



Decision Matrix

Policy Options for 2012 General Assembly Session

November 22, 2011

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PURPOSE OF DOCUMENT:

- A. To review and discuss findings, public comments, and policy options regarding staff reports and other issues that came before the Commission and its subcommittees in 2011.
- B. To develop legislative recommendations for the 2012 General Assembly Session.

Considerations in Adding Pseudoephedrine as a Schedule III Controlled Substance (SB 878)

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

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

Background

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

Results of the JCHC study indicate that there is a correlation between making pseudoephedrine a prescription medication and the number of methamphetamine labs in a state. After Oregon passed legislation requiring a prescription for pseudoephedrine, methamphetamine lab production fell from a high of 525 in 2002 to 13 in 2010. In Mississippi, which adopted a prescription-only law in 2009, methamphetamine lab seizures have dropped by nearly 70 percent. However, for consumers, requiring a prescription would result in the added inconvenience and cost of having medical appointments with a physician in order to receive and renew prescriptions. Individuals without health insurance or who live in medically-underserved areas may have to delay or forgo cold/allergy symptom relief. It also is possible that the law would increase health care system costs and reduce the level of State tax revenue generated by over-the-counter pseudoephedrine sales.

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

- making pseudoephedrine available only by prescription,
- requiring retail sellers of pseudoephedrine to keep an electronic log with real-time stop sale capability (NPLEx), and
- strengthening laws associated with the possession of precursor drugs for the purpose of manufacturing methamphetamine.

Policy Options and Public Comment

Three comments were received regarding the policy options; comments were submitted by:

- John Jones, Executive Director, on behalf of the Virginia Sheriffs' Association (VSA)
- Michael Weber
- John R. Gibson, Director of US Public Affairs & Policy, on behalf of Pfizer, Inc.

Summary of Public Comment

Options	In Support	In Opposition
1 Take no action.	0	0
2 Legislation to make pseudoephedrine (PSE) a prescription drug.	0	2 (Pfizer, M. Weber)
3 Legislation to use the National Precursor Log Exchange.	2 (Pfizer, VSA)	0
4 Legislation to limit PSE purchase to 9 grams within 30 days and to make exceeding the limit a misdemeanor offense.	1 (M. Weber)	0
5 Legislation to limit possession or acquiring PSE to 9 grams within 30 days.	0	0
6 Legislation to make obtaining or procuring PSE by fraud, deceit, or forgery a misdemeanor offense.	0	0

Option 1: Take no action.

Option 2: Introduce legislation to amend the *Code of Virginia* § 54.1-3450 to add pseudoephedrine to Schedule III of the Drug Control Act, which would prohibit it from being sold without a prescription.

Michael Weber commented against Option 2

John R. Gibson on behalf of Pfizer, Inc. commented against Option 2

Option 3: Introduce legislation to amend of the *Code of Virginia* § 18.2-248.8 to require that the log, currently required to be maintained by sellers of products containing ephedrine, pseudoephedrine, or any of their salts, isomers, or salts of isomers, must be kept by a State level law enforcement agency in electronic format, utilizing the National Precursor Log Exchange (NPLEx).

John Jones on behalf of the Virginia Sheriffs' Association (VSA) commented in support of Option 3

John R. Gibson on behalf of Pfizer, Inc. commented in support of Option 3

Option 4: Introduce legislation to amend the *Code of Virginia* § 18.2-248.8 to make the purchase of ephedrine and pseudoephedrine, in excess of statutorily-determined amounts, a misdemeanor offense and to establish the maximum amount of ephedrine and pseudoephedrine that can be legally sold or purchased in a 30 day period:

§ 18.2-248.8. Sale **and purchase** of the methamphetamine precursors ephedrine and pseudoephedrine; penalty.

A. The sale of any product containing ephedrine, pseudoephedrine, or any of their salts, isomers, or salts of isomers, alone or in mixture, shall be restricted when provided or sold by a retail distributor or pharmacy as follows:

1. Retail sales **and purchases** shall be limited to no more than 3.6 grams total of either ephedrine or pseudoephedrine daily and **9 grams within any 30 day period** per individual customer.

Michael Weber commented in support of Option 4

Option 5: Introduce legislation to amend Title 18.2 of the *Code of Virginia* to make it unlawful to possess, receive, or otherwise acquire more than 9 grams of ephedrine, pseudoephedrine, or any of their salts, isomers, or salts of isomers; or phenylpropanolamine in any product, mixture, or preparation within any 30 day period. (This restriction does not apply to any quantity of product, mixture, or preparation obtained pursuant to a valid prescription drug order prescribed by a practitioner with appropriate authority.)

Possession of more than 9 grams of ephedrine, pseudoephedrine, or phenylpropanolamine constitutes a rebuttable presumption of the intent to use the product as a precursor to methamphetamine or another controlled substance. This rebuttable presumption does not apply to:

- (1.) A retail distributor of drug products;
- (2.) A wholesale drug distributor, or its agents;
- (3.) A manufacturer of drug products, or its agents;
- (4.) A pharmacist licensed by the Board of Pharmacy; or
- (5.) A licensed health care professional possessing the drug products in the course of carrying out professional duties.

Option 6: Introduce legislation to amend the *Code of Virginia* § 18.2-258.1.A to add ephedrine, pseudoephedrine, or any of their salts, isomers, or salts of isomers to the current list:

§ 18.2-258.1. Obtaining drugs, procuring administration of controlled substances, etc., by fraud, deceit or forgery. A. It shall be unlawful for any person to obtain or attempt to obtain any drug or procure or attempt to procure the administration of any controlled substance, marijuana, ~~or~~ synthetic cannabinoids, ***or ephedrine, pseudoephedrine, or any of their salts, isomers, or salts of isomers:*** (i) by fraud, deceit, misrepresentation, embezzlement, or subterfuge; or (ii) by the forgery or alteration of a prescription or of any written order; or (iii) by the concealment of a material fact; or (iv) by the use of a false name or the giving of a false address. (Class 1 misdemeanor)

Excerpts from Public Comments

John Jones on behalf of the Virginia Sheriffs' Association (VSA) commented in **support of Option 3:**

“The Virginia Sheriffs” Association (VSA) supports the development of an automated NPLEX system. There are other options that will be considered by the VSA as the legislative process moves forward, but the VSA has already voted to support (as a priority) a statewide system designed to detect multiple purchases of substances used to make meth.

Based on a recent survey of sheriffs, [meth production] was identified as a major and costly problem in Virginia, both as a public safety issue and as a financial burden to localities for cleaning up the labs that have been busted.”

Michael Weber commented **against Option 2** and in **support of Option 4:**

“The regulation currently in place is fine. When you go to buy this medication you must show an id - the government does not need to be involved anymore than they are with this medication. Isn't option 4 the one that is being used now? If not, I have no problem with option 4. I do not want to have to go to the doctor in the spring and fall for this sinus medication.”

John R. Gibson on behalf of Pfizer, Inc. commented **against Option 2** and in **support of Option 3**:

“While Pfizer, Inc. understands the ongoing challenges of Meth usage and production in Virginia (especially in Southwest) and many other states, the company is opposed to making Pseudoephedrine a Schedule III Drug in the Commonwealth...Reclassifying these products as schedule III will require legitimate consumers to see a doctor and get a prescription every time they have a cough, cold or allergy. It will add stress and costs onto law-abiding consumers and an already burdened healthcare system – while only marginally, if at all, decreasing meth use... Additionally, it is important to note that Pseudoephedrine by itself is NOT addictive which is certainly why Attorney General Cuccinelli’s office has informally stated that it likely could not be classified as a Schedule III in the first place...we support the NPLEX tracking system that was aptly outlined in your presentation...NPLEX is a tried and true method currently in use in many states and would cost neither the state nor pharmacies any additional monies to implement... And, as you know the NPLEX system has the support of many key pharmaceutical companies and trade organizations and we believe it is the best way to achieve the results desired.”

Study of Eating Disorders in the Commonwealth (SJR 294)

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

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

Background

Eating disorders, which include anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified, affect approximately 24 million people in the United States. Approximately 90 percent of those afflicted are women. Although eating disorders can affect people of all ages, 86 percent of individuals with an eating disorder report that it began before the age of 20, and the age of onset has decreased dramatically in recent years. In addition, the occurrences of eating disorders among college-age women are approaching epidemic levels with between 19 and 30 percent of this age group displaying bulimic behavior.

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

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

Policy Options and Public Comment

Comments, in response to the JCHC study on eating disorders, were submitted by:

- Laura Collins, Executive Director, on behalf of F.E.A.S.T. (Families Empowered and Supporting Treatment of Eating Disorders)
- Lisa Gorove
- Lynn S. Grefe, Chief Executive Officer, and Lara Gregorio, STAR Program Manager on behalf of the National Eating Disorders Association (NEDA)
- Beverly Magida, LCSW, BCD
- Carol Blum Papillon, MPH, RD, President, on behalf of the Virginia Dietetic Association (VDA)

Lisa Gorove commented to request “action to inform families, teachers, pediatricians, policymakers, etc. about how eating disorders are triggered and how crucial it is to intervene early.”

Laura Collins on behalf of F.E.A.S.T. commented without supporting a specific option, taking issue with the inclusion of family dynamics as one of the causal factors for eating disorders and with the lack of content on parents in the presentation.

Summary of Public Comments

Policy Options	In Support
Option 1: Take no action.	0
<input checked="" type="checkbox"/> Option 2: Request by letter of the JCHC Chairman that the Virginia Department of Education encourage grade schools, middle schools, and high schools to provide homeroom teachers and school nurses with instruction <i>or information</i> approved by the American Medical Association or the National Eating Disorders Association on how to recognize eating disorders and how to help youth who may be affected get the care they need.	1 NEDA*
<input checked="" type="checkbox"/> Option 3: Request by letter of the JCHC Chairman that the Virginia Department of Education encourage schools to provide instruction <i>or information</i> approved by the American Medical Association or the National Eating Disorders Association on healthy eating habits and positive body image to students at some point during the fourth, fifth, or sixth grade.	2 NEDA* VDA
Option 4: Request by letter of the JCHC Chairman that: <ul style="list-style-type: none"> A. The Medical Society of Virginia encourage pediatricians and general practitioners to complete an online continuing education course on eating disorders, such as the new 15 minute, online course created by the American Medical Association. B. The Virginia Nurses Association encourage nurse practitioners and nurses to complete an online continuing education course on eating disorders, such as the new 15 minute, online course created by the American Medical Association. 	3 NEDA* VDA B. Magida
*Lynn S. Grefe and Lara Gregorio on behalf of NEDA commented in support of Policy Options 2, 3, and 4 but requested they “be amended to call upon the Department of Education, the Medical Society of Virginia, and the Virginia Nurses Association to work with NEDA, and other interested parties, to implement the JCHC’s directives [and for JCHC]...staff to report in 2012 on the progress made...as well as [on] any additional recommendations arising out of implementation.”	

Additional Options Suggested:

Lynn S. Grefe and Lara Gregorio on behalf of **NEDA** asked JCHC to consider the following proposed option:

Amended Potential Option 5: Request by letter of the JCHC Chairman that the Virginia Department of Health and the Virginia Department of Education collaborate with the National Eating Disorders Association, and other interested stakeholders, to ~~develop~~ *study* an evidence-based eating disorder screening program for *potential* implementation in Virginia’s school systems. JCHC staff will report back to the JCHC in 2012 regarding progress ~~made~~

~~on developing an evidence-based eating disorder school screening program and deliver staff's and staff recommendations for potential legislative implementation.~~

Carol Blum Papillon on behalf of the **Virginia Dietetic Association** also suggested an additional option for JCHC consideration. Ms. Papillon noted that eating disorders involve “the highest mortality of any psychiatric diagnosis. The [JCHC] report clearly identifies that many cases are not diagnosed due to the stigma involved or lack of training by medical professionals, and once they are diagnosed the treatment is not supported adequately to provide treatment needed to cure the disease. These issues clearly reinforce the need for prevention, early diagnosis and thorough treatment which we support within any policy approach that is put forward....The proposed policy options do not address the current lack of treatment that exists. Therefore, we encourage further study of policy options that would enhance treatment among those afflicted within the Commonwealth and insurance coverage thereof.”

Potential Option 6: Include in the 2012 work plan for JCHC’s Healthy Living/Health Services Subcommittee, continued study of options that would enhance treatment and address insurance coverage for eating disorders.

Replicating James Madison University's Caregivers Community Network

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

In 2009, JCHC conducted the study, *Improving Aging-at-Home Services and Support for Culture Change Initiatives*, and members approved a policy option to include on the JCHC 2010 work plan a staff study of the feasibility of replicating James Madison University's Caregivers Community Network in other areas of the Commonwealth. It was determined that one of the proposed policy options would be to introduce a budget amendment to fund demonstration grants for a two-year period. Consequently, presentation of the study was delayed until 2011 to correspond with the beginning of the two-year budget cycle.

Background

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

To encourage other Virginia universities and colleges to create their own Caregiver Community Network programs, it is suggested that two to three demonstration grants be awarded via a competitive process that would provide two years of funding to allow schools adequate time to develop and implement the program. After the first two years, the new programs should be sustained using a combination of grants, student tuition, fundraising, and care-recipient fees.

Policy Options and Public Comment

Six comments were received regarding the Caregivers Community Network. The commenters generally explained how valuable the JMU program had been for them and only one specifically addressed the proposed options. Comments were submitted by:

- Lynne Seward on behalf of the Virginia Adult Day Health Services Association (VADHSA)
- Courtney Tierney on behalf of the Virginia Association of Area Agencies on Aging (VAAAA)
- Bernice Stipic
- Ken Lane
- Ginny Joseph
- Barbara Meadows

Option 1: Take no action.

Option 2: Introduce a budget amendment (language and funding) for the Virginia Department for the Aging to provide grant funding of \$370,900 GFs for two demonstration projects to replicate JMU's Caregivers Community Network at other colleges or universities in the Commonwealth.

Option 3: Introduce a budget amendment (language and funding) for the Virginia Department for the Aging to provide grant funding of \$509,400 GFs for three demonstration projects to replicate JMU's Caregivers Community Network at other colleges or universities in the Commonwealth.

Option 4: Include on the JCHC 2012 work plan, a staff study of the availability of respite services for caregivers in the Commonwealth. (Option added by JCHC members)

Lynne Seward on behalf of the Virginia Adult Day Health Services Association commented in support of Option 4.

Four caregivers (**Bernice Stipic, Ken Lane, Ginny Joseph, and Barbara Meadows**) discussed the benefits they and their loved ones received from JMU's Caregivers Community Network Program.

Courtney Tierney on behalf of the **Virginia Association of Area Agencies on Aging** commented in support of "expanding the availability of regular respite in the community with best practices from around the country guiding that work." Ms. Tierney wrote:

"We appreciate the Commission's awareness of the enormous impact that family caregiving has on thousands of Virginians and the demonstrated value of regular respite for those dedicated families....we can validate the importance of regularly scheduled respite in decreasing depression, illness and stress among caregivers, thus increasing coping skills and wellness for both the caregiver and the older family member needing care. With 80% of care in the U.S. provided by family members, we all need to determine the best ways to support these caregivers in their important role without compromising their own health and overall wellness.

...Although a full range of respite services is not available in all Virginia communities, even in areas where it is readily available, resources are underutilized and underfunded. Many caregivers are reluctant to ask for help and paying for that help is a barrier for many who have had to leave the workforce prematurely to take on caregiving.

...We would ask that The Joint Commission on Health Care recommend expanding the availability of regular respite in the community with best practices from around the country guiding that work. We ask that you seek out these successes and work to ensure that our Virginia families can access them. As always, the V4A is most willing and ready to assist in your endeavors."

In a subsequent discussion, Ms. Tierney asked that V4A be included if a JCHC study is approved for 2012. She also asked that the study focus on the most useful support services for family and informal caregivers, whether those services are designated as respite or not. Virginia's 25 area agencies on aging have enjoyed flexibility in designing support programs that address the needs of their family and informal caregivers; however, some of the programs are not designated as respite care services.

Potential Revision of Option 4: *Include on the JCHC 2012 work plan, a staff study of the benefit and availability of support services for family and informal caregivers in the Commonwealth. In completing the study, staff will work with representatives of the Virginia Department for the Aging, the Virginia Association of Area Agencies on Aging, AARP-Virginia, Virginia Alzheimer's and Related Disorders Commission, Virginia Center on Aging, and other stakeholders.*

Study of Shaken Baby Syndrome (HJR 632)

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

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

Background

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

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

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

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

There are a number of established prevention programs, most of which seek to teach new parents how to handle their frustration when their infant cries for long periods of time. These prevention programs typically have a hospital-based component which includes educational activities such as discussions with new parents, pamphlets, and videos describing the consequences of SBS and alternative ways to deal with frustration. While the hospital-based form of prevention is vital, additional prevention activities designed to reach men who are not the children’s fathers and informal caregivers are needed also.

Policy Options and Public Comment

Two public comments were received regarding the policy options:

- **Commissioner Karen Remley commented on behalf of the Virginia Department of Health in support of a revised Option 4** (shown below).
- **Steve Stowe, President, Shaken Baby of Virginia**, commented in **support of Options 2 through 6 and** to suggest **an additional option**, shown as “Potential Addition to Option 4” (meaning both Option 4 and Revised Option 4).

Option 1: Take no action

Option 2: Introduce budget amendments (language and funding) to allow the Virginia Department of Health to undertake or contract for a hospital-based prevention program to include training maternity staff to talk with parents of newborn babies, and provide those parents with a video presentation on the dangers of shaking infants.

- A. Statewide program (estimated cost to be determined but not expected to exceed \$300,000 per year)
- B. One or more demonstration projects at \$10,000 or \$50,000 per year

Option 3: Introduce budget amendments (language and funding) to allow the Virginia Department of Health to undertake or contract for a pediatric office-based prevention program to provide staff training and video presentations on the dangers of shaking infants.

- A. Statewide program (estimated cost to be determined but not expected to exceed \$300,000 per year)
- B. One or more demonstration projects at \$10,000 or \$50,000 per year

Option 4: Request by letter of the JCHC chairman that such State agencies as the Departments of Health, Social Services, Behavioral Health and Developmental Services, Rehabilitative Services, and Education collaborate with other public and private stakeholders to develop a more comprehensive SBS prevention initiative. The initiative, which would be reported to the chairmen of the Joint Commission and the Virginia Disability Commission, should include:

- A collection of prevention and training programs designed for use in hospitals, pediatricians’ offices, child day care and foster-care training, middle school classes, and juvenile and adult court and correctional settings.
- Public service announcements and advertisements.
- Supportive programs for victims of Shaken Baby Syndrome and their families.
- Creation of a surveillance and data collection program to measure the incidence of SBS and traumatic brain injury in infants and children in the Commonwealth of Virginia.

Commissioner Karen Remley, in discussing a revision to Option 4, indicated that VDH “has several ongoing initiatives that promote the prevention of Shaken Baby Syndrome.

...These targeted tactics are part of a larger, comprehensive strategy by VDH to focus on the critical issue of infant mortality, of which Shaken Baby Syndrome is one aspect....VDH has, for the last several years, addressed infant mortality through the Health Commissioner’s Workgroup on Infant Mortality. The Workgroup brings together representatives from private, public, and non-profit sectors. Members include representatives from hospitals, DMAS, obstetricians,

academia, neonatal experts, and others. One current initiative is to survey Virginia hospitals regarding the content of prenatal courses provided to expectant families. The results will be analyzed to identify opportunities to enhance the use of messages and tools capable of preventing the death of infants....[We] will be looking at whether key messages to prevent Shaken Baby Syndrome are being shared. By taking this broad approach to infant health and safety, we believe we can promote synergy as well as efficient use of resources.

VDH would like to recommend that the Joint Commission consider approaching infant mortality and safety policy with a comprehensive strategy parallel to that of the Health Commissioner's Workgroup on Infant Mortality....[since] factors increasing the risk of an infant's death are often linked....A comprehensive approach can potentially address root causes and leverage resources."

 **Revised Option 4:** *Request by letter of the chairman that the Departments of Health, Social Services, Behavioral Health and Developmental Services, Rehabilitative Services, and Education collaborate with other public and private sector stakeholders to identify current best practices, state-wide programs, surveillance and data, initiatives and interventions dedicated to addressing infant mortality in Virginia, including those efforts dedicated with specific attention to Shaken Baby Syndrome as a cause of infant mortality. The Virginia Department of Health, by July 1, 2013 and in collaboration with other agencies and stakeholders, shall submit a report to the Joint Commission on Health Care [and the Virginia Disability Commission] detailing these efforts with recommendations for improving public awareness and professional intervention and collaborative practices, and future program and policy development, supported by appropriate evaluation and outcome measures.*

Steve Stowe, President of Shaken Baby of Virginia, commented in support an additional policy option. Mr. Stowe wrote, "In reference to the Policy Options for what we believe should be named, "Jared's Law." Our professional opinion which has been derived from not only hundreds of hours of research, but also the two years, eight months, and two days that we cared for our grandson, Jared Nicholas Patton, which was a demanding twenty four hour a day task....We feel that we are more than qualified to be of service to the State while the needed time is being spent on the decisions such as medical coding issues, policy procedures, and the many hours ahead of tireless work from the members of the Department of Health and the J.C.H.C. As Shaken Baby Syndrome of Virginia, Inc., we have trained over 5000 soldiers at Ft. Eustis. We have been called upon from too many family advocacy groups to list. We have literature in the offices of Pediatricians, Vision specialists, and various professional stations throughout the community wherever education and awareness about Child Abuse is in need. Up to this point we have been self funded. We are determined to do what we can to prevent SBS in Virginia. We have created a training version very close to the Diaz Model. Postpartum is the most effective setting for educating parents and helping them keep their new born babies safe. **We would like to request that the J.C.H.C. consider contracting SBS of VA., Inc. to train staff, help hands on at postpartum, or any part of the needed options within perhaps a certain area of the State while the above mentioned work is in progress.** We feel strongly that just standing by while so many decisions need to be governed would be neglecting the safety of all new born babies during this time frame. Whatever it costs the State to contract someone during this tenor, we all know it is just a fraction of what it will cost the State to do nothing."

Potential Addition to Option 4: After collaborate with other public and private sector stakeholders, add the language “including officers of Shaken Baby Syndrome of Virginia” if either version of Option 4 is approved.

Option 5: Introduce a joint resolution to establish the third week of April as Shaken Baby Awareness Week in Virginia. The resolution would be in memory of Jared and the many other victims of Shaken Baby Syndrome in Virginia.

Option 6: Include in the 2012 work plan for the Behavioral Health Care Subcommittee, continuation of the study for a second year to consider definitional and medical coding issues.

Involuntary Admission of Persons in Need of Substance Abuse Treatment (HJR 682)

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

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

Background

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

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

In general, MOT was used when the client was either "likely to harm self" or "lacking the capacity to protect self or provide for basic human needs." Approximately one-third of the clients placed on MOT were required to receive substance abuse treatment services as well as services for mental illness. CSB representatives indicated that two aspects of their civil commitment process made MOT more feasible: they waited a full 48 hours before initiating the temporary detention hearing to give clients more time to consider and agree to treatment on an outpatient basis; and a second evaluation was completed immediately prior to the hearing to give the client another opportunity to express a willingness to participate in outpatient treatment. The MOT was found to meet the needs of clients who "fall somewhere in between inpatient care and dismissal" and the clients generally were very cooperative with treatment.

Policy Options and Public Comment

Option 1: Take no action.

Option 2: Include in the 2012 work plan for the Behavioral Health Care Subcommittee, a study of whether mandatory outpatient treatment can be structured to address more effectively the needs of persons with substance abuse treatment. In addition, by letter of the Chairman, request that representatives of the Department of Behavioral Health and Developmental Services, community services boards, and other interested parties participate in the study.

No public comment was received regarding these policy options.

Review of Certain Board of Pharmacy Practices (HB 1961 and HB 1966)

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

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

Background

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

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

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

The current disciplinary process includes several opportunities for Board staff and members to identify conflicts of interest. Board of Pharmacy representatives indicated members tend to be overly cautious, they have received very few complaints regarding conflict of interest and recusal, and that more prescriptive language in statute would not be useful. However, the Board of Pharmacy could improve its documentation by recording in the minutes of formal disciplinary hearings, a statement regarding any known conflict of interest or recusal of a Board member participating in the hearing (Option 2). There are also opportunities for the Board to keep complainants informed of Board activities that are being undertaken to address their complaints. It is especially important to inform complainants regarding potential actions taken by the Board that are confidential and not made public (Option 3).

HB 1966: Reporting on Substance Abuse or Mental Health Issues. Current law (*Code* § 54.1-2400.8) already allows any person to report to the Board of Pharmacy or Department of Health Professions on any health care practitioner regarding unprofessional conduct or competency with immunity “unless such person acted in bad faith or with malicious intent.” The Board of

Pharmacy went further in 2008 by voting to support legislation requiring mandatory reporting for pharmacies and pharmacists that mirrors the requirements in place for hospitals and health care institutions on disciplinary actions or evidence that a “professional is in need of treatment of has been committed or admitted as a patient...for substance abuse or a psychiatric illness that may render the health professional a danger to himself, the public or his patients.” (*Code* § 54.1-2400.6) However, legislation was not introduced (Option 5).

Policy Options and Public Comment

Dr. Diane Reynolds-Cane, Director of the Virginia Department of Health Professions, commented in opposition to Options 2 and 3. No additional public comment were received.

Option 1: Provide a written report to the Chairman of the House Committee on Health, Welfare and Institutions without taking any other action.

Option 2: Provide a written report to the Chairman of the House Committee on Health, Welfare and Institutions and include in the letter that JCHC voted:

In support of recommending that the Board of Pharmacy record, in the minutes of any formal disciplinary hearing, a statement regarding any Board member who recused himself from participating in the hearing.

Dr. Reynolds-Cane commented in opposition to Option 2.

Option 3: Provide a written report to the Chairman of the House Committee on Health, Welfare and Institutions and include in the letter that JCHC voted:

In support of amending the *Code of Virginia* § 54.1-2400.2.F to change the permissive “may” to a compulsory “shall” as shown:

“The relevant board ~~may~~ shall also inform the source of the complaint or report (i) that an investigation has been conducted, (ii) that the matter was concluded without a disciplinary proceeding, (iii) of the process the board followed in making its determination, and (iv) if appropriate, the result of the proceeding including that an advisory letter from the board has been communicated to the person who was the subject of the complaint or report without the content of the letter.”

Dr. Reynolds-Cane commented in opposition to Option 3.

Option 4: Provide a written report to the Chairman of the House Committee on Health, Welfare and Institutions and include in the letter that JCHC voted:

In support of amending Title 54 of the *Code of Virginia* to extend mandatory reporting requirements (similar to the requirements for hospitals and other health care institutions in *Code* § 54.1-2400.6) to require pharmacists and pharmacies to report on disciplinary actions, treatment needs, and commitments and inpatient admissions related to “substance abuse or psychiatric illness that may render the....[pharmacy-related] professional a danger to himself, the public or his patients.”

Comment Excerpts:

Dr. Reynolds-Cane, in commenting on **Option 2** stated:

“We are uncertain about what sort of “statement” is contemplated. *If a board member recuses himself at a formal hearing (or an informal conference), the minutes of the meeting would*

already include that occurrence.... There are numerous scenarios surrounding the issue of recusal, so the Department has some concerns as to whether there is an expectation about the “statement” in the minutes apart from recording the fact of a member’s recusal at the formal hearing, which would already be captured in the minutes.”

Dr. Reynolds-Cane, in commenting in opposition to **Option 3** stated:

“While it is currently discretionary, boards within the Department already do provide the information enumerated in the Code in the letter that goes to a source of a complaint. However, it would be our preference for the boards to have *authorization* to share such information with a source but to retain the current permissive language.”

Chronic Health Care Homes (HJR 82 – 2010)

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

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

Background

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

When HJR 82 was introduced, the concept of a patient-centered medical home (PCMH) was just beginning to gain attention. Since that time, there have been many discussions promoting new and better ways to provide medical care as well as pilot programs which indicate that medical homes may become a useful, sustainable model. PCMHs involve a team-based model of care in which a personal physician leads a team of providers responsible for planning and delivering ongoing care for the “whole person.” The National Committee for Quality Assurance, which developed standards for designation as a medical home, had recognized approximately 450 practices in 24 states and D.C. as medical homes as of March 2010. PCMHs have been shown to improve access to medical care and reduce unnecessary medical costs.

- In Pennsylvania, medical home patients had a 14% reduction in hospital admissions; a trend toward a 9% reduction in medical costs was identified also (Geisinger Health System).
- In Michigan, emergency room visits were reduced by 50% and inpatient hospitalizations by 15% (The Genesee Health Plan HealthWorks model).

Provisions of the Patient Protection and Affordable Care Act (PPACA) created the Center for Medicare and Medicaid Innovation within CMS to test innovative payment and service delivery models (including PCMHs) to reduce the rate of growth of Medicare and Medicaid expenditures. In Virginia, an Innovation Center will be established as a nonprofit center hosted by the Virginia Chamber of Commerce. While many of the details of how the Center will operate have not been determined as the projected start date for the Center is January 2012, “the Innovation Center will serve as a resource in Virginia by:

- Researching and disseminating knowledge about innovative models of health promotion and health care to Virginia employers, consumers, providers, health plans, public purchasers, and communities;

- Developing multi-stakeholder demonstration projects aimed at testing innovative models of health promotion and health care; and,
- Helping Virginia employers, providers, purchasers, health plans, and communities accelerate their pace of innovation for the benefit of Virginians.”

(Description sent to JCHC staff by Health and Human Resources Secretariat staff in August 2010.)

Medical home initiatives are being undertaken in Virginia already:

- 18 Carilion physician practices in the Roanoke and New River valleys are recognized as Level-3 (highest) Patient-Centered Medical Homes by the National Committee for Quality Assurance.
- An increasing number of practices in the Hampton Roads area are transforming themselves into PCMHs.
 - Physicians and faculty of Eastern Virginia Medical School will soon apply for recognition as a medical home.
 - Several Sentara practices are also in the application process.

Furthermore, DMAS has partnered with the Southwest Virginia Community Health Systems, Community Care Network of Virginia, and Carilion in order to transition a Medicaid primary care program in southwestern Virginia into a medical home pilot. The medical home pilot, which received a technical assistance grant from the National Academy of State Health Policy and the Commonwealth Fund, will provide primary care, behavioral health, disease and case management, and other services.

Policy Options and Public Comment

Option 1: Take no action.

Option 2: Continue to monitor the progress of primary care medical homes and other health care innovations in Virginia by including reports on initiatives in the 2012 work plan of the Healthy Living/Health Services Subcommittee.

No public comment was received regarding these policy options.

All-Payer Claims Databases

Stephen W. Bowman
Senior Staff Attorney/Methodologist

A 2010 JCHC study of the availability and use of catastrophic health plans (HJR 99 – Delegate Stolle) included a policy option to review the development of an All-Payer Claims Database (APCD) in an effort to improve quality and health outcomes in the Commonwealth.

Background

APCDs may include data from medical, eligibility, provider, pharmacy, and/or dental claims from private (health insurance) and public (Medicare, Medicaid, Veterans Administration) payers. APCDs can facilitate a better understanding of cost and utilization across institutions and populations. Twelve states currently have an APCD and two states are in the process of implementing such databases. Some of the specific ways in which these APCDs are being used include:

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

Some of the important decisions to make in developing an APCD include governance structure, voluntary or mandatory submission of data, payers that will be required to submit data, rules for release and for public dissemination of data, and funding sources.

The Healthy Living/Health Services Subcommittee met on October 3rd and heard from three stakeholder groups: Virginia Hospital and Health Care Association, Virginia Association of Health Plans, and Virginia Health Information. The Subcommittee discussed various principles for an APCD but no votes were taken; however, staff was directed to develop policy options. During the October 17th JCHC meeting, staff reviewed the Subcommittee's discussions.

Policy Options and Public Comment

Nine written comments were submitted regarding this study by the following organizations: Donald Gehring for Anthem, Chalmers M. Nunn, Jr., M.D. for Centra, Jodi Fuller for MeadWestvaco, Nicole Riley for National Federation of Independent Business – Virginia (NFIB-VA), David R. Maizel, M.D. for Sentara, Doug Gray for Virginia Association of Health Plans (VAHP), Eileen E. Ciccotelli, MPM for Virginia Business Coalition on Health (VBCH), Christopher S. Bailey, for Virginia Hospital and Healthcare Association (VHHA), and Jim Cronin for UnitedHealthcare.

The following public comment summary is grouped according to position taken.

Summary of Public Comment

<p>Supports taking no action: Virginia Association of Health Plans</p>
<p>Supports APCD legislation: National Federation of Independent Business – Virginia</p>
<p>Supports developing an APCD administered by VHI: MeadWestvaco Sentara Virginia Hospital and Healthcare Association</p>
<p>Supports APCD legislation that requires insurers to report claims information: Centra</p>
<p>Supports APCD legislation adhering to national data standards that requires reporting of claims information: Virginia Business Coalition on Health</p>
<p>Opposes APCD legislation at this time and supports further study: Anthem</p>
<p>Opposes an APCD at this time and recommends Virginia define data infrastructure goals and priorities in the near and long term, and construct a system to that end: UnitedHealthcare</p>

Option 1: Take no action.

In Support: **VAHP**

Option 2: Introduce legislation and accompanying budget amendment (*amount is dependent on decisions made related to the APCD design and funding structure*) to amend Chapter 7.2 of Title 32.1 of the *Code of Virginia* to expand health data collected in order to develop an All-Payer Claims Database.

In Support: **Centra, NFIB-VA, and VBCH**

In Opposition: **Anthem**

Option 3: By letter of the JCHC Chairman, indicate support for the creation of a Virginia All-Payer Claims Database. The letter would be sent to the Senate Committee on Commerce and Labor; House Committee on Commerce and Labor; Senate Committee on Education and Health; and House Committee on Health, Welfare and Institutions.

(No comments in support or opposition)

Option 4: Include in the legislation or a Chairman’s letter (if Option 2 or 3 is approved), specific attributes for the All-Payer Claims Database.

A. Governance structure is housed at:

- 1. Virginia Health Information (VHI)

In Support: Sentara, MeadWestvaco, and VHHA

- 2. Another public or private entity other than VHI.

(No comments in support or opposition)

B. Types of data collected

- 1. Adhere to national reporting standards for medical claims (e.g. Accredited Standard Committee X12 standards when finalized)

In Support: VAHP¹ and VBCH

- 2. APCD will determine the required data elements

(No comments in support or opposition)

C. Data collection from health insurers

- 1. Mandated collection

In Support: Centra, VBCH, and VHHA

In Opposition: UnitedHealthcare

- 2. Voluntary submission

In Opposition: UnitedHealthcare

Option 5: Include in the 2012 work plan for JCHC’s Healthy Living/Health Services Subcommittee, continued study of an All-Payer Claims Database for Virginia.

¹ VAHP supports this option only if an APCD is developed.

Public Access to Vital Records (SB 865)

Stephen W. Bowman
Senior Staff Attorney/Methodologist

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

Background

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

Birth records – 100 years after the date of birth.

Death, marriage, and divorce records – 50 years after the date of occurrence.

Some family members are allowed to access vital records prior to their public release by presenting valid identification and paying a \$12 processing fee (immediate family may access all types of records, grandparents may request birth records by presenting evidence of need, and grandchildren and great grandchildren may access death records).

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

Concerns Related to Public Access

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

Identity Theft. Considering that so much personal information is available already through Internet searches, the primary concern relates to the fact that vital records often include social security numbers. Social security numbers may be redacted from records and indexes, although this is less of a concern for death records since the federal government maintains a Social Security Death Index, a publicly-accessible listing that includes such personal information as name, date of birth and death, last address, and social security number.

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

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

The Office of Vital Records does not have a complete index or digitized copies of all records in its possession. Constructing an index and digitized records would be time-consuming and costly, but would allow records to be published online. Ancestry.com officials have indicated a willingness to create digitized records and/or an index of those records in exchange for a period of exclusive use.

Policy Options and Public Comment²

A total of 387 written comments were received regarding this study.³ Seventy-two percent (277 of 387) of the respondents appear to live in Virginia and 16 genealogical or historical organizations commented. The majority of comments opposed further restrictions on access to vital records and supported expansion of public access.

In general, the comments fall into two broad categories: those that provided general feedback and those that addressed support or opposition to a particular policy option. Many of the general comments indicated that access to vital records should not be restricted further (123 comments) and/or that public access to vital records should be expanded (89 comments). Only two commenters recommended making no changes to existing policy and only one commented in support of further restricting access to vital records.

² Public comments represented were those received by November 7, 2011.

³ In instances in which individuals or organizations provided multiple comments only the most recent comment was incorporated in the public comment counts presented.

Summary of Public Comment

	Comments in Support	Comments in Opposition
Option 1 Take no action.	2	145
Option 2 Change time period for <i>birth records</i> to become public information from 100 years.		
2A to 125 years	1	8
2B to 75 years	247	0
Option 3 Change time period for <i>marriage, divorce, and annulment records</i> to become public information from 50 years.		
3A to 75 years	1	7
3B to immediately	151	0
<input checked="" type="checkbox"/> Potential 3C to 25 years	96	n/a
Option 4 Change time period for <i>death records</i> to become public information from 50 years.		
4A to 75 years	1	6
<input checked="" type="checkbox"/> 4B to 25 years	147	0
Potential 4C <i>Individuals wrote in support of making death records available immediately</i>	241	n/a
Option 5 Allow State Registrar to disclose entire SSN on death record.	148	1
Option 6 Allow additional family members to receive birth, marriage, divorce, and annulment records in keeping with the authority that immediate family members have now.	251	0
Option 7 Allow additional family members to receive death records in keeping with the authority that immediate family members have now.	255	0
Option 8 Introduce budget amendment to require the State Registrar to develop a publicly-available index by 2014		
8A index created by Vital Records VDH estimates cost of \$2.6 million over 2.5 years	0	0
8B index created using public-private partnership	0	1
8C index and digital copies of records created using public-private partnership	3	1
<i>Individuals wrote in support of the principle of Option 8</i>	147	n/a
Potential 8D <i>Individuals wrote in support of allowing the Library of VA (due to its expertise) to create and operate an index of vital records</i>	145	n/a
Potential 8E <i>Once vital records are no longer "closed," VDH should be required to turn over records to Library of VA</i>	96	n/a

Option 1: Provide a written report to the Chair of the Senate Committee for Education and Health, the chief patron of SB 865 (Sen. Blevins), and the Clerk of the Senate, without taking any other action.

	Comments in Support	Comments in Opposition
Option 1	2	145

Option 2: Introduce legislation to amend the *Code of Virginia* § 32.1-271(D) to change the time period that birth records “in the custody of the State Registrar may become public information” from 100 years to:

- A. 125 years (*preliminary recommendation of CDC*)
- B. 75 years (*in compliance with the Library of Virginia’s statutory confidential records time period*)

	Comments in Support	Comments in Opposition
Option 2A	1	8
Option 2B	247	0

Option 3: Introduce legislation to amend the *Code of Virginia* § 32.1-271(D) to change the time period that marriage, divorce, and annulment records “in the custody of the State Registrar may become public information” from 50 years to:

- A. 75 years (*preliminary recommendation of CDC*)
- B. Immediately (*the records held by Circuit Courts are open for public inspection already*)

	Comments in Support	Comments in Opposition
Option 3A	1	7
Option 3B	151	0

Potential 3C – 25 years (96 comments in support)

Option 4: Introduce legislation to amend the *Code of Virginia* § 32.1-271(D) to change the time period that death records “in the custody of the State Registrar may become public information” from 50 years to:

- A. 75 years (*preliminary recommendation of CDC*)
- B. 25 years (*Social Security Death Index provides extensive information already*)

	Comments in Support	Comments in Opposition
Option 4A	1	6
Option 4B	147	0

Potential 4C – In addition, 241 comments supported making death records immediately available.

Option 5: Introduce legislation to amend the *Code of Virginia* § 2.2-3815 to allow the State Registrar to disclose the entire social security number on a deceased individual’s death record.

	Comments in Support	Comments in Opposition
Option 5	148	1

Option 6: Introduce legislation to amend the *Code of Virginia* § 32.1-271 to allow additional family members to receive birth, marriage, divorce and annulment records from the State Registrar in keeping with the authority that immediate family members currently have.

- Degree of lineal kinship to record requestor would need to be determined.
 - *Code of Virginia* § 6.2-1074 uses 5th degree kinship language
- The vital record disclosed may be of a living person.

	Comments in Support	Comments in Opposition
Option 6	251	0

The vast majority of the comments supporting Option 6 urged that “family members” be defined liberally.

Option 7: Introduce legislation to amend the *Code of Virginia* § 32.1-271 to allow additional family members to receive death records from the State Registrar in keeping with the authority that immediate family members currently have.

- Degree of lineal kinship to record requestor would need to be determined.

	Comments in Support	Comments in Opposition
Option 7	255	0

The vast majority of the comments supporting Option 7 urged that “family members” be defined liberally.

Option 8: Introduce a budget amendment to require the State Registrar to create by 2014, a publicly-available index of vital records that are authorized for release to the public. *(At a minimum, the Index would include first and last name, year of birth, and gender.)*

- A. The index will be created within the Office of Vital Records.
 - Budget language and funding – VDH estimates \$2.6 million over 2.5 years to create an online index of public records
- B. VDH will seek to enter into a public-private partnership to create a publicly-available index by an organization that has demonstrated experience in copying and indexing historical vital records. *(State Registrar and the Library of Virginia may publish the index as well.)*
 - Budget language
- C. VDH will seek to enter into a public-private partnership to create a publicly-available index and digital copies of public vital records by an organization that has demonstrated experience in copying and indexing historical vital records. *(State Registrar and the Library of Virginia may publish the index as well.)*
 - Budget language

	Comments in Support	Comments in Opposition
Option 8A	0	0
Option 8B	0	1
Option 8C	3	1

These additional comments were received:

Support Option 8 in principle (147 comments)

Potential 8D – Support the LVA creating and operating any index of vital records... (145 comments)

Potential 8E – Support requiring VDH to turn over records to LVA, once vital records are no longer closed (96 comments)

Summaries of Selected Comments

Library of Virginia (LVA)

- A. Vital record date restrictions should be kept as they are currently written
- B. Electronic vital records indices should be compiled, beginning with those that are currently open public records
- C. Indexing should be accomplished under the auspices of a state agency
- D. Microfilm copies of open records should be made available for research at LVA

Virginia Bankers Association (VBA)

- A. Oppose any release of SSNs; it would increase the likelihood of financial fraud and coupled with birth and death records could facilitate the use of false identities

Virginia Department of Health (VDH)

- A. Increase the closed period for birth certificates to 125 years
- B. Increase the closed period for marriage, divorce, annulment and death records to 75 years
- C. Allow the Office of Vital Statistics (OVS) to provide the Social Security Number on all vital statistics
- D. An undue burden on OVS if additional family members may receive vital records during the closed period because it will be necessary for the customer to prove their kinship and for OVS to verify the information
- E. Exploring a public-private partnership in creating a publicly available index is worthwhile
- F. Digital copies of vital records should not be placed on line

Virginia Genealogical Society (VGS)

(These recommendations reflect the same preferences of 127 other comments).

- A. Decrease the closed period for the birth certificate to 75 years
- B. Make marriage, divorce, annulment and death records immediately available in the public domain
- C. Allow family members that “descended from a common ancestor” to be granted access to vital records during the closed period
- D. Allow the Office of Vital Statistics to provide the Social Security Number on death certificates
- E. LVA should control or supervise indexing publicly available vital records

Virginia Press Association (VPA)

- A. Opposes the lengthening of statutory non-disclosure periods
- B. Opposes a vital records index if it would only be available to the public through an exclusive provider at costs exceeding what the Freedom of Information Act provides.

Membership

The Honorable Benjamin L. Cline, Chair
The Honorable Linda T. Puller, Vice-chair

SENATE OF VIRGINIA

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

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The Honorable David A. Nutter
The Honorable John M. O'Bannon, III
The Honorable Christopher K. Peace

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

STAFF

Kim Snead, Executive Director
Stephen W. Bowman, Senior Staff Attorney/Methodologist
Michele L. Chesser, Ph.D., Senior Health Policy Analyst
Jaime H. Hoyle, Senior Staff Attorney/Health Policy Analyst
Sylvia A. Reid, Publication/Operations Manager

Joint Commission on Health Care
900 East Main Street, 1st Floor West
P.O. Box 1322
Richmond, VA 23218
804.786.5445
804.786.5538 fax
Website: jhc.virginia.gov