, and disruptive to home-based family life. There is no statewide data available regarding the frequency in which minors are involved in voluntary admissions, voluntary admission over objection, or court cases involving objecting minors.

Private hospitals and residential facilities are not required to provide mental health care and in certain areas of the State, there are relatively few inpatient psychiatric beds. In addition, there are instances in which an open bed exists but a facility may not accept the minor for patient-or facility-related reasons. Patient-related reasons may include gender, violent behavior, status as a sex offender, or a medical condition that cannot be managed. Facility-related reasons may include the demands of the current unit population or that staff may not have the training to treat certain individuals.

VIRGINIA'S CURRENT LAW

The admissions process for minors younger than 14 years of age and consenting minors 14 and older is defined in *Code* § 16.1-338. The requirements for admission are:

- 1) parental consent,
- 2) application for admission,
- 3) willing facility, and
- 4) minor's consent if over 14 years of age.

Within 48 hours of admission, a qualified evaluator is required to conduct a personal examination of the minor and make the following written findings:

- “1. The minor appears to have a mental illness serious enough to warrant inpatient treatment and is reasonably likely to benefit from the treatment; and
2. The minor has been provided with a clinically appropriate explanation of the nature and purpose of the treatment; and



3. If the minor is 14 years of age or older, that he has been provided with an explanation of his rights under this Act as they would apply if he were to object to admission, and that he has consented to admission; and
4. All available modalities of treatment less restrictive than inpatient treatment have been considered and no less restrictive alternative is available that would offer comparable benefits to the minor.”

If admission is sought to a State facility, “the community services board serving the area in which the minor resides shall provide...a preadmission screening report conducted by an employee or designee of the community services board.” For admission to a private facility, a qualified evaluator conducts the examination; the evaluator can be the facility medical director.

The admission process for a minor 14 years of age or older who objects to admission or is incapable of making an informed decision is defined in *Code* §16.1-339 which specifies the opportunity for judicial review. A minor under this section may be admitted to a willing facility upon the application of a parent and within 24 hours will be examined by a qualified evaluator designated by the community services board that serves the area the facility is located. As noted below, the evaluator must determine whether the minor meets the criteria for admission, which is a much-higher standard than the voluntary commitment required in *Code* §16.1-338.

“The evaluator shall prepare a report that shall include written findings as to whether:

1. Because of mental illness, the minor (i) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusional thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control;
2. The minor is in need of inpatient treatment for a mental illness and is reasonably likely to benefit from the proposed treatment; and
3. Inpatient treatment is the least restrictive alternative that meets the minor's needs. The qualified evaluator shall submit his report to the juvenile and domestic relations district court for the jurisdiction in which the facility is located.”

When an objecting minor or one that is incapable of making an informed decision is initially admitted under *Code* §16.1-339, the facility files “a petition for judicial approval no sooner than twenty-four hours and no later than ninety-six hours....Upon receipt of the petition, the judge appoints a guardian ad litem for the minor and counsel to represent the minor....The court and the guardian ad litem shall review the petition and evaluator's report and shall ascertain the views of the minor, the minor's consenting parent, the evaluator, and the attending psychiatrist.” The court may order the facility to release the minor, authorize continued hospitalization for up to 90 days on the basis of the parent’s consent, or schedule a commitment hearing.

APPROACHES TAKEN BY OTHER STATES

State laws vary significantly and can be classified into three basic groups: very protective of parents’ rights, very protective of minors’ rights, or intermediate in approach.

States that Are Very Protective of Parents' Rights. These states provide no judicial review requirement for parental admission of a minor. An independent examiner, usually the facility's medical director, makes the determination of whether a minor meets the criteria for admission. The typical criteria for admission are the minor will benefit from treatment and that the treatment cannot feasibly take place in a less restrictive setting. Examples of these states include Arizona, Missouri, Minnesota, Ohio, Oklahoma, Oregon, and Texas.

States that Are Very Protective of Minors' Rights. These states require a judicial hearing for an objecting minor and most have no "holding period" until the hearing. In some of these states, the criteria for admission when a minor objects are the same as their involuntary commitment standards. Examples of these states include Florida, Hawaii, Iowa, and New York.

States with an Intermediate Approach to Parental Admissions. Most of the states that take an intermediate approach set a minimum age at which the minor may object to his admission (12, 14, 15, or 16). The maximum "holding period" after admission but before judicial review varies widely, from three to 21 days. All of these states require a hearing for an objecting minor while some require the court to determine that the minor meets the criteria for involuntary commitment. Examples of these states include Colorado, Connecticut, Illinois, Kentucky, Louisiana, Michigan, New Jersey, North Carolina, South Dakota, Virginia, Washington, and West Virginia.

ACTIONS TAKEN BY THE JOINT COMMISSION ON HEALTH CARE

JCHC members voted to take the following actions.

Introduce legislation to amend *Code of Virginia* §§ 16.1-338 and 16.1-339 in order to:

- Increase the time allowed before a petition for judicial approval is filed from 96 hours (4 days) to 120 hours (5 days).
- Require that the mental health facility notify the consenting parent immediately if a minor 14 or older objects at any time to further treatment. In addition, the parent shall be informed of the avenues available to request continued admission under *Code* §§ 16.1-339, 16.1-340.1, or 16.1-345.
- Change the mental health criteria for admission of an objecting minor to make it consistent with the existing mental health criteria for a voluntary admission of a consenting minor in *Code* § 16.1-338.

By letter of the JCHC Chair, request that the Institute of Law, Psychiatry and Public Policy review and describe current practices regarding admission of minors for inpatient psychiatric treatment in Virginia and report to JCHC when findings and conclusions are available.

Include in the JCHC work plan for 2015, a staff review of the implications of allowing a minor to consent for inpatient treatment at a mental health facility without the consent of the minor's parent. The review shall include consideration of 1) amending *Code* § 16.1-338 to allow a minor 14 years of age or older to consent for voluntary inpatient mental health treatment without the consent of the minor's parent, 2) creating a judicial review regarding release under *Code* § 16.1-339 when the minor desires to continue inpatient treatment and consent for continued admission is withdrawn by the parent who consented to the minor's admission, and 3) reimbursement issues for services provided when a minor receives inpatient mental health treatment without the consent of the minor's parent.

LEGISLATIVE ACTION

Senate Bill 779 - Senator Jeffrey L. McWaters

SB 779 sought to amend *Code of Virginia* §§ 16.1-338 and 16.1-339 in order to:

- i) increase the time that a non-consenting minor aged 14 or older could be held in an inpatient mental health facility from 96 to 120 hours;
- ii) make the basis for judicial authorization, to continue hospitalization despite the minor's objection, consistent with the criteria for a voluntary admission of a consenting minor; and
- iii) require that facility staff notify a parent immediately if his/her child (aged 14 or older) objects to further inpatient treatment while providing the parent with an explanation of the procedures for requesting continued treatment.

SB 773 (Senator McWaters) and HB 1717 (Delegate LeMunyon), companion bills which addressed two provisions included in SB 779, were considered and approved before SB 779 was heard in Senate Courts. Consequently, Senator McWaters asked that SB 779 be amended to address only the excluded provision - to increase the time a non-consenting minor may be held from 96 to 120 hours.

SB 773, HB 1717, and SB 779 were enacted
(*Acts of Assembly 2015* Chapters 543, 504, and 535 respectively).

Dental Safety Net Capacity and Opportunities for Improving Oral Health

In 2012, Senate Joint Resolution 50 (Senator George L. Barker) directed JCHC to conduct a two-year study of the fiscal impact of untreated dental disease in the Commonwealth. The study resulted in a policy option to include in the 2014 JCHC work plan a targeted study of the dental capacity of Virginia's oral health care safety net providers, an option that was approved by JCHC members.

The approved policy option specifically requested that JCHC conduct “a targeted study of the dental capacity and educational priorities of Virginia's oral health care safety net providers – to include an in depth look at ways to more proactively divert patients from ERs to dental resources within their communities and to include discussion on alternative settings where additional providers (such as registered dental hygienists) can practice to access additional patient populations that are not being reached. The study and its objectives should be led by the many and diverse stakeholders in the oral health community: The Virginia Department of Health, Virginia Association of Free and Charitable Clinics, Virginia Community Healthcare Association, the Virginia Dental Hygienists' Association, the Virginia College of Emergency Physicians, Virginia Dental Association, Virginia Commonwealth University School of Dentistry, Virginia Health Care Foundation, Old Dominion Dental Society, Virginia Oral Health Coalition, Virginia Health Care Association, and Virginia Rural Health Association will be asked to work with JCHC staff in determining the need for any additional funding and resources to take care of Virginia's most vulnerable citizens. Furthermore, the group would be charged with taking a longer view of resources needed to improve education, awareness and proactivity for changing oral hygiene habits. The group would also collaborate with the Department of Education and other education stakeholders to expand oral health education in public schools.”

Many Virginians do not have dental insurance and cannot afford regular dental services. These individuals lack preventive care and often develop serious dental problems, with negative consequences for their overall physical health and their ability to thrive as productive members of society. Dental disease, and the chronic pain that it often causes, affects a person's ability to eat, sleep, and perform regular daily activities, including going to school or work. In addition, bacteria and inflammation from oral disease have negative effects on conditions such as diabetes, cardiovascular disease, respiratory infection, and osteoporosis; and can result in adverse pregnancy outcomes.

Dental Work Group Subcommittees

- Dental safety net capacity
- Development of an emergency department diversion plan
- Potential expansion of the Remote Supervision of Dental Hygienists model
- Education and prevention
- Teledentistry

A work group of approximately 30 individuals representing a broad range of stakeholders was convened. During the first meeting, five subcommittees were established to address the issues identified as most relevant to the study. The full work group and five subcommittees each met twice for a total of 12 meetings.

Dental-Service Sites	Staffing	Patients Served 2013	Estimated Need
95 operatories (25 on-site, 5 dental offices) serve 30 of 60 clinics	462 volunteer dentists, 142 volunteer dental hygienists	14,500 patients with \$5 million budget	\$3.3 million to expand in currently operating clinics

While these clinics are able to provide dental care to a significant number of Virginians, most are not able to meet the high demand for services in their community. Many have long wait lists and/or have stopped accepting new dental patients; and some are only able to treat for pain. With additional funding of \$3.3 million, the dental clinics already providing dental care would be able to treat 15,474 additional patients per year – twice the number who currently can be seen.

DEVELOPMENT OF AN EMERGENCY DEPARTMENT DIVERSION PLAN

Lack of access to dental care often means people with dental problems seek care in emergency departments (EDs) which typically are only able to provide an antibiotic and/or pain medication, and at a significantly higher cost. Data obtained this year from five Virginia hospitals indicate that the proportion of ED visits that are dental related mirrors the national estimate of 1 to 2 percent. In addition, study results, from the ED diversion pilot program at Virginia Commonwealth University (VCU) and data from the Memorial Hospital of Martinsville and Henry County regarding their efforts to divert patients to a community dental clinic, indicate ED diversion plans can be effective in helping individuals find the oral health care they need in a more appropriate setting. However, these programs are only possible in localities in which there is a dental school or full-time community dental clinic to receive the diverted patients. Significant portions of the State lack a dental safety net facility; and in the localities with a safety net provider, many have waiting lists and/or lack the resources to care for all who are in need of services. It is unlikely that successful ED diversion can occur without additional funding for dental safety net providers.

EXPANSION OF REMOTE SUPERVISION OF DENTAL HYGIENISTS MODEL

In 2009, the General Assembly enacted legislation to reduce the dentist oversight requirement for hygienists employed by VDH in areas designated as dentally underserved. In these areas, dental hygienists are allowed to work under remote, rather than general or direct supervision of a dentist.

Under remote supervision “a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but such dentist may not have done an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided” (*Code § 54.1-2722*). Under remote supervision, VDH hygienists may perform an initial examination of teeth and surrounding tissues, charting existing conditions; administer prophylaxis of natural and restored teeth; conduct scaling using hand instruments and ultrasound devices; provide dental sealant, assessment, maintenance and repair; apply topical fluorides; and provide educational services, assessment, screening or data collection for the preparation of preliminary records for evaluation by a licensed dentist.

While the remote supervision program initially was limited to services provided in schools, additional legislation was passed in 2012 allowing a dental hygienist employed by VDH to practice throughout the Commonwealth. The program has “improved access to preventive dental services for those at highest risk of dental disease, as well as reduced barriers and



costs for dental care for low-income individuals” (*Report on Services Provided by Virginia Department of Health Dental Hygienists Pursuant to a “Remote Supervision” Practice Protocol 2013*, Report Document No. 30 – 2014). The Board of Health Professions is currently considering expanding the model to include dental hygienists not employed by VDH and in a potentially broader range of settings. The options to expand the model include allowing non-VDH dental hygienists to practice via remote supervision in safety net facilities, hospitals, nursing homes, or all dental sites, including the private sector, in order to provide access to a greater portion of Virginia’s underserved population.



The subcommittee on remote supervision considered the range of expansion options and the majority of members supported an incremental approach with initial expansion to safety net facilities only. Further, it was suggested that a work group of primary stakeholders, including Virginia Dental Association, Virginia Dental Hygienists’ Association, Virginia Department of Health, Virginia Association of Free and Charitable Clinics, Virginia Community Healthcare Association, Virginia Oral Health Coalition, Virginia Board of Dentistry, Old Dominion University’s School of Dental Hygiene, and the VCU School of Dentistry, be created to develop a pilot program for the expansion of the remote supervision model, giving stakeholders the chance to be involved in determining the bounds and scope of the model and specific protocol.

EDUICATION AND PREVENTION

The subcommittee on education and prevention focused on improving oral health education in the Virginia school system. Currently, the topic of oral health is only covered in the kindergarten and first grade Standards of Learning (SOLs). The subcommittee, including members from VDH and the Virginia Department of Education, recommended inclusion of oral health education in the SOLs for all school-grades, along with the curriculum “Saving Smiles Series” developed by VDH for kindergarten through 10th grade. Curriculum information can be found at <http://www.vdh.virginia.gov/OFHS/childandfamily/dental/ohe/>

TELEDENTISTRY

Questions remain regarding the range of appropriate uses for teledentistry and obstacles may need to be addressed to facilitate its adoption in Virginia. While the *Code of Virginia* includes a section on reimbursement for telemedicine, teledentistry is not specifically authorized. As a result, it is unclear whether teledentistry can be bill for reimbursement. In 2013, the Virginia Oral Health Coalition created a teledentistry work group to review these issues. The work group members recommended encouraging the efforts of the Coalition’s work group and suggested a report of its findings be submitted to JCHC by October 2015.

ACTION BY THE JOINT COMMISSION ON HEALTH CARE

JCHC members voted to take no action.

Scope of Practice Exemptions in Approved Hospitals

The 2013 staff study, *Update on the Virginia Physician Workforce Shortage*, addressed some scope of practice issues and JCHC members approved a specific review of allowing certain providers working within an approved facility to be exempt from Virginia's scope of practice laws. The exempted providers would be allowed to perform activities that would otherwise require a license from the board of medicine, nursing, pharmacy, or physical therapy and were expected to include:

- **Military-trained Personnel:** Applies only to individuals performing activities substantially similar to health care training and experiences that they received in the military.
- **Individuals Licensed in Other States:** Applies only to individuals, licensed by a health professionals' regulatory body in another state, who perform activities within their level of training but will not perform activities that exceed those approved for a similarly-trained professional licensed in Virginia.
- **Non-specific Grouping:** Applies only to individuals that have the requisite education or training to perform the designated activities. Practice activities may be limited by the hospital or hospital governing body for individuals practicing under this exemption within its facility. Furthermore, additional limitations may be set by the provider's supervising physician through the practice agreement.

SCOPE OF PRACTICE EXEMPTIONS IN OTHER STATES

Various types of scope of practice exemptions are allowed in the United States. Some of the traditional types of exemptions allowed in other states include:

- Practitioner licenses may be issued without examination to individual physicians who are licensed in states that have equal or more rigorous requirements than the licensing state (Connecticut, Kentucky, Louisiana, and Oregon).
- A limited license may be issued on an individual-basis for applicants who received medical residency training outside of the United States and Canada (South Carolina).
- The physician-requirement for a single year of postgraduate medical education is waived for individuals who practice in medically-underserved areas (Nebraska).
- Foreign- and domestically-trained physicians who have been accepted to train in an approved cancer center may be issued a 1-year license and certain practitioners who were educated in foreign nations may apply for restricted licenses if they pass a prescribed exam and practice under the supervision of another physician (Florida).
- Physicians and surgeons who are licensed to practice in another state may practice medicine in a state institution if supervised by a practitioner licensed in that state (California).
- Out-of-state medical practitioners may practice during emergencies in Arkansas if they work within their scope of practice and are in good standing in their home state and in Oklahoma as volunteers.

California's Health Workforce Pilot Project. In 1972, the California State Assembly created the Health Workforce Pilot Project (HWPP) to allow health organizations the opportunity to demonstrate, test, and evaluate new or expanded roles for health care professionals. Nonprofit educational institutions, community hospitals, clinics, and governmental agencies engaged in health or education were allowed to apply and the pilot projects were allowed to expand the scope of practice for licensed health professionals in

medical auxiliaries, dental auxiliaries, nursing, maternal child care, pharmacy, mental health, and other health care areas.

A 2009 review by the California HealthCare Foundation, an independent philanthropy, found that the projects undertaken under the HWPP assisted California's lawmakers in considering changes in scope of practice and some statutory changes have been made particularly related to nurse practitioners, physician assistants, and pharmacists. "This is not to say however, that all projects were effective in changing laws to the extent desired by project sponsors. Legislative decisions remain in the hands of the state legislature, which is in no way bound by the outcomes of the HWPP projects...."⁶

UNDERTAKING A PILOT PROJECT IN VIRGINIA

JCHC staff met with representatives of the Virginia Hospital and Healthcare Association (VHHA) to seek assistance in finding a hospital interested in exploring a pilot-project. VHHA provided the following statement regarding a pilot-project:

"VHHA appreciates the Joint Commission on Health Care's consideration of a pilot of a facility based scope of practice exemption for certain services or individuals. We are interested in further considering this pilot, especially in the context of hiring qualified veterans into the healthcare workforce. Virginia hospitals are moving rapidly to hire qualified veterans into health care jobs through our Troops to Healthcare initiative in partnership with the Virginia Values Veterans (V3) initiative. We are assessing with our members the level to which state health care licensure requirements pose a barrier to the hiring of qualified veterans and would like to re-visit this policy option once that assessment is completed."

ACTION BY THE JOINT COMMISSION ON HEALTH CARE

No policy options were developed as the study was completed on an information-only basis.

⁶ California HealthCare Foundation Issue Brief, *Improving Access to Health Care in California: Testing New Roles for Providers*, December 2009, p.4.

Grand Aides and Similar Models of Health Care Delivery

During the 2013 General Assembly Session, House Joint Resolution 571 (Delegate Patrick A. Hope) directed JCHC to study the feasibility of developing a program of trained primary care personnel to extend the reach of primary care services and reduce health care costs in the Commonwealth. Although the resolution was left in the House Rules Committee, Delegate Hope requested by letter that JCHC conduct the study.

THE GRAND AIDES MODEL

The Grand Aides model was developed in 2008 by Dr. Arthur Garson, a pediatric cardiologist and Director of the Center for Health Policy at the University of Virginia. The Grand Aides Foundation assists health care organizations in training Grand Aides and in implementing a Grand Aide program.

The program goals address:

- Primary care physician shortages and increase access to appropriate health care providers by training laypersons to be part of a team-based model of care.
- Reduce inappropriate/overuse of hospital emergency departments
- Provide chronic disease management services in a home setting and reduce hospital readmissions
- Educate patients on prevention and self-care
- Improve efficiency and reduce costs in the health care system

A Grand Aide is a Certified Nurse Aide who has received additional training in the Grand Aide curriculum to be an extender for a nurse, nurse practitioner, or physician. A Grand Aide typically specializes in prevention and self-care education.

For patients transitioning from hospital to home, the Grand Aide meets with the patient 1-2 days prior to discharge and then accompanies the patient home from the hospital. For patients with chronic disease who are not hospitalized, the Grand Aide will meet in his/her clinic/physician's office. At home, the Grand Aide assists the patient in developing regimens for medication adherence and reconciliation as well as other parts of the treatment plan. Home visits are daily for the first week and then as needed. The Grand Aide may continue to see the patient and change level of intensity as patient's illness (or adherence) changes. For those with multiple chronic diseases, and especially the frail elderly, patient-specific protocols are developed and may also include assessment of mental health of chronic patients.

The Primary Care Grand Aide is employed in a physician's practice or clinic to implement efficient, cost-effective care for adults and children by providing a mechanism by which patients who have non-serious primary care problems can stay at home rather than make an unnecessary visit to an emergency department or physician's practice. The Grand Aide Foundation estimates that each Grand Aide can help care for 150 to 300 primary care patients per year.

REVIEW OF SIMILAR CARE MANAGEMENT PROGRAMS IN VIRGINIA

As part of the study, all Medicaid health plans completed an emailed questionnaire about the components of their care management program; and interviews were conducted with Optima, VA Premier, and VCU's Virginia Coordinated Care program. All of Virginia's Medicaid health plans have care management programs to address hospital readmissions, misuse of emergency departments, and/or the need for chronic disease management. Many of these programs are similar to the Grand Aides model, sharing the same goals but differing in design to varying degrees

Preliminary research suggests that the Grand Aides model can play a role in reducing the number of hospital readmissions, providing care management for persons with chronic diseases, and reducing health care costs. Medicaid reimbursement for home-based telemedicine, scope of practice, and State certification of community health workers are policy issues relevant to the Grand Aides model that continue to be debated.

ACTION BY THE JOINT COMMISSION ON HEALTH CARE

No policy options were developed as the study was completed on an information-only basis.

Annual Reporting by Virginia's Health Conversion Foundations

The Virginia Consortium for Health Philanthropy requested a review by JCHC “regarding the need for Virginia’s health conversion foundations to continue providing a joint annual report regarding their charitable activities.” These annual reports were requested in House Joint Resolution 179, introduced in 1998 by Delegate Alan A. Diamonstein on behalf of JCHC.

REVIEWS AND ACTIONS CONCERNING HOSPITAL CONVERSIONS IN THE 1990S

During the 1990s, a number of not-for-profit hospitals converted to for-profit status. The U.S. General Accounting Office (GAO) issued a report in December 1997 which concluded: “Concerns about the conversion of not-for-profit hospitals and the transfer of millions of dollars in charitable assets still exist, because they are carried out essentially privately between boards of the selling hospitals and management of the purchasing for-profit companies. These conversions are not routinely subject to any disclosure requirements, which leave little opportunity for community involvement outside of the community members who serve on the not-for-profit hospitals’ boards. A growing number of states are recognizing that the public interest is at stake and, as a result, are becoming more involved in overseeing the conversion process and monitoring the terms of such transactions. This increased state oversight may address some questions and concerns related to obtaining fair value for charitable assets, obtaining public disclosure and community input, and ensuring that the proceeds of the transaction are used for appropriate charitable purposes.”⁷

The GAO report also noted that as of August 1997, 24 states including Virginia had enacted some form of legislation regarding conversions.

House Bill 2335 Authorized Role for the Attorney General. HB 2335, enacted during the 1997 Session, amended Title 55 of the *Code* establishing a process and role for the State’s Attorney General to monitor conversion activities. The legislative provisions required any nonprofit hospital, health services plan, or health maintenance organization planning a transaction which would dispose of or change control of its assets, to provide written notification to the Attorney General at least 60 days before the proposed transaction; within 10 days of that notification, the Attorney General was required to place “a public notice of the transaction to be published in a newspaper in which legal notices may be published in that jurisdiction.”

Senate Joint Resolution 298 requested JCHC Study of Indigent and Uninsured Populations. In completing the study requested by SJR 298 (1997), the impact of hospital conversions on the provision of care was examined. JCHC study findings included:

- Hospital conversions often resulted in the establishment of conversion foundations to continue the not-for-profit mission.
 - Federal law included strict rules regarding how assets could be used following conversion from not-for-profit to for-profit status.
 - Most of the newly-established health foundations had been created through hospital conversions and some nonprofit “leaders and state regulators believe the...assets [should] provide care for indigent and uninsured persons in their communities.”

⁷ GAO/HEHS-98-24, *Not-For-Profit Hospitals: Conversion Issues Prompt Increased State Oversight*, Dec. 1997, p. 31.

- As of 1997, five hospitals in Virginia had converted from not-for-profit to for-profit status and established foundations with assets ranging from \$4 million to \$140 million; in addition, three hospitals created foundations in disposition of assets to another not-for-profit organization. The newness of most of the conversions meant that the impact on the provision of care could not be determined.⁸

Based on the review of hospital conversions, JCHC members voted to introduce the resolution that resulted in the annual reporting request (House Joint Resolution 179 – 1998).

ANNUAL REPORTING AND OTHER PRESENT-DAY REQUIREMENTS

Currently there are 14 health conversion foundations in Virginia, eight of the foundations “are the result of sales and/or lease to for-profit entities” and are therefore subject to JCHC’s annual reporting request. The Virginia Consortium for Health Philanthropy (VCHP), an informal association of health foundations, has submitted a joint annual report on behalf of the health conversion foundations within its membership for the last 16 years. (The Greensville Memorial Foundation was not listed as a VCHP member and did not have information included in the FY 2012 or FY 2013 annual report. The Harvest Foundation was not listed as a VCHP member and did not have information included in the FY 2013 annual report.)

VCHP contracts with a consultant to assemble and compile information from each of the reporting health foundations; four foundations that were not “required” to submit information chose to do so for the 2013 report.

Foundation	Total Assets*	Grant Awards*
The Alleghany Foundation	\$67.2 million	\$3.1 million
The Cameron Foundation (Petersburg)	\$122.3 million	\$5.6 million
Danville Regional Foundation	\$215.0 million	\$10.3 million
Greensville Memorial Foundation (Emporia)	\$12.3 million – FY 2011	\$313,324 – FY 2011
The Harvest Foundation (Martinsville)	\$197.4 million – FY 2012	\$13.7 million – FY 2012
Jenkins Foundation (Richmond)	\$47.5 million	\$2.3 million
John Randolph Foundation (Hopewell)	\$40.4 million	\$758,013
Wythe-Bland Foundation (Wytheville)	\$51.0 million	\$2.5 million
*As reported in the 2013 Report or previous reports of Virginia’s Conversion Health Foundations, if so indicated.		

The 2013 report indicated that Virginia’s conversion foundations serve specific geographic areas which cover “34% of Virginia’s cities and counties....The largest proportion of health and human services grants was awarded for projects related to access to health services (\$11.6 million; 44%) – a continuing priority for the foundations. This general category includes access to medical, dental and mental health (as well as substance abuse) services....The conversion foundations are making a significant contribution to improving the health status of residents in the communities they serve. They are dedicated to strengthening existing community-based nonprofits and helping to establish new organizations that may be needed to address pressing health needs. There is tremendous

⁸ JCHC *Study of the Indigent/Uninsured Pursuant to SJR 298*, SD No. 43 – 1998, pp. II-21-22.

long-term potential for these foundations to assist in bringing lasting and positive change to the health of Virginia's residents."⁹

Request for JCHC Review of Continued Need for Annual Report. As previously noted, in October 2013 VCHP requested a JCHC-review of the continued need for health conversion foundations to submit annual reports of their charitable activities. Mary Fant Donnan, Executive Director of the Alleghany Foundation and Jeanne Zeidler, President of the Williamsburg Health Foundation attended the JCHC meeting in June 2014 to speak to the VCHP request. Ms. Zeidler made the following comments in observing that much "has changed since 1998:

- Health conversion foundations were relatively new then and there were only a few. Their value and impact was unknown. Those who were around at the time remember your predecessors' interest in monitoring the activity of these new entities to ensure that their resources would be put to good use within their communities.
 - Virginia now has 14 health conversion foundations. Most have existed for more than five years. All have stellar records of using their resources to enhance their communities and improve the health status of those who live in their service areas. All of us also have a record of transparency and regular reporting to our communities...[O]ur communication vehicles appropriately include annual reports to our communities, press releases, websites, community presentations, and social media such as FACE BOOK and Twitter...none of these social media tools were available 16 years ago....
- Since 1998 there have been several other mechanisms created that also help ensure the accountability and transparency of conversion foundations.
 - For example, our federally mandated 990 tax reports are now required to be publicly available. Most of us post them on the national Guidestar website, which is known as the place to go to learn about any nonprofit tax-exempt organization. In addition, these 990 forms contain much more detail than those that existed 16 years ago.
 - There is now an official process for the Attorney General to review the circumstances and charter of any new conversion foundations, a process that is not exist in 1998.
- For these reasons, we find ourselves wondering if the report we produce for you may have outlived its usefulness and may be redundant....The letter we sent to your leadership last October, indicated our willingness to continue to produce the report if you think there is a compelling reason to do so."¹⁰

ACTION TAKEN BY THE JOINT COMMISSION ON HEALTH CARE

JCHC members voted to take no action; the expectation is that an annual joint report will continue to be submitted by Virginia's health conversion foundations.

⁹ *Virginia's Conversion Health Foundations 2013 Report to the Joint Commission on Health Care*, September 26, 2014, pp. ii-iii.

¹⁰ Transcript of comments made by Jeanne Zeidler, President and CEO of the Williamsburg Health Foundation representing the Virginia Consortium for Health Philanthropy, during June 11, 2014 meeting of JCHC.

MEETING AGENDA 2014

Joint Commission on Health Care

- June 11 **Election of Officers**
Senator Linda T. Puller
- 2014 Work Plan Proposals**
Kim Snead, Executive Director
- Letter Request from Virginia Consortium of Health Philanthropy**
Mary Fant Donnan, Executive Director, The Alleghany Foundation
Jeanne Zeidler, President, Williamsburg Health Foundation
- September 16 **Adoption of JCHC’s FOIA Policy on Remote Participation**
JCHC Membership
- VHI 2014 Annual Report and Strategic Plan Update: Big Data for Better Decisions**
Michael T. Lundberg, Executive Director, Virginia Health Information
- Staff Report: Study of Viral Hepatitis in the Commonwealth**
Michele L. Chesser, Ph.D., Senior Health Policy Analyst
- Medical Homes: Building Blocks to Health System Reform**
Barbara Wirth, MD MS, Program Manager, National Academy for State Health Policy
- October 8 **Review of Public Comments**
Kim Snead
- STAFF REPORTS:**
- Interim Report on Progress in Expanding Access to Brain Injury Services**
Portia L. Cole, Ph.D., Senior Health Policy Analyst
- Minor Consent Requirements for Voluntary Inpatient Psychiatric Treatment**
Stephen W. Bowman, Senior Staff Attorney
- Dental Safety Net Capacity and Opportunities for Improving Oral Health**
Michele L. Chesser, Ph.D.
- November 5 **Staff Report: Scope of Practice Exemptions in Approved Hospitals**
Stephen W. Bowman
- Update on SB 627 Work Group on Training Center Closures**
Debra K. Ferguson, Ph.D., Commissioner
Department of Behavioral Health and Developmental Services
- Decision Matrix: Review of Policy Options and Legislation for 2015**
JCHC Staff

Behavioral Health Care Subcommittee

August 20

Welcome New Members

Delegate Christopher P. Stolle, Co-Chair

DBHDS Behavioral Health Update and Priorities

Debra K. Ferguson, Ph.D., Commissioner

Department of Behavioral Health and Developmental Services

OSIG Overview and Review of Mental Health Services in Local and Regional Jails

State Inspector General June W. Jennings

The Honorable Gabriel A. Morgan, Sr., Sheriff of Newport News

The Honorable Brian K. Roberts, Sheriff of Brunswick County

INVITED SPEAKERS

Stephany Melton Hardison, MSW, Acting Executive Director

National Alliance on Mental Illness of Virginia

Jennifer Faison, Executive Director

Virginia Association of Community Services Boards

Ashley Everette, Policy Analyst

Coordinator, Campaign for Children's Mental Health

Voices for Virginia's Children

October 8

2013 Compensation Board Report on Mental Illness in Jails

Robyn de Socio, Executive Secretary

Compensation Board

Medicaid Payments for Community Hospitalization of Incarcerated Offenders

Jack Quigley, Special Projects Manager

Department of Medical Assistance Services

Determining Medicaid Eligibility for Offenders in State Correctional Institutions

Fred Schilling

Department of Corrections

Recommendations of the Governor's Taskforce on Improving Mental Health Services and Crisis Response

Holly Coy, Policy Director

Office of the Lieutenant Governor

Components of A *Healthy Virginia* Action Plan

Jennifer S. Lee, M.D.

Deputy Secretary of Health and Human Resources

Healthy Living/Health Services Subcommittee

August 20

Welcome New Members

Delegate T. Scott Garrett, Co-Chair

Cracking the Code on Health Care Costs: A Report by the State Health Care Cost Containment Commission

Raymond Scheppach, Ph.D.

The Miller Center and UVA School of Leadership and Public Policy

Trends in the Financial Burden of Health Care Spending for Families

Peter Cunningham, Ph.D.

VCU Department of Health Care Policy and Research

Staff Report: Grand Aides and Similar Models of Health Care Delivery

Michele L. Chesser, Ph.D.

September 16

Military Credentials Review and NGA Veterans' Licensure and Certification

Elizabeth A. Carter, Ph.D.,

Executive Director, Virginia Board of Health Professions

Director, DHP Healthcare Workforce Data Center

VDH Overview and Initiatives

Marissa Levine, M.D., MPH

State Health Commissioner

Priorities of the Department of Health Professions

Dr. David E. Brown D.C., Director

Department of Health Professions

Policy on Remote Participation Due to Emergency or Personal Reasons

It is the policy of the Joint Commission on Health Care (JCHC) that individual members may participate in JCHC meetings by electronic means as permitted by *Code of Virginia* § 2.2-3708.1. This policy shall apply to the entire membership and without regard to the identity of the member requesting remote participation or the matters that will be considered or voted on at the meeting.

As required by state statute, whenever an individual member wishes to participate from a remote location, a quorum of the JCHC membership shall be physically assembled at the primary or central meeting location, and arrangements shall be made for the voice of the remote participant to be heard by all persons at the primary or central meeting location. When such individual participation is due to an emergency or personal matter, participation shall be limited to two meetings or 25 percent of the meetings of the Joint Commission per member each calendar year, whichever is fewer. Furthermore, individual participation from a remote location shall be approved unless such participation would violate this policy or the provisions of the Virginia Freedom of Information Act. If a member's participation from a remote location is disapproved because such participation would violate this policy, such disapproval shall be recorded in the meeting minutes with specificity. Member-participation in a meeting shall be defined as occurring when a member calls into the meeting and voices his/her presence on the call but not when the member calls in and listens to the meeting presentations without identifying himself or herself. In order to qualify for and receive the legislative per diem, JCHC members who call into the meeting must voice their presence on the phone line.

The provisions set forth in this policy do not affect the medical and disability meeting attendance provisions specifically allowed for in *Code of Virginia* § 2.2-3708.1 (A) 2. which allows for participation if “a member of a public body notifies the chair of the public body that such member is unable to attend a meeting due to a temporary or permanent disability or other medical condition that prevents the member's physical attendance and the public body records this fact and the remote location from which the member participated in its minutes....”

STATUTORY AUTHORITY

§ 30-168. (Expires July 1, 2018) 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.

§ 30-168.1. (Expires July 1, 2018) 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.

§ 30-168.2. (Expires July 1, 2018) 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.

§ 30-168.3. (Expires July 1, 2018) 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.

§ 30-168.4. (Expires July 1, 2018) Staffing.

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

§ 30-168.5. (Expires July 1, 2018) 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.

§ 30-169.

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

§ 30-169.1. (Expires July 1, 2018) 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.

§ 30-170. Expires July 1, 2018) Sunset.

The provisions of this chapter shall expire on July 1, 2018.



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