JOINT COMMISSION ON HEALTH CARE

2018 ANNUAL REPORT

COMMONWEALTH OF VIRGINIA
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2018 Annual Report
Joint Commission on Health Care

To the Governor and the
General Assembly of Virginia

Report Document #231

Commonwealth of Virginia
Richmond
2019

JOINT COMMISSION ON HEALTH CARE

Senator Rosalyn R. Dance, Chair

Delegate T. Scott Garrett, Vice Chair

June 25, 2019

The Honorable Ralph Northam
Governor of Virginia
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

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

Dear Governor Northam 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, 2018.

This report includes a summary of the Joint Commission's activities including legislative recommendations to the 2019 Session of the General Assembly. In addition, many 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,

Rosalyn R. Dance

Michele L. Chesser, Ph.D., Executive Director
Joint Commission on Health Care
P.O. Box 1322/Richmond, Virginia 23218

Joint Commission on Health Care

Legislative Members

The Honorable David L. Bulova
The Honorable Benjamin L. Cline
The Honorable T. Scott Garrett
The Honorable C.E. Cliff Hayes, Jr.
The Honorable Patrick A. Hope
The Honorable Riley E. Ingram
The Honorable Kaye Kory
The Honorable Christopher K. Peace
The Honorable Christopher P. Stolle
The Honorable Roslyn C. Tyler

The Honorable George L. Barker
The Honorable Charles W. Carrico, Sr.
The Honorable Rosalyn R. Dance
The Honorable Siobhan S. Dunnavant
The Honorable John S. Edwards
The Honorable L. Louise Lucas
The Honorable Glen H. Sturtevant, Jr.
The Honorable David R. Suetterlein

Ex Officio Member

The Honorable Daniel Carey, M.D.
Secretary of Health and Human Resources

Commission Staff

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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, 2022 during the 2017 General Assembly Session (Senate Bill 1043 and House Bill 1736).

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.

Senator Rosalyn R. Dance served as Chair in 2018 and Delegate T. Scott Garrett served as the Vice Chair. During the work-plan meeting in June 2018, the commission voted to eliminate the Behavioral Health Care Subcommittee and the Healthy Living/Health Services Subcommittee.

Delegate Benjamin L. Cline is not returning in 2019 as he was elected to serve in the House of Representatives in November 2018. The Commission would like to thank him for his invaluable and dedicated service. Delegate Cline represented the 24th district. He was appointed to the Joint Commission in 2003 and has served as Commission Chairman in 2010 and 2011. Delegate Cline introduced several bills on behalf of JCHC that were enacted including:

HB 1161 on behalf of JCHC during the 2012 Session. HB 1161, which sought to limit unlawful access to the precursor ingredients needed to manufacture methamphetamine, was enacted (2012 Acts of Assembly, Chapter 252). HB1251, which allows physician recommendation for any condition determined by the physician to benefit from THC-A or CBD oil, was enacted (2017 Acts of Assembly, Chapter 246).

TABLE OF CONTENTS

ACTIVITIES

In keeping with its statutory mandate, the Joint Commission received reports from state agencies and other health-related groups; completed studies; considered comments from public and private organizations, advocates, industry representatives, citizens and other interested parties; and made policy recommendations to advance the quality of health and health care services in the Commonwealth.

Joint Commission on Health Care

The full Commission met five times in 2018. These meetings were held in Senate Room A of the Pocahontas Building on June 15th, August 22nd, September 18th, October 15th, and November 7th. The Commission also met on February 19th in Subcommittee Room 1 to discuss changing the study approval process. This meeting resulted in the creation of the JCHC Executive Subcommittee which decides, with input from all members, the JCHC work-plan for the year. The executive subcommittee meeting was held on April 17th in Subcommittee Room 3 of the Pocahontas Building. Meeting materials (including agendas, presentations, handouts and minutes) are posted on the JCHC website at http://jchc.virginia.gov.

Six staff reports were presented during the 2018 Joint Commission meetings:

- *Quality of Health Care Services in Virginia Jails and Prisons, and Impact of Requiring Community Services Boards (CSBs) to Provide Mental Health Services in Jails* (continued from 2017)
- *Pharmacy Drug Disposal Program*
- *Requiring the Installation of Onsite Temporary Emergency Electrical Power Sources for Assisted Living Facilities*
- *Addiction Relapse Prevention Programs in the Commonwealth*
- *Prevalence and Risks of ADHD Medications in Virginia* (continued from 2017)
- *Medical Aid-in-Dying in Virginia* (continued from 2017)
- *Options for Increasing the Use of Telemental Health in the Commonwealth- Final Report*
    - A written report was provided to members instead of a meeting presentation

In addition to the staff reports, invited guests delivered the following presentations at the meetings (go to http://jchc.virginia.gov/meetings.asp to view them):

- *Virginia's Plan for Well-Being – 2018 Update* presented by M. Norman Oliver, M.D., MA, State Health Commissioner of Virginia

- *Department of Behavioral Health and Developmental Services (DBHDS) Implementation Update on 2018 General Assembly Directives*, presented by S. Hughes Melton, M.D. MBA, Commissioner of the Virginia Department of Behavioral Health and Developmental Services
- *Department of Medical Assistance Services' (DMAS) Update for the Joint Commission on Health Care: 2018* presented by Jennifer Lee, M.D., Director of DMAS
- *The State Targeted Response to the Opioid Crisis Grant Awarded to Virginia and Emergency Department Pilots*, presented by Mellie Randall, Substance Use Disorder Policy Director at the Virginia Department of Behavioral Health and Developmental Services
- *Governor Northam's Health and Human Resources Strategic Priorities* presented by Daniel Carey, M.D., Secretary of Health and Human Resources
- *Medical Addiction and Recovery Treatment Services (ARTS) - Outcomes from the First Year* presented by Katherine Neuhausen, M.D., Chief Medical Officer, and Tammy Whitlock, Deputy of Complex Care, Department of Medical Assistance Services
- *Department of Social Services (DSS) Update for the Joint Commission on Health Care* presented by Duke Storen, Commissioner of Virginia Department of Social Services
- *Results of DBHDS Work Group on Improving the Quality of Direct Support Professional Workforce for the Developmental Disability Waiver Population* presented by Holly Mortlock, MSE, Policy Director, Virginia Department of Behavioral Health and Developmental Services
- *Trauma-Informed Mental Health and Child Development Services* presented by L. Robert Bolling, Chief Executive Officer of ChildSavers
- *Developmental Disabilities Waivers Update for the Joint Commission on Health Care* presented by Dawn Traver, M.Ed., Director of Waver Operations, Division of Developmental Services, Virginia Department of Behavioral Health and Developmental Services
- *2018 Annual Report and Strategic Plan Update* presented by Michael Lundberg, Executive Director, Virginia Health Information, Inc. (VHI)

STAFF ENDEAVORS

In 2018, JCHC staff engaged in a range of additional activities such as the following:

Virginia Memberships:

Children's Health Insurance Program Advisory Committee (CHIPAC)

DMAS Hospital Payment Policy Advisory Council (HPPAC)

Early Periodic Screening Diagnosis and Treatment (EPSDT) Project

Graduate Medical Education (GME) Residency Grant Committee

Virginia Values Veterans (V3)

Presentations:

JCHC 2017 Medical Cannabis Study and JCHC Studies Planned for 2018 presented to the Breast Cancer Foundation during Annual Advocacy Day

Panelist at the Virginia Quality Health Network's Breakfast with the Experts

Panelist at the Virginia Health Law Legislative Update and Extravaganza

Quality of Health Care Services in Virginia Jails and Prisons, and Impact of Requiring Community Services Boards to Provide Mental Health Services in Jails presentation to the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century

The Implementation of Virginia Medicaid Expansion presented to the Greater Williamsburg Chronic Care Collaborative

Virginia Joint Commission on Health Care: Background, Current Priorities and Recommendations and *Choosing a Career in the Health Policy Field* presented to Academy Health Student Chapter, Virginia Commonwealth University

Conferences, Seminars and Workshops Attended:

Academy Health National Health Policy Conference

Academy Health Annual Research Meeting

Accumulator Adjusters and Health Care Cost Shifting Strategies Seminar

Aligning State Medicaid Value-Based Payment Approaches with MACRA Policies and Measures Webinar

Association for Training on Trauma and Attachment in Children (ATTACh) Conference

Goodbye cost shifting, hello employer activism Webinar

Grant Management Workshop

Information Sharing During the Opioid Crisis: Challenges and Solutions Webinar

Mid-Atlantic Teleheath Summit (MATRC)

National Academy of Sciences' Physician-Assisted Death: Scanning the Landscape and Potential Approaches Workshop

Promising Practices for Meeting the Behavioral Health Needs of Dually Eligible Older Adults Webinar

Reference Based Pricing -- Leveraging State Purchasing Power to Lower Health Costs Webinar

Virginia Health Care Foundation's Mental Health Roundtable

The CMS Transparency Mandate: Turn a Liability to Your Advantage Webinar

The Medicaid Buy-In Landscape: Goals, Options and Design Considerations Webinar

Meetings Attended:

Department of Medical Assistance Services Capitation Rate Setting

Geriatric Mental Health Work Group

Health Insurance Reform Commission

House Health, Welfare and Institutions COPN Work Group and the Joint Commission on Administrative Rules

Joint Subcommittee for Health and Human Resources Oversight

Joint Subcommittee to Study Mental Health Services in the Twenty-First Century

Tobacco Region Revitalization Committee

Virginia Health Workforce Development Authority

Other Staff Activities:

Provided assistance in formulating a survey for the Virginia Poverty Law Center

Provided National Public Radio (NPR) interview regarding geriatric issues in Virginia's jail and prison systems

Visited ChildSavers to learn about the services they provide for children who have experienced trauma

Taught HCPR 601, Introduction to Health Policy, in the Department of Health Behavior and Policy at Virginia Commonwealth University

Taught HCPR 692, Applied Health Policy Research, in the Department of Health Behavior and Policy at Virginia Commonwealth University

Assisted many constituents and legislators with health care questions and inquiries

EXECUTIVE SUMMARIES

During 2018, Commission staff conducted studies in response to mandates or requests from the General Assembly or from the Joint Commission on Health Care membership. In keeping with the Commission's statutory mandate, the following studies were completed.

Quality of Health Care Services in Virginia Jails and Prisons, and Impact of Requiring Community Services Boards to Provide Mental Health Services in Jails (Final Report)

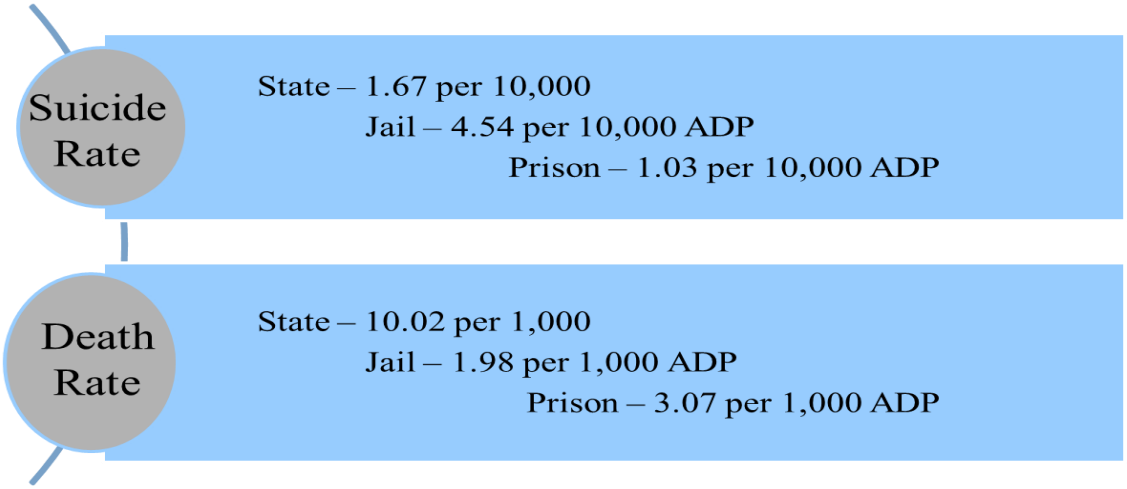
Study Mandate

This is the final report of a two-year study on two related topics--the quality of health care services in Virginia jails and prisons and whether the Community Services Boards (CSB) should be required to provide mental health services in jails. The study is based on 2017 resolutions by Delegate O'Bannon (HJR 616) and Delegate Holcomb (HJR 779) that were tabled in House Rules Committee with the understanding that JCHC would consider the study requests. JCHC members approved the studies during the work plan meeting in May of 2017.

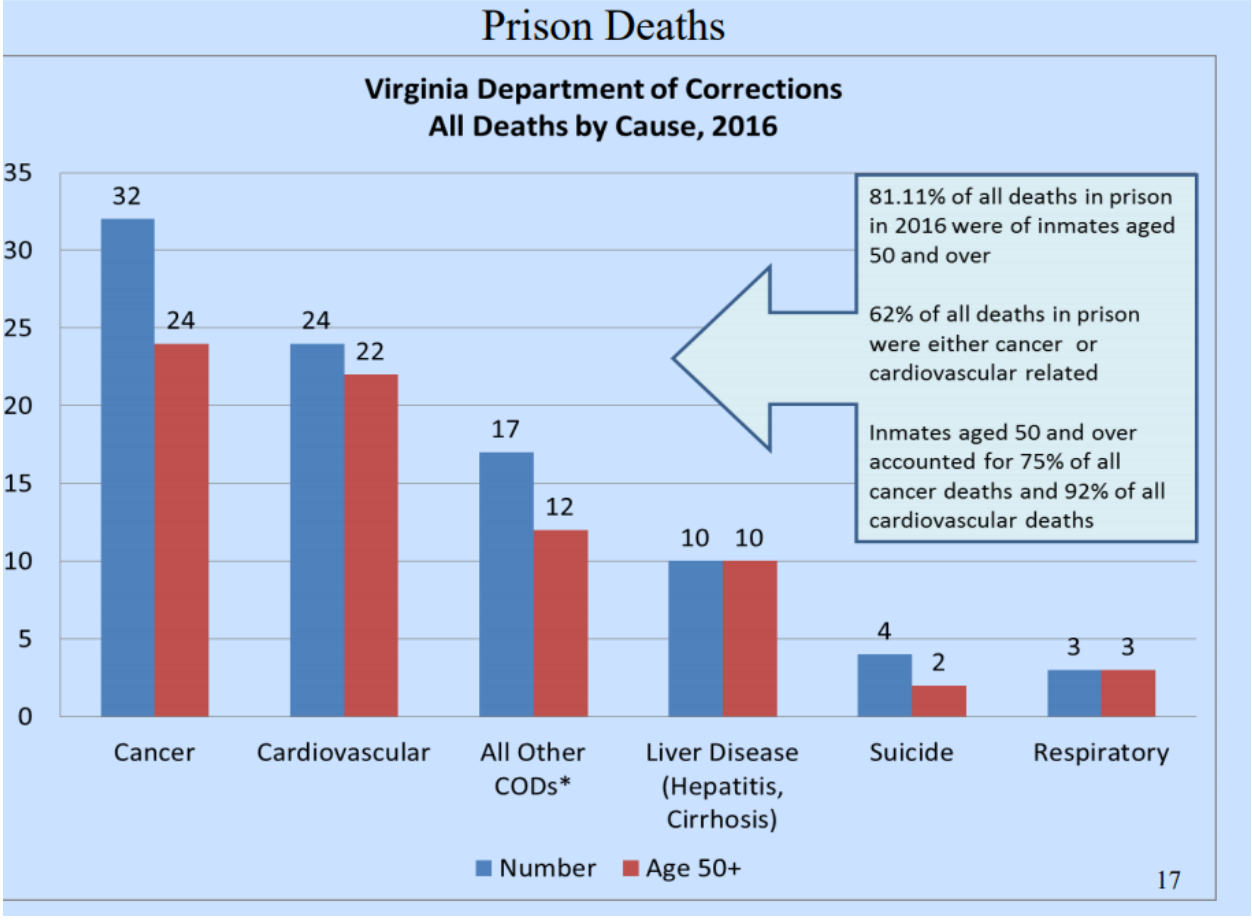
Putting Health Care in Jails and Prisons into Perspective

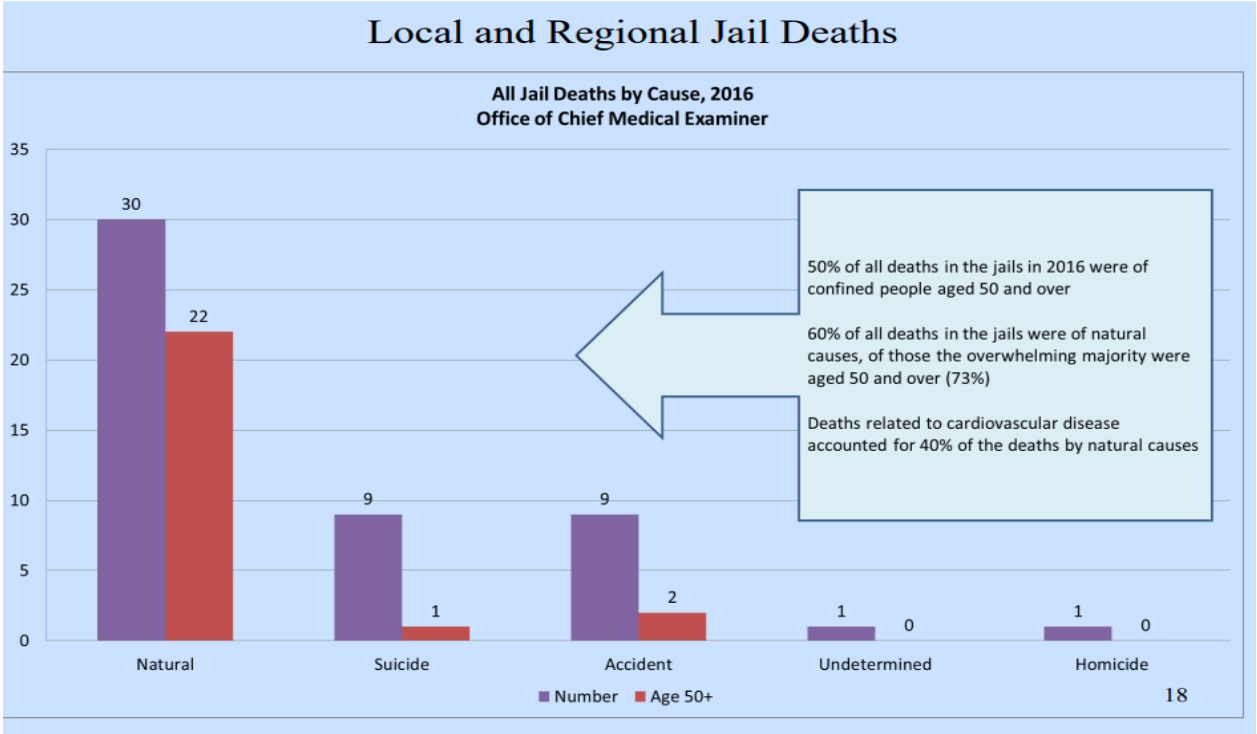
- The current jail and regional jail system is made up of 23 regional jails with 107 different member jurisdictions and 35 locally controlled jails. There were over 314,000 jail confinements during 2017 involving 170,303 individuals. The average daily population for the entire jail and prison system is approximately 60,000 (27,477 in local and regional jails and 28,887 in prisons). The average length of stay in jails was 17 days while in prisons it was six years.
- Local and regional jails and prison health care systems operate within the context of the overall health care system. Health care related staff shortages of physicians, nurses and psychiatrists impact the correctional setting as much as it does the private sector.
- Establishing quality measures in the correctional setting is a challenge in the jail and prison setting due to a lack of good data from the correctional systems.

- When put into the context of the overall health care system, mortality rates in jails and prisons are better than those in the general population. The only exception is the suicide rate in jails.

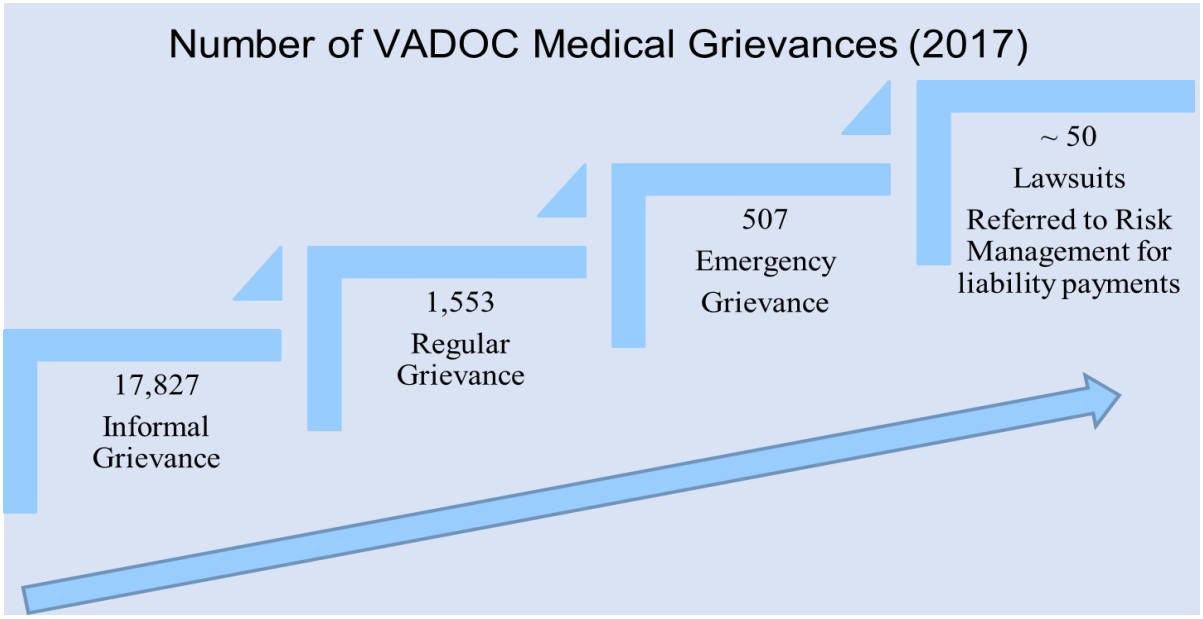


- The leading causes of death in both systems involve cancer and cardiovascular disease and the majority of deaths are offenders over age 50.





- The number of medical grievances filed by Virginia Department of Corrections (VADOC) offenders in state prisons provides a unique challenge to prison officials who must determine which are legitimate. Over 90% are resolved at the facility. Offenders can appeal the outcome of a grievance at any level, elevating them to the VADOC central office Medical Director / Medical Unit, and filing lawsuits. The Attorney General is currently working on 35 cases filed in 2018. Some may be dismissed while others may be referred to Risk Management.

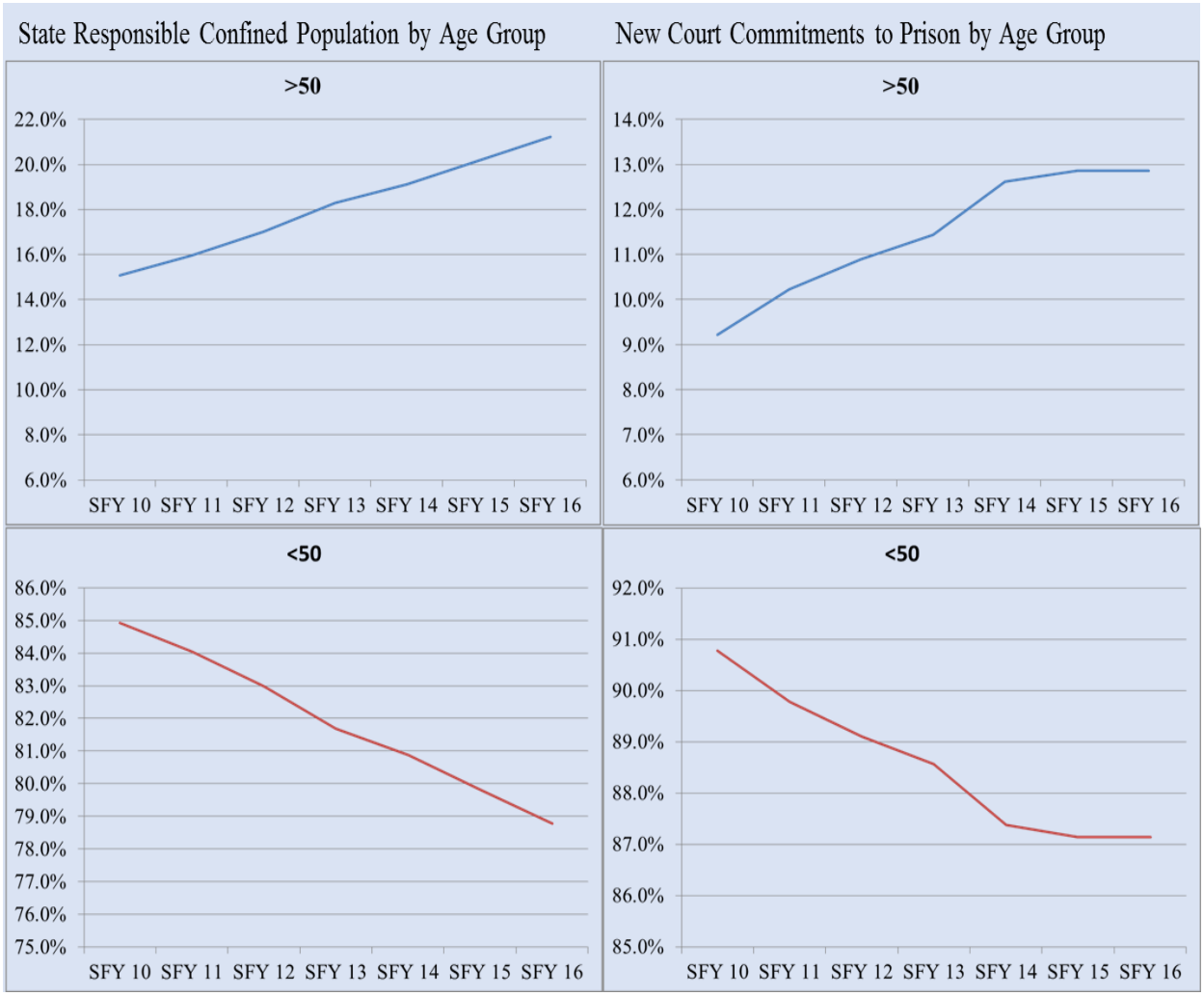


Measuring Quality

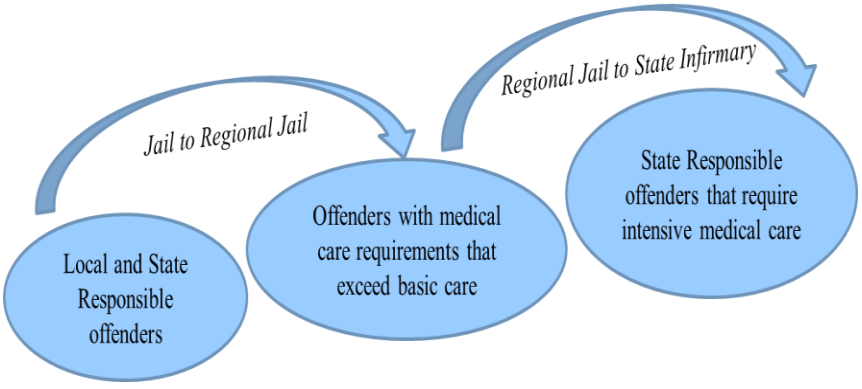
- Local and regional jails and prisons are legally required to provide access to health care services for offenders but there is no requirement regarding the quality of the services.
- VADOC contract monitors review medical charts to assess contract compliance by health care vendors within the system and penalties are assessed for non-compliance. As of August 2018 Armor has been penalized $265,000 for being out of compliance with several provisions of its contract at Sussex I and II, and Greensville.
- In 2017, VADOC formed an internal central office Continuous Quality Improvement (CQI) committee. The CQI committee meets eight times per year to review contract compliance and quality of care issues related to the state operated prisons.
- Almost all state operated prisons are accredited by the American Correctional Association.
- The Virginia Board of Corrections (BOC) certification requirements for local and regional jails involve a review of written policies and procedures, but the review does do not include an evaluation of quality. To ensure quality, some local and regional jails are accredited by the American Correctional Association (ACA) and/or the National Commission on Correctional Health Care (NCCHC) that include health care quality components for accreditation purposes.
- Offenders served in offsite private hospitals and by private physicians receive the same quality of care as any other patient. Anthem BC/BS is a third party administrator for the prisons and 48 of the 58 local and regional jails. Anthem has its own quality program for providers.
- Accreditation does not preclude local and regional jails and prisons from being sued. The Fluvanna Correctional Center for Women is part of a class action lawsuit settlement, signed in 2016. Fluvanna was accredited before, during and after the settlement agreement.
    - A recent un-announced visit from the court monitor indicated that considerable improvements occurred within the last eight months, but more action is needed to comply with the settlement agreement.

The Confined Population

A rising geriatric population in the prisons is being driven by new court commitments of offenders aged 50 and above. The facilities operated by VADOC were not built for the aging population. Two facilities, Powhatan Infirmary and Deerfield Assisted Living Center, are overcrowded barracks-style buildings not conducive to quality of care.



- Offenders are moved to different jail and prison locations for health care. None of the systems are integrated. Paper files are moved with the offenders.
- Offenders with dementia and pregnant offenders with an opioid addiction are being confined in jails because there are no other providers to care for them in the system.



Community Services Boards in Local and Regional Jails

- The number of offenders held in local and regional jails with mental health disorders has grown 53% since 2008; and the number of offenders in Department of Corrections (DOC) prison facilities with mental health disorders has grown 29% since 2009.[1]

	United States 2016	Virginia 2016	Virginia Jails June 2017	Virginia Prisons June 2017
Percent Any Mental Illness	18.3%	19.9%	17.63%	27.4%
Percent Serious Mental Illness	4.2%	4.6%	9.55%	2.71%

Number of Offenders in Jail
Suspected to be Mentally Ill - Seriously Mentally Ill

Year	# of Individuals suspected of having any mental illness	% of total jail population suspected of having any mental illness	# of Individuals suspected of having a serious mental illness	% of total jail population suspected of having a serious mental illness
2012	6,322	11.07%	3,043	5.33%
2013	6,346	13.45%	3,553	7.53%
2014	6,787	13.95%	3,649	7.50%
2015	7,054	16.81%	3,302	7.87%
2016	6,554	16.43%	3,355	8.41%
2017	7,451	17.63%	4,036	9.55%
Change: 2012-2017	**1,129**	6.56%	**993**	4.22%
% Change	**17.86%**	59.26%	**32.63%**	79.17%

Source: Mental Health Standards for Virginia's Local and Regional Jails. Department of Behavioral Health & Developmental Services. August 31, 2018 (7).

- The percent of offenders with any mental illness is highest within the Virginia prison system while the percent with serious mental illness is highest in Virginia jails.
- People in the jails may be "situationally mentally ill," have a history of mentally illness, or be seriously mentally ill. Offenders that are situationally mentally ill pose unique and sometimes challenging problems for jail officials, including suicidal behavior. These offenders did not have any issues prior to confinement and may not have any issues once released.

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1 *Mental Illness- (adults aged 18 and older)*. (2016). Retrieved from National Institute of Mental Health (NIMH): https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_154785; Substance Abuse and Mental Health Services Administration (SAMHSA). 2015-2016 NSDUH State-Specific Tables. Table 103, Virginia. (https://www.samhsa.gov/data/report/2015-2016-nsduh-state-specific-tables); Mental Health in the Jails Report, 2017. Compensation Board. Data reported for the month of June 2017 and Mcgehee, Warren. Re: Mental Health Codes. Email to Stephen Weiss. August 29, 2018.

- Most arrests of individuals with a mental health and/or substance use disorder may occur when law enforcement responds to a disturbance call involving loitering, petty larceny or a similar event, and the individual argues with the officer or displays resistance. At that point, it is likely that the person will be arrested and charged with a felony rather than a misdemeanor befitting the original crime.
- Felony charges often include longer sentences, are more serious, and may prevent the use of jail diversion or placement with a community provider. According to the Compensation Board's "2017 Mental Illness in Jails Report," 76.9% of all mentally ill in the jails are charged with a felony crime.
- Immediate access to a magistrate, either because the magistrate is in the facility or available via the court tele-network, leaves little time to determine if jail is the most suitable place for a mentally ill offender.
- Providing office space with computer access to CSB staff improves communications between the CSB and the jail.
- There are six Department of Criminal Justice Services' pilot projects developed to create relationships between the jails, CSBs and other community providers. The lack of stable funding was cited as an obstacle for the projects, along with data collection and a lack of affordable housing for appropriate placement of mental health offenders outside of the jails.
- Twenty-one local and regional jails have designated mental health units. Of the jails with mental health units, nine provide office space and a computer to a CSB and four through the Department of Criminal Justice Services (DCJS) pilot. Another seven local and regional jails without a mental health unit provide office space to a CSB, six with computers and one through the DCJS pilot project.
- Sixty percent of the mental health treatment provided in the jails is done by CSBs.
- The Henrico County jail and CSB collaborative program is an example of a model program. The CSB provides the mental health and substance abuse services to Henrico County offenders. The program includes diversion programs involving judges and magistrates, discharge planning, and the requirement that all health and mental health care providers use the same electronic health record system. The cost to operate the program is $349 per offender.
- There is a significant amount of confusion over the use and implementation of HIPAA requirements that interferes with offender care and treatment within the local and regional jails.
- DBHDS formed a workgroup to develop mental health standards for local and regional jails. The workgroup integrated BOC, NCCHC and best practice material into the following list of 14 minimum behavioral healthcare standards specifically written for Virginia's local and regional jails.

Access to Care	Mental Health Assessment
Policies & Procedures	Emergency Services
Communication of Patient Needs	Restrictive Housing
Mental Health Training for Correctional Officers	Continuity & Coordination: Health Care During Incarceration
Mental Health Care Liaison	Discharge Planning
Medication Services	Basic Mental Health Services
Mental Health Screening	Suicide Prevention Program

- Requiring via code that CSBs provide mental health and substance use disorder services in all jails may be a problem for jails that are not near a CSB and may be disruptive to existing local relationships between community providers and jails that are successful partnerships.
- As a result, the workgroup concluded that the state should allow the local and regional jails to determine which entities and providers are best for them as they comply with the standards.

Actions taken by the Joint Commission on Health Care

1. Introduce legislation to amend Chapter 53.1 of the Code of Virginia by adding that the Virginia Department of Corrections (VADOC) Continuous Quality Improvement (CQI) Committee for state operated prisons become part of the required duties of VADOC and that standardized quality reports be developed and made available to the public on the VDOC website.

2. Introduce legislation to amend the Code of Virginia by adding in Chapter 53.1-5 to require the Board of Corrections (BOC) to adopt minimum health care standards for local and regional jails that are not accredited by the American Correctional Association or National Commission on Correctional Health Care. Such standards should require that standardized quarterly CQI reports be submitted to BOC from all local and regional jails and that the report be made available to the public on the BOC website.

3. By letter from the JCHC Chair, request that the Compensation Board, Department of Behavioral Health and Developmental Disabilities, and Director of Health Services for the Virginia Department of Corrections create a single statewide HIPAA compliant release form that can be used by all offenders and persons being served through the community services board and state psychiatric system that will allow for easier sharing of data and medical information among the different organizations that receive state funds. A joint written report with the approved form is to be submitted to the JCHC by October 1, 2019.

4. By letter from the JCHC Chair, request that the Secretary of Health and Human Resources, Secretary of Administration and the Secretary of Public Safety and Homeland Security establish a "Local and Regional Jail and Mental Health and Substance Use Disorder Best Practice Committee" and designate the appropriate state agency staff to serve as members. The committee should conduct an annual forum for state and local officials to identify and share experiences and processes used at the state and local level of government to overcome barriers and improve the delivery of services between local and regional jails and the state psychiatric system and community services boards.

Legislation Enacted

Department of Corrections; health care continuous quality improvement committee.

HB 1917 Amended – Delegate Stolle
SB 1273 Amended – Senator Lucas

Requires the Director of the Department of Corrections to establish a health care continuous quality improvement committee, consisting of the Director and specified health care professionals employed by the Department. The bill requires the committee to (i) identify appropriate criteria for evaluation of the quality of health care services provided by the Department, (ii) monitor and

evaluate the quality of health care services provided by the Department utilizing the criteria identified, and (iii) develop strategies to improve the quality of health care services provided by the Department. The bill also requires the committee to publish quarterly continuous quality improvement reports setting forth such data and information as the committee deems appropriate on a website maintained by the Department. Each facility shall submit quarterly continuous quality improvement reports containing such data and information as may be required by the committee at such times as may be required by the committee, for inclusion in the committee's quarterly continuous quality improvement report. As introduced, this bill is a recommendation of the Joint Commission on Health Care.

Enacted - Acts of Assembly Chapter text (CHAP0463 and CHAP0320) respectively

Board of Corrections; minimum standards for health care services in local correctional facilities.

HB 1918 - Delegate Stolle
SB1598 - Senator Dunnavant

Authorizes the Board of Corrections (Board) to establish minimum standards for health care services in local, regional, and community correctional facilities and procedures for enforcing such minimum standards, with the advice of and guidance from the Commissioner of Behavioral Health and Developmental Services and State Health Commissioner. The bill provides that (i) such standards shall require that each local, regional, and community correctional facility submit a standardized quarterly continuous improvement report documenting the delivery of health care services, along with any improvements made to those services, to the Board and (ii) such reports shall be available to the public on the Board's website. The bill also authorizes the Board to determine that a local, regional, or community correctional facility accredited by the American Correctional Association or National Commission on Correctional Health Care meets such minimum standards solely on the basis of such accreditation; however, without exception, the requirement to submit standardized quarterly continuous quality improvement reports shall be a mandatory minimum standard. This bill is a recommendation of the Joint Commission on Health Care.

Enacted -Acts of Assembly Chapter text (CHAP0695 and CHAP0696) respectively

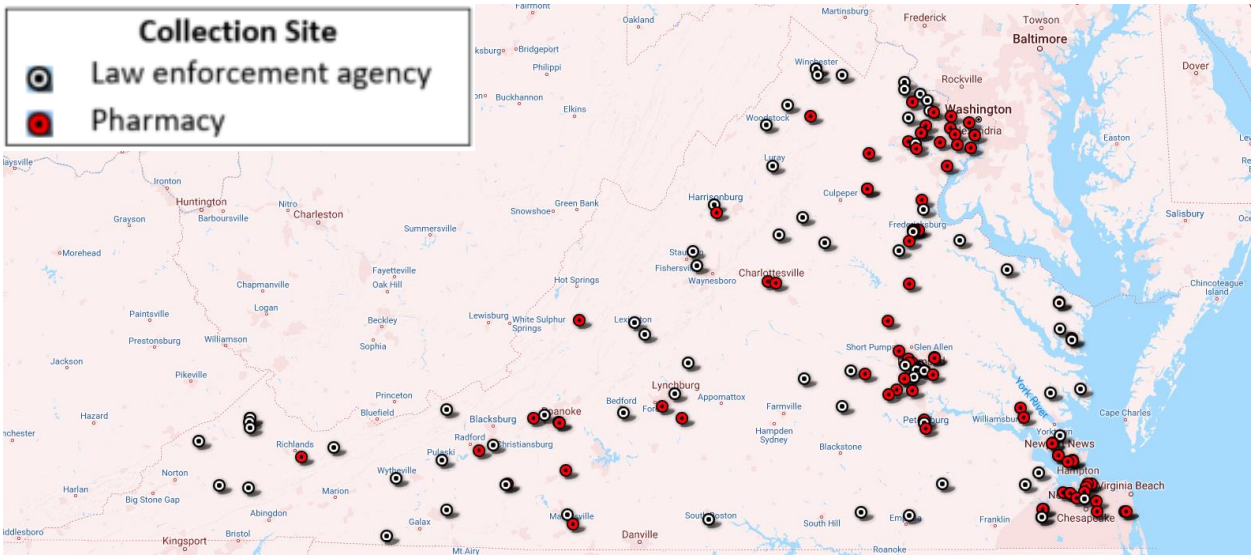
Pharmacy Drug Disposal Program

Study Mandate

In 2018, Senate Bill 962 would have required participation in a drug disposal program by pharmacies that: dispense Schedule II and III controlled substances; do not dispense primarily by mail, common carrier, or delivery service; and are not located within a hospital. The bill was passed by Indefinitely in Senate Education and Health with a letter from the Senate Clerk requesting that the JCHC study the subject matter. JCHC members approved the study during the 2018 work plan meeting.

Background

- Unused and inappropriately stored or disposed of medicines pose a variety of health risks including drug diversion and environmental risks. In fact, up to 80% of U.S. streams have detectable amounts of drugs.
- Federal regulations allow pharmacies to modify their registration to dispose of unused medicines through two methods that meet DEA standards: secure disposal bins or mail-back. Other disposal methods are recommended by the FDA and EPA only under certain circumstances.
- However, use of methods meeting DEA standards or recommended by the EPA/FDA remains highly limited. Fewer than 10% of individuals reportedly consider using FDA-recommended disposal methods and in Virginia only 4% of licensed pharmacies are currently registered as authorized collectors (see map).
- In 2015, the Governor's Task Force on Prescription Drug and Heroin Abuse made ten recommendations related to medicine disposal/collection. While some recommendations had been fully or mostly addressed, the majority were, at best, only partially addressed. A common theme was to secure additional funding and increase consumer outreach and education to fully implement recommendations.
- Currently, DBHDS and Virginia Department of Health (VDH) implement initiatives to encourage appropriate medicine disposal, but these initiatives do not use disposal methods that meet DEA standards



Medicine Take-Back Models

Program Type	Public funding?	Pharmacy participation required?	Examples
Government-supported / implemented	Yes	No	• CO, NE, NY*
	No	No	• IA, ND
Government-regulated	No	Yes	• Santa Cruz County
	No	No	• WA, MA, NY**, VT • 22 municipalities

* Refers to pilot program (2017) ** Refers to State law (2018)

- Two medicine take-back program models have been put into place in other states and municipalities:
  - Government-supported or implemented model: government plays a direct funding and/or program administration role. Annual budgets – that include General Funds, private funds and wholesale manufacturers fees – range from $175,000 to $600,000, with annual tonnage disposed ranging from 1.5 to 18 tons.
  - Government-regulated model ("Extended Producer Responsibility" [EPR]): the State or municipality oversees program implementation by a third party. States have mandated this approach across a variety of other industries, including two EPR laws in Virginia.

- Since 2012, twenty-three municipalities and four states have established EPR programs for unused medicines. The following is a summary of the common elements:

Included in 100% of programs:

- Program must accept all medicines (prescription/non-prescription)
- Geographic "convenience" standards specified
- Manufacturers responsible for program costs and fees
- Manufacturer point-of-sale and point-of-collection fee prohibited
- Consumer education and outreach required
- Programs can be operated singly or jointly by manufacturers

Included in <100% of programs:

- Mail-back option required (11 of 12 programs)
- Disposal by incineration only (5 of 12 programs)
- Municipality specifies benchmark program (3 of 12 programs)
- Retail pharmacy participation required (1 of 12 programs)

- Washington State is one of four states to adopt the EPR approach through its Unwanted Medication Disposal Act (2018). Key features include:
  - The Act covers all controlled and non-controlled medicines with some exceptions
  - Manufacturers are responsible for establishing and fully funding the program
  - A "program operator" contracts with manufacturers to implement the program
  - The Department of Health reviews, approves and monitors implementation by the program operator
- A widely cited estimate is that medicine take-back programs cost approximately $0.01 for every $10 in pharmaceutical sales. Cost data obtained for this report from pharmacies that currently take back medicines range from $850 - $1,200 and data from other States suggest a range of $500 – $1,800 per year per pharmacy.
- Estimated annual cost of a Virginia statewide program if all DEA-authorized collectors participated would be $3.2M – $5.4M.

Actions taken by the Joint Commission on Health Care

1. Introduce legislation to amend § 54.1-3319 of the Code of Virginia to add counseling on medicine disposal to the list of topics on which pharmacists may counsel persons who present a new prescription for filling (Code currently only lists storage as a topic).

2. Introduce legislation (Uncodified Act) directing the Board of Pharmacy to work with stakeholders to determine ways to enhance public awareness of proper drug disposal methods, including existing community-based collection and disposal opportunities. Note: The member who requested the policy option at the meeting later suggested that it be a language only budget amendment.

Legislation Enacted

Pharmacist; counseling for new prescriptions; disposal of medicine.

HB 1743 – Delegate Bulova
SB1405 – Senator Dance

Allows a pharmacist to include information regarding the proper disposal of medicine when giving counsel to a person who presents a new prescription for filling.

Enacted -Acts of Assembly Chapter text (CHAP0135 & CHAP0096) respectively

Board of Pharmacy; enhance awareness of drug disposal methods (language only)

Budget Amendment
Item 299- Delegate Peace

The Board of Pharmacy shall report to the Joint Commission on Health Care by October 1, 2019, on state and local efforts to promote proper drug disposal methods, including existing community-based collection and disposal efforts.

Requiring the Installation of Onsite Temporary Emergency Electrical Power Sources for Assisted Living Facilities

Study Mandate

HJR 123 (Delegate Hope) requested that JCHC study the feasibility of requiring an onsite temporary emergency electrical power source for licensed assisted living facilities (ALFs). The study was approved by JCHC at the June 15, 2018 planning meeting with the following instructions: the study should be limited to determining the number/percent and size of ALF facilities that do not currently have a generator and an estimate of cost based on facility size.

Virginia Code Related to ALFs

- Residential living facilities that serve four or more residents are licensed as ALFs by the Department of Social Services (DSS).

- ALFs are required to have emergency preparedness plans, meet building codes, and those with six or more residents are required to have a permanent connection to a temporary emergency electrical power source approved by the local building official.
  - Under the current rules an ALF can use a portable generator and must include how it will be operated during a power outage in its emergency management plan that is submitted to the local emergency management office. According to the State Fire Marshal, there are state and local fire safety codes that need to be followed related to the use and storage of extension cords and gasoline unless the portable generator connects to a transfer switch that is installed at the electrical box.

- A survey circulated by DSS, with a response rate of 53 percent (295 of the 553 ALFs), produced the finding that:

  - Fifty-six percent (n=161) of ALFs have a backup generator on site with full facility coverage, and
  - Forty-five percent (n=134) of ALFs have no generator or partial/limited facility coverage
    - 27 reported no backup generator on site (9.2% of total responses)
    - 107 reported backup generator on site with partial/limited facility coverage (36.3% of total responses)

- The following tables provide cost estimates to install onsite backup electrical generators based on the size of the ALF, *assuming that*:
  - The generator provides backup power to the whole house (costs may be less if the generator can be wired for specific appliances)
  - The responses to the survey are representative of conditions for all licensed ALFs
  - The ALFs reporting only partial facility coverage will require new backup generators because there is no way to know how many are functioning/operational and able to satisfy requirements regarding all of the facility items that must be powered during an outage
  - The requirements apply to ALFs that have seven or more licensed beds

Estimated Cost to Install Backup Emergency Electrical Power By Licensed Bed Capacity of ALFs						
Licensed Bed Capacity Range	**Generator Size (water cooled - commercial)**	**Equipment & Auto Transfer Switch**	**Installation**	**Engineering**	**Minimum Cost Per Facility**	**Maximum Cost Per Facility**
7 to 13	25kw	$9,500	$12,393	$1,559	$23,452	$51,013
14 to 24	45kw	$14,399	$18,783	$2,363	$35,545	$60,711
25 to 59	60kw	$25,000	$32,612	$4,102	$61,715	$145,646
60 to 89	130kw	$41,800	$54,528	$6,859	$103,187	$153,060
90 to 129	175kw	$60,000	$78,270	$9,845	$148,115	$212,298
130 to 199	250kw	$71,661	$93,482	$11,758	$176,901	$270,795
200 to 349	400kw	$100,000	$130,450	$16,408	$246,858	$430,767
350	750kw	$240,000	$313,080	$39,380	$592,459	

Engineering costs include written plans required to meet local building and fire codes for commercial building. Minimum and Maximum costs calculated based on licensed bed ranges. Prices based on industrial standby generator, meeting life and safety code – National Fire Protection Association (NFPA) 110-1

- *NFPA 110-1 standards cover installation, maintenance, operation, and testing requirements; including power source, transfer equipment, controls, supervisory equipment, as well as electrical, mechanical auxiliary and accessory equipment*

Sources: a) Newton, Lee, VP; Bay Diesel; Generator for Assisted Living. Email to Stephen Weiss, July 18, 2018 and b) Sharpe, John; Power Solutions Manager; Generac Industrial Power. Meeting October 4, 2018.

Estimated Number of Licensed ALFs by Region and Size Impacted by Requiring Onsite Temporary Emergency Electrical Power (i.e. Generator) and Estimated Costs

Generator Size	**25kw**	**45kw**	**60kw**	**130kw**	**175kw**	**250kw**	**400kw**	
Capacity Range / Region	**7 to 13**	**14 to 24**	**25 to 59**	**60 to 89**	**90 to 129**	**130 to 199**	**200 to 349**	**Grand Total**
Central	23	12	13	11	8	6	5	78
Fairfax	13	0	3	3	6	5	5	35
Northern	2	3	3	4	2	4	1	19
Piedmont	6	4	11	7	5	2	3	38
Valley	1	5	11	4	2	0	0	23
Western	1	4	6	4	3	0	0	18
Eastern	3	3	6	10	3	3	0	28
Peninsula	2	1	4	2	3	1	1	14
Total	**51**	**32**	**57**	**45**	**32**	**21**	**15**	**253**
Cost Estimate:								
Minimum Cost / Facility	$23,452	$35,545	$61,715	$103,187	$148,115	$176,901	$246,858	
Maximum Cost / Facility	$51,013	$60,711	$145,646	$153,060	$212,298	$270,795	$430,767	

Examples of Requirements in Maryland and Florida:

- Maryland: generator must provide electricity to specific areas of an ALF, fire pumps, well and sewage pumps, heating equipment, etc.
- Florida: generator must maintain ambient air temperature at 81°F for 96 hours in designated areas of an ALF, the size of the area can be no less than 20 square feet per resident, calculated based on 80% of the licensed bed capacity of the ALF.
  - Florida allows ALFs to use portable generators and "spot coolers" to comply with the new rules. The designated areas are considered "areas of refuge" and residents are not required to

use them. However, employees of the ALFs are required to do "wellness" checks on residents every 30 minutes.

*A*dditional Follow-up Information Regarding Less-Costly Options

- Electrical panels have to be suitable for the addition of a generator and *costs may be reduced by as much as 50%* depending on the condition of the electrical panel, configuration of the interior, age and the wattage requirements of the appliances that will be powered by a generator. Or, for the same reasons, the *costs may be significantly more expensive*.
  - An electrical engineer for a generator company has installed *residential and light commercial generators for anywhere from $5,000 to over $30,000* depending on how the house is wired and whether specific appliance circuits (breakers) are available in the electric panel.
  - Generators come in all sizes, are ordered and installed based on the calculated electric loads of the building and appliances.
- *Home improvement stores sell 8kw portable generators for less than $1,000* that are sufficient if the only items that need to be powered are the refrigerator and freezer, some lights and other small appliances. The portable generators are gasoline operated, hold 7 to 12 gallons depending on the model, have an electric start up with a built in battery and an emergency pull start. These generators will run for up to 12 hours if the overall load is half the generator's capacity, or no more that 4kw's of demand when running continuously.
- *Home improvement stores also sell and install 16kw and 22kw whole house generators costing between $7,800 and $9,000***,** for equipment and installation, for residential homes no larger than 3,600 square feet. The cost is based on the availability of either propane or natural gas and is dependent on the installer assessment of the house.
  - While the home improvement store will not rewire or reconfigure electrical panels to operate only a few items in the house, a person can purchase a generator and hire an independent installer.
  - Home improvement stores often refer customers to commercial installers for homes larger than 3,600 square feet.

Maryland - Required Coverage for Backup Generator

Areas of egress and protection as required by the State Fire Prevention Code and Life Safety Code 101 (as adopted by State Fire Prevention Commission)	Nurses' station and call system	Drug distribution station or unit dose storage
Heating equipment - minimum temperature of 70°F (24°C) in all common areas or areas of refuge	Elevator: if operable on emergency power; if required for evacuation purposes	Sewerage pump and sump pump
Fire pump	Well pump	Life support equipment
Area for emergency telephone use with at least one telephone to make and receive calls	Emergency generator location and switch gear location	Nonflammable medical gas systems
If applicable, toilet rooms of common areas or areas of refuge	Kitchen	Areas where life support equipment is used
Boiler or mechanical room		

Actions taken by the Joint Commission on Health Care

1. Introduce legislation to amend section 63.2-1732 of the Virginia Code by including the following language: Assisted Living Facilities shall disclose to prospective residents, prior to admission as evidenced by the written acknowledgment of the resident or his legal representative, whether or not the facility has an onsite emergency backup electrical generator and whether or not the backup electrical generator provides power to the entire facility or only to selected utilities and appliances as listed in the disclosure.

Legislation enacted

Assisted living facilities; emergency electrical power source; disclosure to prospective residents.

HB 1815 Amended – Delegate Hope

Directs the State Board of Social Services to adopt regulations that require assisted living facilities to disclose to each prospective resident, or his legal representative, in writing in a document provided to the prospective resident or his legal representative and as evidenced by the written acknowledgement of the resident or his legal representative, whether the facility has an on-site emergency electrical power source for the provision of electricity during an interruption of the normal electric power supply and, if the assisted living facility does have an on-site emergency electrical power source, (i) the items for which such on-site emergency electrical power source will supply power in the event of an interruption of the normal electric power supply and (ii) whether staff of the assisted living facility have been trained to maintain and operate such on-site emergency electrical power source to ensure the provision of electricity during an interruption of the normal

electrical power supply. The bill also provides that an on-site emergency electrical power source shall include both permanent on-site emergency electrical power sources and portable on-site emergency electrical power sources, provided such portable on-site emergency electrical power source remains on the premises of the assisted living facility at all times.

Enacted - Acts of Assembly Chapter text (CHAP0602)

Addiction Relapse Prevention Programs in the Commonwealth

Study Mandate

By letter of request, Delegate Kory asked the JCHC to study addiction relapse prevention, with a particular focus on opioid addiction, and address the following questions: What programs exist in Virginia that offer assistance to persons who have successfully completed substance abuse recovery regimens and have been released into the community? How do former addicts maintain addiction-free or relapse-free lives? What are reported rates of success and failure and how is success defined and tracked? Is there a best practices model for relapse prevention programs? What is needed to "cure" addiction in terms of pharmaceutical management? What role does counseling play and what are the requirements for success? What training/technical assistance is needed for peer counselors? What are the costs? What cost-effectiveness data exist? If Virginia data are scarce, what does the national picture indicate and how can we effectively collect it?

Study Findings

Key Points	Related Policy Options
• Relapse is commonly viewed as an expected part of the recovery process and an opportunity to evaluate the appropriateness of intensity and/or frequency of Substance Use Disorder (SUD) treatment services received	N/A
• State-level data on relapse rates are limited:	
• Federal regulations (42 CFR Part 2) greatly restrict the ability to collect the most direct measure of relapse – urine drug screen results – by SUD services payers, program funders, etc.	None: capturing urine drug screen data would likely incur significant administrative costs and legal liabilities with unintended consequence of deterring treatment seeking or continuation
• Conversely, a variety of service utilization data (e.g., continuity of Opioid Use Disorder (OUD) pharmacotherapy) can serve as proxy measures of both relapse and quality of SUD care; DMAS anticipates collecting data on three relapse proxy measures under Addiction and Recovery Treatment Services (ARTS)	None: Three relapse proxy measures – continuity of OUD pharmacotherapy, SUD treatment readmissions rates, follow up after ED discharge – anticipated to be collected under ARTS
• Programs in Virginia with recovery and relapse prevention components span multiple agencies and cover clinical and non-clinical services, including:	N/A; Table 1, below, provides an overview of SUD programs most directly connected to recovery and relapse prevention

Key Points	Related Policy Options
• DOC/DBHDS Medication Assisted Treatment (MAT) pilot with recovery support navigators: currently being implemented in three of the Probation and Parole districts which have among the State's highest positive opioid drug test rates	**Policy option 2** provides an additional recovery resource in the three MAT pilot districts – Day Reporting Centers which were found to be effective in Virginia and have a positive cost-benefit ratio more generally
• DBHDS Project Link: currently being implemented in nine CSB regions, DBHDS data indicate higher rates of SUD service utilization by pregnant and parenting women in Project Link sites compared to non-Project Link sites	**Policy option 3** would expand Project Link to 5 new CSB regions that experience the highest rates of neonatal abstinence syndrome
• While recent State-level initiatives – such as the Governor's Advisory Commission on Opioids and Addiction – are expected to ensure coordination of State initiatives in SUD treatment and recovery, information about SUD programs made available to the public through State agencies or State-connected resources is not well-aligned (e.g., of over 250 SUD treatment/recovery resources listed by three State-connected websites, fewer than 20% are listed by all three)	**Policy options 4, 5 and 6** address those gaps in terms of opioids, substance more generally, and in the context of Emergency Department settings, respectively
• While ARTS has lowered barriers to accessing SUD services for the Medicaid population and workforce initiatives focused on clinical providers of SUD services have begun to address some supply-side constraints:	
• Coverage of SUD case management and peer support services in commercial health plans is variable (both are covered services under ARTS for the Medicaid population)	**Policy option 7** requires insurance coverage of case management and peer support services by health plans regulated by the Bureau of Insurance
• Available data suggest that the current Virginia statute on barrier crimes may unnecessarily limit the number of Peer Recovery Specialists (PRS) or others seeking employment in CSB or licensed provider substance abuse programs	**Policy option 8 and 9** provide two alternatives to reduce the impact of barrier crimes to employment of PRS in CSBs or among licensed private providers while maintaining safety/quality of the work force

Table 1. SUD programs in Virginia

SUD Program	Focus Population	Oversight Agency	Date of inception	Funding source	SUD Service			Geographic Coverage	Notes
					Clinical*	Recovery**	Wrap-around†		
Substance Abuse Vocational Rehabilitation Counselors	Individuals with significant barriers to employment	DARS / DBHDS	1988	Public (State/Federal)			x	19 Counselors statewide	
Peer support services (SUD warmlines)	General population	DBHDS	2017	Public (Federal)		x		Statewide	OPT-R grant-funded
Peer support services (ED-based Peer Recovery Specialists)	General population	DBHDS	2017	Public (Federal)		x		6 hospitals	OPT-R grant-funded
Permanent Supportive Housing	Pregnant / parenting women	DBHDS	2019 (anticipated)	Public (State/Federal)			x	Up to 75 women statewide	
Project Link	Pregnant / parenting women	DBHDS	1992	Public (State/Federal)	x		x	9 CSB regions	Links women to clinical Tx
Project Link for Pregnant and Post-Partum Women	Pregnant / parenting women	DBHDS	2017	Public (Federal)	x	x	x	9 CSB regions (same as above)	SAMHSA pilot grant
Recovery housing (Oxford House model)	General population	DBHDS	1990	Public (Federal)			x	~ 1,065 beds statewide	DBHDS supports admin costs

Table 1. SUD programs in Virginia

SUD Program	Focus Population	Oversight Agency	Date of inception	Funding source	SUD Service			Geographic Coverage	Notes
					Clinical*	Recovery**	Wrap-around†		
Model Addiction Recovery Programs	Justice-involved population	DCJS	2017	Public (local/State)	x	x	x	4 jails	
Residential Substance Abuse Treatment Program	Justice-involved population	DCJS	1994	Public (State/Federal)	x	x	x	1 jail; DOC (1 grant)	
Housing/employment supports	Medicaid (high-need beneficiaries)	DMAS	2019 (anticipated)	Public (State/Federal)			x	Statewide (phased-in regionally)	Part of Medicaid expansion
Clinic-based treatment programs*	Medicaid members	DMAS	2016	Public (State/Federal)	x		x	Statewide	ARTS benefit
Clinic-based treatment programs*	Non-Medicaid population	N/A	N/A	Private (insurance; self-pay)	x		x	Statewide	Services covered vary by insurer
Peer support services	Medicaid members	DMAS	2016	Public (State/Federal)		x		Statewide	ARTS benefit
Peer support services	Non-Medicaid population	N/A	N/A	Private (insurance; self-pay)		x		Statewide	
Therapeutic Communities	Justice-involved population	DOC	1994	Public (State)	x	x		2 facilities	

Table 1. SUD programs in Virginia

SUD Program	Focus Population	Oversight Agency	Date of inception	Funding source	SUD Service			Geographic Coverage	Notes
					Clinical*	Recovery**	Wrap-around†		
Community Corrections Alternative Programs	Justice-involved population	DOC	2017	Public (State)	x	x	x	Statewide	3 provide intensive SUD Tx
Day Reporting Centers (discontinued in 2008)	Justice-involved population	DOC	1993	Public (State)	x	x	x	12 Probation and Parole districts	Program closed in 2009
Prison MAT pilot	Justice-involved population	DOC / DBHDS	2018	Public (State)	x	x	x	3 Probation and Parole districts	
Vocational/job training	Individuals with significant barriers to employment	DSS	1999	Public (local / State/Federal)			x	Statewide	
Recovery housing and/or Recovery Support Organizations	General population	N/A	N/A	Private		x	x	Statewide	
Mutual support/12-step groups	General population	N/A	N/A	Private / free		x		Statewide	
Drug Treatment Courts	Justice-involved population	Supreme Court	2004	Public (local / State/Federal)	x	x	x	38 Courts statewide	

* Examples: MAT, psychotherapy, etc. provided in inpatient/residential, outpatient clinics, etc.

** Examples: peer support, mutual support groups, recovery housing

† Examples: case management, vocational rehabilitation

Actions taken by the Joint Commission on Health Care

1. Introduce a budget amendment to support the placement of Day Reporting Centers in 3 DOC probation and parole districts (Richmond City, Norfolk City, Buchanan/Tazewell) that experience the highest rates of positive opioid drug tests results and overdoses among individuals on state probation supervision, with the Day Reporting Centers offering non-pharmacological SUD treatment and recovery services as well as wraparound supports to offenders in need of initial or ongoing SUD services.

- DOC estimates an annual cost of $660,000 per Day Reporting Center ($1,980,000 total)
- DOC anticipates seeking funding for additional Recovery Support Navigators in 11 probation and parole districts identified as high-need for OUD services

2. By Letter of the JCHC Chair, request that the Secretaries of Health and Human Resources (HHR) and Public Safety and Homeland Security (PSHS) to convene a workgroup that includes representatives of DBHDS, Department of Health Professions (DHP), DMAS, VDH, Department of Aging and Rehabilitative Services (DARS), DSS, DCJS, DOC, the Attorney General's Office, Virginia State Police (VSP) and Department of Veteran Services (DVS) to study the current alignment and coordination of information made publicly available through State agencies on substance use disorder treatment and recovery resources, making recommendations to the General Assembly and JCHC by November 1, 2019 on legislation and/or budget amendments required to improve alignment and coordination of SUD treatment/recovery resource information made available by State agencies

Legislation Enacted

Budget amendment language did not pass.

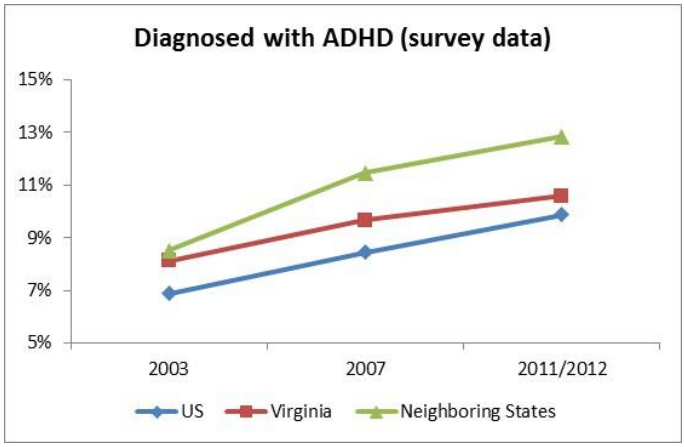
ADHD Prevalence and Risks of ADHD Medications in Virginia

Study Mandate

In 2017, HB 1500 (Item 30(A)) requested that the JCHC identify methods to: raise awareness of health/addiction risks of Attention Deficit Hyperactivity Disorder (ADHD) medication use; compile/track statistics on Virginia school children diagnosed with ADHD; limit antipsychotic use; and identify the incidence/prevalence of prescribing anti-psychotics for off-label use.

Background

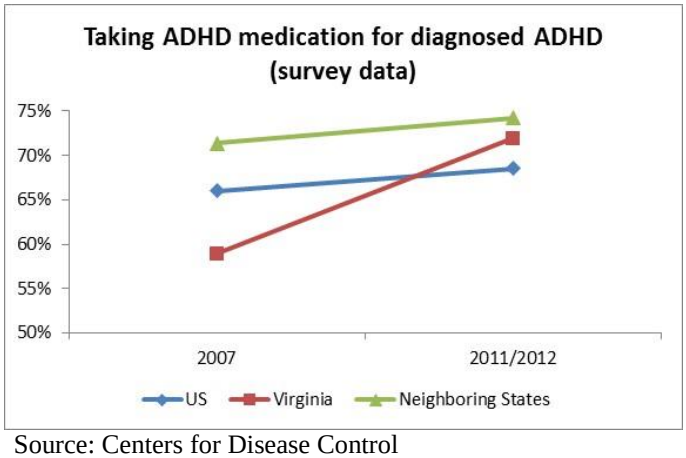
- ADHD is the most commonly diagnosed neurodevelopmental childhood disorder in the United States, with an estimated childhood/adolescent prevalence of around 5%.
- Survey data indicate that diagnosed prevalence of ADHD in Virginia is lower than that of all neighboring States but higher than the national average.
- With ADHD symptom persistence of 60% into adulthood, ADHD has been found to have adverse impacts on health, academic achievement, employment and criminality.



Source: Centers for Disease Control

ADHD Treatment

- Stimulants are 1st-line medications used to treat ADHD, with a variety of psychological interventions also used.
- Use of ADHD medications has risen dramatically in recent decades, with stimulant prescriptions tripling between 1990 and 2000.
- In the short term, ADHD medications have been found to reduce symptoms and, when combined with psychotherapy, improve outcomes such as behavioral co-morbidities, academic achievement and social functioning. Over the longer term, evidence of positive effects is much less consistent.

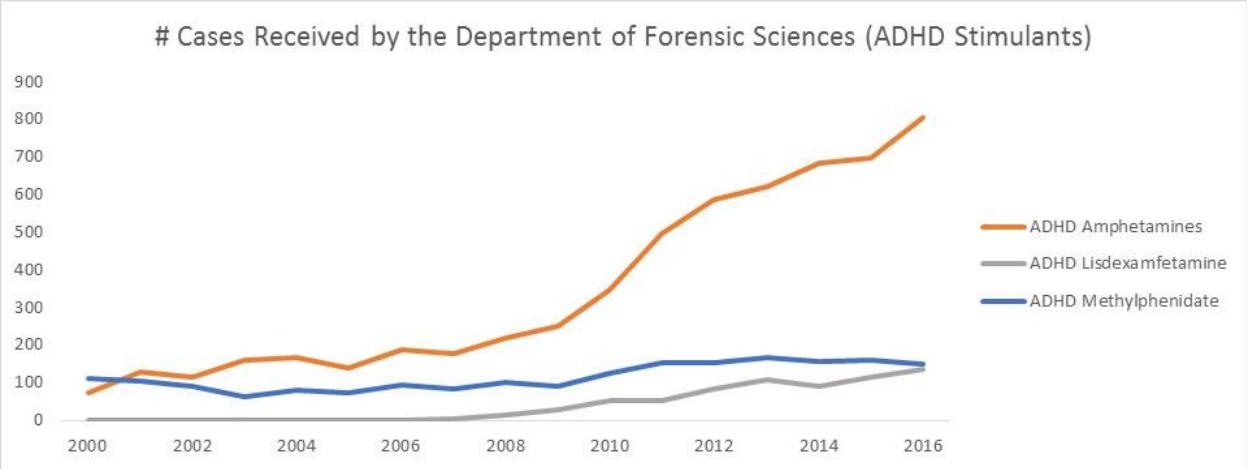


Source: Centers for Disease Control

- There is evidence that ADHD medication use may cause short-term growth reductions in children, but there is little evidence that ADHD medication use is associated with other health risks – such as Substance Use Disorder and other mental health illnesses.

Non-Medical Use of ADHD Stimulants

- Studies find non-medical use of stimulants in 5% to 9% of grade and high school-age children, and 5% to 35% of college age students, and Emergency Department (ED) visits involving stimulants tripled nationally between 2005 and 2010. However, the formulation of ADHD stimulants substantially reduces abuse potential compared to illicit stimulants (e.g., methamphetamine), and there is little evidence of addiction to ADHD stimulants.
- In Virginia, the number of law enforcement cases in Virginia involving ADHD stimulants increased from 184 in 2000 to 1,089 in 2016.



Source: Department of Forensic Sciences

Antipsychotic Medications

- ADHD is one of the most common mental health diagnoses among youth prescribed atypical antipsychotic (AAP) medications, which may be due to co-occurrence of ADHD with conditions for which AAPs are prescribed (on- or off-label), or off label use of AAPs for ADHD itself.
- In Virginia, data from insured populations in commercial markets indicate that around 30% of those prescribed AAPs between 2015 and 2016 did not have a FDA-indicated diagnosis for the prescribed AAP. In the Medicaid population, around 55% of those prescribed AAPs between 2015 and 2017 did not have a FDA-indicated diagnosis for the prescribed AAP.
- While AAPs have been found to probably reduce conduct problems and aggression in children with ADHD as well as clinical severity in patients with ADHD, they are also associated with risks summarized in the table above.

Adverse Event/Side Effect	Evidence of Risk
Any drug-induced movement disorder	Probably increases
Weight/BMI	Probably increases slightly
Total cholesterol	May increase
Triglycerides	Probably increases
Sedation/somnolescence	Probably increases

Source: Agency for Healthcare Research and Quality

- Historically, a high rate of use of psychotropic medications – including AAPs – among foster youth has prompted the federal government and States to closely monitor prescribing practices in this population.

Policies on ADHD and Psychotropic Medications in Virginia

- Department of Education (DOE) is required by Code to prohibit school personnel from recommending the use of psychotropic medications for any student.
- DMAS and Managed Care Organizations (MCOs) have implemented Service Authorizations (SAs) for ADHD medications/stimulants for children outside of FDA-approved age range as well as adults 18 years or older, and for antipsychotics for individuals younger than 18 years old.
- To address concerns surrounding the appropriate use of AAPs in the foster youth population, DSS has been working with DMAS to implement a review process to monitor off label use of psychotropic medications in children, as well as modify its case worker database to better track foster youth medical and prescription history. However, data entered into the case worker database are done so manually, and the database is not synchronized with prescription history data from DMAS.

Methods to Raise Awareness of ADHD Medications Risks

- For the general public, the FDA raises awareness of risks of medications, including psychotropic medications, through safety communications and regulations on labeling of pharmaceuticals.
- In the college and university settings, Radford University provides information on its website on risks of taking selected licit and illicit drugs, while George Mason University requires all students prescribed medication for treating ADHD to sign a "Medication Contract" outlining the patient's roles and responsibilities.

Methods to Track ADHD Diagnoses Among School Children

- While some States actively collect statistics on ADHD diagnoses through data collection collaborations between State health and education agencies, the quality of data collected across school divisions is unknown. Virginia's DOE estimates that establishing an ADHD diagnosis data collection system for Virginia public school children would incur a one-time investment cost of $2.9M and annual recurrent costs of $81,200 and would be operational in 2 years and be able to produce reports in 3 years. However, DOE officials expressed concerns that data quality uncertainties found in other States would be similar for Virginia should such a data collection system be established.

Methods Used to Limit Antipsychotic Use

- Nationally, State payers of pharmaceuticals commonly employ a variety of methods to limit and/or ensure the appropriate use of psychotropic medications, including
  - Service authorization (i.e., prescription pre-approval)
  - Peer review (i.e., manual clinician review of prior authorization requests)
  - Drug Utilization Review (DUR) Program (i.e., a process conducted by all State Medicaid agencies involving prospective screening of prescription drug claims to identify potential problems and retrospective of claims data)

Methods to Identify Off-label Prescribing of Antipsychotics

- Identifying off-label prescribing of AAPs from administrative claims data is not straightforward because diagnosis codes are not generally required data elements on prescription claims. As a result,

DMAS has not been able to endorse a methodology that would be able to produce public use information in tracking off label prescribing of AAPs based on claims data.

Actions taken by the Joint Commission on Health Care

JCHC members chose to maintain status quo.

Medical Aid-in-Dying in Virginia

Study Mandate

Delegate Kaye Kory requested via letter that the JCHC study the issue of Medical Aid-in-Dying (MAID) including a review of states that currently authorize MAID and addressing the following questions:

- What has been the impact of informing patients about end-of-life options such as hospice care and palliative care?
- In current MAID states, how have health care systems, institutions and providers acted to implement the law?
- In current MAID states, have people been coerced to ingest end-of-life medication?
- Have any of the states enacted protections to discourage or prevent coercion?
- Has the implementation of the law impacted any state's health care costs?
- Using data from states that allow MAID, how many people would likely utilize MAID if it became law in Virginia?

JCHC members approved the study during the Commission's May 23, 2017 work plan meeting.

Background

Medical Aid-in-Dying is the ability of a patient to obtain, from a physician, a medication that the patient may use to end their life if they are competent, terminally ill, and over 18 years of age. Current Virginia Statute § 8.01-622.1 provides an injunction against assisted suicide, allows for the recovery of compensatory and punitive damages, and indicates that a health care provider who assists/attempts to assist a suicide shall have his/her certificate or license to provide health care services in the Commonwealth suspended or revoked by the licensing authority.

Existing Medical Aid-in-Dying Statutes:

- Oregon (1998)
- Washington (2008)
- Vermont (2013)
- California (2016) May 24, 2018: Judge overturns law; June 15, 2018: Judgement is stayed in appeals court. Currently legal, pending further litigation.
- Colorado (2016)
- Washington, D.C. (2017)
- Hawaii (2018)
- **By Judicial Review:**
- Montana (2009)

Generally, existing MAID statutes include:

Eligibility Criteria:

- Adult, 18 years of age and older
- Resident of the state
- Suffer from a terminal illness
- Able to self-administer the medication

Requires physician provide the following to the patient:

1. Diagnosis with prognosis
2. Range of options including palliative care and hospice care
3. Risks and probable death from prescription

Process:

- Attending and consulting physicians determine and agree that the patient suffers from a terminal disease with less than six months to live.
- Patient must provide 2 voluntary oral requests no less than 15 days apart.
- Patient must provide a signed written request (form provided) for the medication, co-signed by 2 witnesses
- Physician to provide prescription at least 15 days after the initial oral request and at least 48 hours after the signed request.
- Before providing the prescription, the physician must confirm the patient has not rescinded the request and remind the patient that the patient is not required to ingest the medication.
- If either physician believe the patient is suffering from depression or any behavioral health condition that may be impacting their choice, they are to refer the patient to a psychiatrist before proceeding.
- For prescription: After obtaining patient approval, attending physician calls pharmacy to alert pharmacist of the prescription to be filled and sends the written prescription through specified means.
- When ingesting, patient must self-administer the medication.

MAID Work Group:

- A work group was created to discuss Medical Aid-in-Dying. Six meetings were held with approximately 20-30 participants per meeting.
- Discussions focused primarily on the reasons to support/oppose MAID, the preferred name of the practice (e.g. MAID vs. Physician Assisted Suicide) and, using Oregon statute as a blueprint, the many components that should be included or removed from the language of any potential Virginia statute. Ultimately, the work group decided to use California's language with additions listed in policy option two (see below). It was established that, for members who oppose MAID, working on language for a potential Virginia statute does not indicate support for MAID.

Areas of Work Group Member Disagreement:

- Term used in statute (e.g. MAID vs Physician Assisted Suicide)
- Accuracy of "terminal illness (likely death in ≤ 6 months)" language
- Overall, balance in language between safeguards and access to MAID
- Requirements necessary to recognize and prevent individuals from using MAID whose judgment is impaired by depression
- Potential for discrimination against the disabled and other vulnerable groups
- Need for additional language to further decrease the likelihood of coercion
- Definition of informed decision
- Voluntarily expressing wish to die (relating to forms of communication)

(*Please see in PowerPoint presentation appendix the 4 Compassion and Choices slides and the four slides titled "10 Reasons to Oppose Physician Assisted Suicide" for examples of arguments in support of and in opposition to MAID. The presentation can be found on the JCHC website in meetings; 2018; September 18, 9:00 am meeting.)

Information addressing study request questions:

- All MAID statutes require that both the attending and consulting physician inform the patient about end-of-life options, including hospice and palliative care.
- The last 20 years of research show a wide variation in implementation policies/practices among health care systems, hospitals, hospice and palliative care programs and physicians.
- The majority of researchers conducting studies in MAID states have found that physicians, nurses, social workers, clergy and others in health care systems, institutions or private practice want and need education and guidance on MAID.
- In 2012, Compassion and Choices convened the Physician Aid-in-Dying Clinical Criteria Committee to create guidance for physicians willing to provide MAID to eligible patients.
- To decrease the likelihood of implementation challenges, participating institutions should create a plan to review, evaluate, and provide real-time guidance to help address any problems that may occur.
- A significant number of hospice programs set limits regarding "(a) providing information to the patient, (b) notifying the primary physician of the patient's request, (c) providing or assisting with the medications necessary to hasten a patient's death, and (d) permitting the presence of staff members at ingestion or death" (Norton and Miller, 2012).
- All state statutes except Vermont's define coercion and fraud as felony offenses. One can assume it is possible that some instances of coercion or fraud in MAID states may have occurred but it may not have been witnessed or interpreted as coercion/fraud, or substantiating the claim may not have been successful. However, to date, JCHC staff could not find any cases of substantiated accusations of fraud or coercion. It is possible that current penalties are sufficient to discourage coercion and fraud.
- States are not allowed to use federal Medicaid funds to pay for MAID services. As a result, some states utilize state funds to pay for MAID among Medicaid enrollees. However, given the relatively low cost of MAID medications and additional physician visits required during the MAID process coupled with the very low percentage of individuals participating in MAID who also are enrolled in Medicaid, cost to the state is minimal.

Additional Options to Consider: Improving End of Life Care in Virginia

- The POLST (Physician Orders for Life Sustaining Treatment) program began in Oregon in 1991 and currently exists at some level in 42 states. A state's POLST program can be endorsed by the National POLST Paradigm (i.e. the national oversight body) if the requirements set forth by the NPP are met. In 2016, Virginia was the 19th state (out of 21) to be endorsed.
- The POLST program is supported by a range of organizations including AARP, American Academy of Hospice and Palliative Medicine, American Bar Association, American Nurses Association, Catholic Health Association of the United States, Institute of Medicine, National Association of Social Workers, Pew Charitable Trusts, and Society for Post-Acute and Long-Term Care Medicine.
- The POLST document is a standardized, portable, brightly colored single page medical order that documents a conversation between a provider and a patient with a serious illness or frailty towards the end of life and is intended to work in conjunction with an advance directive. Unlike an advance directive, the POLST form is a set of medical orders created by a health care professional during a conversation with the patient. The patient has the original and a copy is placed in the patient's

medical record and in a state registry (if state has one). It is designed to be actionable throughout an entire community in that it is intended to be immediately recognizable and used by doctors and first responders (including paramedics, fire departments, police, emergency rooms, hospitals and nursing homes).

- While Virginia's program has been endorsed by the national oversight body, currently there is a roadblock to wide-spread use of the POST (Physician Orders for Scope of Treatment*) form. (*States can have slight variations in the term used.)
  - § 54.1-2987.1 of Virginia Code does not specifically mention POST
    - § 54.1-2987.1 regarding reciprocity between states of Durable Do Not Resuscitate orders includes the language "A Durable Do Not Resuscitate Order or **other order regarding life-prolonging procedures.**" This additional language was included to indicate that Physician Orders for Life Sustaining Treatment (POLST) Paradigm forms from other states are covered by this statement of reciprocity.
  - 12VAC5-66-10 of Administrative Code only *specifically* mentions POST in DNR section, but on POST form that is only Section A of a set of questions/orders. Remaining parts are not specifically about DNR.
  - Writers of the Code section thought language was specific enough; however, legal counsel of some health care systems and hospitals have advised against using the POST form due to uncertainty.
  - POST supporters believe that an Opinion from Virginia's Attorney General that this Code language does apply to the POST form, in full, would address the problem.
    - If the Opinion states that the Code language does not apply to the POST form, legislation to change the Code may be needed as well as, *perhaps*, an official memo from the Virginia Board of Health assuring/clarifying that the POST form is recognized in Virginia as an appropriate practice for eliciting, documenting and honoring a patient's medical wishes are needed.
    - Communication with the Office of the Attorney General confirmed that it is appropriate to request an Opinion on this issue.

Actions taken by the Joint Commission on Health Care

JCHC members chose to maintain status quo.

MEETING AGENDAS 2018

February 19, 2018	**Introduction** Senator Charles W. Carrico, Sr., Chair **Discussion of changing study approval process** Michele Chesser, Ph.D, Exective Director **Review of current FOIA policy**
April 17, 2018	**EXECUTIVE SUBCOMMITEE MEETING** **Introduction** Senator Charles W. Carrico, Sr., Chair **Discussion of Work Plan for 2018**
June 15, 2018	**Call to Order and Welcome New Members** Senator Charles W. Carrico, Sr., Chair **Election of Officers Comments from Elected Chair and Vice Chair** **Discussion of 2018 Work Plan Proposal** Michele L. Chesser, Ph.D. Executive Director **ADHD Prevalence and Risks of ADHD Medications in Virginia, Final Report** Andrew Mitchell, Sc.D., Senior Health Policy Analyst
August 22, 2018	**Call to Order** Senator Rosalyn R. Dance, Chair **Virginia's Plan for Well-Being: 2018 Update** Norman Oliver, MD, State Commissioner of Health **DBHDS Implementation Update on 2018 General Assembly Directives** Hughes Melton, MD, Commissioner for the Department of Behavioral Health and Developmental Services **DMAS Update for the Joint Commission on Health Care: 2018**

	Jennifer Lee, MD, Director for the Department of Medical Assistance Services **The State Targeted Response to the Opioid Crisis Grant Awarded to Virginia and Emergency Department Pilots** Mellie Randall, Substance Use Disorder Policy Director, and Stacy Gill, Assistant Commissioner for Behavioral Health Community Services, DBHDS **Medical-Aid-in-Dying, Final Report** Michele Chesser, Ph.D., Executive Director
September 18, 2018	**Call to Order** Senator Rosalyn R. Dance, Chair **Governor Northam's HHR Strategic Priorities** Daniel Carey, M.D., Secretary of Health and Human Resources **Update on the ARTS (Addiction and Recovery Treatment Services) Program** Tammy Whitlock, Deputy Director of Complex Care, and Kate Neuhausen, M.D., Chief Medical Officer; Department of Medical Assistance Services (DMAS) **Staff Report: Quality of Health Care Services in Virginia Jails and Prisons, and Impact of Requiring Community Services Boards to Provide Mental Health Services in Jails (Final Report of Two-Year Study)** Stephen Weiss, MPA Senior Health Policy Analyst **Staff Report: Virginia Pharmacy Drug Disposal Program** Andrew Mitchell, Sc.D. Senior Health Policy Analyst **Staff Report: Medical Aid-in-Dying in Virginia (Final Report of Two-Year Study)** Michele Chesser, Ph.D. Executive Director

October 15, 2018	**Call to Order** Senator Rosalyn R. Dance, Chair **VDSS Role in Medicaid Expansion** Commissioner S. Duke Storen, Department of Social Services **Results of DBHDS Work Group on Improving the Quality of Direct Support Professional Workforce** Holly Mortlock, Policy Director, Department of Behavioral Health and Developmental Services **ChildSavers: Trauma-Informed Mental Health and Quality Early Care Services for Children** L. Robert Bolling, Chief Executive Officer, ChildSavers **Staff Report: Addiction Relapse Prevention Programs in the Commonwealth** Andrew Mitchell, Sc.D., Senior Health Policy Analyst **Staff Report: Requiring the Installation of Onsite Temporary Emergency Electrical Power Sources for Assisted Living Facilities** Stephen Weiss, MPA, Senior Health Policy Analyst
November 7, 2018	**Call to Order** Senator Rosalyn R. Dance, Chair **Developmental Disabilities Waivers Update** Dawn Traver, Director of Waiver Operations, Department of Behavioral Health and Developmental Services **VHI Annual Report and Strategic Plan Update** Michael Lundberg, Executive Director, VHI **The Truth Behind Addiction** Courtney Nunnally, President, Addiction Uncuffed (Presentation requested by JCHC Chair) **Decision Matrix** Study-overviews, with public comment results, and review of policy options JCHC Staff

STATUTORY AUTHORITY

§ 30-168. (Expires July 1, 2022) 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, 2022) 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, 2022) 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, 2022) 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, 2022) 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, 2022) 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, 2022) 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, 2022) Sunset.
The provisions of this chapter shall expire on July 1, 2022.
(1992, cc. 799, 818, § 9-316; 1996, c. 772; 2001, cc. 187, 844; 2006, cc. 113, 178; 2009, c. 707; 2011, cc. 501, 607.)

2014, cc. 280, 518.

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