Joint Commission on Health Care

Decision Matrix

December 19, 2007
Revised

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 2007.

B. To develop Commission recommendations to advance to the 2008 General Assembly.

Joint Commission on Health Care
Decision Matrix

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Review of Presentations

Staff Report:
Impact of Barrier Crime Laws on Social Service and Health Care Employers

Background

SJR 106 of the 2006 General Assembly Session directed the Joint Commission on Health Care (JCHC) to study the impact of barrier crime laws on social service and health care employers, and to present its findings to the Governor and the 2008 General Assembly. Barrier crime laws prohibit persons convicted of certain statutorily-defined crimes from obtaining employment with employers specializing in the care of vulnerable populations, such as children, the elderly, and those with mental disabilities.

Virginia's Barrier Crime Laws

The following crimes listed in the *Code of Virginia* §63.2-1719 and §37.2-314 are barrier crimes for all social service and health care entities. The 89 felonies include:

- Murder,
- Abduction,
- Assaults & Bodily Wounding,
- Carjacking,
- Threats of death or bodily injury,
- Arson,
- Use of Machine Gun,
- Use of Sawed-off Shotgun,
- Incest,
- Abuse & Neglect of Children,
- Possession of child pornography,
- Abuse & Neglect of Incap. Adults,
- Escape from Jail, and
- Malicious Wounding by mob,
- Abduction for Immoral Purpose,
- Robbery,
- Felony Stalking,
- Sexual Assault,
- Drive-by Shooting,
- Aggressive use of Machine Gun,
- Pandering,
- Taking Indecent liberties, custodial relationship,
- Poss. of Pornography with intent to distribute,
- Electronic Facilitation of Pornography,
- Delivery of Drugs to Prisoners
- Felonies by Prisoners.

The 21 misdemeanors that can be barriers to employment include hazing, simple assault, failure to secure medical attention, employing or permitting a minor to assist in an act constituting an obscenity offense, arson and sexual battery. Additional barrier crimes, such as burglary, extortion by threat and drug related felonies apply only to child welfare agencies, foster and adoptive homes, children's residential facilities, as well as CSBs, BHAs and DMHMRSAS employees in direct consumer care positions. (*Code of Virginia* §37.2-314).

Options

Option 1: Take no action.

One comment was received in support of Option 1.

> The Eastern Shore Community Services Board believes "having these crimes clearly delineated with legislative authority is the best practice."

Option 2: Introduce legislation to remove the barrier crime provisions from *Code*

of Virginia §§37.2-506, 37.2-416 and allow CSBs, BHAs and DMHMRSAS to consider the entire criminal background record, along with all other relevant information, when hiring persons in direct consumer care positions in adult mental health and/or substance abuse programs. This would have the effect of removing all barrier crimes placing the full responsibility for making the hiring decision on the employing entity.

- As this study was requested by the CSBs, this option reflects the desire of the majority of CSBs.
- This option would allow only CSBs and DMHMRSAS-licensed providers to consider the entire criminal background record, along with all other relevant information, when hiring persons in direct consumer care positions in adult mental health and/or substance abuse programs. This option would remove the reference to the barrier crimes statute (*Code of Virginia* §37.2-314) in these two statutes only.
- *14 comments were received in support of Option 2.*
  The Virginia Association of Community Services Boards and the McShin Foundation support this option.
  One comment suggested the possibility of requiring due diligence on the part of the employer.
  The majority felt this option "would create no added risk to consumers" because these employers already maintain "scrupulously careful screening procedures to protect consumers;" and this option would allow employment for "many qualified, capable people in stable, long-term recovery who have been prevented from pursuing their careers because of a barrier crime in their long-ago (often 20-30 years) history."
  One comment supports this option, if the barrier crimes remain in the *Code* as a guideline.

Option 3: Introduce legislation to amend the *Code of Virginia* §§37.2-506, 37.2-416 to allow for a rehabilitation assessment for any applicant who has been convicted of a barrier crime, unless the offense was intentional violent harm against an adult or child, to work in adult substance abuse or adult mental health treatment programs.

- This option would expand the list of barrier crimes that would allow for a rehabilitation assessment. These barrier crimes now would include additional misdemeanor offenses such as, hazing, simple assault, sexual battery, arson, and abuse and neglect. It would also allow a person to be assessed after a felony conviction of involuntary manslaughter related to driving while intoxicated.
- This option would apply to persons applying to work in adult substance abuse or adult mental health treatment programs only.

10 comments were received in support of Option 3.

The Virginia Association of Community Services Boards supports this option, although Option 2 is their first choice.

One comment supports this option, but with the consideration that the potential for any repeat violent behavior be addressed during the assessment. Additionally, the assessment should be given initially and as needed.

One comment was received in opposition.

Option 4: Introduce legislation to amend *Code of Virginia* §§37.2-506, 37.2-416 to provide a screening option for consumers with serious mental illness to be assessed for employment in adult mental health and/or adult substance abuse treatment centers.

- This option would provide a screening option, similar to the one provided for consumers with substance use disorder in §§ 37.2-506(C) and (D), 37.2-416 (C) and (D), for consumers with serious mental illness to be assessed for employment in adult mental health programs and/or adult substance abuse treatment centers.

Four comments were received in support of Option 4.

Two comments opposed this option.

One person expressed discomfort with the use of the term "consumer" rather than "prospective employee," and the other felt that the entire option was discriminatory.

☑ **Option 5:** Introduce legislation to amend *Code of Virginia* §§37.2-506, 37.2-416 to allow persons convicted under §§18.2-57(A) and 18.2-57.2(A) to also be assessed for rehabilitation as set forth in §§37.2-506(C) and (D), 37.2-416(C) and (D); Specify that the rehabilitation assessment will apply only to persons seeking employment in adult substance abuse programs and adult mental health programs and that the criminal behavior was substantially related to the substance abuse disorder and/or mental illness.

- THIS OPTION WAS ADDED IN NOVEMBER.
- This option would now allow persons convicted of misdemeanor assault and battery under §§ 18.2-57 and 18.2-57.2 to also be assessed for rehabilitation.
- It specifies that the rehabilitation assessment will apply to persons seeking employment in adult substance abuse programs and adult mental health programs, and that the criminal behavior was substantially related to the substance abuse disorder and/or mental illness.

VACSB indicated its full support for Option 5.

Staff Report:
Increasing the Availability of Health Insurance Providers in Rural Areas

Background

House Bill 1324 of the 2006 General Assembly Session directed the Commissioner of Insurance to prepare a plan to double the level of competition among providers of health insurance products in the Commonwealth's rural areas. The bill was passed by in the House Commerce and Labor Committee and a letter was sent requesting a JCHC study of the issues.

Rural Challenges

Some of the known challenges in health care for rural areas are:

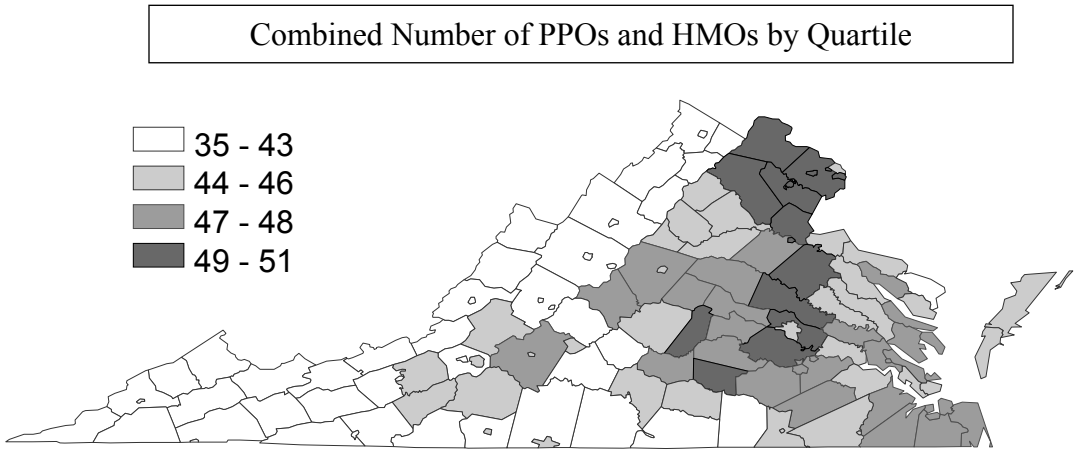
- Difficulty in establishing a network with so few health care providers
- Lack of primary care providers
- Lack of medical care specialists
- Fewer economies of scale available for insurers
- Fewer than half of small employers provide employer-sponsored coverage to employees
- Higher percentage of small businesses
- Higher percentage of the population unemployed
- Lower per capita income
- Higher rate of population at 200% or below FPL

When rural is defined as localities with less than 120 people per square mile; distinct differences emerge between rural and non-rural localities.

		Rural Localities	**Non-rural Localities**
2000 Localities' persons per square mile	Average	61	1,106
	Median	*56*	*326*
2004-05 Median family income	Average	$38,596	$51,341
	Median	*$36,375*	*$46,890*
2004-05 Rate of population 200% or below the Federal Poverty Level (FPL)	Average	32.1%	24.2%
	Median	*32.0%*	*21.5%*
2004-05 Unemployment rate	Average	4.4%	3.8%
	Median	*4.4%*	*3.3%*
2004-05 Uninsured rate	Average	14.8%	13.4%
	Median	*14.8%*	*12.9%*

There are 20 HMOs that operate in Virginia; 18 are medical and 2 are dental.
There are 63 PPOs and 37 are medical or medical/dental.

All localities have at least 35 licensed and certified PPOs/HMOs. For rural areas, the average number of HMOs is 9 and for PPOs 34. For non-rural areas, the average is 12 and 35, respectively.



The lack of health insurers and products is not the leading issue in rural areas. Many of the previously mentioned health care issues facing rural areas are more important than further developing the health insurance market in these areas.

Some potential ways to increase insurers in rural areas are allowing a mandate-free health insurance product line and providing tax incentives for insurers to develop products for targeted areas.

Since cost is such an important factor in accessing health care coverage, one potential way to assist rural employers with the high cost of insurance coverage is to provide subsidies to rural small employers that provide health insurance to employees.

Options

Comments from the Virginia Association of Health Plans:

"VAHP appreciates this opportunity to comment on proposals slated for consideration by JCHC …. The research shows that rural residents have a choice between a minimum of 35 licensed PPOs and HMOs…. Despite a diverse selection of health insurers a number of other issues, including cost, affect an individual's access to care. To address access related issues such as cost, VAHP members are continually researching and developing new products."

The Governor's introduced budget includes funding of $2.6 million (GFs) in 2009 and $5.1 million (GFs) in 2010 for the VirginiaShare Health Insurance program. It would provide health insurance coverage for uninsured individuals who work in small businesses. The Commonwealth would provide premium assistance of up to one-third (not to exceed $75) of the costs, with one-third being paid by the employer and the remaining third being paid by the individual. Individuals with incomes ≤ 200 percent of the federal poverty level would be eligible. Over 5,000 Virginians are expected to gain health insurance through the program.

Option 1: Take no action

Option 2: Introduce legislation to exempt health insurance products provided in specific rural areas from having to include mandated coverage as required in *Code of Virginia* Title 38.2, Chapter 34.

Option 3: Introduce legislation to provide a partial tax exemption for accident and sickness insurance policies. This will allow for an exemption of 20% of an insurance provider's revenue earned from the policies that are issued after July 1, 2008 in the Counties of Carroll, Dickenson, Grayson, Halifax, Highland, Lee, Scott, Smyth, and Washington.

Option 4: Introduce a budget amendment of $520,000 GFs for each year of the 2008-2010 biennium to allow for a demonstration project to encourage small employers, operating in specific rural areas of Virginia, to begin offering health insurance for their employees.

The demonstration project would provide a subsidy to reimburse 33 percent of all employee health insurance expenditures paid by a small employer during the tax year. To qualify for the demonstration project, the employer would need to meet all of the following criteria:

- (principal business location) is located in Carroll, Dickenson Grayson, Halifax, Highland, Lee, Scott, Smyth, or Washington County;
- employs between 2-50 full-time employees;
- did not offer or subsidize employee health insurance prior to January 1, 2009.

The only health insurance premiums that would qualify for subsidy would be those premiums paid to an entity licensed by the State Corporation Commission that is (i) an insurer that issues individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, (ii) a corporation providing individual or group accident and sickness subscription contracts, and (iii) a health maintenance organization providing a health care plan for health care services.

☑ **Option 5:** Endorse the concept of subsidizing a health insurance product for uninsured Virginians.

Staff Report:
Health Care Costs

Background
SJR 4 of the 2006 General Assembly Session directed JCHC to examine "factors leading to rising health care costs in the Commonwealth; derivative effects of rising health care costs including increases in health insurance premiums and denial of coverage; and, ways to reduce health care costs in the Commonwealth and alleviate the burdens associated with the rising cost of health care." A report was presented to JCHC on October 19, 2006; however, specific findings were delayed until 2007.

Health Care Costs
Health care costs continue to rise. Spending has increased at an average annual rate of 9.8% since 1970.

- In the U.S., health care expenditures were $75 billion in 1970, $2.0 trillion in 2005 and are estimated to reach $4.0 trillion in 2015.
- Health care costs are not equally distributed across the population in that 10% of the population accounts for 70% of the costs and conversely 50% of population accounted for 3% of the costs.

In Virginia, $35.8 billion was spent on health care in 2004.

Health Insurance Premiums
Although health insurance premiums continue to increase, that increase was reduced to 6.1% in 2006 from its recent high of 13.9% in 2003. Larger firms offer health benefits more often than smaller firms as detailed below.

Percentage of Firms Offering Health Benefits (2006)

# Employees	% Offering Health Benefits
3 to 9	45%
10 to 24	76%
25 to 49	83%
50 to 199	94%
200 or more	99%
All Firms	**60%**

Approximately 77% of covered employees pay less than half of premium costs of their employer sponsored health insurance.
Virginia small group health plans are ranked 3rd most inexpensive in the U.S.

Average Monthly Premiums

	Virginia	United States
Individual Plan	$246	$311
Family Plan	$645	$814

States Affordable Cost Strategies
Many states have devised strategies to make health care costs affordable and Virginia has undertaken some of these strategies.

State Affordable Cost Strategies	Virginia Initiative
Pooled Purchasing	HB761(2006)- Health Group Cooperatives
Consumer driven plans -HSAs	Established in 2005
Examining insurance mandates	Special Advisory Commission on Mandated Health Insurance Benefits
Decrease health care acquired infections	Virginia Improving Patient Care and Safety (VIPCS)
	July 1, 2008 hospitals will report certain types of infections
Cost transparency & disclosure	Virginia Health Information (VHI)

One additional strategy that Virginia could consider would be to require that employers offer 125 plans with a state insurance connector.

- Section 125 plans allow for pretax monies to go toward health insurance.
- For example, a 125 plan can save the employee $1,140 per year on the purchases of a $3,000 health insurance plan (assuming the employee earns $50,000 and was taxed at a combined total of 38% rate for federal, state, Medicare, FICA taxes).

For employees that do not have an employer with a Section 125 plan, they must use after tax earnings to purchase most types of health insurance.

Another strategy is states providing significant financial assistance for many of its citizens to become insured. This is expected to decrease health care premium costs because uninsured health care costs are partially paid for by the insured.

Virginia Reports Reviewed
During this study, many reports were reviewed including two Virginia specific reports. The JLARC study *Options for Extending Health Insurance to Uninsured Virginians* explained a number of options including the positive and negative effects of the option. The options included:

- Allowing small employers to utilize State employee or Local Choice health plans
    - Makes providing insurance more affordable and attractive by reducing premium and administrative costs
    - Leads to higher premiums for State and Local Choice employees, increased administrative burden and costs for the State
        - Small employers would still incur substantial premium costs
- Establishing a market exchange that small employers could designate as their employer plan
    - Could encourage more small employers to offer health insurance because it would provide the opportunity to offer pre-tax employer contribution without any administrative responsibilities
    - Eliminating the administrative burden may not provide sufficient incentive to offer health insurance
- Expanding Medicaid/FAMIS eligibility
    - Allows Virginia to cover more low-income individuals
    - Expands the use of federal matching funds
    - Adds costs to the State
- Providing direct subsidies to low-income individuals to purchase health insurance
    - Fills gap between what some individuals can afford and the price of insurance
    - Requires substantial subsidy for individuals to engage
    - Adds costs to State
- Providing subsidies to small employers
    - Could provide through tax incentive or direct payment
    - Could require that employers contribute to employees' health insurance
    - Would require substantial subsidy for small employers to engage
    - Would add costs to State

The *Governor's Health Reform Commission's Roadmap for Virginia's Health* also provided options that would affect health care costs. One option was to create a private health insurance product for working uninsured Virginians and small businesses who have limited access to other health insurance options. It would be available to uninsured individuals who work for small employers that have not offered health insurance for at least the last 6 months. Specifics of the option include:

- $50,000 capped health care insurance policy
- $135 estimated monthly premium
- Those under 200% of the Federal Poverty Level
    - 1/3 paid by employer
    - 1/3 paid by employee

    - 1/3 paid by Commonwealth
- Individuals over 200% FPL can purchase w/o a State contribution
- Estimated cost to the Commonwealth $20,000,000

Governor's Health Reform Commission also recommended that the Health IT Council assist Virginia Health Information (VHI) in developing a consumer-friendly portal for all Virginians that would be a clearinghouse for health care quality, pricing and literacy.

Options

Option 1: Take no action

Option 2: Request by letter of the Chairman that the Joint Commission convene a workgroup to develop a plan i) establishing a Virginia health insurance exchange targeted for small businesses, ii) increasing employer adoption of Section 125 plans, and iii) any other health insurance issues as deemed appropriate. A report to JCHC would be due by November 2008.

Workgroup will include:

- Bureau of Insurance representatives
- Health insurance brokers representatives
- Health insurers representatives
- Small business employers representatives

☑ **Option 3:** Include in the 2008 JCHC work plan a study of the advisability of: i) establishing a Virginia health insurance exchange targeted for small businesses, ii) increasing employer adoption of Section 125 plans, and iii) any other health insurance issues as deemed appropriate. A report to JCHC would be due by November 2008.

Presentation on Amyotrophic Lateral Sclerosis (ALS)

Ken Nicholls
Executive Director
ALS Association—DC/MD/VA Chapter
*This summary of Mr. Nicholls' presentation uses his wording except for any underlined wording.

Facts about ALS

- Progressive, always fatal, neurodegenerative disease; attacks nerve cells and pathways in brain and spinal cord
  - About 30,000 Americans have ALS at any given time; 5,000+ new cases each year
  - Average age of onset is 55
  - Commonly known as Lou Gehrig's Disease
  - Average life expectancy 2-5 years
  - Not just Lou Gehrig's disease – ALS occurs throughout the world with no racial, ethnic or socioeconomic boundaries
  - *NO KNOWN CAUSE OR CURE*

Factors Linked to ALS

- Aging
- Genetic predisposition
- Military Service
- Other potential factors:
  - Smoking
  - Exposure to environmental toxins
  - Athletic activities

The ALS Association: Who we are

The ALS Association's mission is to lead the fight to cure and treat ALS through global, cutting edge research, and to empower people with Lou Gehrig's Disease and their families to live fuller lives by providing them with compassionate care and support.

- **The ALS Association—DC/MD/VA Chapter**
  - Part of a national organization with over 40 chapters across the country; serving all of Virginia, Maryland, and DC
- ***All… services are offered free of charge:***
  - Individual support/home visits
  - Information & referral
  - Support groups
  - Medical equipment loan closet
  - Respite care grants
  - Transportation grants
  - Augmentative communication/assistive technology services
  - Multidisciplinary ALS clinic
- **Needs of the ALS Community are Great**

- Cost of care for an ALS patient can cost the family upwards of $200,000 per year
- Custodial care disease – most patients remain at home and cared for by family

- **How the Commonwealth can support families living with ALS**
  - **Home based care program –** case management funding to provide home visits, crisis intervention, and to work with local, state, and federal agencies on Medicare/insurance and social security issues.
  - **Assistive Technology Program –** [u]p to 75% of ALS patients lose their ability to communicate. The program provides augmentative communication and computer access services by a certified Assistive Technology (AT) Specialist working with Speech Language Pathologists (SLP) contractors.
  - **Transportation Program –** [p]rovide funds for wheelchair accessible transportation for patients' who have no other means of getting to medical appointments, support groups, or other Chapter related services.
  - **Medical Equipment Loan Program –** [m]any expensive pieces of medical equipment required by ALS patients are not covered by insurance. To offset the cost of the disease, the Chapter loans medical equipment and supplies to patients. Over 1,000 items are loaned each year and the Chapter incurs the cost to clean, repair, and deliver the equipment.
  - **Multidisciplinary ALS Clinic at UVA –** [p]rovide support to the only multi-disciplinary ALS Clinic in the Commonwealth of Virginia in order to [e]xpand hours, allowing access to clinic services by more PALS, more frequently; ALS can progress rapidly, requiring regular monitoring and support.

JCHC Staff Addition:
Contacts were made with the Department of Rehabilitative Services (DRS) and the University of Virginia. DRS officials indicated that a very small number of individuals with ALS apply for and receive services through such programs as rehabilitative case management and personal assistant services. DRS officials believe that few individuals with ALS know of the services and noted that they would be subject to the waiting list and associated long wait for services that others with need for the services experience. It is more likely that individuals with ALS would seek care through the ALS Association and/or from the Richard Dart Clinic at the University of Virginia given the waiting lists and the fact that some needed services such as transportation are not available through DRS.

The ALS Association has helped to fund the services provided by the Richard Dart Clinic at UVa for the last three years and has paid for a social worker to work at the clinic whenever it is open. The Clinic currently operates two to three Wednesdays a month from 1:00 pm to 4:00 pm. The Association has budgeted between $20,000 and $25,000 to support Clinic services next year. In requesting that the General Assembly provide $100,000 per year during the 2008-2010 biennium for the Richard Dart Clinic, the ALS Association hoped the Clinic would be able to expand its hours to serve additional ALS patients.

Options

Option 1: Take no action.

The Governor's introduced budget includes funding of $50,000 GFs for the second year of the biennium for the ALS Association via a State grant to a nonstate entity.

Option 2: Introduce a budget amendment to provide funding for each year of the 2008-2010 biennium to allow the ALS Association—DC/MD/VA Chapter to provide one of more of the following services:

2A.	Home-based care program	$375,000 GFs
2B.	Assistive Technology Program	$150,000 GFs
2C.	Susan Brown Transportation Program	$ 50,000 GFs
2D.	Medical Equipment Loan Program	$ 75,000 GFs
TOTAL		**$650,000 GFs**

☑ **Option 3**: Introduce a budget amendment to provide funding of $100,000 GFs for each year of the 2008-2010 biennium for the Richard Dart ALS Clinic at the University of Virginia.

Option 4: Introduce a budget amendment (language only) recognizing that the services needed by individuals with Amyotrophic Lateral Sclerosis (ALS) should be supported in the adopted budget whenever possible.
(THIS OPTION WAS ADDED IN NOVEMBER)

VDH Report on Human Papillomavirus (HPV) Vaccine

Dr. Carl Armstrong
Office of Epidemiology, Virginia Department of Health

*This document is a summary of Dr. Armstrong's presentation. Efforts were made to communicate the information presented clearly and accurately. The exact wording from the presentation was used when possible.

Office of Epidemiology, Virginia Department of Health Future Plans:
The Division of Immunization is also developing a three-pronged educational and outreach initiative targeting: a) the parents of preteens and adolescents; b) all females 11-26 years of age; and c) health care providers administering care to preteens and adolescents. As required by the enactment of HB2035 and SB1230 from the 2007 session of the General Assembly, educational material will be distributed through local health departments statewide and, through a partnership with the Department of Education, to all 132 school districts. The educational material will inform parents about HPV and its association with cervical cancer, why they should consider vaccinating their children, the risks and benefits associated with vaccination, and whom to contact if they need additional information. Information provided to physicians will be tailored to their areas of specialization (i.e. pediatricians vs. gynecologists).

Health departments will tabulate from school records the number of students that have received the vaccine. School and health department officials will assume that the parents of students for whom there is no record of HPV vaccination have elected to not have their children immunized against HPV.

These expanded vaccination and educational/outreach initiatives will be supported by the $1.4 million first appropriated by the General Assembly for FY 2008.

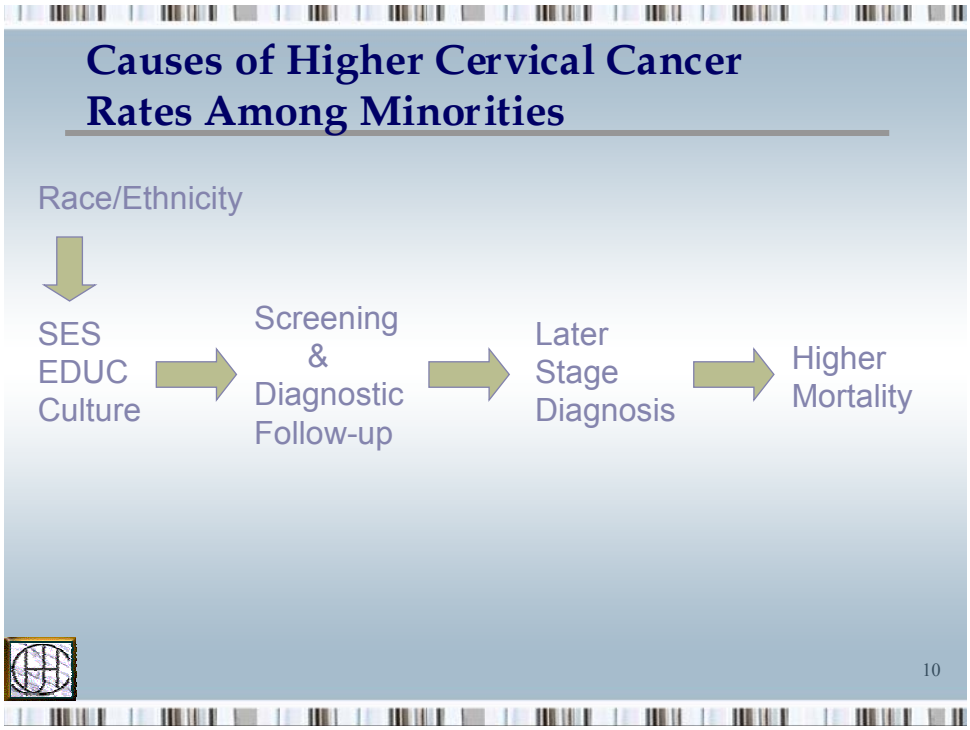
Staff Report:
Higher Rates of Cervical Cancer Among Minority Women

Report of the Governor's Task Force on Cervical Cancer, 2005

- Recommendation 1 of 5: Request the Joint Commission on Health Care to further study racial, ethnic, and cultural disparities in cervical cancer incidence to identify causes and develop a plan to address findings.

Racial/Ethnic Disparities in Cervical Cancer Rates

- Higher incidence of cervical cancer among minority women
- Higher rates of cervical cancer mortality among minority women
- Cervical cancer in minority women more likely to be diagnosed at later stages



The Virginia Breast and Cervical Cancer Early Detection Program (BCCEDP) known under the program name of "Every Woman's Life" operates under the authority of the federal the Breast and Cervical Cancer Mortality Prevention Act of 1990, Public Law 101-354. This Act authorized by the Centers for Disease Control and Prevention to develop and implement a national prevention program.

Virginia's program receives $2.44 million in federal funding through the CDC each year.

- The federal funding only pays for screening/diagnosis and treatment (through Medicaid) of women 40-64 years old.

State funding of $405,176 was appropriated for each year of the 2006-2008 biennium, thereby allowing younger women (18-39 years old) who were in the program and had an abnormality or were symptomatic for breast or cervical cancer to receive services (i.e. it does not pay for actual screening).

Options

☑ **Option 1:** Take no action.

The Governor's introduced budget includes $300,000 GFs for FY 2010 to allow VDH to provide "breast and cervical cancer screenings and diagnostic tests for an additional 1.333 women ages 18-44."

Option 2: Introduce a budget amendment for the Department of Health to provide additional funding of $405,176 GFs for each year of the 2008-2010

biennium to provide additional screenings for cervical cancer screenings (an additional 1,330 women would be expected to be screened).

VDH staff reported that the funding request in Option 3 is no longer needed as the anticipated increase in vaccine cost has not materialized and the vaccine has not been approved for use by males.

Option 3: ~~Introduce budget amendment (amount to be determined later) to increase current appropriations (above the $1.4 million approved for FY 08) to cover the increase in cost of administering the HPV vaccine due to expected rise in per-dose costs and the covering of males (most likely through the Vaccines for Children program).~~

Option 4: Introduce legislation for mandatory insurance coverage of the HPV vaccine.

2007 Report of the Virginia Alzheimer's Disease and Related Disorders Commission

Russell H. Swerdlow, MD
Chair, Alzheimer's Disease and Related Disorders Commission

*This document is a summary of Dr. Swerdlow's presentation on August 16, 2007. Efforts were made to communicate the information presented clearly and accurately. The exact wording from the presentation was used when possible.

Respite care is any service or set of services that allows a caregiver of a demented individual to temporarily escape from the caregiver role (e.g. adult day care, in home respite care, or institutional respite care)

Scope of the Problem

- 7 of 10 people with AD live at home
- 75 percent of their care is provided by family and friends
- On average each care recipient receives $23,436 worth of informal care
- In 2005, Virginia had almost 250,000 caregivers with an equivalent of 215,563,228 hours of unpaid care per that year valued at over $2.1 billion

Respite helps preserve both the mental and physical status of caregivers, which keeps them productive in their communities and in the workforce. Although the number of Alzheimer's patients in the Commonwealth has markedly increased in the past 20 years, the amount of funding by the Virginia General Assembly for its Respite Care Initiative has not increased in 20 years.

JCHC Staff Addition:
The Respite Care Initiative administered by the Virginia Department for the Aging (VDA) has an annual budget of $536,716. VDA reported providing respite care services to 374 families at an approximate cost of $2,476 per family. There are 264 families on the current waiting list for services.

Options

Option 1: Take no action.

The Governor's introduced budget reduced funding for the Alzheimer's Waiver by $200,000 GFs and $200,000 NGFs in each year of the 2008-2010 biennium.

☑ **Option 2:** Introduce a budget amendment for VDA to provide funding of $200,000 GFs for each year of the 2008-2010 biennium to allow approximately 80 additional families to benefit from the Respite Care Initiative.

No. of Families Served from Waiting List	Estimated Cost	Additional Funding Needed
50	$2,476/family	$123,800
100	$2,476/family	$247,600
150	$2,476/family	$371,400
200	$2,476/family	$495,200

264	$2,476/family	$653,664

Report on the "Integrated Policy and Plan to Provide and Improve Access to Mental Health and Mental Retardation and Substance Abuse Services for Children, Adolescents and their Families"*

Raymond R. Ratke, Deputy Commissioner
Department of Mental Health, Mental Retardation and Substance Abuse Services

*This summary of Mr. Ratke's presentation uses his wording except for any underlined wording.

Recent Efforts to Build and Improve Services

- Pilot evidence-based systems of care demonstration projects in four localities (two urban and two rural) across the state.
- Four child psychiatry fellowships and four child psychology internships with payback provisions to work in underserved areas of Virginia.
    - DMHMRSAS reported that only 5 of the 8 positions have been funded as of early November.
- CSB mental health services are now available at all twenty-three detention centers across the state.
- Virginia's Part C Early Intervention System funding for direct services.
- CSA and DMHMRSAS are collaboratively working on alternatives to residential placement using community based services to eliminate the need for placing children in costly residential settings.
- DMAS was awarded a demonstration grant to help provide community based alternatives to psychiatric residential treatment facilities.
- DMAS amended the State Medicaid Plan to provide Medicaid funds for substance abuse treatment for adolescents.
- DMHMRSAS and the Commission on Youth conducted a system of care and evidence-based services conference September 16-18, 2007 in Roanoke.

The Unmet Behavioral Health Needs of Virginia's Children

- CSB child and adolescent early intervention treatment services – especially "intermediate level services" - are unavailable in many communities.
- Of the over 30,000 children and adolescents who received mental health or substance abuse treatment services in CSBs in 2006, most received only the most basic services, case management and limited outpatient counseling.
- Many behavioral health clinicians, pediatricians, and other health care providers serving children and adolescents lack specialized knowledge to effectively treat children at risk of serious emotional disturbance (SED) or substance use disorders.
- The lack of child psychiatrists and other specialized child serving clinical staff remains a challenge.
- Unmet behavioral health needs spill over into juvenile justice and educational systems.

What Works? Community Based Systems of Care

- Community based systems of care allow localities to reduce their current

reliance on high-cost, highly restrictive residential and in-patient treatment and move toward lower cost, evidenced-based services.

- This shift allows all children to be served in settings either at home or in their home community.
    - A fully developed continuum of services and supports allows families to stay together and avoids unnecessary custody relinquishment.

Priority Funding Recommendations for FY 2009 <u>are shown as Options</u>:

The Governor's introduced budget included the following:			
<u>Agency</u>	**<u>New Funding Description</u>**	**<u>FY 2009</u>**	**<u>FY 2010</u>**
DMHMRSAS	Outpatient services for children ineligible for CSA	$2.8 million GFs	$3.0 million GFs
CSA	Funding for mandated services (for projected growth of 10%)	$65.4 million GFs	$93.2 million GFs
CSA	Collect outcome data	$225,000 GFs	$52,000 GFs
TOTAL		**$69.5 million**	**$98.8 million**
CSA	Incentives to serve children in the community	($1.5 million GFs) *reduction	($11.0 million GFs) *reduction

☑ **Option 1:** Take no action.

Option 2: Introduce one or more budget amendments to increase service capacity by funding:

2A.	Intermediate-level community based services	$20.0 M
2B.	12 systems of care projects	$3.6 M
2C.	MR family support	$2.5 M
2D.	*MR waiver slots*	*$6.0 M*
2E.	Part C early intervention	$1.73 M
2F.	3 additional project LINK programs	$375,000
2G.	Outpatient substance abuse services	$ 3.0 M
2H.	School-based mental health clinicians in 20 middle schools	$1.8 M

Option 3: Introduce budget amendment ($990,000 suggested) to fund infrastructure in the DMHMRSAS Office of Child and Family Services to support these initiatives statewide.

Option 4: Introduce budget amendment ($1,100,000) to fund 4 new child psychiatry fellowship and 2 new child psychology internship slots.

Option 5: Introduce budget amendment ($700,000) to establish 3 Teaching Centers of Excellence to organize, coordinate, and lead the training of clinicians

in evidence-based and promising practices for children's behavioral health treatment statewide.

Option 6: Introduce budget amendment ($100,000 suggested) to fund .5 FTE for Resource/Service Coordinator and administrative support to assist families in accessing needed services, to educate families about available services and link families with support systems.

Total Cost - Recommendations $41,831,000

Staff Report:
Discussion of Mental Health Recommendations Related to the Virginia Tech Tragedy

Review of Findings

Background
In the wake of the tragedy at Virginia Tech (VT) on April 16, 2007, two workgroups were convened to review the events, understand what went wrong, and make recommendations for improvement and prevention: the Virginia Tech Review Panel and the Virginia Tech Internal Review.

- The Supreme Court's Commission on Mental Health Law Reform (subsequently referred to as the MHLR Commission), which was convened prior to the tragedy, will issue a preliminary report on civil commitment this winter.
- In addition the House Health, Welfare and Institutions Committee and the House Courts of Justice Committee met to hear presentations and study findings related to the VT tragedy.

Access to Community-Based Services
Numerous studies and reports have indicated that Virginia's mental health system lacks needed community-based services. Recent studies indicate the following:

- Most community services boards (CSBs) "do not provide a comprehensive range of crisis intervention services for those with mental illness and substance abuse disorders….As a result, ESPs [emergency services programs] deal with crisis situations that could have been prevented if the consumer had received more intensive or a different array of services." (Source: *Review Of Community Services Board Mental Health Case Management Services for Adults,* Office of the Inspector General For Mental Health, Mental Retardation & Substance Abuse Services.)
- Virginia has an inadequate number of practicing psychiatrists -- 47 Virginia localities have no practicing psychiatrists and 87 Virginia localities have no practicing child psychiatrists.
    - "Medicaid rates for professional psychiatric services have generally been flat for over the last 6 years…[and] may contribute to the shortage of psychiatrists." Additionally, higher rates are "paid by Medicare and other insurers." (Source: JLARC study, *Availability and Cost of Licensed Psychiatric Services in Virginia)*

The Involuntary Commitment Process
Emergency Custody Orders (ECOs) (*Code of VA* § 37.2-808)

ECOs are issued by a magistrate who has probable cause to believe that a person:

- Has mental illness; and
- Is in need of hospitalization or treatment; and
- Is unwilling to volunteer or incapable of volunteering for hospitalization or treatment; and
- Presents an imminent danger to himself or others as a result of mental illness or is so seriously mentally ill as to be substantially unable to care for himself.

The CSB/BHA is responsible for conducting or arranging for the ECO evaluation. The person subject to an ECO is held until a Temporary Detention Order is issued or until released, but the period of custody cannot exceed 4 hours.

Temporary Detention Orders (*Code of VA* § 37.2-809)

A TDO may be issued upon the sworn petition of any responsible person or upon the magistrate's own motion. The magistrate can issue a TDO, if the criteria are met (which is the same as that for the issuance of an ECO), only after an in-person, independent evaluation by an employee or designee of the local CSB.

Once the TDO has been approved, *Code of VA* § 37.2-809.G requires a hearing to be held within 48 hours unless the expiration occurs on a weekend or legal holiday. (The hearing would then be held the next day that was not a weekend or legal holiday.) This timeframe has been criticized as being too short to allow for a thorough assessment of the individual; the MHLR Commission is specifically examining the timeframe. Any increase in the timeframe would have a fiscal impact as State funding for the hospital services is provided for individuals who do not have health insurance.

The VT Review Panel found there was little interaction or sharing of information by the hospital staff with the independent evaluator while the individual is being held in the hospital. The Panel recommended to:

- Clarify the role and responsibilities of the independent evaluator in the commitment process;
- Clarify the steps required to assure that the necessary reports and collateral information are assembled before the independent evaluator conducts the evaluation;
- Include the following documents so they can be presented at the commitment hearing:
    - The complete evaluation of the treating physician, including collateral information; reports of any lab and toxicology tests; reports of prior psychiatric history; and all admission forms and nurse's notes.

In addition, the VT Review Panel recommended amending the Virginia Health

Records Privacy Act to:

- Provide a safe harbor provision which would protect health entities and providers from liability or loss of funding when they disclose information in connection with evaluations and commitment hearings.
- Ensure all entities involved with treatment have full authority to share records with each other and all persons involved in the involuntary commitment process, while providing the legal safeguards needed to prevent unwarranted breaches of confidentiality.
- Expressly authorize treatment providers to report non-compliance with involuntary outpatient orders.

The MHLR Commission is reviewing the question of whether the involuntary commitment process is a health-related or judicial proceeding which would affect privacy questions.

Involuntary Commitment Standard and Hearing Procedures

Virginia's involuntary commitment standard is one of the most restrictive in the nation; the *Code of Virginia* § 37.2-817.B requires the judge or special justice to find:

> "by clear and convincing evidence that (i) the person presents an imminent danger to himself or others as a result of mental illness or has been proven to be so seriously mentally ill as to be substantially unable to care for himself and (ii) alternatives to involuntary inpatient treatment have been investigated and deemed unsuitable and there is no less restrictive alternative to involuntary inpatient treatment, the judge or special justice shall by written order and specific findings so certify and order that the person be admitted involuntarily to a facility for a period of treatment not to exceed 180 days from the date of the court order."

The VT Review Panel recommended modifying the criteria for involuntary commitment to promote more consistent application of the standard and to allow involuntary treatment in a broader range of cases involving severe mental illness.

The MHLR Commission is examining Virginia's involuntary commitment standard to offer options for the Reform Commission's consideration. Four preliminary proposals were developed and presented in August as no consensus had been reached by the Commitment Task Force members at that time.

- Proposal 1 would not change commitment criteria.
- Proposal 2 would only change the criteria slightly by specifying factors that the Court would be required to consider in reaching its judgment.
- Proposal 3 would substantially change the criteria to make them less vague by including such wording as "substantial likelihood that in the near future" that physical harm would occur to self or others due to the individual's mental illness "as evidenced by recent behavior" or that harm

will be suffered due to substantial deterioration or an inability to protect or provide for him/herself.
- Proposal 4 would substantially change the criteria by adding a third criterion for commitment that addresses containing deterioration in the individual's "previous ability to function in the community."

CSB staff is not required in statute to attend involuntary commitment hearings and there is no requirement for CSBs to be notified of hearings. The Inspector General found that "CSB attendance at commitment hearings is inconsistent across the state." Additionally, CSBs reported barriers to meeting attendance:
- 48% cited staffing limitations
- 25% hearings held outside of service area
- 20% distance to hearings within service area.

Virginia Tech Review Panel Recommendations
The VT Review Panel recommended amending the *Code of Virginia* to:
- Extend the time periods for temporary detention to allow for more thorough mental health evaluations;
- Authorize magistrates to issue temporary detention orders based on evaluations conducted by emergency physicians trained to perform emergency psychiatric evaluations;
- Require the presence of the pre-screener, or other CSB representative, at all commitment hearings, and to provide adequate resources to facilitate CSB compliance.
    - The independent evaluator, if not present in person, and the treating physician should be available where possible if needed for questioning during hearing.

Treatment Following Commitment
As noted in the Inspector General's investigatory report, CSBs are required to develop discharge plans as part of the involuntary commitment process; but:
- There is no requirement to provide CSBs with assessments completed by the independent evaluator or the attending physician;
- The meaning of "course of treatment" is unclear;
- BHA/CSBs or designated providers are required in *Code of VA* § 37.2-817.C to monitor "compliance with the treatment ordered by the court" but there are no statutory provisions regarding actions to be taken if individual does not comply with treatment plan; including no guidance for holding a subsequent commitment hearing unless "there is clear evidence that new behaviors…meet TDO or commitment criteria…."

Involuntary Outpatient Treatment
Additional issues related to involuntary outpatient treatment orders as noted by the Inspector General's report include:
- Limited access to involuntary outpatient treatment;

- Average wait times for CSB outpatient treatment services were:
  - Clinician 30.22 days for adults (13.54 days post emergency)
  - Clinician 37.42 days for children (16.5 days post emergency)
  - Psychiatrist 28.16 days for adults (13.54 days post emergency)
  - Psychiatrist 30.36 days for children (15.46 days post emergency)
- Due to the limitations in outpatient treatment capacity:
  - "Often not possible to prevent crises
  - Individuals seeking service lose interest and fail to follow through
  - Staff have limited time to follow up on those who drop out
  - Not possible to meet the needs of the court for outpatient commitment
  - Court ordered treatment will cause delays for those who seek treatment voluntarily."

The VT Review Panel recommended clarifying with regard to involuntary outpatient orders:

- Need for specificity in involuntary outpatient orders.
- Appropriate recipients of certified copies of orders.
- Party responsible for certifying copies of orders.
- Party responsible for reporting non-compliance with outpatient orders and to whom noncompliance is reported.
- Mechanism for returning the noncompliant person to court.
- Sanctions to be imposed on the noncompliant person who does not pose an imminent danger to himself or others.
- Respective responsibilities of the detaining facility, the CSB and the outpatient treatment provider in assuring effective implementation of involuntary outpatient treatment orders.

The MHLR Commission is examining issues related to involuntary outpatient orders within its review.

Options

☑ **Option 1:** Take no action**.**

The Governor's introduced budget includes funding of $830,964 GFs for each year of the biennium (an increase of $50,000 GFs from FY 2008) for "physician financial incentives such as loan repayment, one-time salary bonuses and travel expenses to physicians, <u>including psychiatrists</u> who commit to practice in underserved areas of the state." (VDH Item 289.A)

Option 2: Review any health-related workforce initiatives that are funded to ensure that mental health professionals are included where appropriate:

- In any budget amendments – add or designate funding or add language to allow initiatives to address the need for mental health professionals too.

The Governor's introduced budget included the following:

Agency	New Funding Description	FY 2009	FY 2010
DMHMRSAS	CSB Emergency Services (including 36 Crisis Stabilization Beds)	$5.3 million GFs	$9.3 million GFs
DMHMRSAS	106 CSB Case Managers to Reduce Caseloads	$3.5 million GFs	$5.3 million GFs
DMHMRSAS	40 Outpatient CSB Clinicians/Therapists	$1.5 million GFs	$3.0 million GFs
DMHMRSAS	Training for Crisis Intervention for Law Enforcement	$300,000 GFs	$300,000 GFs
DMHMRSAS	Jail Diversion Pilots to Divert and Serve 300-500	$3.0 million GFs	$3.0 million GFs
DMHMRSAS	Better Oversight and Monitoring of CSBs	$300,000 GFs (and 4 FTEs)	$575,000 GFs
TOTAL		**$13.0 million**	**$21.6 million**

Option 3: Fund additional crisis stabilization units (estimated annual cost of $1 million per unit)

- Statewide coverage may require as many as 24 units, but it has been suggested to begin by funding 4 or 5 units.

The Governor's proposed legislation includes requiring CSB staff to participate in involuntary commitment hearings.

Additional proposed legislation will address

- Allowing an ECO to extend to 8 hours, revising ECO criteria to meet commitment criteria
- Requiring independent evaluators and treating physicians to be available during TDO hearings
- Revising the criteria for ECOs and TDOs "from 'imminent danger' terminology to 'substantial likelihood that in the near future he will (a) cause serious physical harm to himself or other person, as evidenced by recent behavior causing, attempting, or threatening such harm, or (b) suffer serious harm due to substantial deterioration of his capacity to protect himself from such harm or provide for his basic human needs."
- Clarifying "the roles and responsibilities of the community services boards and the independent examiner throughout the detention process, the commitment hearing, and the subsequent disposition."
- Authorizing the "disclosure of information between providers in order to deliver, coordinate or monitor treatment, and between providers and the courts to monitor and report on service delivery and compliance with treatment."

Option 4: Amend the *Code of Virginia* to require CSB staff participation (while allowing use of video conference or conference call) in all involuntary commitment hearings.

Option 5: Increase State funding for CSBs (amount to be specified) to:

- Allow for increased work if changes such as lowering the standard for involuntary commitment are enacted
- Provide for needed community-based services (including those involved in involuntary outpatient treatment orders).

	JCHC Budgets Amendments for 2008 General Assembly Session Approved in November 2007		
		Approved by JCHC in November	**Introduced Budget**
~~1~~	~~VDH~~	~~**Restore** reduction in new funding for **sickle cell disease services** within VDH **(≥$100,000 GFs) for FY 2008.**~~	While the reduction of $100,000 GFs remains for FY 2008, the Governor's budget includes $200,000 GFs for each year of the 2008-2010 biennium
~~2~~	~~VDH~~	~~**Restore** reduction in new funding for **community-based sickle cell disease services (≥$50,000 GFs) for FY 2008.**~~	While the reduction of $50,000 GFs remains for FY 2008, the Governor's budget includes $100,000 GFs for each year of the 2008-2010 biennium
1	DMAS	Provide funding to add 500 MR waiver slots for each year of the 2008-2010 biennium.	$2.3 million GFs & NGFs FY 2009 $4.9 million GFs & NGFs FY 2010 to add 75 MR waiver slots each year
2	HHR Office	Language to develop and report on implementation plan for State home for ASD or DD.	$100,000 GFs each year (and 1 FTE) for DMHMRSAS to fund "a community resource manager to support ASD services. The new position will be responsible for coordinating with families and community resources to determine the statewide availability of and need for ASD services."
3	DMHMRSAS	Provide funding of $410,000 GFs in each year of 2008-2010 biennium for outpatient restoration of adults.	
4	UVA	Provide funding of $100,000 GFs for each year of the 2008-2010 biennium for the Richard Dart ALS Clinic.	
5	VDA	Provide funding of $200,000 GFs for each year of the 2008-2010 biennium to allow approximately 80 additional families to benefit from the Respite	

		Care Initiative.	

JCHC Bills for 2008 Session

*Bill approved in November

1*	Amend *Code of Virginia* § 19.2-169.3.B to limit to 45 days the timeframe for treatment provided to restore competency for a defendant charged with a minor, nonviolent misdemeanor offense.		
2*	Amend *Code of Virginia* §§ 19.2-182.8 and 19.2-182.9 to move language clarifying that voluntary admission to a State hospital should not automatically result in revocation of the acquittee's conditional release.		
~~3~~	~~Amend *Code of Virginia* Title 37.2 to require participation by staff of the appropriate CSB/BHA in commitment hearings.~~		
3	Amend *Code of Virginia* §§ 37.2-506 and 37.2-416 to allow community services boards and providers licensed by DMHMRSAS to hire as a direct care employee in adult substance abuse or mental health treatment programs someone with certain misdemeanor assault and battery convictions, as long as such offences sere substantially related to substance abuse and the applicant has been rehabilitated.		
4*	Amend *Code of Virginia* §§ 32.1-111.11 to require delineation of a uniform destination plan for pre-hospital stroke patients.		
~~9~~	~~Amend the *Code of Virginia*, Title 38.2, Chapter 34 to exempt health insurance products provided in Carroll, Dickenson, Grayson, Halifax, Highland, Lee, Scott, Smyth, and Washington counties from being subject to the mandated coverage requirements as specified in the *Code of Virginia* Title 38.2, Chapter 34.~~		
~~10~~	~~Amend the *Code of Virginia*, Title 58.1 to provide a tax deduction to HI providers that offer new small group HI plans provided in Carroll, Dickenson, Grayson, Halifax, Highland, Lee, Scott, Smyth, or Washington counties.~~		