

Joint Commission on Health Care

Decision Matrix

Revised

November 16, 2009

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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 2009.
- B. To develop Commission recommendations to advance to the 2010 General Assembly.

Staff Report: Improving Aging-at-Home Services and Support for Culture Change Initiatives

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Senior Health Policy Analyst

Background

This is the final report of a two-year JCHC study addressing issues requested in:

- HJR 69 – 2008 (Delegate Kenneth R. Plum) to study alternative solutions to long-term care needs.
- SJR 102 – 2008 (Senator Walter A. Stosch)/HJR 238 – 2008 (Delegate Stephen C. Shannon) “to study support services for family caregivers of the frail elderly and disabled and community-based caregiver support organizations.”

The following issues and programs were examined in the final study:

- Utilizing Virginia’s Existing Resources to Support Caregivers
 - The Virginia Caregiver Coalition
 - James Madison University’s Caregivers Community Network
 - The Virginia Center on Aging
- Streamlining the System for Accessing Community Resources
 - No Wrong Door: A Significant Improvement to the System
- Virginia’s Department for the Aging 4 Year Plan for Aging Services
- Increasing Eligibility for Community-Based Services: The Home and Community-Based Services State Plan Option
- Strengthening Culture Change Initiatives for Virginia’s Long-Term Care Facilities
 - The Virginia Culture Change Coalition

Only the study topics which are relevant to potential policy options are discussed in this summary.

The Virginia Caregiver Coalition

- Founded in 2004: 22 members from public, private, and non-profit sectors
- 2009: 85 members, bi-monthly meetings
- Primary focus on education, advocacy, and caregiver support
- Received 2007 Grant from National Association of Caregivers
- Held Caregiver Recognition Events in 2007
- Conducted awareness campaign during the 2008 Virginia General Assembly Session
- Provided caregiver training, via 8 Video Conference Sites, on different ways to deal with caregiver stress; family dynamics and involving the whole family in caregiving; caregivers of persons with hearing and vision loss; and respite care resources and aids

The Coalition’s future plans include:

- Continue Caregiver Training Programs
- Revise the Caregiver Resource Guide produced by the Virginia Department for the Aging (VDA)
- Work with the Centers for Medicare and Medicaid (CMS) to hold a conference on issues affecting employed caregivers

- Recruit members of other caregiver populations
- Work with the Veterans Administration
- Continue to engage in outreach and collaboration efforts to increase awareness of caregiver issues, educate professional and family caregivers, and provide support for caregivers.

James Madison University's Caregivers Community Network

Since 2001, the network has offered the following services for all frail elders and their family caregivers in Augusta, Rockingham, Page and Shenandoah counties:

- Personalized in-home companion care on a regular basis
- Educational workshops and support services
- Telephone consultation to supply caregivers with support, caregivers tips and resources
- Partnership with community service and faith based organizations to provide a well coordinated referral system
- Errand running, such as picking up prescriptions, groceries or dry-cleaning to aid the caregiver
- 2 to 4 hours of respite care for caregivers weekly/biweekly.

The program is housed in the James Madison University Institute for Innovations in Health and Human Services and coordinated through the school's Nursing Program:

- Utilizes trained students (that can use their involvement in the program to fulfill an internship requirement) and volunteers from the community
- Serves approximately 150 frail elders and their family caregivers each year on a sliding fee scale
- In July 2009, the network was 1 of 6 organizations nationwide to receive The National Alliance for Caregiving and MetLife Foundation Honor: Innovators Making a Difference in the Lives of Caregivers which included a \$25,000 award.

Utilizing Virginia's Existing Resources

Improving aging-at-home services involves providing support for family caregivers via the organizations committed to providing information, training, support and other resources. This may be one of the least expensive methods to enable more individuals to age-at-home for a longer period of time and prevent or delay the use of Medicaid for the provision of LTC services for a significant segment of the elderly population. The Virginia Caregiver Coalition and James Madison University's Caregivers Community Network already possess an extensive network of professionals and volunteers and a collaborative relationship with each other and many other agencies and organizations interested in aging and/or caregiver issues; and James Madison University's Caregivers Community Network offers an award-winning model that could be replicated throughout the Commonwealth.

The Home and Community-Based Services State Plan Option

During last year's presentation, the strict requirements to be eligible for the Elderly and Disabled with Consumer Direction (EDCD) waiver were discussed. To qualify for the waiver, one must meet the requirements for nursing home eligibility including needing assistance with 4 out of 5 ADLs (Activities of Daily Living). The great majority of individuals in the aging community prefer to stay in their homes or live with loved ones for as long as is possible. While the EDCD waiver is designed to give the elderly

and disabled this option, the eligibility requirements prevent individuals from taking advantage of the waiver while they are still healthy enough to not require nursing home care. What is needed is a solution that enables more elders to utilize home and community-based services before they need institutionalized care. One solution considered was the possibility of reducing the nursing home eligibility requirement to 3 out of 5 ADLs; however, this was determined to be too costly due to more individuals qualifying for EDCD waiver and nursing home care. Another possible solution is for Virginia to adopt Medicaid's Home and Community-Based Services State Plan Option.

Authorized by the Deficit Reduction Act of 2005, the Home and Community-Based Services State Plan Option [i.e. 1915(i) benefit] provides states greater flexibility in determining eligibility for home and community-based services (HCBS) than that found with the HCBS waiver. Therefore, the State Plan Option allows states to provide these services to Medicaid eligible elderly or disabled individuals (whose income does not exceed 150% of the federal poverty level) who do not qualify for the HCBS waiver. For example, whereas the level of care required for the HCBS waiver is assistance with 4 of 5 ADLs, Virginia would have the option of requiring assistance with only 3 of 5 ADLs for the State Plan Option.

The primary benefit of the State Plan Option would be to enable elderly or disabled individuals to receive home and community-based services (such as case management services, homemaker/home health aide and personal care services, adult day health services, habilitation services, and respite care) earlier, thus preventing or delaying institutionalization. However, some concerns have been voiced by DMAS staff:

- May be considered an entitlement
 - Would require providing services to everyone who qualifies and requests home and community-based services
 - Possible litigation from individuals on waiting list
- It is unknown whether Virginia's increased cost of providing services to currently ineligible individuals would be offset by preventing or delaying their need for Medicaid funded nursing home care.
- Many states are still waiting for further clarification of the state plan option regulations, or are not interested in implementing the state plan.

In order to address these concerns, one possible course of action is to request a JLARC study to investigate the costs and benefits of implementing the HCBS state plan option.

Options and Public Comments

Option 1: Take no action.

Public Comments

William L. Lukhard, AARP Virginia Executive Council and Madge Bush, Director of Advocacy for AARP Virginia do not support this option.

 **Option 2:** Introduce a joint resolution requesting that JLARC study the costs and benefits of implementing the Home and Community-Based Services state plan option.

Public Comments

William L. Lukhard and Madge Bush of AARP are strongly in support of this option.

Mary Ann Bergeron, Executive Director of Virginia Association of Community Services Boards, supports this option and suggests that if JLARC is unable to conduct the study the Secretary of Health and Human Resources could be directed to work with related state agencies to determine the costs and benefits of implementing the state plan option.

Marcia A. Tetterton, MS; Executive Director of Virginia Association for Home Care and Hospice; is in support of this option.

Option 3: ~~Introduce~~ Reconsider a budget amendment (language and funding) during the 2012 session to increase the general funds appropriated for the Virginia Department for the Aging to be allocated to the Virginia Caregiver Coalition.

Public Comments

William L. Lukhard and Madge Bush of AARP are strongly in support of this option.

 **Option 4:** Include on the JCHC 2010 workplan a staff study of the feasibility of replicating James Madison University's Caregivers Community Network in other areas of the Commonwealth.

Public Comments

William L. Lukhard and Madge Bush of AARP are strongly in support of this option.

**Staff Report:
Opportunities for Early Identification and
Preventive Care of Chronic Diseases (SJR 325 – 2009)**

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

Authority for Study

Senate Joint Resolution 325, introduced by Senator Houck in 2009, directed the JCHC to “(i) examine clinical and other studies concerning the manner in which early identification and preventive care can be utilized to halt or slow the evolution of such conditions as diabetes, hypertension, kidney disease, obesity, and pneumonia into chronic and terminal conditions; (2) assess the means by which Virginia can address fragmentation of services across the health delivery system and the patient’s community in order to enhance early identification and preventive care and care management for chronic disease, and to identify opportunities for providing more coordinated care management for individuals with multiple chronic diseases; and (iii) estimate the fiscal impact on the Commonwealth and private payers from such strategies.”

Background

In the United States, chronic diseases are a leading cause of adult disability and account for 70% of all deaths. The costs for people with chronic diseases account for more than 75% of the nation’s \$2 trillion in health care expenditures. Expenses for chronic diseases are typically driven by the reoccurrence of acute events, such as emergency room (ER) visits, hospitalizations, or costly inpatient and outpatient treatment plans. People with chronic conditions typically have multiple health care providers, treatment plans and prescriptions written by different physicians who may be unaware of the other providers treating the individual, often resulting in unnecessary and costly ER and hospital admissions.

Spectrum of Approaches to Address Chronic Diseases

There is a spectrum of potential approaches to address chronic disease and the fragmentation of the health care system. This spectrum ranges from disease management programs which base care coordination around the identification of specific disease states rather than on the whole person, to programs that focus on all of the person’s needs and the service delivery system, to those that focus on prevention and wellness.

Disease Management Programs. Disease Management Programs are designed to coordinate the delivery of care to patients, improve clinical outcomes, and reduce costs for participants living with specific chronic conditions that have high prevalence rates and/or expensive treatment costs. They typically involve

combinations of enhanced screening, monitoring, self-management and education, and the coordination of care among providers.

In 2006, Virginia implemented a disease management program, “Healthy Returns,” for its Medicaid fee-for-service recipients who have asthma, chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes. During the JCHC study, the potential for adding an Integrated Care Model (ICM) for Chronic Kidney Disease (CKD) was discussed. CKD, a precursor to kidney failure, is a growing epidemic in the US, with almost two-thirds of CKD patients also having diabetes, hypertension or both. The ICM model delivers integrated plan/coordination of care to address these health care needs at the dialysis centers.

Chronic Care Management Models. Other approaches focus less on the chronic disease but on the delivery of care, with the idea that a coordinated delivery system for all will enable the prevention and early identification of chronic diseases. These Chronic Care Management Models are more comprehensive, community-based approaches. They focus on the needs of the whole person, rather than only the disease. The models also use community resources to address the non-medical needs of the patient, understanding that many persons with chronic conditions have other needs that prevent them from getting care, such as, transportation, child care, and housing. DMAS released a request for proposal (RFP) in July 2008 to implement such a model for the Medicaid and FAMIS fee-for-service recipients at highest risk for high utilization and cost of services. DMAS withdrew the RFP due to a number of technical issues.

Patient-Centered Medical Homes. An example of an approach focusing on the delivery system is the patient centered medical home. This approach uses a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient’s lifetime to maximize health outcomes. The personal physician is responsible for the “whole person” and coordinates patient care across the health system and community.

Prevention and Wellness Approaches. Other approaches recognize the growing body of evidence that earlier identification of chronic diseases coupled with preventive care can halt or slow the progression of chronic diseases, thereby improving patient health and well-being while reducing medical costs. Some employers are adding on-site medical clinics in an effort to save on health care costs and encourage employee wellness. Wellness programs in general are a growing trend in the private sector which is mandating health testing and wellness programs in order to improve employee health and decrease costs. Well over half of large companies in the U.S. have launched such initiatives. There is anecdotal evidence of improved health; however, health care costs were often at least 3% higher in the first year of wellness programs due to increased health care utilization.

In July 2009, a pilot program for State employees in the Hampton Roads area was implemented to focus on wellness and preventive care. The two-year contract with Optima Health for the pilot program, designated as “COVA Connect” will cover 17,000 State employees and seek to reduce chronic conditions and control health care costs.

Recent Cost Saving Initiatives

As part of Governor Kaine’s September 2009 cost savings actions, the decision was made not to renew the DMAS contract for the Healthy Returns Disease Management program. As a result, effective October 31, 2009, the program was discontinued.

Options and Public Comments

Option 1: Take no action.

Option 2: By letter of the Chairman, request that DMAS report to JCHC no later than August 2010, regarding recommended options for addressing the chronic care needs of Virginia’s Medicaid and FAMIS enrollees. The options should consider at a minimum issues related to:

- whether to retain a disease management program (perhaps incorporating additional diseases and an integrated care model for Chronic Kidney Disease),
- whether to reissue a proposal for chronic care management services, and
 - whether to initiate one or more demonstration projects for a patient-centered medical home.

Public Comments on Option 2. Three comments were received. Two comments address support and make suggestions regarding chronic care management. The third comment addresses the role of prenatal and childhood home visitation programs in chronic care management.

Becky-Bowers Lanier, commenting on behalf of AmeriHealth Mercy, indicated: “We [AmeriHealth Mercy] have found that due to the complexity of health issues experienced by the Medicaid population, management of a single condition does not optimally support the participants nor does it drive improved cost efficiency. Too often, other contributing factors are not considered, such as co-morbidities, behavioral/mental health issues, safety, housing and other concerns that affect appropriate access to care. If the Commonwealth pursues the creation of a chronic disease prevention and chronic care management program for Medicaid recipients, AmeriHealth Mercy would be very interested in discussing this.”

Marcia Tetterton of the Virginia Association for Home Care and Hospice commented in support of Option 2 with the “modification that home health also be included in the model....The Chronic Care Model (CCM)...is an accepted model of chronic care management....It has recently been suggested that this model be expanded to be a home-based chronic care model.”

Lisa Specter-Dunaway, of CHIP of Virginia, noted “surprise at the absence of research or discussion about the prevention of chronic diseases that result from premature

and/or low-birth weight, childhood asthma, or adverse events in the lives of infants and young children.” Ms. Specter-Dunaway continued by saying: “There are significant data at the national and local levels highlighting opportunities for low cost chronic care models, specifically **prenatal and early childhood home visitation programs**....The Commonwealth has an opportunity to wisely invest scarce resources in proven programs that can decrease short and long term health care costs associated with chronic diseases. I urge you to consider the role home visiting programs can have in accomplishing this goal.”

Option 3: By letter of the Chairman, request that the Department of Human Resource Management report to JCHC regarding the feasibility and advisability of initiating a pilot program with on-site medical clinics for State employees.

Option 4: By letter of the Chairman, request that the Department of Human Resource Management report to JCHC (after July 2010) regarding the costs and benefits of the recently implemented COVA Connect pilot program.

Staff Update:

HJ 101 Task Force on Adverse Medical Outcomes

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

Background

HJR 101 of the 2008 General Assembly directed the Joint Commission on Health Care (JCHC) to study, in the case of medical errors and adverse medical outcomes, the use of disclosure, apologies, alternative dispute resolution and other measures. JCHC was also directed to study the impact of such measures on the cost and quality of care, patient confidence and the medical malpractice system. At the end of the study, JCHC recommended convening a Task Force consisting of representatives of the primary stakeholders to include the Medical Society of Virginia; Virginia Hospital and Healthcare Association; Department of Health; Department of Health Professions; Board of Medicine; Virginia Trial Lawyers Association; Virginia Association of Defense Attorneys; the medical malpractice insurance industry; and broader physician, health care provider and consumer representation. The Task Force was charged with:

- building upon the work already done by the 101 Study Committee;
- developing agreed-upon working definitions of key terms such as adverse outcome, medical error, and disclosures, to facilitate discussions in Virginia;
- tracking results and developments in disclosure and resolution programs now operational in Virginia and other states, and federal developments in this area; and
- crafting a model or models for disclosure and early resolution programs that could be offered to Virginia health care providers, insurers and attorneys for their use.

Task Force Progress

This is the second year that JCHC has convened a group to study the use of disclosure, apologies, alternative dispute resolution and other measures in the case of adverse medical outcomes. The Phase 1 study report (RD 109 – 2008) recognized that the issues raised by this subject are numerous, and can be complex. So during Phase 2 of the study, staff continued to research other programs as well as federal developments and formed a broad-based Task Force (See Attachment 1) to focus on the development of a model program for disclosure programs. The essential challenge put to the Task Force was twofold: to identify what a pilot model program could look like in Virginia, and to identify ways to incentivize its use so that the concept would be fairly tested. Draft legislation for a Pilot Project for Disclosure Programs was circulated to the Task Force in advance of its full day meeting in September, allowing for early preparation and comment. At that meeting, the Task Force agreed to the following elements of the Pilot Disclosure Program:

- Triggered by an injury to the patient.
- Voluntary participation by health care providers in 5-year pilot program.
- Oversight by the Virginia Department of Health (VDH) with cooperation and support from the Virginia Board of Medicine.

- Guidelines or conditions of participation developed by VDH with advice and consultation from stakeholder groups.
- Encourage proactive, pre-claim responses and possible resolution of all size injuries at the discretion of the participating provider.
- Broad flexibility for programs to develop their protocols within agency parameters.
- Bifurcated process provided for:
 - Disclosure
 - Resolution process for patient compensation that includes a right to counsel.
- A patient's opt-in (to enter into a resolution process) must be preceded by full explanation of orientation to the process, including notice of the right to be legally represented and giving the patient a reasonable period of time for consideration after the offer of process.
- Legal provision that liability carriers cannot take negative action (invoke cooperation clause or later deny coverage) to a participant.
- Requirement for participants to report evaluation of experiences to VDH.

Privilege as set forth in the Pilot Project for Disclosure Program covers information developed, activity, and communications in the disclosure program process but does not privilege or prohibit use of "fact." It is not drafted to affect what may or may not be other privileged information concerning other activities outside of a participating Pilot Project Disclosure Program. Privilege also applies to the resolution process used, if one is used.

Representatives of the Virginia Trial Lawyers Association (VTLA) expressed that they could not support the privilege provision, but would continue to work with the remaining Task Force members on satisfactory language. Tension exists, and was duly noted, between: (1) the concern on the part of the VTLA that a privilege should not be created that could allow an abuse of the privilege to harm or disadvantage an injured patient's exercise of his/her legal rights to achieve fair compensation; and on the other hand, (2) the fact that providers will be deterred from complying with the full disclosure required in a pilot program when they fear that they thus lay themselves open to perceived harsh and unfair punitive consequences other than a fair compensation of the patient. As described in the HJR 101 report (RD 109), the end result of this tension is often that what a provider will view as a fair and appropriate disclosure may not meet the standards of those to whom disclosure is made. The point of this pilot would be to test what happens when a robust disclosure program with potential for ensuing resolution process is pursued.

Following the September meeting, no changes have been made that would alter the substantive meaning of the provisions agreed to in September. Knowing that the draft would need some technical improvement, in the letter inviting members to participate on the Task Force, staff reserved a date in October for the Task Force to discuss technical changes. Furthermore, as these changes were made to the draft legislation, updated versions were circulated to the Task Force to ensure that the concepts remained unchanged and to allow for continual comment. Even as the VTLA objected to the privilege provision as drafted, they continued to work with the Task Force, as recently as last week, to find common ground.

Federal Developments

On September 9, 2009, President Obama announced a plan to provide \$25 million in grants for states and health systems that carry out and evaluate evidence-based patient-safety and medical-liability demonstrations. The demonstration initiatives administered by the Agency for Health Care Research and Quality within the U.S. Department of Health and Human Services, are designed to “test models that meet the following goals:

- Put patient safety first and work to reduce preventable injuries;
- Foster better communication between doctors and their patients;
- Ensure that patients are compensated in a fair and timely manner for medical injuries, while also reducing the incidence of frivolous lawsuits; and
- Reduce liability premiums.”

Three-year grants of up to \$3 million will be available for applicants to implement and evaluate demonstration projects, and one-year grants of up to \$300,000 and technical assistance will be available for states and organizations that want to plan demonstrations. Applications will be accepted from December 20, 2009 through January 20, 2010.

Options and Public Comments

Option 1: Take no action.

Option 2: Introduce legislation to amend the *Code of Virginia* by adding a § 8.01-581.20:2 to authorize a Disclosure Pilot Program as discussed in the Task Force’s proposal.

Option 3: Request by letter of the Chairman that the Secretary of Health and Human Resources pursue federal grant funding for technical assistance or the implementation of a Disclosure Pilot Program or demonstration project, as outlined by the Agency for Health Care Research and Quality.

Public Comments

Two comments were received: One comment from the Virginia Trial Lawyers Association opposing Option 2, and one comment from the Medical Society of Virginia in support of Options 2 and 3.

Steven W. Pearson, providing an initial public comment on behalf of the Virginia Trial Lawyers Association indicated: “While VTLA appreciates the good intentions and hard work of all of the participants in the process, the complexity of the issues, the difficult schedule, and the composition of the Task Force have all contributed to a fundamentally flawed proposal, to which VTLA is strongly opposed.... [I]t is worth noting now that we retain serious concerns about: 1) access of the patient or family to counsel at the appropriate time; 2) access of the patient to full information about the health care delivered to that patient; 3) the need for such a program in light of such factors as health care industry consolidation; 4) the effect of such a program upon equal access to justice; 5) the need for secrecy of circumstances related to incidents and the delivery of health care; 6) whether a new privilege would be necessary for the success of

a program of early offers; 7) how the program will be evaluated; 8) fundamental fairness; and a variety of other factors.

Nothing in this correspondence should be taken to question the good faith or the hard work of the participants on this very difficult issue. We appreciate the opportunity for involvement in this process and request an opportunity to speak to our position concerning the proposed pilot Program and accompanying enabling statute on November 12 at the full Commission meeting.” (Additional comment dated November 11, 2009 is attached.)

Daniel Carey, commenting on behalf of the Medical Society of Virginia, indicated: “Our strong support for Option 3...Given the timely availability of federal grant funds, coupled with an approaching grant application deadline, we urge you to recommend by letter to the Secretary of Health and Human Resources that she pursue federal grant funding for technical assistance with or implementation of a Disclosure Pilot Program or demonstration project consistent with the grant outline...We would be glad to offer member and staff assistance to the Secretary in the development of a grant application.”

Attachment 1
Virginia Bar Association and Joint Commission on Health Care
HJ 101 Study: Adverse Medical Outcomes Task Force

Hon. John M. O’Bannon, III
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Thomas “Tom” Williamson, Jr.
Virginia Trial Lawyers Association

Staff Report: Notification for Breaches of Personal Health Records

Stephen W. Bowman
Senior Staff Attorney/Methodologist

Authority for Study

Senate Bill 1229 (2009) was referred to JCHC and JCOTS for study. SB 1229 sought to provide additional protections for medical information by requiring that individuals be notified of security breaches involving databases containing their health information.

Report Findings

Individually identifiable health information is collected or retained by numerous public and private entities. These entities include but are not limited to physicians, hospitals, insurers, businesses that bill for other health care entities, government monitoring programs, and websites which store individuals personal health records (PHRs). With the enactment of the Health Insurance Portability and Accountability Act (HIPAA) in 1996, stringent standards were established in protecting the privacy of health information held by health care providers, health insurers, and health care clearinghouses. Recently, new entities called PHR vendors have emerged and hold sensitive identifiable health information provided by consumers. These organizations are not subject to existing statutory requirements to protect the privacy of health information or to notify anyone if an unauthorized access or breach occurs. SB 1229 sought to create a notification requirement for breaches of identifiable health information, especially for PHR entities.

Since the time that SB 1229 was referred to JCHC and JCOTS, a number of federal notification requirements have been enacted to address health information breach notifications. Effective September 2009, the Federal Trade Commission and the Department of Health and Human Services enacted new notification requirements for breaches of individually identifiable health information. These regulations were enacted pursuant to the HITECH Act that was a part of the American Recovery and Reinvestment Act of 2009. These regulations cover PHR vendors, such as Google Health and Microsoft Vault; PHR business associates and third-party providers; and the entities that have historically been subject to HIPAA.

A joint JCHC and JCOTS Subcommittee met and determined that the HITECH Act had achieved the goals of SB 1229 and that no further action was needed regarding the bill. Of note, the HITECH Act does not require breach notification for all collections of individually, identifiable health information maintained by Virginia government entities, such as the Department of Health Professions' Prescription Monitoring Program. The joint-Subcommittee directed staff to

study government collections outside of breach notification requirements and if appropriate to draft legislation for the 2010 Session to remedy.

Options and Public Comments

Option 1: Take no action.

Option 2: Continuation of the study in the 2010 Workplan, if the current JCOTS and JCHC review is not completed in time for 2010 Session. The second year of study would focus on electronic records of individually identifiable health information held by state and local government entities that are not required to notify individuals in the event of a breach.

No public comments were received.

Staff Report:

Virginia's Health Care Workforce: Present and Future Need

Physicians, Psychiatrists, Dentists, Clinical Psychologists and Pharmacists

Stephen W. Bowman
Senior Staff Attorney/Methodologist

Background

This study was suggested as a policy option in a 2007 presentation regarding the shortage of geriatricians in the Commonwealth. The policy option called for a two-year study by JCHC of Virginia's pipelines for the education of certain health care professionals as compared with the projected need for those professionals. This is the second year of the study.

The statewide demand for health care is projected to increase as the Commonwealth's population; the over-65 population in particular, increases. Virginia's "general population is expected to increase by 17% between 2000 and 2020, whereas that growth among the population over 65...will increase by 65%" according to the VDH FY 2007 Workforce Report.

Report Findings

Health care professionals are participants in a national market. Virginia competes to have such professionals locate and practice in the Commonwealth. According to the American Medical Association, Virginia has 3.1 physicians per 1,000 persons. As Virginia's population increases, Virginia must add 281 physicians a year to match its current rate. This number is understated as it does not include needs created by physicians retiring or the graying of Virginia's population. Individuals over 65 years of age require two to three times the amount of physician services compared to the national average. Maldistribution is also issue as most physicians are located in more urban localities.

This review found that the most critical physician shortages were in primary care, geriatric care, psychiatry, emergency medicine and general surgery. Shortages were also found for dentists and mental health professionals.

There are a number of avenues Virginia does or could take to address health care professional shortages and maldistribution including:

- Increased funding for State-supported family medicine programs,
- Fund State loan repayment programs (recently defunded),
- Increasing Medicaid reimbursement rates,
- Encouraging medical schools to enroll students more likely to provide services to underserved areas,
- Educating the current physician workforce about geriatric care issues through physician groups and the Board of Medicine, or
- Expanding telemedicine services and payment for such services.

In addition, collecting better data about dentists and clinical psychologists would be useful in determining the magnitude of shortages and how best to address them.

Two additional areas that could be considered for addressing shortages and maldistribution would require additional study. The areas involve (1) studying the prevalence, distribution and scope of practice for nurse practitioners and physician assistants and (2) considering whether to allow qualified clinical psychologists to prescribe psychopharmacological medications.

Options and Public Comments

Twenty-nine comments were received regarding the options presented to JCHC addressing Virginia’s Health Care Workforce. A list of all individuals that submitted comments is included in *Appendix B* with selected excerpts, particularly from comments that explained conditional support or opposition for an option. Comments in support and opposition for the two options that had opposition are included in *Appendix C*. In addition, comments which suggested new policy options are presented in *Appendix D*. The distribution of the public comments received on each Policy Option is shown below.

Policy Option	Support	Conditional Support	Oppose
1	0	0	0
2	9	0	0
3	8	0	0
4	7	0	0
5	7	0	0
6	4	2	0
7	5	0	0
8	4	1	0
9	2	1	0
10	4	0	0
11	2	0	2
12	7	0	0
13	5	0	0
14	4	0	0
15	2	0	9
16	3	1	0
17	3	1	0
18	6	0	0
19	2	0	0

Option 1: Take no action.

 **Option 2:** When state revenue allows, ~~restore~~ consider a budget amendment to restore funding for the State Loan Repayment Program (SLRP) & Virginia Loan Repayment Program (VLRP).

9 commented in support:

Roger Hofford, Family Medicine Residency Director	Medical Society of Virginia
VA Chapter: National Association of Social Workers	Piedmont Access to Health Services
UVA Health System	VA College of Emergency Physicians
VA Community Healthcare Association	VCU Dept. of Family Medicine
VA State Rural Health Plan's Workforce Council	

 **Option 3:** When state revenue allows, increase dedicated funding for the EVMS, UVA and VCU Family Practice Residency Programs.

8 commented in support:

Roger Hofford, Family Medicine Residency Director	Medical Society of Virginia
Piedmont Access to Health Services	UVA Health System
Via College of Osteopathic Medicine	VA Community Healthcare Association
VCU Dept. of Family Medicine	
VA State Rural Health Plan's Workforce Council	

 **Option 4:** Request by letter of the JCHC Chairman that the Department of Medical Assistance Services (DMAS) develop and report on a methodology and cost estimate for providing enhanced Direct Medical Education (DME) and Indirect Medical Education (IME) payments to graduate medical programs in Virginia that train primary care, general surgery, psychiatrists, and emergency medicine physicians. The letter would include a request that DMAS present its report to JCHC by August 30, 2011. *(Enhanced payments are expected to increase state Medicaid costs to some degree.)*

7 commented in support:

Roger Hofford, Family Medicine Residency Director	Medical Society of Virginia
UVA Health System	Via College of Osteopathic Medicine
VA College of Emergency Physicians	VCU Dept. of Family Medicine
VA State Rural Health Plan's Workforce Council	

 **Option 5:** When state revenue allows ~~introduce~~ consider a budget amendment (language and funding) to increase Medicaid reimbursement rates to match the level of Medicare reimbursement rates for primary care physicians.

7 commented in support:

Medical Society of Virginia	Piedmont Access to Health Services
Via College of Osteopathic Medicine	VA College of Emergency Physicians
VCU Dept. of Family Medicine	VA Association of Community Service Boards
VA State Rural Health Plan's Workforce Council	

 **Option 6:** Request by letter of the JCHC Chairman that the medical schools at Eastern Virginia Medical School, University of Virginia, ~~and~~ Virginia Commonwealth University, Edward Via Virginia College of Osteopathic Medicine, and Virginia Tech Carilion School of Medicine and Research Institute make efforts to increase their enrollment of medical students from rural communities in Virginia and individuals with an interest in serving underserved and minority populations.

4 commented in support:

Roger Hofford, Family Medicine Residency Director VA Community Health Association
VCU Dept. of Family Medicine
VA State Rural Health Plan's Workforce Council

2 commented in conditional support:

Medical Society of Virginia Via College of Osteopathic Medicine

 **Option 7:** When state revenue allows, ~~introduce~~ consider a budget amendment (language and funding) to allow the Department of Health Professions (DHP) to develop a Continuing Medical Education course focusing on medication issues of geriatric patients targeted for primary care physicians. The objective would be for the course to be offered online and at no cost to Virginia licensed physicians.

5 commented in support:

Roger Hofford, Family Medicine Residency Director Medical Society of Virginia
UVA Health System VA Assn of Community Service Bds.
VA State Rural Health Plan's Workforce Council

 **Option 8:** Request by letter of the JCHC Chairman that the Board of Medicine include and promote geriatric care issues among its online educational resources and/or most appropriate venue.

4 commented in support:

Roger Hofford, Family Medicine Residency Director UVA Health System
VA Assn of Community Service Bds
VA State Rural Health Plan's Workforce Council

1 commented in conditional support:

Medical Society of Virginia

 **Option 9:** Request by letter of the JCHC Chairman that the Virginia Chapter of the American College of Physicians include and promote geriatric care issues among its online educational resources and/or most appropriate venue.

2 commented in support:

UVA Health System VA State Rural Health Plan's Workforce Council

1 commented in conditional support:

Medical Society of Virginia

 **Option 10:** Request by letter of the JCHC Chairman that the Virginia Academy of Family Physicians continue to promote geriatric training among its membership.

4 commented in support:

Roger Hofford, Family Medicine Residency Director Medical Society of Virginia
UVA Health System
VA State Rural Health Plan's Workforce Council

XOption 11: Include in the 2010 JCHC work plan, a study of the prevalence, distribution and scope of practice for nurse practitioners and physician assistants in Virginia.

2 commented in support:

UVA Health System VA State Rural Health Plan's Workforce Council

2 commented in opposition:

Medical Society of Virginia Via College of Osteopathic Medicine

 **Option 12:** Send a letter from JCHC Chairman to the Special Advisory Commission on Mandated Health Insurance Benefits to support SB 1458 (Wampler) and HB 2191 (Philips) which require health insurers, health care subscription plans, and health maintenance organizations provide coverage for the cost of telemedicine services.

7 commented in support:

UVA Health System	Via College of Osteopathic Medicine
VA Chapter: National Association of Social Workers	VA Assn of Community Service Bds
VA Community Health Association	VA Telehealth Network
VA State Rural Health Plan's Workforce Council	

 **Option 13:** Request by letter of the JCHC Chairman that the Department of Human Resource Management consider and if appropriate conduct pilot programs for selected telemedicine-covered services within the state employee health insurance program. Consideration should be given to obstetric care for high-risk pregnancies, telestroke services, and telepsychiatry.

5 commented in support:

Via College of Osteopathic Medicine	VA Assn of Community Service Bds
VA Chapter: National Association of Social Workers	VA Telehealth Network
VA State Rural Health Plan's Workforce Council	

 **Option 14:** Request by letter of the JCHC Chairman that the Department of Behavioral Health and Developmental Services (DBHDS) report regarding the Department's current and historical utilization of telemedicine and telepsychiatry services, effectiveness of such services, locations offering such services, use of telemedicine by CSB providers, and impediments to greater adoption and usage by the Department and CSBs. This letter would include a request that DBHDS present a report to JCHC by August 30, 2010.

4 commented in support:

Via College of Osteopathic Medicine	VA Assn of Community Service Bds
VA State Rural Health Plan's Workforce Council	VA Telehealth Network

 **Option 15:** Introduce a joint-resolution requesting that JCHC convene a task force to review allowing qualified clinical psychologists to prescribe psychopharmacological medications and report to JCHC. The report will detail licensure and educational requirements, oversight structure, changes to licensure and regulatory oversight processes, medications that may be prescribed, requirements for physician review and/or oversight for prescribing medications. The resolution would require an interim report to JCHC in 2010 with a final report by September 1, 2011. Task force participants include:

- | | |
|-------------------------------|--------------------------------------|
| - Board of Medicine | - Psychiatric Society of Virginia |
| - Board of Pharmacy | - Virginia Psychological Association |
| - Board of Psychology | - Virginia Pharmacists Association |
| - Medical Society of Virginia | |

2 commented in support:

RxP (Prescription Privileges) Task Force for the VA Academy of Clinical Psychologists
VA State Rural Health Plan's Workforce Council

9 commented in opposition:

Medical Society of Virginia	Asha Mishra, CSB Medical Director
National Alliance on Mental Illness	NOVA Chapter: Washington Psychiatric Society
Psychiatric Society of Virginia	Robert Strange, Psychiatrist
Via College of Osteopathic Medicine	VA Association of Community Psychiatrists
VA Chapter: American Academy of Child and Adolescent Psychiatry	

 **Option 16:** Request by letter of the JCHC Chairman that the Department of Health Professions improve the information collected and compiled about clinical psychologists which is retained in the Healthcare Workforce Data Center.

3 commented in support:

Department of Health Professions	Medical Society of Virginia
Via College of Osteopathic Medicine	

1 commented in conditional support:

VA State Rural Health Plan's Workforce Council

 **Option 17:** Request by letter of the JCHC Chairman that the Department of Health Professions improve the information collected and compiled about dentists which is retained in the Healthcare Workforce Data Center.

3 commented in support:

Department of Health Professions	Via College of Osteopathic Medicine
VA Dental Association	

1 commented in conditional support:

VA State Rural Health Plan's Workforce Council

 **Option 18:** When state revenue allows ~~introduce~~ consider a budget amendment (language and funding) to extend basic dental benefits to adults eligible for Medicaid.

6 commented in support:

Roger Hofford, Family Medicine Residency Director	Via College of Osteopathic Medicine
VA Community Health Association	VA Dental Association
VA State Rural Health Plan's Workforce Council	
Virginians for Improving Access to Dental Care	

 **Option 19:** Request by letter of the JCHC Chairman that the Virginia Pharmacists Association, the Virginia Department for the Aging, and local area agencies on Aging collaborate to provide and disseminate information about Medicare's Medication Therapy Management (MTM) program to pharmacists, prescription counselors, and Medicare beneficiaries that qualify for MTM services.

2 commented in support:

Via College of Osteopathic Medicine	VA State Rural Health Plan's Workforce Council
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Virginia Cancer Plan Update

Kirsten Edmiston, MD, FACS
CPAC Advisory Board Co-chair
Diane Cole, MPH
CPAC Co-chair

Dr. Edmiston and Ms. Cole presented on behalf of the Cancer Plan Action Coalition (CPAC), a statewide network of partners established in 1998. Ms. Cole indicated that the “mission of CPAC is to:

- Reduce the incidence and impact (financial, psychological, and spiritual) of cancer and improve the quality of life for cancer survivors.
- Facilitate collaborative partnerships.
- Promote and assist with implementation of the Virginia Cancer Plan, the blueprint for cancer control in the Commonwealth.”

Dr. Edmiston reported that CPAC is interested in:

- Supporting the creation of a Cancer Awareness Caucus within the General Assembly,
- Advancing awareness and use of the most-recently developed Virginia Cancer Plan.

The Virginia Cancer Plan for 2008-2012, developed by CPAC and the Virginia Comprehensive Cancer Control Project (within the Virginia Department of Health), was released earlier this year. As noted in its *Letter to the Citizens of Virginia*, “the plan is a working document and provides a framework that includes key goals and strategies to eliminate preventable cancers and minimize deaths and disabilities. It provides guidance for design, implementation, surveillance, and evaluation of cancer-related actions and issues for the general public, people with cancer and their families, health care providers, policymakers, and the broader health care system.”

Discussions following the CPAC presentation focused on ways in which JCHC could assist in increasing awareness and utilization of the Virginia Cancer Plan. One suggestion was to introduce legislation to request a presentation to JCHC of the Virginia Cancer Plan whenever it is updated and to submit that Plan to be printed and maintained as a legislative document.

Options

Option 1: Take no action.

Option 2: Introduce ~~legislation~~ a joint resolution to request that Cancer Plan Action Coalition report to the Joint Commission on Health Care regarding the Virginia Cancer Plan, whenever it is updated, and submit the Plan as a report to the Governor, the Joint Commission, and the Virginia General Assembly.

Staff Update: Review of Statutory Language on Barrier Crimes

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

Background

In 2008, HB 1203 and SB 381 were introduced on behalf of JCHC in order to ease a few employment restrictions to allow a person with a misdemeanor assault conviction to be assessed for employment in adult substance abuse or mental health treatment programs. To be considered for employment, the assessment would have to determine that the individual's offense was substantially related to his mental illness and that subsequently he had been successfully rehabilitated. (This type of assessment has been allowed for individuals seeking to work in adult substance abuse programs since 2001 - *Code of VA* §§ 37.2-416 and 506.)

As HB 1203 and SB 381 were considered by the House Health, Welfare and Institutions Committee, both were supposed to be amended to remove the provision that would allow for a conviction of assault and battery against a family or household member. HB 1203 was amended appropriately. However, in SB 381, the provision was removed from *Code* § 37.2-416 (addressing employment by providers licensed by the Department of Behavioral Health and Developmental Services) but was not removed from *Code* § 37.2-506 (addressing employment by community services boards). The oversight was not discovered until after both bills were signed by the Governor, and since SB 381 was signed last, its provisions became law on July 1, 2008.

Actions Taken in 2009

During the 2009 General Assembly Session, two identical bills (HB 2288 and SB 1228) were introduced on behalf of JCHC to address the previously described oversight. Both bills were left in the Senate Education and Health Committee to allow JCHC to reconsider the issue.

The original bills (HB 1203 and SB 381) as introduced in 2008, intended to include a misdemeanor conviction of assault and battery against a family or household member as one of the permissible offenses. The 2007 JCHC study found that these assault convictions often occurred when individuals were in crisis and going through an involuntary commitment process. There is no provision for reviewing the circumstances of the convictions, so even misdemeanor convictions prevent individuals from being employed in adult treatment programs. Furthermore, being employed is crucial to the individual's recovery and community services boards and many private providers would like to have

the option of assessing individuals in recovery for employment in their adult treatment programs.

Options and Public Comments

Option 1: Take no action.

Option 2: Introduce legislation to amend the *Code of Virginia* § 37.2-416.C to allow an individual with a conviction of assault and battery against a family or household member to be assessed for employment by providers licensed by the Department of Behavioral Health and Developmental Services.

Option 3: Introduce legislation to amend the *Code of Virginia* § 37.2-506.C to remove the provision allowing an individual with a conviction of assault and battery against a family or household member to be assessed for employment by community services boards.

No public comments were received for this report.

Mental Health Coverage: Overview of State Law and Federal Mental Health Parity Law

Jacqueline A. Cunningham, Deputy Commissioner
Life and Health Division, Bureau of Insurance, State Corporation Commission

Virginia's mental health parity law is inconsistent with the federal parity law which became effective for new health insurance plan years beginning October 3, 2009.

Virginia Laws

As Deputy Commissioner Cunningham reported:

- *Code* § 38.2-3412.1 **mandates** coverage for mental health and substance abuse services, but allows certain coverage limitations, i.e. 20 days inpatient coverage per contract year (25 days for children); 20 outpatient visits per contract year.
 - Applies to all fully insured health insurance products issued to individuals, small groups and large groups.
- *Code* § 38.2-3412.1:01 requires coverage for "biologically based" mental illnesses on **parity with physical illnesses**. Biologically based mental illnesses include schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcohol addiction.
 - The Section's exception from the parity requirements for "policies, contracts, or plans issued in the...small group markets to employers with 25 or fewer employees" cannot be enforced as it does not comply with federal HIPAA provisions. (HIPAA does not allow an insurer to offer a product to a "subgroup" of a small group market.)

Federal Laws

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008:

- "Does not mandate mental health or substance abuse coverage, but requires that *if* such coverage is provided, coverage must be on parity with coverage for physical illnesses, [which address such benefit provisions as] deductibles, copays and out-of-pocket maximums; [and] treatment limitations, (frequency of treatment, number of visits, etc.)
 - Allows for an 'opt-out' by employers if their costs to provide coverage increase by 2% in the first year or 1% in subsequent years – exemption can only be requested for one plan year at a time.
 - Applies to **large employer groups only** (51 or more employees)."

General Comparison of State and Federal Mandates

	Virginia Law		Federal Law
	<i>Code § 38.2-3412.1</i>	<i>Code § 38.2-3412.1:01</i>	Mental Health Parity & Addiction Equity Act
Individual and small group markets	Mandates coverage for MH/SA services but allows for certain limitations in coverage.	Does not apply to individual contracts or to contracts in the "individual market" (non-employer group contracts); BUT applies to all other small and large groups.	(The federal MHPAEA is applicable to large employer groups only.)
Large group markets (51 or more employees)	Mandates coverage for MH/SA services but allows for certain limitations in coverage.	"Mandates coverage for biologically based mental illness on parity with physical illness...."	While MH/SA coverage is not required, if provided "may not be more restrictive than for physical illness; separate requirements are not allowed."

Because of the inconsistencies between the State mandates and the federal parity requirements, a court could rule that Virginia’s State law is preempted by the federal law. Were that to happen, to the extent that the State law was ruled to be preempted, Virginia would lose its ability to:

- Review, approve or disapprove forms
- Review market conduct actions
- Assist consumers with questions or complaints relating to their coverage for mental health and substance abuse services."

Options

Option 1: Take no action.

Option 2: Introduce legislation to amend the *Code of Virginia* § 38.2-3412.1 to repeal the benefit limitations for large group markets while maintaining the mandate to provide coverage for inpatient, partial hospitalization, and outpatient mental health and substance abuse services ~~for large group markets~~.

The existing benefit limitations would continue to apply to individual and small group markets.

Option 3: Introduce legislation to amend the *Code of Virginia* § 38.2-3412.1 to replace the mandate for coverage with a mandate to offer coverage to provide mental health and substance abuse services, specifically:

- a) For which markets – individual, small group, and/or large group markets.
- b) For large group markets, the existing benefit limitations would need to be repealed to comply with the Mental Health Parity and Addiction Equity Act of 2008.

Option 4: Introduce legislation to repeal *Code of Virginia* §§ 38.2-3412.1 and 38.2-3412.1:01 which would remove the State mandates for coverage for mental health and substance abuse services in health insurance products subject to regulation under Title 38.2.

Option 5: Introduce legislation to amend the *Code of Virginia* § 38.2-3412.1:01 to address the inconsistency with federal HIPAA provisions by:

- a) Exempting small group markets of employers with 50 or fewer employees, or
- b) Removing the language providing an exception from the parity requirements for “small group markets to employers with 25 or fewer employees.”

Commission on Mental Health Law Reform: Current and Planned Activities

Richard J. Bonnie, L.L.B., Chair
Commission on Mental Health Law Reform

Authority for Study

This is the second year of a two-year evaluation requested in Senate Joint Resolution 42 - 2008 (Senator Lucas). SJR 42 directed JCHC to evaluate "the impact of certain recommendations and legislation on the mental health system in the Commonwealth." Responsibility for the evaluation was assumed by the BHC Subcommittee.

Legislative Actions in 2009

Twenty bills addressing mental health reform were enacted during the 2009 General Assembly Session. The *Summary of Mental Health Reform Legislation* (shown on page 31) includes a brief explanation of those bills which address such systemic matters as:

- Crisis stabilization to divert individuals from the involuntary civil commitment system.
- Alternatives to transportation by law enforcement for individuals subject to emergency custody orders, temporary detention orders, and involuntary commitment orders.
- Expansion of advance medical directives to allow for decisions related to mental health treatment.
- Provision of mandatory outpatient treatment and voluntary admission for minors.

2009 Progress Report of the Commission on Mental Health Law Reform

During the October meeting of the BHC Subcommittee, Mr. Bonnie reported on the major activities of the Reform Commission. Mr. Bonnie indicated that some of the key accomplishments include:

- The consensus developed among the many different parties who have been involved in the review through "habits of collaboration,"
- The collection and analysis of data necessary for setting policy and providing oversight, and
- The development of a "common understanding of problems...and key elements of the solutions."

The Reform Commission expects to continue to have significant work in the areas of emergency services and commitment reform and empowerment and self-determination. With regard to emergency services and commitment reform the Commission expects to:

- "Continue to enhance opportunities for intensive intervention services to prevent, ameliorate and stabilize crises without invoking commitment process or initiating criminal process
- Lengthen TDO period to facilitate thorough evaluation and stabilization before scheduled hearing
- Facilitate discharge or conversion to voluntary status in clinically appropriate cases

- Based on experience and available resources, identify most appropriate role for mandatory outpatient treatment (MOT)
- Develop integrated, stand-alone “Psychiatric Treatment of Minors Act”
- Continue to reduce reliance on law enforcement transportation through Alternative Transportation Orders.”

With regard to empowerment and self-determination, the Reform Commission continues to work on the implementation and refinement of the Health Care Decisions Act, with special emphasis on the new advance directive provisions for mental health care. These initiatives will be described in more detail in the Reform Commission’s 2009 Progress Report which will be sent to JCHC members in December.

Activities Planned for 2010

A request was made for JCHC to provide an “umbrella of oversight” for a proposed one-year study of mental health issues in higher education. During our October 7th meeting, JCHC members voted in favor of this request. The study will be “coordinated with the State Council on Higher Education and the Department of Education as well as the Commission on Mental Health Law Reform” (which intends to conclude its review in 2010). Mr. Bonnie’s October 7th memorandum describing the study follows on pages 32 and 33.

Summary of Mental Health Reform Legislation Enacted in 2009

Crisis Stabilization Teams

- SB 1294** (Edwards) The Department of Criminal Justice Services and the Department of Behavioral Health and Developmental Services (DBHDS) using available federal or state funding are to “support the development and establishment of crisis stabilization team programs in areas throughout the Commonwealth.”

Transportation

- HB 2460** (O’Bannon)
SB 823 (Cuccinelli) Allows a family member, friend, CSB representative or “other alternative transportation provider” with trained staff to transport a person subject to an emergency custody order, temporary detention order, or involuntary commitment order.

Emergency Custody and Involuntary Commitment Processes

- HB 2486** (Ward)
SB 1079 (Howell) Authorizes a law-enforcement officer to take into emergency custody, a person being transported following his consent to voluntary admission, if that person revokes consent but meets requirements for emergency custody.

- HB 1948** (Shuler) Adds marriage and family therapists as professionals allowed to “conduct independent examinations of persons who are subject to a hearing for involuntary commitment.”

Advance Medical Directives and Voluntary Admission

- HB 2396** (Bell)
SB 1142 (Whipple) Revises the Health Care Decisions Act to add conditions under which an incapacitated person with mental illness could be admitted to a facility for treatment.
- HB 2257** (Albo) Provides that a person’s compliance/noncompliance with treatment will be considered in determining whether to allow him to consent to voluntary admission.

Notification and Disclosure

- HB 2459** (O’Bannon)
SB 1076 (Howell) Allows a consumer in a mental health facility to identify a person to be notified of “his general condition, location, and transfer to another facility.”
- HB 2461** (O’Bannon)
SB 1077 (Howell) Authorizes disclosure to a family member or friend regarding certain information (such as location and general condition) about a person subject to an emergency custody order, temporary detention order, or involuntary commitment order.

Technical and Administrative Changes

- HB 2060** (Hamilton)
SB 1083 (Howell) Clarifies a number of technical “issues resulting from the overhaul of mental health laws during the 2008 Session.”
- SB 1081** (Howell) Clarifies that “a special justice serves at the pleasure of the chief justice of the judicial circuit in which he serves, rather than the specific chief justice that makes the original appointment.”
- SB 1078** (Howell) Allows “special justices, retired judges, or district court substitute judges presiding over involuntary commitment hearings” to receive reimbursement for associated mileage, parking, tolls (and postage).
- SB 1082** (Howell) Clarifies the responsibilities for the Office of the Executive Secretary of the Supreme Court and DBHDS with regard to preparing various documents.

Psychiatric Inpatient Treatment of Minors Act

- HB 2061** (Hamilton)
SB 1122 (Lucas) Allows for mandatory outpatient treatment and voluntary admission for treatment of minors for mental illness; clarifies when a “qualified evaluator” must attend the minor’s hearing and the circumstances in which the evaluator’s report would be admissible.

UNIVERSITY OF VIRGINIA SCHOOL OF LAW



Richard J. Bonnie
Harrison Foundation Professor of Medicine and Law
Hunton & Williams Research Professor
Professor of Psychiatry and Neurobehavioral Sciences
Director of Institute of Law, Psychiatry and Public Policy

Memorandum

To: Senator R. Edward Houck, Chair, Joint Commission on Health Care

Re: Proposed JCHC Study of Mental Health Issues in Higher Education

Date: October 7, 2009

This memorandum supplements my memorandum to you dated August 31, 2009, in which I described a possible study of mental health issues in higher education under the auspices of the Joint Commission on Health Care. Conducting such a study would serve the interests of the people of the Commonwealth and would be timely in light of the opportunity for coordination with the Supreme Court's Commission on Mental Health Law Reform before the Commission completes its work in 2010. I am confident that the study can be carried out successfully within the next year without any JCHC financial support and without diverting staff attention from the Joint Commission's other priorities.

Steering Committee. The proposed study would be directed by a steering committee that I would chair. The members of the steering committee would include Chris Flynn, the director of the counseling service at Virginia Tech (who would chair a task force on access to mental health services); Jim Stewart, the Inspector General for Behavioral Health and Developmental Services, Professor John Monahan, my colleague at UVA who is an expert on empirical research in mental health law; Diane Strickland, a former Circuit Court judge and member of the Governor's Panel on the Virginia Tech Shootings; Jim Reinhard, Commissioner of Behavioral Health and Developmental Services; Ron Forehand, Deputy Attorney General; Susan Davis, an experienced lawyer who also serves as a student affairs officer at UVA (who would chair a task force on legal issues); and any others who may be suggested by the Joint Commission. Joanne Rome, a Staff Attorney in the Supreme Court, will serve as liaison from the Court, but not as a member.

Coordination with Other Agencies. The study would be formally coordinated with the State Council on Higher Education and the Department of Education as well as the Commission on Mental Health Law Reform, facilitating advice and collaboration throughout the process. The Commission will provide assistance and guidance, as needed, regarding data collection and outreach to relevant constituencies and agencies.

Task Forces. As outlined in my previous memorandum, the Steering Committee would oversee the activities of two task forces, one on Legal Issues in College Mental Health and a second on Access to Mental Health Services by College and University Students. Membership would be drawn from colleges and universities of varying sizes and locations, both public and private. The Steering Committee would develop a specific charge for each of the task forces. For the moment, it is perhaps sufficient to say that the task force on legal issues would be charged with addressing the roles and responsibilities of colleges in responding to possible student mental health crises, including notification and sharing of information, threat assessment, initiation and participation in commitment proceedings and follow-up. The task force on access to services would be charged with assessing the current need for mental health services among Virginia's college and university students, and the current availability of services to address these needs. Each task force would make recommendations for training, institutional policies and practices, and any legislative action that may be needed.

With the direction and guidance of the Steering Committee, the task forces would conduct surveys of colleges and universities in their respective domains, assemble available information regarding these issues,

including experience in other states, and would prepare a report and recommendations for consideration by the Steering Committee, review and comment by the Commission on Mental Health Law Reform and other interested parties, and eventual submission to the Joint Commission.

Composition of Task Forces. Our tentative roster for the legal issues task force includes counseling center directors from George Mason and James Madison Universities, campus police officials from Virginia Tech and Christopher Newport, and student affairs officials from UVA, William and Mary, Randolph Macon, ODU, Bridgewater, VCU and Piedmont Community College. Our tentative roster for the access task force includes counseling center directors from Virginia Tech, Longwood University, VCU, Virginia Wesleyan, Virginia State University, Norfolk State, University of Richmond, Radford University, Christopher Newport University, and ODU; two officials from the community college system; and two officials from community services boards. The respective task forces will be advised by representatives of the General Counsel's offices from UVA (legal issues task force) and Virginia Tech (access task force). We will also seek to involve parent organizations and student peer counseling organizations and other stakeholders in the work of the two task forces.

Institutional Support. The legal issues task force will be headquartered at UVA and the access task force will be headquartered at Virginia Tech. I am grateful to each of these institutions for agreeing to provide the core infrastructure support for the study. The responsibility for organizing task force meetings, summarizing deliberations, conducting and analyzing the surveys and drafting and circulating reports would be borne by the respective chairs and by other willing task force members, with the support of their own institutions and agencies. The costs of attending meetings, communications and logistics, and photocopying materials generated by and circulated to task force members will be borne by their respective institutions.

Schedule. If the Joint Commission is willing to provide an umbrella of oversight for the proposed study, the target date for formal appointment of the Task Forces would be the end of October, 2009. Progress reports to the Steering Committee and the Joint Commission Council would be expected in April, 2010 and July, 2010, with the final reports being due in October, 2010.

Staff Report: Virginia's Long-Term Care Ombudsman Program

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

Background

A study of Virginia's Long-Term Care Ombudsman Program (VLTCOP) was requested by AARP with cooperation from the program's state office.

- Study should examine the role of the Long-Term Care Ombudsman Program in Virginia, determine whether state and federal mandates are being fulfilled, and examine the adequacy of program resources to meet current and future need for services.
- 1 to 2 year study

Overview of Virginia's Long-Term Care Ombudsman Program

Ombudsman Activities

- Investigate & resolve complaints
- Provide consultation to facilities
- Provide information & consultation to individuals
- Make regular, non-complaint related facility visits
- Provide input to assist regulatory agencies
- Develop and work with resident and family councils
- Educate community & work with media
- Monitor, analyze, and comment on laws, regulations, and government policies

In 1983, the Virginia General Assembly expanded the scope of the program to include individuals receiving community-based long-term care services provided by state and private agencies.

Headed by the Office of the State LTC Ombudsman, there are currently 20 local ombudsman offices located in Area Agencies on Aging (AAAs) and a total of 31 local ombudsman staff. Sixteen of the thirty-one ombudsmen are full-time, and there are 109 volunteers.

Key Elements of Program that Were Evaluated & Relevant Findings

Program Funding. Funding for Virginia's LTCOP has steadily increased over time. However, funding has not kept up with inflation and growing demands on the program due to:

- Increasing elderly population
- Broadened scope of the program to include community-based LTC services

Percentage of total funds allocated to the State Ombudsman Office (relative to the local LTCOPs) has decreased over time.

- 1995: 68% of total funds were allocated to the state office.
- 2008: 21% of total funds were allocated to the state office.
 - Due to an intentional effort by the Virginia Department for the Aging (VDA), The Virginia Association of Area Agencies on Aging (V4A), and the state office to gradually shift

funding as more local offices were developed and to direct additional funds to the local offices. However, funding for the state office now appears to be too low to adequately fulfill all its mandates including supporting the work being done at the local level. The state office provides guidance, information, staff ombudsman training, systems advocacy, data collection and analysis, etc.

Program Placement & Organizational Structure. In 1995, the General Assembly transferred the LTC Ombudsman Program from VDA to the AAAs. The Virginia Association of Area Agencies on Aging (V4A) began operation of the State Long-Term Care Ombudsman Program under contract with VDA on July 1, 1995.

- Benefits:
 - Connection and opportunities for collaboration with the Aging Network
 - Logical fit within the family of aging services
- Challenges:
 - Real or perceived conflicts of interest
 - “Non-fit” of ombudsman program vis-à-vis other AAA programs and services due to its broad scope
 - Bifurcation of local ombudsman’s accountability to the state ombudsman program vs. their local AAA
 - Under the Older Americans Act, the State Ombudsman Office is responsible for managing the statewide program; however, it lacks administrative control over resource allocation & other administrative decisions.

Program Staffing. Although the average for the state is one staff ombudsman for 2300 beds, the program does not currently meet the Institute of Medicine’s Recommendations of:

- 1 paid designated ombudsman FTE to 2000 beds
- 1 full-time staff ombudsman to 40 volunteers
- Each local office should have at least 1 full-time paid ombudsman (not FTE). Additional paid program staff may be part-time, but should have no duties conflicting with their role as ombudsmen.

This is due to the fact that many of the staff ombudsmen are responsible for more than one PSA (Planning and Service Area) and there are many PSAs with ratios much lower than 1/2000 (For example, PSA 20 has a ratio of 1 staff ombudsman/8156 beds).

Community Education. Given the program’s resources, staff does a good job of educating the community about the program and long-term care issues. In the past year, staff provided:

- 207 Community Education Events
- 36 Interviews or Discussions with Media
- 5 Press Releases
- Dissemination of information via the program’s website

Individual Advocacy. Given the program’s resources, staff does a good job of advocating for individuals in long-term care facilities. In the past year, staff conducted:

- 201 Non-Complaint Related Visits to Nursing Homes
- 196 Non-Complaint Related Visits to ALFs
- 13,456 Consultations with Individuals

- 1,372 Consultations with LTC Facility Staff
- 1,936 of 2,462 Complaints Investigated Were Resolved or Partially Resolved

Systems Advocacy. Program staff provides a significant amount of systems advocacy for long-term care recipients, especially in the area of long-term care facility culture change. However, the program has very limited involvement with complaint handling in home/community-based care situations due to lack of resources for additional staff, training, and marketing of ombudsman services. As a result, there has been little to no systems advocacy in this area.

Degree of Preparedness for Future Population and Systemic Changes. The program does not have adequate resources to provide services to the growing elderly population and an evaluation of the effectiveness of ombudsmen's work with individuals receiving LTC services in their home is not possible due to the small volume of home care complaints referred to the program.

Adequate provision of ombudsman services in the midst of a growing elderly population and a shift toward community-based care will require:

- Increasing staff and volunteer ombudsmen
- Additional training for staff and volunteer ombudsmen on the complex issues involved in providing LTC services in the home and community
- A public information campaign to educate individuals about broadened scope of the program
- Reformatting the data collection system to include non-facility data
- Increasing funding for the program
- Maintaining services and support for the elderly in LTC facilities

Conclusion

Overall, Virginia's LTC Ombudsman Program is performing well.

- Performs a vital role in protecting the rights and safety of older residents and in improving the overall quality of care in LTC facilities
- Meets federally mandated requirements
- Is considered to be an effective program by LTC facility administrators and staff and volunteer ombudsmen
- Is a strong and effective advocate for LTC culture change and other system-wide efforts to improve the provision of long-term care to the elderly

However, the current level of resources allocated to the state office and the local offices appears to be inadequate to meet projected future demands on the program that will result from the growth in the elderly population and the state mandate to provide ombudsman services for individuals receiving community-based care.

The placement and organizational structure of the program needs to be reexamined to determine whether the level of authority that the Office of the State Ombudsman Program has over local ombudsman offices is appropriate.

The allocation within the program needs to be reexamined to ensure that the distribution corresponds with current programmatic needs.

Options and Public Comments

Option 1: Take no action.

Public Comments in Opposition

William L. Lukhard, AARP Virginia Executive Council and Madge Bush, Director of Advocacy for AARP Virginia do not support the option of taking no action.

Paul Lavigne, Chair, on behalf of the Long-Term Care Ombudsman Program Advisory Committee and Joani F. Latimer, Virginia State Long-Term Care Ombudsman, on behalf of the Office for the State Long-Term Care Ombudsman and local ombudsmen commented that they “strongly urge the Joint Commission not to adopt Option 1.” Limitations in staff place program staffing levels below the standard recommended by the Institute of Medicine and set out in the *Code of Virginia*. “Option 1 would also ignore the huge projected growth in the population of those over age 65...which will result in more residents of LTC facilities as well as more Virginians receiving long-term care services in the community.”

Option 2: Request by letter of the JCHC Chairman that ~~VDA~~ JLARC examine the need for additional state funding for the Office of the State Ombudsman and the local ombudsman offices.

Public Comments in Support

Paul Lavigne and Joani F. Latimer commented in support of this option **support the intent** of this option **but indicate the study should be performed by an independent entity such as JCHC or JLARC.**

William L. Lukhard and Madge Bush of AARP

Option 3: Introduce a budget amendment (language and funding) during the 2012 Session to increase the general funds appropriated for the LTC Ombudsman Program.

Public Comments in Support

William L. Lukhard and Madge Bush of AARP support this option and **indicate that it should be a high priority for the 2012 General Assembly.**

Paul Lavigne and Joani F. Latimer support this option.

Option 4: Request by letter of the JCHC Chairman that ~~VDA~~ JLARC study whether the state ombudsman office should have greater administrative control over resource allocation & other administrative decisions. (Requests in Options 2 and 4 will be combined into one study resolution.)

Public Comments in Support

William L. Lukhard and Madge Bush of AARP support the intent of this option **but indicate the study should be performed by an independent entity such as JCHC or JLARC.**

Paul Lavigne stated, “we do believe that there is the **need for new strategies and better lines of communication and input in some of these areas,** which would warrant some programmatic and implementation changes...”

Joani F. Latimer indicated that “**the greatest need is for additional training for the aging services network in the discrete role and functions of the program so that its unique autonomous operation within that network is better understood and supported.**”

HIV/AIDS in Virginia

Kathy Hafford, Director
Division of Disease Prevention, VDH
Sue Rowland, Executive Director
Virginia Organizations Responding to AIDS

Ms. Hafford from the Virginia Department of Health presented about the continuing HIV epidemic in Virginia.

- 1 in 370 Virginians is known to be living with HIV Infection.
- 1 in 1,400 Virginians is infected with HIV and does not know his/her infection status.

Those with HIV infections are more concentrated in certain groups. For every 5 Virginians living with HIV Infection, approximately: 4 are Men, 3 are Black, 3 live in the Eastern or Northern region, and 2 are men who have sex with men (MSM). In 2006 (the most recent year for which data is available):

- Virginia estimates that 1,220 new HIV infections occurred.
- Blacks accounted 55% of new HIV infections.
- Men were 5 times more likely than women to be newly infected.
- Ages 13-29 accounted for 36% of the new infections.

Most of Virginia's funding towards HIV/AIDS is federal. For state funded HIV care services, Virginia has four: Arthur Ashe Community Health Center, Central Virginia Health District-Lynchburg, Statewide Pharmaceutical Assistance Program, and the Virginia HIV/AIDS Resource and Consultation Center. In addition, two state funded prevention grants supported:

- AIDS Services and Education Grants (\$200,000)
- Comprehensive HIV/AIDS Resources and Linkages for Inmates (\$600,00)

Ms. Rowland from Virginia Organizations Responding to AIDS presented about HIV prevention and the cost to treat someone with HIV. She indicated that 20,593 Virginians had HIV in 2009 and the lifetime cost to treat HIV is \$618,900. The total cost of care for the Virginians living with HIV could be over \$11 billion. Treatment costs for HIV are higher when treatment begins late. Ms. Rowland emphasized prevention as a better response and stated that Virginia's prevention programs are small, scattered, inconsistently available, and constantly struggling to maintain funding. She submitted options.

Options Submitted on behalf of Virginia Organizations Responding to AIDS

Option 1: Take no action.

 **Option 2:** ~~Introduce~~ When revenue allows, consider a budget amendment of \$250,000 GFs for each year of the 2010-2012 biennium for two to four HIV prevention programs targeted at young people under 25 years of age. The Department of Health shall administer the funds and select programs in two health districts in which the

annualized HIV incidence rate exceeds the state's incidence rate. The Department shall use an internally competitive process to select the health districts and encourage local public-private partnerships in the awarding of the funding for the prevention programs.

Option 3: Include in the ~~2008~~-2010 JCHC work plan, a study of Virginia's current HIV prevention and treatment programs. Focus shall be given to assessing program and policy effectiveness in reducing the incidence of new HIV cases in Virginia. Recommendations shall include any state-directed policies that would result in a reduction in the number of new HIV cases. A report to JCHC would be due by November 2010.

Health Access for the Uninsured

Jill Hanken, Staff Attorney
Virginia Poverty Law Center

Jill Hanken presented to the Healthy Living/Health Services Subcommittee regarding provisions of the Child Health Insurance Program Reauthorization Act of 2009 and previous recommendations of studies by JCHC and other Commissions to address health access improvements. The following comments and options were submitted by Ms. Hanken for JCHC's consideration.

Children's Health Insurance

There are 167,000 uninsured children in Virginia. The federal Child Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allocates additional federal funding to Virginia to reach more uninsured children. Virginia receives a 65% federal match for its FAMIS Program. To utilize available federal funding, Virginia must enact changes to reach more children and pregnant women and/or streamline enrollment procedures. If such changes are not implemented, Virginia's 2011 federal allotment will be reduced, hampering the state's ability to reach more uninsured children. CHIPRA-related policy options include:

Option 1:

- A. ~~Introduce~~ Reconsider legislation and accompanying budget amendment to increase FAMIS eligibility from 200% to 300% FPL, and offer a full "buy-in" for uninsured children in families with higher income. Eventually, 20,000 more children would qualify at 300% FPL; unknown number of children would qualify through the buy-in. (Estimated Cost: \$5 million GFs in first year of implementation, reaching \$15 million GFs after three years - 65% federal match.)
- B. Introduce legislation and accompanying budget amendment to increase FAMIS eligibility from 200% to 250% FPL to eventually reach 10,000 more children. (Estimated Cost: \$2.5 million GFs in first year of implementation - 65% federal match.)

Most legal immigrants are barred from Medicaid for the first 5 years they are in the U.S., and Virginia is also one of only 9 states that continue to bar legal immigrants from Medicaid, even after the initial 5-year bar ends. A new CHIPRA option allows states to cover legal immigrant children and pregnant women during (and after) their first 5 years in the United States. (DMAS already plans to cover Medicaid eligible legal immigrant children to save \$700,000 GFs.)

Option 2:

- A. Introduce a budget amendment (language and funding) to offer coverage to legal immigrants who are Medicaid eligible pregnant women. DMAS already covers their labor/delivery costs as an emergency service.

This would provide needed access to prenatal care. (Estimated Cost: \$770,531 GFs for 1st year, \$1,016,148 GFs for 2nd year - at least an equal amount in FFP will be available each year.)

~~B. Introduce a budget amendment (language and funding) to offer coverage to legal immigrants who are FAMIS-eligible children. (Estimated Cost: \$140,000 GFs - 65% federal matching.)~~

C. Introduce a budget amendment (language and funding) to offer coverage to legal immigrants who are FAMIS-eligible pregnant women. (Estimated Cost: \$87,000 GFs - 65% federal matching.)

 **Option 3:** Introduce a budget amendment (language only) directing DMAS to develop, to the extent that it is budget neutral or likely to result in cost savings, express lane eligibility provisions and other administrative procedures to simplify child health enrollment and improve retention. Any provisions that are estimated to be cost neutral or result in cost savings shall be implemented by December 1, 2010.

Medicaid Eligibility for Parents

Parent eligibility in Virginia is between 22% and 30% of the poverty line, depending on where the parent resides. This is the 44th lowest eligibility level in the nation. During the past nine years, several Virginia studies (JCHC, JLARC, 2008 Health Commission) have recommended increasing eligibility to 100% FPL. Pending legislation in Congress would raise Medicaid eligibility nationwide, but not until 2013 or 2014.

 **Option 4:** ~~Introduce~~ Reconsider a budget amendment (language and funding) to adopt a single income eligibility level for Medicaid eligible parents, set at 30% FPL. The eligibility limit would increase to 30% FPL for about 3,000 extremely impoverished parents in 117 Virginia counties and cities. (Estimated Cost: \$5.6 million GFs - this would be matched with an equal amount of FFP.)

Adult Dental Coverage in Medicaid

Only emergency extractions are now covered for adults, and poor oral health is linked to a multitude of health problems. Many Virginia studies (JCHC, 2008 Health Commission) have recommended coverage of dental care for adults receiving Medicaid.

 **Option 5:** ~~Introduce~~ Reconsider a budget amendment (language and funding) to provide dental coverage to pregnant women who are eligible for Medicaid and/or FAMIS Moms. (Estimated cost to be determined.)

 **Option 6:** ~~Introduce~~ Reconsider a budget amendment (language and funding) to provide dental coverage to other Medicaid adults. (Estimated cost to be determined.)

Option 7: Take no action.

Appendices

Task Force on Adverse Medical Outcomes

Appendix A

Steven W. Pearson, P.C.

On behalf of the Virginia Trial Lawyers Association

Virginia's Health Care Workforce: Present and Future Need

Appendix B

Summary of Public Comments

Appendix C

Full-text of Comments Supporting and Opposing Options 11 and 15

Appendix D

Public Comment: Additional Policy Options

LAW OFFICE OF
STEVEN W. PEARSON, P.C.
ONE MONUMENT AVENUE
413 STUART CIRCLE, SUITE 130
RICHMOND, VIRGINIA 23220

November 11, 2009

Jaime H. Hoyle, Esquire
Senior Staff Attorney and Health Policy Analyst
Joint Commission on Health Care
900 East Main St. 1st Floor
Richmond, Va.23219

Re: Task Force on Adverse Medical Outcomes

Dear Jaime;

As I mentioned in my correspondence of November 4, 2009, due to the short period of time to consider the earlier draft of the Task Force on Adverse Medical Outcomes related to the proposed legislation dealing with early offers, I would be submitting further comments on behalf of the Virginia Trial Lawyers Association. We have now had a chance to further consider the November 4 draft, and have received yet another draft on November 5, 2009. The comments contained herein address the November 5th draft.

At the outset, let me observe simply that significant portions of the draft are new. Neither I nor Mic McConnell, another Task Force member, had seen them prior to November 5. There has been insufficient time to expose VTLA members to the new provisions, especially those in paragraphs G and F, which are considerable, important, and either new to us (paragraph F) or different (paragraph G) from what was drafted by the Paragraph G subcommittee with which I was involved. These provisions are not what was presented to the VTLA Medical Malpractice Legislative Committee on November 4, after I called you and requested the draft report. The changes drastically broaden the scope of the proposed new privilege, beyond that which had been discussed by the Task Force or the subcommittee, and they take the legislative proposal in an entirely wrong direction. Our substantive objections to this draft will be discussed in more detail below, following a brief discussion of why legislation is not necessary at all in this area.

As to the proposal itself, VTLA is opposed to the establishment of a new privilege as drafted or in any other form. A program of early offers or early resolution of potential medical malpractice actions is not dependent for viability on a new form of privilege. Such a program can be established under existing law by any health care provider which desires to do so, without the need for a new privilege. Current law protects apologies, benevolent conduct and gestures, expressions of sympathy and condolence. Settlement

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discussions and offers of settlement are inadmissible in judicial proceedings. A patient should always be entitled to disclosure of facts and medical opinions relating to that patient's care, and that has been generally acknowledged by the Task Force participants during the Task Force process. As a result, the facts relating to the patient's care and the adverse outcome should always be relevant and subject to disclosure. Apologies and benevolent expressions related to those facts are protected, and any offers of settlement would likewise be protected. There is simply no need for a privilege, which would result in significant injustice, unfairness and inequality. And there has been no demonstration of need for this type of program in Virginia, nor any evidence that the Commonwealth or patients would benefit from such a program. At no time was the Task Force presented with evidence showing a need for such a privilege in Virginia. Thus, VTLA is opposed to establishment of such a privilege.

The proposal is for the Health Department to establish guidelines under which any health care provider or hospital (a very broad range of actors) may establish a program to deal with the adverse outcomes of the delivery of health care. The idea is essentially to provide to patients and their families a suitable explanation of the events coupled with apologies and offers to settle liability for such adverse events, encouraging early, and presumably, favorable settlements. In order to facilitate such programs, the proponents assert the necessity of a new privilege, found in paragraph G of the draft, which would make inadmissible (i) offers to participate and actual participation in such a program; (ii) offers of compromise made during a program; and (iii) disclosures made during a program. The substance of (i) and (ii) is inadmissible under current law, as settlement negotiations, so legislation is not necessary to authorize these elements of a program.

The problem here is the scope of (iii), disclosure, and the scope of privilege afforded by this definition is so broad that nobody who participates in a "program" would be able to sue following unsuccessful settlement negotiations, because the evidence necessary to prove the case would be privileged, unavailable to the patient, and inadmissible. The draft bill defines "disclosure" as including "preparation for, execution of, or conclusion of a disclosure program involving an adverse medical outcome." Disclosure includes "all documentation about an adverse medical outcome, its known or suspected cause, its impact on patient safety and health care providers, its actions to remediate the known or suspected cause, together with statements of admission." All of the foregoing would be privileged under any program once established, and there is little if any useful information left which would remain unprivileged. Virtually none of it should be privileged under any fair system of adjudication of grievances. Current discovery rules and law recognize the necessity of this type of information in the proof of cases, and permit the discovery and introduction of such evidence. Excluding such evidence would

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make it impossible to prove a case, an unfair result in fundamental conflict with the purpose of the Medical Malpractice Act. Application of such a privilege would result in the exclusion of facts relating to the treatment of the patient from suits brought over that same treatment. The injustice is manifest.

In addition, the bill draft would make any regulatory action other than summary suspension of a license unlawful if the provider is engaged in a "program" established under this proposal. Paragraph F of the draft provides that where reports or complaints are filed concerning a licensee who is engaged in a "program", the Board of Medicine is to take "no further action". Thus, the Board would be unable to exercise its statutory duties in overseeing the practice of medicine. The Board would be unable to restrict practices or revoke licenses, even for unrelated reasons including fraud, substance abuse, intentional conduct, medical or physical incapacity, criminal activities, or sexual relationships with patients, among other things. Insofar as activities related to the adverse events dealt with in the "program", the draft would apply the full privilege to all facts, statements, etc., as described above (within the definition of "disclosure"), making it impossible for any regulatory agency to obtain or use the protected information in its proceedings. In effect, participation in a "program" would immunize practitioners from nearly all regulatory actions.

The draft proposal has many other serious deficiencies, as well, that require serious consideration even if the Commission believes that establishment of such a program is warranted. The problems here are quite numerous and complex. I will discuss several, but not all, of the problems.

The "program" would be available only in cases where both the patient and the provider agree, but there are no limitations on the provider obtaining agreement prior to treatment (before the patient is aware of any of the consequences of the future mistreatment), no disclosure requirements other than advising the patient of rights to counsel and to terminate the process. Thus, the patient might not even be told that a privilege would attach to the essential facts related to her treatment, effectively preventing a future suit. There would be no requirement that the agreement be obtained separately from consent to treatment or from the patient intake process, and no requirement that the patient know or be told what she is agreeing to by signing the agreement. Even if the agreement is obtained following treatment, there are no safeguards to prevent oppressive conduct at a time when patients and families may be exceptionally vulnerable. And there is no requirement that the patient be told that malpractice may have occurred, if that may be the case. Separate consideration needs to be given to the issues surrounding dealing with family members in cases in which the patient has died, but no such provisions are included in the draft, nor is the Health Department directed to establish such protocols.

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There has been no consideration either by the Task Force or in the draft legislation, of issues relating to the overall fairness of such programs to the universe of patients. Health care facilities are free to design their own "programs" and may or may not choose to use them with particular patients. Thus, they could use them only when a suit seems likely, and otherwise not all, which would not benefit patients. They could be used in the cases in which medical negligence is clear, but not in the more difficult cases, with unfair results for patients. Facilities also could exclude certain providers or include others, with an unfair effect.

There is no requirement that patients be represented by counsel, or that some independent arbiter of the fairness of the process to the patient or family be involved. Given the potential for abuse and oppressive conduct, this is needed. In addition, there is no requirement that providers NOT tell patients such things as "you don't need a lawyer—we'll take good care of you—a lawyer will just reduce your recovery" and similar statements which may influence vulnerable patients to sacrifice their rights unwisely. Nor is there any timing requirement for initiation of a process only after the patient has had the opportunity to understand what has happened—a kind of "cooling off" period.

There are no reporting requirements applicable to the contents of reports, either from providers to the Department of Health, or from the Department to the General Assembly. Any reports generated from such a program should be comprehensive, enabling a thorough investigation of the nature of the facility's use of the program, an accurate assessment of the benefits, if any, to the facility, and the effect on patients, both in terms of health outcomes and including financial stability and remediation of the bad effects of medical negligence.

There are no limitations on the number or kind of program participants from the provider community. The program is apparently available to all comers, without limit, and it is easy to envision an environment in which small offices participate and through skillful use of the program, effectively immunize themselves from the consequences of medical negligence.

Other significant problems exist with this proposal, but we will leave such an itemization for a later time. On the whole, however, VTLA is strongly opposed to this proposal. It would create a process clothed in secrecy, with case selection controlled by the likely defendants in any future suits. The opportunities for self-serving conduct are apparent and rife. It will be extremely difficult to evaluate the effectiveness of the "programs" established, whether patients have been fairly compensated, whether the "program" has been fairly administered and fairly available to patients, or whether they have sheltered oppressive conduct from view and provided opportunities for taking advantage of the vulnerable and unsuspecting. There will be no oversight of the promises or threats made

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to induce patient participation, and no way to evaluate whether the disclosure has been fair and accurate. While VTLA does not believe that any such program makes sense, this proposal, as designed, clearly does not make sense, is not in the public interest or the interest of patients, and should not be implemented.

Sincerely,



Steven W. Pearson
Counsel, Virginia Trial Lawyers Association

Cc: Jack Harris
Malcolm P. McConnell, III

Virginia's Health Care Workforce Appendix B

SUMMARY OF PUBLIC COMMENTS: Virginia's Health Care Workforce: Present and Future Need

Organizations/Individuals Submitting Comments

Twenty-nine comments were received regarding the options presented to JCHC addressing Virginia's Health Care Workforce. The comments were submitted by:

- Anita L. Auerbach, Ph.D., Chair of the RxP (Prescription Privileges) Task Force for the Virginia Academy of Clinical Psychologists
- Ellen Austin-Prillaman RDH, President of the American Dental Hygienists' Association
- Dr. John Ball, Ph.D., Clinical Psychologist
- Mary Ann Bergeron, Executive Director of the Virginia Association of Community Service Boards
- Catherine Bodkin, Licensed Clinical Social Worker
- Tegwyn H. Brickhouse D.D.S., Ph.D., and Chair of the Virginians for Improving Access to Dental Care
- Kay Crane, CEO of the Piedmont Access to Health Services
- James F. Dee, M.D., President of the Northern Virginia Chapter of the Washington Psychiatric Society
- Steven T. DeKosky, M.D., Vice President and Dean of the University of Virginia School of Medicine
- Terry Dickenson, D.D.S., Executive Director of the Virginia Dental Association
- Thomas W. Eppes, Jr., M.D, President of the Medical Society of Virginia
- Baltij Gill, M.D., President of the Virginia Association of Community Psychiatrists
- Roger Hofford, M.D., Program Director of the Carilion Clinic Family Medicine Residency
- Anton Kuzel, M.D, Chair of Department of Family Medicine, Virginia Commonwealth University
- Janet McDaniel, Ph.D., M.P.H., Chair of the Workforce Council for Virginia's State Rural Health Plan
- Asha S. Mishra, MD, DFAPA, Medical Director of Chesterfield CSB and Professor of Psychiatry, VCU Health System
- J. Edwin Nieves, M.D., President of the Psychiatric Society of Virginia
- Peter J. Pagnussi, M.D., President of the Virginia College of Emergency Physicians
- Cathleen A. Rea, Ph.D., Chair of the Licensure Task Force for the Virginia Academy of Clinical Psychologists
- Karen S. Rheuban, M.D., and President of the Virginia Telehealth Network
- Debra A. Riggs, Executive Director of the Virginia Chapter of the National Association of Social Workers
- Sandra Whitley Ryals, Director of the Department of Health Professions
- Rick Shinn, Director of Public Affairs, Virginia Community Healthcare Association
- Mira Singer, Executive Director of the National Alliance on Mental Illness

- Bela Sood, M.D., President of the Virginia Chapter of the American Academy of Child and Adolescent Psychiatry
- Robert Strange, M.D., Psychiatrist
- Marcia A. Tetterton, M.S., Executive Director of the Virginia Association of Home Care and Hospice
- Dixie Tooke-Rawlins D.O., Dean and Executive. Vice President of the Via Virginia College of Osteopathic Medicine
- James L. Werth, Jr. Ph.D., Professor of Psychology and Director of the Doctor of Psychology Program in Counseling Psychology, Radford University

Workforce Policy Options Address Three Areas			
	Increase Appropriations	Review Scope of Practice	Work with Existing Organizations and Agencies
Physicians	2, 3, 4, 5, 7	11	6, 8, 9, 10, 12, 13
Dentists	18	-	17
Mental Health Professionals	-	15	12, 13, 14, 16
Pharmacists	-	-	19

Summary of Comments

Policy Option 2 received the largest number of comments in support (9) with none opposing. Options 2-19 received at least 2 comments of unconditional support; the Options proposing an increase in appropriations (Options 2-5, 7, 18) generally received the largest number of supportive comments and no comments in opposition. Conditional support (for Options 6, 8, 9, 16, 17) entailed three types of changes in the options: additional entities that should be included, requests that entities promote education using the “most appropriate venue,” and clarifying the data to be collected. Option 15 (to study whether to allow prescriptive authority for clinical psychologists under stipulated conditions) received the largest number of comments in opposition (9) and 2 comments in support.

Excerpts from Comments for Selected Policy Options

Option 2: When state revenue allows, restore funding for the State Loan Repayment Program (SLRP) & Virginia Loan Repayment Program (VLRP).

Support: 9

Conditional Support: 0

Oppose: 0

In Support:

Rick Shinn, Virginia Community Healthcare Association commented: The loss of funding for the medical and dental loan repayment programs has had a significant and detrimental impact on the abilities of community health centers to recruit primary care physicians and dentists to work in medically underserved areas, particularly the rural areas.

Option 3: When state revenue allows, increase dedicated funding for the EVMS, UVA and VCU Family Practice Residency Programs.

Support: 8

Conditional Support: 0

Oppose: 0

In Support:

Roger Hofford, M.D., Carilion Clinic Family Medicine Residency commented: Over the last six years state funding has decreased significant[ly] to support family medicine residency training. Also occurring in the past six years was “a worsening payor mix of patients served, and decreased Federal funding for graduate medical education.” In the state budget language this money can be used to pay for medical students rotations in family medicine. I would ask the Joint Commission/General Assembly look at whether these monies for students are accomplishing the outcomes we need at the expense of our state supported family medicine residencies.

Anton Kuzel, M.D., VCU Department of Family Medicine commented: For the past four years, we have had 78% of our residency graduates stay in state. “Yet over the past few years, we have suffered funding cuts of 25% (2003), 5% (2008), and now an additional 8% (projected, 2009). We have permanently closed one of our programs in part because of these deep cuts. Dean Strauss strongly supports making restoring the funding of the Family Medicine residencies the top priority amongst the policy options.”

Option 4: Request by letter of the JCHC Chairman that the Department of Medical Assistance Services (DMAS) develop and report on a methodology and cost estimate for providing enhanced Direct Medical Education (DME) and Indirect Medical Education (IME) payments to graduate medical programs in Virginia that train primary care, general surgery, psychiatrists, and emergency medicine physicians. The letter would include a request that DMAS present its report to JCHC by August 30, 2011. (*Enhanced payments are expected to increase state Medicaid costs to some degree.*)

Support: 7

Conditional Support: 0

Oppose: 0

Option 5: When state revenue allows introduce a budget amendment (language and funding) to increase Medicaid reimbursement rates to match the level of Medicare reimbursement rates for primary care physicians.

Support: 7
Conditional Support: 0
Oppose: 0

In Support:

Janet McDaniel, Ph.D., M.P.H., Workforce Council for Virginia's State Rural Health Plan commented: It is very important to increase Medicaid reimbursement rates for primary care physicians and mid-level providers, physician assistants and nurse practitioners, because in rural areas it is difficult to recruit health providers if there is a poorer payer mix due to large numbers of residents on Medicaid.

Option 6: By letter of the JCHC Chairman request that the medical schools at Eastern Virginia Medical School, the University of Virginia, and Virginia Commonwealth University make efforts to increase their enrollment of medical students from rural communities in Virginia and individuals with an interest in serving underserved and minority populations.

Support: 4
Conditional Support: 2
Oppose: 0

In Support:

Rick Shinn, Virginia Community Healthcare Association commented: We support efforts to “grow our own” physicians, dentists, and other health care providers by encouraging young persons from rural and underserved areas to consider health careers. Encouraging our health education centers to increase their enrollments of persons from these areas will help provide a larger base of candidates that may have an interested in returning to their home communities upon graduation. We would suggest that these schools give a preference to students from these areas as a way to help combat the growing shortage and maldistribution of primary care providers.

Conditional Support:

Dixie Tooke-Rawlins D.O., Via Virginia College of Osteopathic Medicine commented: “There is a need to recruit students interested in serving rural communities that is recognized by all five schools.” The option should include Virginia College of Osteopathic Medicine and Virginia Tech/Carilion School of Medicine.

Option 7: When state revenue allows, introduce a budget amendment (language and funding) to allow the Department of Health Professions (DHP) to develop a Continuing Medical Education course focusing on medication issues of geriatric patients targeted for primary care physicians. The objective would be for the course to be offered online and at no cost to Virginia licensed physicians.

Support: 5
Conditional Support: 0

Oppose: 0

Option 8: Request by letter of the JCHC Chairman that the Board of Medicine include and promote geriatric care issues among its online educational resources.

Support: 4

Conditional Support: 1

Oppose: 0

Conditional Support:

Thomas W. Eppes, Jr., M.D, Medical Society of Virginia commented: The Board of Medicine promote geriatric care issues through the most appropriate venues. The Board currently works with a variety of entities to develop and distribute educational information.

Option 9: Request by letter of the JCHC Chairman that the Virginia Chapter of the American College of Physicians include and promote geriatric care issues among its online educational resources.

Support: 2

Conditional Support: 1

Oppose: 0

Conditional Support:

Thomas W. Eppes, Jr., M.D, Medical Society of Virginia commented: Virginia Chapter of the American College of Physicians should promote geriatric issues through the most appropriate venues.

Option 10: Request by letter of the JCHC Chairman that the Virginia Academy of Family Physicians continue to promote geriatric training among its membership.

Support: 4

Conditional Support: 0

Oppose: 0

Option 11: Include in the 2010 JCHC work plan, a study of the prevalence, distribution and scope of practice for nurse-practitioners and physician assistants in Virginia.

Support: 2

Conditional Support: 0

Oppose: 2

In Support:

Janet McDaniel, Ph.D., M.P.H., Workforce Council for Virginia's State Rural Health Plan commented: In rural areas, mid-level practitioners are an important part of the health care infrastructure. As part of the research in this study, we hope that state comparisons of scopes of practice will be included. We believe other states have determined good ways to utilize and expand access to services with these practitioners.

In Opposition:

Thomas W. Eppes, Jr., M.D, Medical Society of Virginia commented: The Department of Health Professions currently has a workforce study underway which includes a focus on nurse practitioners and physician assistants. We suggest JCHC await the findings prior to beginning another study.

Option 12: Send a letter from JCHC Chairman to the Special Advisory Commission on Mandated Health Insurance Benefits to support SB1458 (Wampler) and HB2191 (Philips) which require health insurers, health care subscription plans, and health maintenance organizations provide coverage for the cost of telemedicine services.

Support: 7

Conditional Support: 0

Oppose: 0

In Support:

Karen S. Rheuban, M.D., Virginia Telehealth Network commented:

“Telemedicine is not a specialty unto itself – it is a tool to deliver care to those remote from needed services....The Commonwealth is home to at least 15 grant funded telemedicine networks located in urban and rural locations offering services across the disciplines. Ten states have adopted statutes and regulations to mandate third party private payment for telemedicine.” The Virginia Telehealth Network strongly supports this option.

Option 13: Request by letter of the JCHC Chairman that the Department of Human Resource Management consider and if appropriate conduct pilot programs for selected telemedicine-covered services within the state employee health insurance program. Consideration should be given to obstetric care for high-risk pregnancies, telestroke services, and telepsychiatry.

Support: 5

Conditional Support: 0

Oppose: 0

In Support:

Janet McDaniel, Ph.D., M.P.H., Workforce Council for Virginia's State Rural Health Plan commented:

“Telemedicine is of vital importance to ensuring timely and quality health care services in our rural communities. Use of telemedicine can greatly increase access to specialty care and mental health services in rural Virginia.”

Option 14: Request by letter of the JCHC Chairman that the Department of Behavioral Health and Developmental Services (DBHDS) report regarding the Department’s current and historical utilization of telemedicine and telepsychiatry services, effectiveness of such services, locations offering such services, use of telemedicine by CSB providers, and impediments to greater adoption and usage by the Department and CSBs. This letter would include a request that DBHDS present a report to JCHC by August 30, 2010.

Support: 4

Conditional Support: 0
Oppose: 0

In Support:

Mary Ann Bergeron, Virginia Association of Community Service Boards commented: "Telemedicine as well as telepsychiatry can help to bridge the geographic barriers to treatment faced by many of our rural CSBs."

Option 15: Introduce a joint-resolution requesting that JCHC convene a task force to review allowing qualified clinical psychologists to prescribe psychopharmacological medications and report to JCHC. The report will detail licensure and educational requirements, oversight structure, changes to licensure and regulatory oversight processes, medications that may be prescribed, requirements for physician review and/or oversight for prescribing medications. The resolution would require an interim report to JCHC in 2010 with a final report by September 1, 2011. Task force participants include:

- Board of Medicine
- Board of Pharmacy
- Board of Psychology
- Medical Society of Virginia
- Psychiatric Society of Virginia
- Virginia Psychological Association
- Virginia Pharmacists Association

Support: 2
Conditional Support: 0
Oppose: 9

In Support:

Anita L. Auerbach, Ph.D., RxP (Prescription Privledges) Task Force for the Virginia Academy of Clinical Psychologists commented: "According to government studies about 80-90% of prescriptions for mental health related drugs are provided by non-psychiatric physicians (primarily family practitioners and primary care practitioners) who have little more than 7-10 minutes per patient to try to make a diagnosis, and treat, and who have only about 7 weeks of training on the diagnosis and treatment of mental disorders" ...and "the Council on Graduate Medical Education the manpower shortage within psychiatry is projected to only get worse. Clinical psychologists already outnumber psychiatrists in Virginia by 2:1."... "Multiple studies have shown that for most mental health problems, a combination of psychotherapy and drug therapy (where indicated) is the most effective treatment." "Prescribing Psychologists have had an average of 7 years of doctoral training (including clinical internship and residency) in the diagnosis and treatment of mental disorders, **plus** have completed an additional 3 years of training in medicine/psychopharmacology including over 400 contact hours of post-doctoral training in clinical psychopharmacology, and a year-long 100 patient internship with years more of collaborative practice with a physician. (As

reported by a national association of medical schools, the average medical student receives just 99 hours of pharmacology training).

Prescribing Psychologists have been practicing independently throughout the military (Army, Navy, Air Force, Marines) for the past 15 years, and in more recent years the Public Health Service, New Mexico, Louisiana and Guam.

Presently 9 more states have similar pending legislation under consideration.

Prescribing Psychologists have written tens of thousands of prescriptions including refills and the number of serious adverse outcomes or licensing board complaints: **ZERO**.

Prescribing Psychologists are already one of the most highly trained mental health professionals and are preeminently able to provide **Integrated Care** as a combination of psychotherapy and the conservative use of medication by the same doctor - shown to be the best and most cost-effective treatment for all mental disorders.

In Opposition:

James F. Dee, M.D., Northern Virginia Chapter of the Washington Psychiatric Society commented: Even in limited settings, clinical psychologist prescribing medication lowers the standard of care and endangers patient safety. Clinical psychologists are important partners to psychiatrists in mental health care but they do not have the necessary medical education and training that would enable safe prescribing. And, abbreviated courses in pharmacology cannot provide the important prerequisite skills.

As a physician and a pharmacist, I personally find it frightening that these complex and potentially dangerous drugs could be under the authority of persons who could not treat the complications that often occur even when properly chosen and prescribed. Moreover, as psychiatric medicines rapidly advance and develop, concern about overprescribing should dissuade us from expanding prescriptive authority. In fact, we should encourage more prudent and more coordinated professional judgment rather than less in the interest of convenience.

Mira Singer, National Alliance on Mental Illness commented: "Graduate education for psychologists largely favors a social and behavioral approach that trains psychologists to conduct assessments and provide psychotherapy, not to provide medical treatment. While the social and behavioral aspects are critically important, so too is the unique medical training that psychiatrists receive in treating mental illness. Further, psychotropic medications that are used to treat mental illnesses are powerful and can cause potentially disabling side effects, and require particular expertise among those who prescribe and monitor them. The experience and expertise in monitoring complex medication interactions are critical when taking into account that over 50% of individuals with mental illnesses prescribed psychotropic medications also have other serious medical conditions requiring medications. "

Option 16: Request by letter of the JCHC Chairman that the Department of Health Professions improve the information collected and compiled about clinical psychologists which is retained in the Healthcare Workforce Data Center.

Support: 3

Conditional Support: 1

Oppose: 0

Conditional Support for Options 16 and 17:

Janet McDaniel, Ph.D., M.P.H., Workforce Council for Virginia's State Rural Health Plan commented: "Additional data on our workforce is always helpful to informing our future efforts for training, retention, and recruitment. However, we believe that there needs to be clarification about what "important information" will be collected related to clinical psychologists and how to "improve the information" about dentists. Once this has been determined, we suggest that data for all professions be reviewed and examined.

Option 17: Request by letter of the JCHC Chairman that the Department of Health Professions improve the information collected and compiled about dentists which is retained in the Healthcare Workforce Data Center.

Support: 3

Conditional Support: 1

Oppose: 0

Conditional Support:

See Janet McDaniel's comment in Option 16

Option 18: When state revenue allows introduce a budget amendment (language and funding) to extend basic dental benefits to adults eligible for Medicaid.

Support: 6

Conditional Support: 0

Oppose: 0

In Support:

Terry Dickenson, D.D.S., Virginia Dental Association commented: "With a history of seeing and treating this population via the MOM Project, it is clear that there is an immense need for these services in the adult Medicaid population. ...We certainly have become more aware of the relationship between the inflammatory response due to dental disease and certain systemic diseases, in particular diabetes, cardiovascular disease and pulmonary disease. For a population that struggles for medical care, the challenges of receiving needed dental care can be overwhelming to this population. We believe a healthier workforce, which includes oral health, is essential for healthy communities and the economics of those communities."

Option 19: Request by letter of the JCHC Chairman that the Virginia Pharmacists Association, the Virginia Department for the Aging, and local area agencies on Aging collaborate to provide and disseminate information about Medicare's Medication Therapy Management (MTM) program to pharmacists, prescription counselors, and Medicare beneficiaries that qualify for MTM services.

Support: 2

Conditional Support: 0

Oppose: 0

Appendix C

Full-text of Comments Supporting and Opposing Options 11 and 15

	Option 11	Option 15
Medical Society of Virginia	Oppose	Oppose
Asha S. Mishra, M.D.		Oppose
National Alliance on Mental Illness		Oppose
Northern Virginia Chapter of the Washington Psychiatric Society		Oppose
Psychiatric Society of Virginia		Oppose
RxP (Prescription Privileges) Task Force for the Virginia Academy of Clinical Psychologists		Support
Robert E. Strange, M.D.		Oppose
UVA Health System	Support	
Via Virginia College of Osteopathic Medicine	Oppose	Oppose
Virginia Chapter of the American Academy of Child and Adolescent Psychiatry		Oppose
Virginia Association of Community Psychiatrists		Oppose
Workforce Council for Virginia's State Rural Health Plan	Support	Support

Appendix D

Public Comment: Additional Policy Options

Physician related

- Roger Hofford, M.D., Program Director of the Carilion Clinic Family Medicine Residency
- Peter J. Pagnussi, M.D., President of the Virginia College of Emergency Physicians
- Dixie Tooke-Rawlins D.O., Dean and Executive Vice President of the Via Virginia College of Osteopathic Medicine

Mental Health related

- Dr. John Ball, Ph.D., Clinical Psychologist
- Mary Ann Bergeron, Executive Director of the Virginia Association of Community Service Boards
- Catherine Bodkin, Licensed Clinical Social Worker
- James F. Dee, M.D. , President of the Northern Virginia Chapter of the Washington Psychiatric Society
- Janet McDaniel, Ph.D., M.P.H., Chair of the Workforce Council for Virginia's State Rural Health Plan
- Debra A. Riggs, Executive Director of the Virginia Chapter of the National Association of Social Workers
- Cathleen A. Rea, Ph.D., Chair of the Licensure Task Force for the Virginia Academy of Clinical Psychologists
- Mira Singer, Executive Director of the National Alliance on Mental Illness
- Bela Sood, M.D., President of the Virginia Chapter of the American Academy of Child and Adolescent Psychiatry
- James L. Werth, Jr. Ph.D., Professor of Psychology and Director of the Doctor of Psychology Program in Counseling Psychology, Radford University

Dental related

- Ellen Austin-Prillaman RDH, President of the American Dental Hygienists' Association
- Terry Dickenson, D.D.S., Executive Director of the Virginia Dental Association

Physician related

- **Roger Hofford, M.D., Program Director of the Carilion Clinic Family Medicine Residency**

“Over the last six years our state funding has decreased significant to support family medicine residency training...with a worsening payor mix of patients served, and decreased Federal funding for graduate medical education. In the state budget language this money can be used to pay for medical students rotations in family medicine. I would ask the Joint Commission/General Assembly look at whether these monies for students are accomplishing the outcomes we need at the expense of our state supported family medicine residencies.”

Regarding DMAS reporting on an enhanced medical education funding for selected specialties (Option 4), JCHC should review how South Dakota uses their state line item funding to obtain a Federal match.

- **Peter J. Pagnussi, M.D., President of the Virginia College of Emergency Physicians**

For the Loan Repayment programs, we request that “JCHC examine the option of adding ‘emergency medicine’ as one of the allowable practice areas eligible for loan repayment. Currently, emergency medicine is not included and, in light of presentation highlighting emergency medicine as a physician shortage area, we believe it should be added.”

Related to Option 5, we support introduction of a budget amendment (language and funding) “to increase Medicaid reimbursement rates for emergency physicians. Family practice physicians and emergency physicians have the lowest reimbursements in the state. And, unlike family practice physicians who can stop taking Medicaid patients, emergency physicians have to treat everyone at all times, according to the Federal EMTALA law and cannot turn anyone away.”

- **Dixie Tooke-Rawlins D.O., Dean and Executive Vice President of the Via Virginia College of Osteopathic Medicine**

Loan repayment program monies in Option 2 “should be restored in time for those residents who finish in July 2010 to receive the loan repayment as they enter rural primary care practices. Finally considering the shortages for primary care that exist, the definition of rural should be expanded to include all communities of less than 25,000 and who are over 30 miles from the nearest urban area; and the designation of underserved should be expanded to include the Community Health Centers or Federally Qualified Health Centers so to reach those in most need. These changes would greatly enhance access in rural Virginia. Although this does not match the federal definition, the federal definition does not accurately define rural in Virginia. (an example is Craig Co. which is not considered a rural medically underserved area.)”

“I support increasing funding to the residencies [referenced in Option 3] as they enroll students from all four medical schools in the state who have graduates. I do however request that the funding provided be equally distributed to the all of the family medicine residencies throughout the state. This would include the EVMS and VCOM sponsored family medicine residency programs as well and be distributed according to the number of programs and residents.”

“As state funding is currently limited and “tough decisions” are called for by the General Assembly, re-allocation of funds to support rural residencies might be redirected from programs such as GMEC, which was established to provide a rural rotation for residents in urban primary care programs. GMEC which costs the State over 295,000 per year has only had 20 participating residents locate in Southwest Virginia since 1998. It would be the time to redirect the Graduate Medical Education Consortia to assist new rural primary care residency training programs or rural fellowships where retention in rural areas would be much greater.”

“VCOM is in favor of improving the education of the healthcare workforce in caring for Geriatric patients however this could be done with little or no cost to the State. All five medical schools have Geriatricians on campus and are capable of providing CME. The amendment should call for the State’s Medical Schools (public and private) to provide specific hours of CME on care of the Geriatric patients. The current medical schools and allied health schools would be a greater resource in developing the programs and providing the appropriate CME credits to the participants. If the State believes that a mandate is needed to further Geriatric care then asking that the CME be submitted to the State Medical Licensing Board at the time of renewal may be warranted.

Mental Health related

- **Dr. John Ball, Ph.D., Clinical Psychologist**

Some avenues to address shortages include “protecting and even expanding state funding for the training of new mental health clinicians in programs at EVMS and elsewhere and perhaps an expanded utilization and supported healthcare reimbursement structure for telemedicine in the area of mental services to improve access to care in rural environments.”

Also, the Virginia Board of Psychology is being urged to eliminate their pre-licensure requirement of a one year post-doctoral residency in clinical psychology for new graduates who have already met both 1500 practicum training hours during graduate school and a full time in-residence clinical psychology internship. Any JCHC support of the Board of Psychology eliminating the requirement for a post-doctoral residency year as a prerequisite to licensure would be appreciated.

- **Mary Ann Bergeron, Executive Director of the Virginia Association of Community Service Boards**

“The VACSB would be supportive of a rate increase in reimbursement for any services related to community mental health services and/or treatment.”

- **Catherine Bodkin, Licensed Clinical Social Worker**

“Licensed clinical social workers ...provide more than 50% of the mental health services, especially in rural areas and with low income families... [Licensed clinical social workers] are a vital part of the Commonwealth's substance abuse and mental health system. No report is complete without considering their role in services and the need to support loan repayment programs similar to nurses, doctors, and clinical psychologists. I hope the Commission will request that future studies include statements about the role of licensed clinical social workers in order to be able to accurately assess the system changes that are needed.”

- **James F. Dee, M.D. , President of the Northern Virginia Chapter of the Washington Psychiatric Society**

“There are better ways to build the psychiatric workforce and expand access to mental health care [than Option 15]. Policymakers should support robust psychiatric residency programs that will build a highly-qualified professional population. These programs should include placement requirements for residents to practice in underserved areas. Reimbursement policies should encourage use of technology and the existing workforce to expand telepsychiatry. Collaborative practice arrangements between pediatricians and psychiatrists can establish consultation networks between frontline primary care and subspecialty experts. And, public and private insurance coverage should be required to reflect the public’s need and demand for psychiatric services, especially as patients seek early intervention for mental illness.”

- **Janet McDaniel, Ph.D., M.P.H., Chair of the Workforce Council for Virginia's State Rural Health Plan**

“We suggest working with the insurance companies to reimburse for services provided by doctoral students in clinical psychology programs who are under the supervision of an appropriately credentialed mental health or medical professional. We encourage looking at how other states reimburse care provided by students who are closely supervised by licensed mental health providers (e.g. Ohio).”

- **Debra A. Riggs, Executive Director of the Virginia Chapter of the National Association of Social Workers**

“Each state determines what areas of social work practice are protected by law. It is those discrepancies that allow anyone to identify himself as a social worker despite their qualifications. As an example, fewer than 40% of child welfare workers are professional social workers. This threat to the professionalism of social work has encouraged advocacy within the field for greater protection of the public through a combination of practice and title protection laws with limited exceptions or exemptions to legal requirements. Social Work practice protection refers to licensure laws that require all those who act as social workers to be licensed thus protecting the specific actions performed by social workers by ensuring that only qualified individuals carry out social work functions. A Title protection statute protects a specific social work title, such as Licensed Master Social Worker, from being used by anyone that does not meet the legal definition of a social worker for that level of licensure.”

Also NASW requests “a letter from the JCHC Chairman that the Department of Health Professions improve the information collected and compiled about clinical social workers for the Healthcare Workforce Data Center.”

- **Cathleen A. Rea, Ph.D., Chair of the Licensure Task Force for the Virginia Academy of Clinical Psychologists**

The Virginia Academy of Clinical Psychology strongly recommends that the Joint Commission formally encourage the Board of Psychology to proceed in due haste with promulgation of regulations to eliminate the requirement for a post-doctoral residency year as a prerequisite to licensure.

- **Mira Singer, Executive Director of the National Alliance on Mental Illness**

NAMI believes that public policy on workforce shortage issues should on the underlying obstacles that prevent people from entering the mental health field and should create incentives to attract and retain qualified professionals.

Recommended measures that can be considered include:

- Providing scholarships or stipends to psychiatrist trainees, psychologist trainees, and other mental health professional trainees who commit to providing services to people with mental illnesses in under-served regions or sectors;
- Establishing and expand loan forgiveness programs for psychiatrists, psychologists and other mental health professionals who serve for particular periods in under-served regions;
- Mental health insurance parity for better coverage and access to care;
- Paying adequate wages to case managers, counselors, and other important but traditionally inadequately compensated mental health professionals to retain qualified and dedicated individuals in the field; and

- Employing consumers and family members in a variety of capacities in the mental health field whenever possible, such as peer counselors, support positions, etc.

- **Bela Sood, M.D., President of the Virginia Chapter of the American Academy of Child and Adolescent Psychiatry**

VA AACAP with our “pediatrician colleagues, we have advocated for support of collaborative arrangements that would provide primary care physicians with professional consultations for the complex cases they face in underserved regions – a model of success in other states. We have forwarded these proposals to the Secretary of Health and Human Resources and the Commissioner for Mental Health on several occasions. They have acknowledged these proposals as being viable but have not funded them citing financial shortfall in the state budget. Hence, if any funds should be appropriated, they should be made available for funding “shovel ready” proposals like the Collaborative pediatric/primary care child mental health initiatives to meet the challenges of work force shortages by training pediatricians and not studies for training non medical colleagues.”

- **James L. Werth, Jr. Ph.D., Professor of Psychology and Director of the Doctor of Psychology Program in Counseling Psychology, Radford University**

“Typically insurance does not reimburse for services until Clinical Psychology graduate is licensed.” A solution that would immediately serve to significantly increase access and availability would be to work with the insurance companies to reimburse for services provided by doctoral students in psychology programs who are under the supervision of an appropriately credentialed mental health or medical professional.

To work through issues regarding insurance reimbursement a joint resolution requesting that JCHC convene a task force to review the implications of providing insurance reimbursement for psychology doctoral students, pre-doctoral interns, and post-doctoral residents could be introduced. The report would detail financial implications for insurers, access and availability implications for citizens, and potential likelihood of retaining psychology doctoral program students, interns, and residents in the Commonwealth through and after licensure as Clinical Psychologists. The resolution would require an interim report to JCHC by June 30, 2010 with a final report by December 31, 2010. Task force participants would include:

- Board of Psychology
- Virginia Psychological Association
- Bureau of Insurance
- Doctoral Training Program representatives
- Health insurance company representatives
- Mental Health service agencies

Dental related

- **Ellen Austin-Prillaman RDH, President of the American Dental Hygienists' Association**

“VDHA requests that Policy Option 17 be amended to include dental hygienists. We support any effort that will help the Department of Health Professions to improve and expand the information they have on dental professionals.”

“We would also urge the Joint Commission to study and promote innovative use of technology and expanded duty dental hygienists. There are advancements in teledentistry in Texas and Alaska. Advanced dental hygiene practitioners (ADHP) are expanding access to services in states including Washington, Minnesota, and others. Virginia is fortunate to have rich resources in our dental hygiene programs - we are one of the very few states that have a Masters Degree Program in Dental “Hygiene. The programs put us in a great position to embrace the future of implementing solutions to get the most from our dental workforce.”

- **Terry Dickenson, D.D.S., Executive Director of the Virginia Dental Association**

“[VDA] recommend a more robust safety net via the Department of Health and its health districts- in particular, its dental segment. Dental public health is a critical and necessary part of healthy communities and its dentists serve a vital part in bringing the message of prevention to these communities. Without a sustainable dental public health system, we will continue to struggle with a workforce that doesn't meet the needs of its most vulnerable citizens.”

“[VDA also] recommends the restoration of funding for the loan repayment program as we have seen excellent results in the placement of dentists in the more rural and remote areas of the state. Without this funding, we will continue to struggle to incentivize our dentists, often with heavy debt loads, to locate in communities where there are extreme needs but economies that challenge the successful business plan of a dental practice. Loan repayment programs have been shown to enhance the ability of communities to attract young dentists into moving into those areas with high dental needs. The workforce issue isn't and can't be simply about the numbers- we must continually look for ways to incentivize our young practitioners to consider practicing in communities that have these high needs, but struggle having an environment for successful businesses.”

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