Joint Commission on Health Care

Draft Decision Matrix

November 8, 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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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
  - Founded in 1991 by volunteers to respond to the unmet needs of patients & families
  - Over the past 18 months, provided support to more than 300 Virginia families
  - [ALS] identify and address the needs of the ALS community on multiple fronts
  - Raise awareness and understanding about ALS through advocacy, research, fundraising
- ***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 are cared for by family
- Also provide support to the entire community
  - In-services
  - Information & referral
  - Support for healthcare professionals
  - Research & clinical update information
  - Advocacy efforts, both state and federal

- **How the ALS Association is unique**
  - The only organization in Virginia dedicated solely to helping the ALS community
  - All services offered free of charge regardless of income
  - Live *and* work in the communities [ALS] serve
  - 100% privately funded

- **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.

Options

Option 1: Take no action.

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)

Sickle Cell Disease
An Overview of Current Services and Emerging Needs in the Commonwealth

Michael O. Royster, M.D., M.P.H.
Director, Office of Minority Health and Public Health Policy
Virginia Department of Health

Jene Radcliffe-Shipman, B.S.W.
Comprehensive Sickle Cell Program Manager
Division of Women's and Infants' Health
Virginia Department of Health

*This summary of the presentation includes exact wording used by Dr. Royster and Ms. Radcliffe-Shipman, except for any underlined wording.

What is Sickle Cell Disease?

Sickle cell disease (SCD) describes a spectrum of generic disorders that affect the shape and function of the red blood cells. Constant breakdown of damaged red blood cells (RBCs) release proteins that increase inflammation, clotting, and cause vasoconstriction.

Some of the Complications from Sickle Cell Disease Include:

- Painful crises (bones and chest)
- Bacterial infections (children)
- Acute chest syndrome (children)
- Kidney failure
- Gallbladder stones and inflammation
- Avascular necrosis
- Pulmonary hypertension
- Stroke (children)

Medical Management

- Prevent bacterial infections
  - Immunizations
  - Penicillin treatment from 3 mos. to 5 yrs.
- Transfusions
  - To prevent stroke, decrease crises, reduce complications, correct anemia
- Comprehensive care
  - Comprehensive Pediatric and Adult Sickle Cell Centers
  - Specialist consultation
  - Hydroxyurea (anti-sickling agent taken daily)
  - Pain medication, hydration, oral chelation, oxygen
  - Dialysis or kidney transplant
  - Surgery for gallbladder removal
  - Hip/shoulder replacement for avascular necrosis
  - Bone marrow transplant

- Future treatments
  - Genetic engineering

Hydroxyurea

- 50% reduction in crises
- 40% reduction in mortality
- If given routinely:
  - Up to 70 lives could be saved every 10 years
  - Up to $13.1 million in Medicaid payments could be saved every 10 years

Supportive Services

- Pain management skills
- Ongoing education
- Community-based supportive services
- School and work interventions
  - IEP
  - Accommodations specific for SCD
  - Career/vocational planning

"Teaching the skills necessary for coping with this disease should begin at the time of diagnosis and continue throughout the life of the patient." *Source: NIH, The Management of Sickle Cell Disease, 1984*

Impact of Sickle Cell Disease
~Two million people living with SCD worldwide

Sickle Cell Disease in Virginia

- **~3,700** living with SCD
  - **1 in 325** African Americans (8% higher than national average)
  - **< 1%** identified in other ethnic groups
  - **1 in 12** African Americans identified with sickle cell trait
- ~ **75 newborns** identified with disease yearly

Source: Virginia Birth Records, Virginia Sickle Cell Awareness Program Newborn Screening Tracking Database

Life Expectancy

In the US, as recently as 1970, the average person with SCD died in childhood. In 2000, as a result of early detection and improved treatment, sickle cell patients live into their 40s and 50s.

Virginia Sickle Cell Awareness Program (VASCAP) Services
***Code of Virginia* 32.1-68**

- Title V ($125,000) funded statewide program for the education and voluntary screening of individuals for sickle cell disease, trait and other related hemoglobinopathies.

- Located at the Virginia Department of Health, Division of Women's and Infants' Health
- 1 FTE
- Screening Services
    - ~9000 adults screened yearly
- Health Education and Promotion
- Contract Management

VASCAP collaborates with Virginia Newborn Screening Program to provide:

- Tracking of newborns identified with SCD to insure early entry to care
    - A database of all newborns identified with SCD through the newborn screening program
- Direct parent notification of newborn carrier status (> 2000 yearly) and telephone counseling and or referral upon request

Today, 1257 newborns have been identified with SCD (In July of 1989, Virginia began screening all newborns for SCD)

General Funds Appropriation for VDH Was Not Increased for 13 Years

1994

- Yearly allocation $250,000 to develop regionally located sickle cell clinics and support community-based sickle cell programs

2007

- A budget amendment was introduced to increase funding by $532,900 GFs and add 7 FTEs for the VDH Sickle Cell program "to address rising caseloads and [to] develop transition services for youth who will require adult medical services as they age out of the current program.
    - The General Assembly approved an increase of $200,000 but no additional staff positions were funded.

State-funded Community-based Sickle Cell Programs

2007 Budget Amendment

- A budget amendment was introduced to provide funding of $200,000 GFs to provide funding for community-based programs.
    - The $100,000 allocation approved by the General Assembly authorized grants to community-based programs that provide education and family-centered support for individuals suffering from sickle cell disease
        - VDH [a]llocated through a competitive RFP process
            - 2007 Awards were reduced to $50,000 (50%)
                - Sickle Cell Association of Hampton Roads in Norfolk
                - Organization for Sickle Cell Anemia Resources in Richmond
                - Fredericksburg Area Sickle Cell Association in Fredericksburg

Trends and Challenges

In just one generation, the average survival of patients with sickle cell anemia has increase from 14 years to nearly 50 years.

- In the next 5 years, 400 adolescents will transition to adult chronic disease management
- Will the health care system be ready for them?

Vision: A comprehensive program, similar to those that exist for patients with other chronic illness such as Type II diabetes or cystic fibrosis, will further improve the quality of life for this very vulnerable group of patients.

Challenges

- Increased funding for the development of Adult Comprehensive Sickle Cell Clinics so that our young adults do not begin to utilize expensive emergency care
  - Currently no funding for hydroxyurea treatment for adults without insurance
  - Inequities in care among African Americans, in general, extend to this subpopulation
- Increased access to care outside of urban areas through the development of a network of "experts" who would serve as resources for community-based providers, hospitals or Federally Qualified Health Centers
- Enhance health education and awareness of sickle cell disease through schools of medicine, nursing, social work and teaching

Options

Option 1: Take no action.

Option 2: Introduce a budget amendment to provide funding of $450,000 GFs in the first year of the 2008-2010 biennium and $425,000 GFs in the second year of the 2008-2010 biennium to provide community-based services for individuals with sickle cell disease.

Option 3: Introduce a budget amendment to provide funding of $553,856 GFs for each year of the 2008-2010 biennium to provide "funding and 7 FTEs for VDH's "comprehensive sickle cell program to address rising caseloads and to develop transition services for youth who will require adult medical services as they age out of the current program."

☑ **Option 4**: Introduce budget amendments to <u>restore for FY 2008</u> funding appropriated during the 2007 General Assembly Session that was reduced involving the $200,000 GFs for VDH's sickle cell disease program and the $100,000 GFs for community-based programs addressing sickle cell disease.
(THIS OPTION WAS ADDED.IN NOVEMBER)

GENERAL ASSEMBLY REQUEST

INTRODUCTION

STATEWIDE SICKLE CELL CHAPTERS OF VIRGINIA, INC. (SSCCV)

History

Representatives of five sickle cell chapters from Danville, Fredericksburg, Hampton, Norfolk and Richmond met in the spring of 1977 to discuss plans for a joint statewide conference.

During this meeting the initial plans were made for the first conference on September 22-23, 1978 in Norfolk. Since that time other conferences were held **by the original statewide chapters** in Fredericksburg, Danville, Hampton, Norfolk and Richmond.

It was determined after the continued success of annual conferences that the chapters should incorporate into a statewide organization for a greater impact as a collective body on political, economic and service delivery systems.

Since the incorporation of the original five chapters, chapters in Lynchburg, South Boston and Rocky Mount have been added **and conferences have been held by Lynchburg and Rocky Mount**.

Mission Statement

To educate the public, implement service programs, encourage support for research and empower persons who live with Sickle Cell Disease and advocate on their behalf.

Purpose

The purpose of this organization is to provide leadership with health professionals and the general public to develop a health policy and plan of action regarding the impact of sickle cell disease.

"Striving to improve the quality of life."

Goals

* Organize, sponsor and participate in statewide educational conferences to be hosted by rotating among member chapters.
* Develop and promote the implementation of service programs' standards that will be in the best interest of the affected population.
* Develop positions and promote favorable resolution of issues and activities that could have an adverse effect on sickle cell programs or the affected population.
* Develop and distribute educational materials, written and visual, about the sickle cell problem for all segments of our society.
* Assist in the organization and development of other chapters in the state.
* Provide on-going technical assistance to active member chapters and other interested groups and organizations.
* Encourage adequate support for research activities leading to improving treatment and eventual cure.
* **To encourage patients to share experiences about what works for each individual in terms of diet, medication, pain management, pain partners, stress management**

and the psycho-social aspects of having SC Diseases to gain feelings of empowerment and to dispel the Sickle Cell Myths.

Statewide Sickle Cell Chapters of Virginia, Incorporated is a non-profit tax-exempt community-based organization, hereafter **known as Statewide or SSCCV.**

THE PROBLEM

Sickle cell anemia is a chronic anemia and **incurable** disease of the blood that is inherited. This disease is produced when the sickle cell gene is transmitted by both parents to a child. The red blood cells of a person born with sickle cell disease have a tendency to change from their normal round shape to a "quarter-moon" or sickle-like shape. Sickled cells cannot squeeze through tiny blood vessels so they often jam up, blocking the flow of blood and oxygen to body parts and causing extreme pain. A pain crisis can last for hours, days or even weeks and may occur several times a year.

Today, approximately 1 in 375 African American children is born with a serious sickle cell disorder, making it the most common long term illness identified in this population. Between 70,000 and 80,000 people in the USA suffer with Sickle Cell Disease of which over 3,000 are in Virginia. Over 2,000,000 people in the USA have Sickle Cell Trait and approximately 115,000 are in Virginia. Unfortunately, these figures do not include the expanding Hispanic and Middle Eastern populations because their data is not readily available. The areas that two of our chapters operate within have increasing numbers in both of these populations.

DALLAS, Sept. 27 /PRNewswire/ -- "Sickle Cell Disease is one of the most prevalent and costly genetic disorders in the U.S. Today, **one in every 4,000 Americans is born with a form of SCD and many experience chronic anemia, stroke, spleen and kidney dysfunction, pain crises, and susceptibility to bacterial infections**. **Moreover, the National Institutes of Health (NIH) estimates that almost one-third of adults with SCD develop pulmonary hypertension, a life-threatening condition resulting in a 10-fold greater risk of death."**

"Due to this high disease burden, the Sickle Cell Disease Association of America (SCDAA) reports that Sickle Cell Disease in which abnormal hemoglobin causes red blood cells to become stiff, sickle- shaped and unable to flow easily through blood vessels -- **results in an estimated 750,000 hospitalizations a year. The cost of these hospitalizations is estimated at $475 million annually**."

THE RESOLUTIONS

FAMILY ASSISTANCE - Family Expenses

Because of the high volume of hospitalizations for persons with sickle cell disease, they and their families incur expenses that often go beyond the hospital stay. Families incur medication expense, numerous insurance deductibles and lost of wages because a parent needs to stay out of work to care for the child at home or be with them in the hospital. When a family loses wages, they wind up behind on regular household payments such as rent, utilities, telephone and food.

All eight (8) chapters of the statewide organization help families with expenses where possible, but our resources are limited. Of the eight (8) chapters, six (6) are volunteer

organizations and dependant on donations. With greater funding, we would be able to assist families in a larger and more meaningful way.

PATIENT CONSULTANT SERVICES

SSCCV has already identified several vendors that are able to deliver services to our clients/patients that would improve their ability to cope with their disease and improve their quality of life. The services include stress management, self-esteem and breathing techniques and strategies in the management of chronic pain.

FAMILY ASSISTANCE – Tutorial Assistance

Many SCD clients miss so much time from school that they fall behind in their classes. We would like to employ persons to serve as teachers or tutors to help the clients to keep up with their studies. Community and church already have tutorial programs but these programs require a child to come to them. SCD clients often are too sick or weak to go to them and need someone to come to them in the hospital or home. Although there already is a requirement for homebound instruction, we feel that having persons who are more knowledgeable and understanding of the SDC client creates a better learning environment.

PRINTING OF EDUCATIONAL LITERATURE

SSCCV would like to continue to print literature about Sickle Cell Disease in an effort to better educate the public. We have only been able to distribute a limited amount of literature at health fairs and educational meetings. SSCCV has a small supply of two forms of literature. Usually, one or the other form is distributed, depending on the audience. There is so much more information we could pass on to the public if we had the resources.

OFFICE SUPPLIES – Stationary, Envelops and Stamps

SSCCV would like to take distribution of our educational materials to another level. With the office supplies (stationary, envelops and stamps), we would like to do mass mailings of our literature.

STATE OFFICE – Computers (2) & Software Web Page Design, Rent & Utilities and Staff Person

The Board of Directors of SSCCV determined that too much needed to be done to continue with only quarterly regular meetings, long distance phone calls and e-mails in between and no staff. The board further determined that with more and more couples of mixed races, that the need for greater effectiveness and regularity was a must. After reviewing our history, accomplishments, unfinished efforts and the declining role of some operations in the sickle cell field, the board concluded it must establish an office that would be open on a daily basis and have two full time staff persons to meet the needs of SCD clients in the State of Virginia. Richmond had already been our central meeting point for our quarterly meetings so the board decided to establish an office in Richmond which would also be closest to the State Health Department and VCU/MCV. The Board of Directors of SSCCV has taken the step of naming a volunteer to serve as Administrator for the organization until permanent staff can be hired. The main staff person would be an Executive Director who would have the responsibility of working with and for all eight chapters and serve as the principle SCD educator in the state. The second staff person is necessary to keep the office open and fully running while the Executive Director is meeting essential parties in and out of the offices. This staff needs a place to operate from, with the ability to meet the obligations of rent and utilities, computer equipment to work with and a web site clients and interested person could use to locate us.

CONCLUSION

Statewide Sickle Cell Chapters Of Virginia, Inc. (SSCCV) feels strongly that we must establish a physical presence on a daily basis with a central full time effort to help SCD clients. However, our resources are limited to the dues that eight (8) chapters pay ($150.00 each per year) and small fund raising dollars. SSCCV needs the assistance of the Virginia General Assembly to help fund these needs. Once all aspects are in place, we will be in the position to devote time to grant writing to obtain more funding from other sources to meet the continued needs of the sickle cell community. The grant writing efforts will not materialize over night. As such, we are asking for funds over a four (4) year period, in declining amounts each year, to insure the organizational stability. The following presents our dollar and category requests. SSCCV hopes that you will support our request.

REQUEST FOR COMMUNITY BASED FUNDING FOR SICKLE CELL DISEASE

		1st Year	2nd Year
a.	Patient Assistance		
	1. Family Expenses	$100,000.00	$100,000.00
	2. Patient Consultant Services	$190,000.00	$190,000.00
	3. Tutorial Assistance	$ 5,000.00	$ 5,000.00
b.	Printing of Educational Literature	$ 4,000.00	$ 4,000.00
c.	Office Supplies		
	1. Stationary	$ 3,000.00	$ 2,000.00
	2. Envelops	$ 3,000.00	$ 2,000.00
	3. Stamps	$ 3,000.00	$ 2,000.00
d.	State Office		
	1. Computers (4) & Software	$ 7,000.00	$ 0.00
	2. Rent & Utilities	$ 25,000.00	$ 20,000.00
	3. Staff Person (4 Statewide)	$110,000.00	$100,000.00
		$450,000.00	$425,000.00

Report on Improving the Quality and Safety of Health Care for Virginians; Assessment & Evaluation of Licensed Healthcare Practitioners*

Ed Susank, Chair
Health Care Quality & Safety Task Force, AARP

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

Background

- 98,000 to 195,000 deaths result each year from preventable medical error
- Quality of care varies widely by area, by income and by service type
- Public expectation that they will receive the right care done right
- US health licensure system created for a different era

Groundswell for change

- Pew Commission, IOM, FSMB, and others recommend state licensing boards require periodic assessment & demonstration of competencies as condition of license renewal.
- Board certified physicians are rapidly moving to require Demonstrations of Competency (DOC).
- Some other providers (Nurses, Dentists, Pharmacists, Dietitians) studying DOC.

AARP Action in Virginia
Created Health Care Reform Task Force, including:

Charles Alexander	Kenneth Olshansky MD
Kaye Berry	Nancy Roberts
Raymond Boyd	Joe Sailor
Gerri Holmes	Ed Susank, chair
Dan Johnson	Neil Walsh
Richard Lindsay MD	Rose Wesson
William Lukhard	David Swankin, CAC
John Moore RN	Richard Morrison PhD (deceased)

Bill Kallio, Madge Bush & Amy Gilbody of AARP VA
Ilene Henshaw & Joyce Dubow of AARP National

Researched consumers' views on health care quality revealed:

- 68% believe that being licensed means the provider has undergone periodic evaluation & assessment.
- 98% felt it was important for health professionals to periodically demonstrate current competency.
- 30% report they or a family member have experienced a medical error.

Held discussions with providers on the best ways to demonstrate continued competency.

- Entities involved included the:
  Virginia Board of Health Professions
  Governor's Health Care Commission
  Virginia Medical Society
  Virginia Hospital & Healthcare Association
  Virginia Dental Association
  Virginia Pharmacists Association
  Virginia Nurses Association
  Virginia Health Care Association
- Methods for demonstrating current competencies include:
  Peer review
  Consumer satisfaction surveys
  Records or chart review
  Written or oral examinations
  Performance evaluation
  Program portfolios
  CE based on needs assessment but test to verify grasp of the material

Introduce legislation to require DOC as a condition of re-licensing.

- Commission a study, followed by a report, on how the health professional licensing boards can best implement such a new policy.
- Each licensing board will base its requirements on the characteristics of the professions it regulates.

Comments by the Medical Society of Virginia (MSV)

Scott Johnson, General Counsel
The Medical Society of Virginia

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

MSV and its 8,600 members are also committed to improvement in the quality and delivery of health care. Through the Medical Society of Virginia Foundation, MSV is supporting several initiatives that promote best practices, enhance competencies and provide patient services to improve health outcomes. Three initiatives include:

- The "To Goal" program, focuses on improving recognition and treatment of coronary artery disease and hypertension using strategies to improve physician identification of at-risk patients and providing the tools and resources necessary to ensure that patients adhere to treatment protocols that comply with recommended practice guidelines.
- The "Free Clinic Medical Directors Initiative" provides a forum for free clinic medical directors and free clinic volunteer physicians to network and learn best practices for treating patients and assuring quality medical care at the free clinics.

- The "DOC Rx Relief" Program assists Virginians without prescription insurance coverage obtain the medications they need, free of charge, so they may comply with their recommended medication regimen and improve their health outcomes.

National Initiatives

The MSV supports, along with the American Medical Association, the American Hospital Association, the National Board of Medical Examiners, the Federation of State Medical Boards and many other national organizations, the development by the American Board of Medical Specialties (ABMS) of the Maintenance of Certification (MOC) initiative.

- The MOC initiative focuses on the 6 general competencies deemed necessary for physician specialists:
    - Patient care
    - Medical Knowledge
    - Practice-based learning and improvement
    - Interpersonal and communicative skills
    - Professionalism
    - Systems-based practice

The MOC initiative, adopted by all 24 member boards in 2006, is the new gold standard for physician recertification and encompasses a massive national effort, using evidence-based guidelines and national standards and best practices to improve physician competency through customized continuing education.

- Demonstration of the Maintenance of Certification is achieved through the actual periodic recertification program and by requiring proof of continuing education and experience in between recertification exams.
    - Physician specialties are moving rapidly to develop programs customized for each specialty that are based upon the ABMS general competencies and components.

At its September 2007 interim meeting, the ABMS, through its "Building Bridges to MOC" program brought together representatives from all their member boards to exchange ideas, share progress in implementation and develop performance measures.

- MSV believes this effort by the ABMS and its members is a significant movement toward the vast majority of the ideas proposed by the AARP in its presentation.
- MSV believes that the strong focus on national standards of care and evidence-based guidelines adopted by the ABMS is an appropriate model that marshals the considerable, national resources of the member boards, resources that would not necessarily be available to state licensing boards.

At some point in the future, DOC as identified by the AARP may be a condition of re-licensing by state medical boards. However, at present, MSV would

suggest that such a requirement is premature and should be assessed as the ABMS MOC initiative progresses and matures.

- Allowing the ABMS to take the lead on competency assessment has many advantages, including a national focus, widespread support and participation by physician specialists and the availability of extensive resources and expertise.
- Requiring that the Virginia Board of Medicine include competency assessment as a condition of licensure at this time, when there is so much being done on the national level, would be duplicative of effort, likely much more limited in scope than the MOC and would seriously challenge the Board's existing resources and capacities.
- The Virginia Board of Medicine is funded solely by physician license fees. The Board and its staff are working very hard and do a good job. To mandate what is being proposed would be extremely costly and would divert valuable resources from adjudicating complaints.

Options

☑ **Option 1:** Take no action.

Option 2: Introduce a joint resolution requesting that JCHC study the issue of demonstrating competency as part of the re-licensure process for health care professionals by reviewing activities of professional organizations (such as the American Medical Association) and of other states for protocols related to the re-licensure of health professionals.

The Mental Retardation Services System and Waiver Waiting List Procedures

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.

DMHMRSAS VISION
Our vision is of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life including work, school, family and other meaningful relationships.

Profile of Virginia's Service System

- Over 26,000 individuals identified by CSBs as having intellectual disabilities
  - About 1,400 individuals live in one of five state operated training centers
  - 6,852 individuals enrolled in the MR Waiver
  - 283 individuals enrolled in the Day Support Waiver
- **Providers of Community Based Services**
  - 40 Community Services Boards (CSBs)
  - 295 licensed providers which provide services in:
    - 684 group homes
    - 139 day support programs
    - A variety of other support venues
- **FY 2006 Financial Commitment to Mental Retardation Services**

Medicaid Waiver	$325.6 Million
Day Support Waiver	$ 1.8 Million
State Training Centers	$216.3 Million
Private ICFs/MR	$ 26.1 Million
State GF for Community	$ 20.1 Million
Local Tax Dollars	$ 76.5 Million
SPO Case Management	$ 22.0 Million
Acute Care And Transportation	$ 87.5 Million
Total Effort	**$775.9 Million**

- **MR Waiver Eligibility Criteria**
  - **Diagnostic**: Documentation of mental retardation (or at developmental risk for those < 6)
  - **Functional**: Meets at least two "Level of Functioning Survey" criteria
  - **Financial**: Medicaid eligible per DSS
  - Once found eligible, an individual's urgency of need is assessed; three waiting lists:
    - Urgent Needs
    - Non-urgent Needs

- CSB Planning List
- **Statewide Waiting List <u>of</u> 3847*-–-Urgent Needs (2011*) + Non-urgent Needs (1836*) <u>*figures as of June 1, 2007</u>**
  - Grows at a rate of more than 1 slot per day
  - Slots funded in recent years have not kept pace with this rate of growth:
    - FY07 =145 Community + 110 Children's
    - FY06 =300 Day Support Slots
    - FY05 =700
  - More than 1,500 persons have been added to the Urgent Needs Wait List in the last 1,000 days <u>as of June 1, 2007</u>

DMHMRSAS Study of the Mental Retardation Service System as Reported to JCHC in October 2007

DMHMRSAS Study Findings: Current Strengths of the System

- Choice of community or facility setting in which to receive Medicaid–funded services. The MR Waiver also offers choices of services and service providers
- The portability of MR Waiver slots
- The flexible management of resources tailored toward individual needs
- An ethical and efficient distribution of Waiver resources to individuals on the wait list
- Peace of mind for families of individuals with challenging medical or behavioral needs who reside in state training centers
- Individualization of services available to those who receive Medicaid-funded supports
- Utilization of training centers as regional resource centers for community members
- Some support for community residents not on MR Waiver through:
  - local funding,
  - another Medicaid Waiver,
  - the Department of Rehabilitative Services, or
  - a local philanthropy

DMHMRSAS Study Findings: Gaps and Barriers in the Current System

- Need for funding of more MR Waiver Slots and enhanced reimbursement for MR Waiver services
- Limited provider capacity for certain services and in particular areas
- Lack of affordable housing statewide
- Lack of support for paid employment opportunities in the community
- Aging, less than safe state training centers
- Insufficient and unaffordable medical services for community residents
- Insufficient services for persons with both a mental health and intellectual

disability
- Person-centered practices only in pockets
- Few to no supports for individuals in the community without Waiver funding
- Gaps in systematic transportation services

Federal initiatives that may facilitate some desired outcomes of the study, but also need support to succeed:
- Systems Transformation Grant
- Money Follows the Person Demonstration

DMHMRSAS Recommendations:
Made without regard to budget constraints and competing priorities for the Governor and General Assembly
- 21 priority recommendations (5 core recommendations were reported to JCHC)

#1
- Fund MR Waiver slots for 800 individuals per year for the next four biennia
- Fund the start-up of each of the 800 slots
- Fund a statewide assessment tool

FY 2009 - $30,880,000 FY 2010 - $58,608,000

#2
- Invest in community infrastructure for those exiting facilities and those presently in community
- Renovate CVTC and SEVTC to maintain health and safety

FY 2009 - $13,000,000 FY 2010 - $13,000,000

#3
- Re-establish commitment to support through General Fund dollars, people with intellectual disabilities who have no other avenue for support.

FY 2009 - $40,000,000 FY 2010 - $40,000,000

#4
- Provide for a 25% rate increase for all MR Waiver models of residential support of four beds or less (except "sponsored residential" homes).

FY 2009 – $13,065,561 FY 2010 - $13,145,443

#5
- Fund 125 MR Waiver slots/year for the next two biennia to enable the success of Money Follows the Person.
- Beginning in FY 2013, fund 60 crisis slots/year.
- Fund the start-up of each slot.

FY 2009 - $4,825,000 FY 2010 - $9,150,000

☑ **JCHC Option**: Introduce a budget amendment to fund an additional 1,000 MR waiver slots.

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.

Description
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
Virginia has barrier crime laws relating to the following social services and health care employers:

- Child Welfare Agencies (§63.2-1721),
- Foster or Adoptive Homes approved by Child Placing Agencies (§63.2-1721),
- Family Day Homes approved by Family Day Systems (§63.2-1721),
- Unlicensed and Licensed Exempt Child Day Centers (§63.2-1724),
- Child Day Centers and Family Day Homes (§§63.2-1725, 63.2-1720),
- Assisted Living Facilities (§§63.2-1721, 63.2-1720),
- Adult Day Centers (§63.2-1720),
- Licensed Nursing Homes (§32.1-126.01),
- Licensed Home Care Organization, Home Care Organization Exempt from Licensure, and Licensed Hospice (§32.1-162.9:1),
- Community Service Boards (§37.2-506),
- Behavioral Health Authority (§37.2-607), and
- DMHMRSAS (§37.2-416).

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,
- 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

- Escape from Jail, and Felonies by Prisoners.

The 21 misdemeanors 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).

Virginia Barrier Crime Laws Exceptions

There are some statutory exceptions to Virginia's barrier crime laws. For example, a licensed assisted living facility or adult day care center, licensed nursing home, home care organization or hospice may hire a person convicted of one misdemeanor barrier crime not involving abuse or neglect, if 5 years have elapsed following the conviction. (*Code of Virginia* §§63.2-1720, 32.1-126.01, 32.1-162.9:1) A child day center, children's residential facility, DMHMRSAS provider, CSB, or BHA may hire persons who have been convicted of not more than one misdemeanor offense of assault and battery if 10 years have elapsed following the conviction, unless the person committed the offense during the scope of the employment or the object of the offense was a minor. (*Code of Virginia* §§37.2-416, 37.2-506, 37.2-607, 63.2-1720, 63.2-1726).

Screening Process for Employment at Adult Substance Abuse Treatment Programs

A screening process has been added in statute (*Code of Virginia* §§37.2-506, 37.2-416) to allow CSBs, BHAs and DMHMRSAS providers to consider for employment <u>in adult substance abuse treatment programs only</u>, persons convicted of certain barrier crime offenses including:

- Unlawful hazing (§18.2-56);
- Reckless handling of a firearm (§18.2-56.1);
- Any misdemeanor or felony violation related to:
  - reckless endangerment of others by throwing objects (§18.2-51.3);
  - threat (§18.2-60),
  - breaking and entering a dwelling house with intent to commit misdemeanor in (§18.2-92),
  - possession of burglarious tools (§18.2-94),
  - any felony violation relating to distribution of drugs, except an offense pursuant to subsections H1 or H2 of §18.2-248, or
- An equivalent offense in another state.

Eligibility for screening requires that the applicant shall (i) have completed all prison or jail terms; (ii) not be under probation or parole supervision; (iii) have no pending charges in any locality; (iv) have paid all fines, restitution, and court costs for any prior convictions; and, (v) have been free of parole or probation for at least 5 years for all convictions. Screening will determine (i) if the criminal behavior was substantially related to the applicant's substance abuse; and, (ii)

whether the applicant has been successfully rehabilitated and is not a risk to consumers based on the criminal history background and substance abuse history.

Federal Laws
In general, the federal government does not preclude employment by social services and health entities, but allows states to conduct national background checks in a few specific instances. Individuals who want to provide foster or adoptive home care or may have unsupervised access to children, the elderly, or individuals with disabilities are required to have a background check to determine if they have been convicted of a crime that bears upon their fitness to provide for the safety and well-being of those vulnerable populations. Adam Walsh Act, National Child Protection Act (42 U.S.C. §5119a). Federal legislation that would establish additional background checks for direct access employees of long term care facilities and providers is being considered by Congress. (S.1577/H.R.3078) (H.R.1476).

Other States
States differ in the degree and manner in which they mandate employment restrictions based on the criminal record of the applicants in social service and health care fields. For example, the majority of states require background checks for licensing/employment purposes, but not all of those states list the barrier crimes in Code; barrier crimes might be listed in the Administrative Rules and Regulations of the state, or there may be no specific barrier crimes leaving the hiring decision at the discretion of the employing/licensing entity. The types of barrier crimes also vary across the states from the generalized, "all felonies," to the specific, violent crimes. Additionally, the entities with barrier crime restrictions also vary across the states; some states limit barrier crimes to entities that deal with children while others have barrier crimes for all entities that deal with vulnerable populations.

Colorado allows assessment of a disqualification of eligibility for employment. Assessment is only allowed for certain misdemeanors, and only after a certain period of time has elapsed. Florida provides levels of screening based on the type of employment sought, but also allows exemptions from disqualification. Felonies and misdemeanors can be exempted after a certain amount of time has elapsed and after weighing the mitigating circumstances.

Illinois and New Jersey list the barrier crimes in Code; however, they allow an individual to request a waiver/reconsideration for any crime. This waiver is granted after an evaluation of the evidence and the mitigating circumstances. In New Jersey, the individual must affirmatively demonstrate rehabilitation.

Discrimination Issues
Title VII of the Civil Rights Act of 1964 establishes parameters affecting the scope of a potential employer's inquiries about prior arrests, convictions, and other

aspects of the applicant's criminal history. Under Title VII, employers may exclude applicants with arrest or conviction records if they can prove that the applicant's criminal history prevents the latter from satisfying certain job requirements. Employers can usually defend Title VII challenges by availing themselves of the "business necessity" defense.

Liability Issues

Under the negligent hiring doctrine, an employer could be liable for harm resulting from an employee's conduct if the employer hires a person with known propensities, or propensities which should have been discovered by reasonable investigation, in a position in which it should have been foreseeable that the employee posed a threat to others. An employer is also vicariously liable for an employee's acts that were committed within the "scope of employment."

Enactment of a statutory employment or licensing requirement imputes a duty of care onto employers in the industry governed by the provision. In some states, an employer's failure to perform a state-mandated criminal background check is considered negligence per se in a negligent hiring case. In Virginia, such a failure could be considered negligence per se.

The Transformation Initiative

Whereas the barrier crime laws for employers are becoming more expansive and restrictive, a different movement is occurring in the mental health and substance abuse arena. Specifically, the President launched the New Freedom Commission on Mental Health with the purpose of transforming the mental health system by focusing on recovery and making mental health care consumer and family driven. Virginia has in place its own System Transformation Initiative to transform Virginia's mental health system into one that focuses on recovery, self-determination and empowerment. The vision of the transformed system is that every person with a substance use disorder and/or mental illness can achieve some level of recovery. Evidence suggests that peer support can play an important role in the recovery process. Enforcement of absolute barrier crimes with no opportunity to determine whether intervening factors (particularly those related to an individual's substance use disorder or mental illness) should be considered contradicts the principles of a transformed mental health system.

Workgroup

In March 2007, JCHC staff convened a workgroup to discuss SJR 106. The workgroup included representatives from various stakeholders, including:

- Virginia Association of Community Services Boards;
- Alzheimer's Association of Virginia;
- Virginia Assisted Living Association;
- Virginia Health Care Association;
- Virginia Association for Home Care & Hospice;
- SAARA of Virginia;
- DMHMRSAS, Office of Substance Abuse Services;
- Virginia Health Care Association;

- SAARA of Northern Virginia, President;
- Virginia Association for Nonprofit Homes for the Aging; and,
- Virginia Network for Private Providers.

Research findings and the testimony of stakeholders revealed that persons with a history of mental illness and/or substance abuse problems often have criminal backgrounds related to their illness or substance abuse problems, and often have difficulty obtaining employment, making rehabilitation more difficult. Employers also have difficulty obtaining a qualified workforce. It is difficult to determine the number of individuals in Virginia who have been denied employment because of a criminal conviction. Additionally, it is impossible to determine the number of qualified individuals who do not apply for positions because they do not want to undergo a background check. However, from July 1, 2006- December 30, 2006, the Virginia State Police received 16,601 requests for background checks.

- 13,708 resulted in a no "hit" for a barrier crime.
- 2,893 resulted in a "hit" for a barrier crime and/or qualified for assessment, but required more research for verification.
- The VSP does not track the number of persons out of the 2,893 possible hits for barrier crimes that are actually denied employment because of a barrier crime in their background.

Although workforce shortages affect most of the health and social service providers in Virginia, most of the workgroup participants indicated they were not interested in changing the barrier crime laws affecting their services. However, this was not the sentiment expressed by representatives of CSBs who suggested removing the current barrier crimes provisions pertaining to employment in adult substance abuse treatment facilities and allowing consideration of an individual's entire criminal record. They also suggested providing for a rehabilitation assessment for employment of individuals with serious mental illness similar to the assessment allowed for individuals with substance use disorder.

As noted previously, Virginia law allows individuals with substance use disorder, with certain barrier crimes on their record, be assessed for rehabilitation and therefore become eligible to work in direct care within an adult substance use program. There is no similar provision in Virginia law to allow individuals with mental illness and certain barrier crimes to qualify for rehabilitation assessment. Consumers with serious mental illness may have assaults in their background making them ineligible to be employed as peer counselors. Often, these assaults involve a family member or a law enforcement officer during the ECO/TDO process. Many consumers with serious mental illness could benefit from peer contact, similar to the benefits enjoyed by consumers with substance use disorder. The CSBs estimate that over 40 mental health consumers would qualify for employment if they could be assessed for rehabilitation in the same manner as allowed for substance use disorder.

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.

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.

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

10 comments were received in support of Option 3.

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.

Two comments support this option but want the definition of "intentional violent harm" clarified.

One comment was received in opposition.

This individual expressed concern that the language would exclude persons who have had a bar room fight, an offense of which is often due to alcohol and age.

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.

Four comments were received in support of Option 4.

One individual supports this option, but with the exception that every applicant be screened. This would eliminate the problem of having to determine which individuals would be screened. This suggestion would make Option 3 and 4 the same.

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.

One commenter did not specifically address any of the specific options but wants more support for the mentally ill, including help with employment.

The Virginia Association for Home Care and Hospice reiterated that they "do not currently see a need to change the barrier crimes prohibitions that apply to the home care, hospice or personal care industries. It has been our experience that conducting criminal background checks does not limit the pool of applicants, it actually strengthens our ability to protect those that we serve."

Option 5: Introduce legislation to amend *Code of Virginia* §§37.2-506, 37.2-416 to allow persons convicted under §§18.2-57 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)

Staff Report:
Background Checks for Medical Practitioners

Background

In 2007, H.B. 1944 (Purkey) was passed by in HWI, where it was referred by letter to the JCHC to study. This legislation would:

- Require criminal history background checks for all individuals seeking initial licenses to practice medicine, osteopathic medicine, chiropractic, or podiatry.
- Authorize the Board of Medicine (Board), at its discretion, to require background checks of individuals seeking to renew licenses.
- Set forth approximately 30 crimes that conviction of which would prevent the Board from granting or renewing a license.

Current Virginia Law

Under Virginia law, there is no requirement that an individual undergo a criminal background check before receiving or renewing his/her license to practice medicine. However, every licensee must apply for renewal of his license biennially, and furnish information, such as any convictions, to the Board. (*Code of Virginia* §54.1-2904).

Additionally, there are is no barrier crime law that specifically prohibits a person who has committed certain crimes from practicing medicine. The Virginia Board of Medicine *can* refuse to admit an individual for examination, refuse to issue a license or certificate, or suspend or revoke a license or certificate for certain unprofessional conduct, including, for example:

- Violating any statute or regulation "relating to the manufacture, distribution, dispensing or administration of drugs;"
- Being convicted in any jurisdiction of any felony, or of a misdemeanor involving moral turpitude; or,
- Having had a certificate or license revoked or suspended without having that certificate or license to practice reinstated in another jurisdiction. (*Code of Virginia* § 54.1-2915)

Hospitals must report disciplinary action to the Board. (*Code of Virginia* §54.1-2400.6). Additionally, the clerk of the court in which a medical "practitioner has been convicted [of a felony] or found to be incapacitated or incompetent," shall have a duty to report these findings promptly to the Board" of Medicine. (*Code of Virginia* §54.1-2917) Upon notice, the Board must suspend the license or certificate. However, according to staff at the Department of Health Professions (DHP), the practice of reporting such findings never occurs.

Other States

Twenty-eight states have the statutory authority to run criminal background checks as a condition of licensure. Most of the states that now require background checks

instituted the requirement in recent years, so there is little information about the long-term benefits. Texas started checking backgrounds in 2005 and has found that they are time-consuming and are not revealing many problems. In Arizona, background checks are completed, but the findings are not necessarily used to disqualify someone from being licensed. Kentucky requires a criminal background check of all persons applying for initial licensure and at other times as requested by the Board when good cause is shown. Nevada requires all new medical doctor applicants to be fingerprinted. Additionally, if a formal complaint is filed on a currently licensed physician, he/she will be required to be fingerprinted.

Additional Opportunities for Criminal Background Checks

Criminal background checks are becoming a more common requirement for medical students as part of the application process and as a requirement for clinical clerkships. A survey conducted by the Council on Medical Education during the 2004-2005 academic year found that of the 125 medical schools:

- 24 already required criminal background checks,
- 49 were planning to start in the near future, and
- 52 were not conducting or planning to start criminal background checks.

In February 2006, the Association of American Medical Colleges' Advisory Committee on Criminal Background Checks endorsed the concept of a centralized system for background checks for applicants accepted to medical school.

Since July 2006, the Veterans Administration hospitals have required all employees, including students and residents, to undergo a criminal background check. Additionally, Standard HR. 1.20 of the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations) requires that criminal background checks be conducted on all categories of health care providers (including students and volunteers).

Virginia Department of Health Professions Efforts

To determine what has been missed by not completing background checks, DHP wanted to conduct background checks on a random sample of physicians. However, since DHP would need probable cause to conduct a background check, they instead checked their 280,000 licensees (of all types) against the Virginia Sex Offender Registry. They had 5 hits: 4 licensed by the Board of Nursing and 1 licensed by the Board of Social Work. All 4 nursing licensees had disclosed their convictions.

Issues Related to Requiring Background Checks

- What type of delay will it cause to require background checks prior to licensing.
- How much time, money and staff will be required to conduct background checks on potential licensees.
- The timing of the background check and the time period covered.

- Possibility of multiple background checks.
  - Accepted medical school applicants and enrolled students may now be subject to multiple checks and duplicate charges due to the differing requirements of medical schools, hospitals, and others.
  - Duplication is exacerbated by limitations on sharing information.

Options

Option 1: Take no action.

Option 2: Introduce legislation to amend the *Code of Virginia* §54.1-2930 to require all persons to undergo a criminal background check before being admitted to take the examination for licensure to practice medicine, osteopathic medicine, chiropractic, or podiatry.

Option 3: Introduce legislation to require all persons upon application for a license to practice medicine, osteopathic medicine, chiropractic, or podiatry to undergo a criminal background check.

Option 4: Introduce legislation to amend the *Code of Virginia* to grant the Department of Health Professions the authority to conduct background checks on current and potential licensees in the practice of medicine, osteopathic medicine, chiropractic, or podiatry.

- This option would allow DHP to complete a random check to see what percentage of practitioners is likely to have background hits if the requirement were put in place.
- This option would reinforce the requirement that practitioners report conviction and disciplinary action to the Board by reminding licensees that they are subject to being checked at the initial time of application and upon license renewal.

☑ **Option 5:** By letter of the chairman request that the Virginia Compensation Board and the Executive Secretary of the Supreme Court of Virginia examine, and if necessary, address the extent to which clerks are adhering to the *Code of Virginia* §54.1-2917.

Staff Report:
Minority Access to Mental Health Services

Background
SJR 25, 2004 (Patron: Senator Henry Marsh)

Race/Ethnic Mental Health Disparities
- Minimal "true" epidemiological differences in incidence & prevalence by race and ethnicity
- Key Disparities:
  - Access to quality services
  - Help seeking and help utilization
  - Negative experiences within the system
  - Pervasiveness of stigma
  - Language and cultural competence
  - Lack of inclusion in research and clinical trials

  Many of these disparities can be alleviated by increasing our efforts in the areas of cultural competence and workforce shortages.

Cultural Competence
In the mental health care setting, culture impacts how people label and communicate distress, explain the causes of mental health problems, perceive mental health providers, and utilize/respond to mental health treatment.

Goal of Cultural Competence Involves:
- Recognizing that culturally appropriate, community-driven programs are critical
- Promoting cultural awareness
- Encouraging cultural competence inclusion in medical school and health careers curriculum
- Advocating for the needs of the patients by providing translators, culturally competent information and instructions in simple language
- Encouraging recruitment, admission and retention of persons of color into the health professions
- Fostering mentorships for young people to help them remain in school and work towards a goal
- Supporting other physicians and health workers of color in attaining their goals

Research shows that providing competent cultural and language services can improve health outcomes, increase patient compliance, be more cost effective,

increase patient satisfaction, and increase access to health care.

Current Efforts to Increase Cultural Competence

- DMHMRSAS: Workforce & Cultural Competency Conference. October 24 & 25, 2007. Newport News, VA
- Office of Minority Health & Public Health Policy: CLAS Act Initiative
  - www.CLASActVirginia.org is a resource guide to assist health care providers. Resources include training, reports, and other documents on:
    - Cultural competence
    - Overcoming language barriers
    - Translation
    - Interpretation
  - Resources are specific to Virginia with regionally appropriate information on:
    - Language service programs
    - Multicultural health and human service programs
    - Virginia studies and reports
    - Regional conferences and training
  - Translated resources through the site include
    - Links to thousands of translated documents
    - Commonly used clinical phrases in Spanish and Korean with accompanying audio and visual flip charts

Workforce Shortages

Current Scholarship and Loan Repayment Programs to Increase Health Professionals in Underserved Areas

- Virginia Department of Health Loan Repayment Programs
  - VLRP (State funded program) & SLRP (State/federal matched funds)
    - Purpose is to recruit and retain primary care professionals in health professional shortage areas (HPSAs) and medically underserved areas (MUAs)
    - Intended for post-residency
    - $50,000 for 2 year commitment
    - $35,000 for 1-2 additional year(s)
    - Minimum loan defaults due to flexibility of program
      - I.e. VDH can approve a recipient to change their practice site without going into default.
- Virginia's Nurse Practitioner/Nurse Midwife Scholarship Program
  - $5000 per year for maximum of 2 years
  - Funds appropriated by the VA General Assembly ($25,000)
  - One year of service in medically underserved area required for each year that scholarship was received
- J1 Visa Waiver
  - For foreign medical students to complete residency in the U.S.

- Required to work in medically underserved area for 3 years
- Virginia fills approximately 14 of 30 available slots

- State funding of $493,000 was appropriated for FY2008 for 8 fellowship/internship positions in medically underserved areas for individuals specializing in child psychiatry at a Virginia institution of higher education.

Options

Option 1: Take no action

Option 2: Request by letter from JCHC Chairman for the Virginia Department of Health Professions (or The Board of Medicine and The Board of Psychology) to examine and report on the issue of requiring cultural competence training for licensure of health practitioners or as a mandatory continuing education unit.

☑ **Option 3:** Request by letter from JCHC Chairman for the State Council of Higher Education for Virginia (SCHEV) to examine the issue of requiring cultural competence training as part of college curriculum for health profession majors.

Public Comments:
No public comments were received on any of the policy options.

Reports on Cervical Cancer and HPV Vaccination

HPV Vaccination of women aged 16-26 in Virginia

Jennifer L. Young, MD, MPH, Ruth G. Bernheim, JD, MPH,
Mark R. Conaway, PhD, Mark H. Stoler, MD, Thomas C. Guterbock, PHD, Laurel W. Rice, MD
University of Virginia Health System

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

Overview

Human papillomavirus (HPV)

- Most common sexually transmitted disease
  - 6.2 million people infected each year[1]
  - Prevalence 20 million cases in US[1]
- Lifetime risk: 80% for women by age 50
- Prevalence in sexually active teenagers: 64-82%[2]
  - 28% of 14 year olds sexually active[3]

The HPV Vaccine

- Quadrivalent vaccine: Gardasil® (Merck&Co, Inc.)
  Approved by the FDA June 2006
  Viral types 6,11,16,18
  Tested in over 25,000 young women aged 9-26[4]
  - 95% efficacy in preventing HPV infection
  - 98.5% efficacy in preventing persistent disease necessary for cervical cancer[1]
  - Most efficacious if given before onset of sexual activity
  - Younger age at vaccination associated with more pronounced immune response
- Bivalent vaccine: Cervarix® (GlaxoSmithKline)
  Pending FDA approval
  Viral types 16, 18
  Tested in over 30,000 women aged 15-25[5]
  - 95% efficacy in prevention of first HPV infection
  - 100% efficacy in preventing persistent disease
  - Protection lasts at least 5 years
  - Studies ongoing evaluating cross-reactivity with other viral types

Center for Disease Control Advisory Committee on Immunization Practice (ACIP) Recommendation

- Routine vaccination of girls ages 11-12
- Catch-up vaccination up to age 26

Current Coverage of the HPV vaccine

- 3 shot regimen costing $120/injection or $360 total

- Coverage ≤ 18 years old
  - Public: Federal Vaccines for Children program for Medicaid qualifiers
  - Private: Most insurance companies cover but age range and reimbursements differ
- Coverage > 18 years old
  - Public: No Medicaid allocation
  - Private: Most insurance companies cover but age range and reimbursements differ

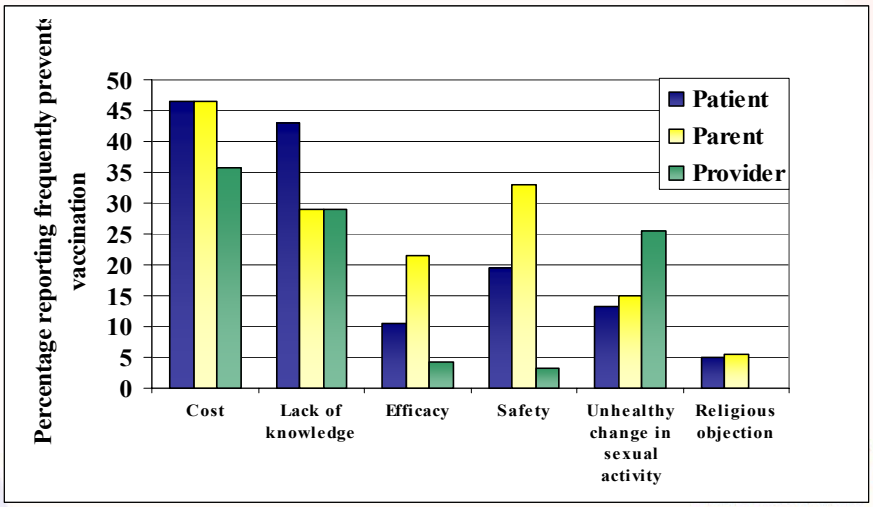
University of Virginia Health Center conducted a study on HPV vaccination of women ages 16-26 in Virginia:

Survey results
- 395 respondents
  - 169 family practitioners
  - 216 ob-gyns
- Response rate 45.4%
- Obstetrician-gynecologists and family practitioners similar in attitudes and behaviors related to HPV vaccine

Provider implementation of HPV vaccine:
- 72% of providers currently offer the HPV vaccine
  - Another 16% plan to offer vaccine in the near future
- $25-$50 charge per injection on average over the cost of the vaccine
- Most common age of vaccination 19-22 years old
- 70.2% recommend the HPV vaccine to all women in this age range
  - 24.3% selectively recommend
  - 5.5 % never recommend

Patient experience with HPV vaccine:
- 36% of patients aged 16-26 have been vaccinated against HPV
  - 26% vaccinated in the provider's office
  - 10% vaccinated elsewhere
- 12% have declined HPV vaccination
- 30% considering HPV vaccination

Summary of Barriers to HPV vaccination



UNIVERSITY OF VIRGINIA HEALTH SYSTEM

Provider views on HPV vaccine policies

Policy options	Providers in Favor
Health department vaccination programs	91%
School-based vaccination programs	54%
Mandatory insurance coverage	73%
Mandatory insurance coverage during postpartum care	74%

UNIVERSITY OF VIRGINIA HEALTH SYSTEM

Provider view on Virginia's school mandate for HPV vaccination

Opinion	Percentage of providers
Strongly favor	37%
Somewhat favor	22.4%
Somewhat oppose	34%
Strongly oppose	0.8%
Other	6.4%

Overall 59.4% of providers support the school mandate

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Conclusions

- Cost and education remain significant barriers to HPV vaccination
- Vaccination refusal may be less prevalent than expected
- Providers support policies to improve HPV vaccination rates among women aged 16-26

Current policy issues

- Current funding allocation for the school mandate may be inadequate
- National leadership for school mandates in other states
- Health department based programs for vaccination of young women without coverage or access
- Mandatory insurance coverage
- Improved patient education

Sources:

1. CDC. Genital HPV Infection. 2004
2. Fraser et al. Ped Infect Dis J 2005.
3. Grunbaum JA et al. MMWR 2004.
4. FUTURE II study group. NEJM 2007; 356:1915.
5. Harper DM et al. Lancet 2004; 364:1757.

Joint Commission on Health Care
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.

HPV Vaccine:
In June 2006, the quadrivalent HPV vaccine (GARDASIL ™), manufactured by Merck and Co., was licensed for use among females aged 9-26 years for prevention of HPV-type-related cervical cancer, cervical cancer precursors, vaginal and vulvar cancer precursors, and anogenital warts.

The national Advisory Committee on Immunization Practices (ACIP) submitted their recommendations for the use of HPV vaccine to the Centers for Disease Control and Prevention (CDC) in June 2006. The CDC updated and clarified wording in the ACIP document and published the recommendation in the March 12, 2007 edition of the *Morbidity and Mortality Weekly Report (MMWR).*

Clinical trials indicate that the vaccine has high efficacy against HPV types 6, 11, 16, and 18, thus preventing most cases of persistent HPV infection, cervical cancer precursor lesions, vaginal and vulvar cancer precursor lesions, and genital warts from these HPV types among vaccinated females who have not already been infected by them. No evidence exists of protection against disease caused by HPV vaccine types with which females are infected at the time of vaccination, and protection would not be expected against HPV types not included in the vaccine. Females infected with one or more HPV types before vaccination would be protected, however, against disease caused by the other vaccine HPV types.

The vaccine is administered by intramuscular injection and the recommended schedule is a 3-dose series with the second and third doses administered two and six months after the first dose. The recommended age for vaccination of females is 11-12 years. Vaccine can be administered as young as age nine years. Catch-up vaccination is recommended for females aged 13-26 years who have not been previously vaccinated. Vaccination is not a substitute for routine cervical cancer screening, and vaccinated females should have cervical cancer screening as recommended.

GlaxoSmithKline has also developed a vaccine against HPV, Cervarix™, targeted at types 16 and 18, that is currently under review by the U.S. Food and Drug Administration (FDA). Having a second vaccine available will enhance vaccine supply.

Current Status:
Since July 2006, local health departments have administered 1,686 doses of HPV vaccine to Vaccines for Children (VFC) program[1] eligible females (11-18 years of age); females enrolled in the 6th grade, and all other females 11-12 years of age. HPV vaccine is also being administered to VFC program eligible females 11-18 years of age by over 2,000 private providers and Community Heath Centers participating in the VFC program. To date, 12,400 doses have been distributed to these facilities.

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 General Assembly appropriation for FY 2008.

Future Needs:
It is expected that per-dose-costs of the vaccine will increase and that the scope of vaccine usage may be expanded to include males. Both changes are likely to drive the need for additional appropriations to cover the associated costs.

[1] Through the VFC program, public purchased vaccine is available at no charge to enrolled public and private health care providers for eligible children. Children 18 years of age and under that meet at least one of the following criteria are eligible for VFC vaccine: 1) Medicaid eligible; 2) Uninsured; 3) American Indian or Alaska Native; 4) Underinsured – defined as a child whose health insurance benefit plan does not include vaccinations.

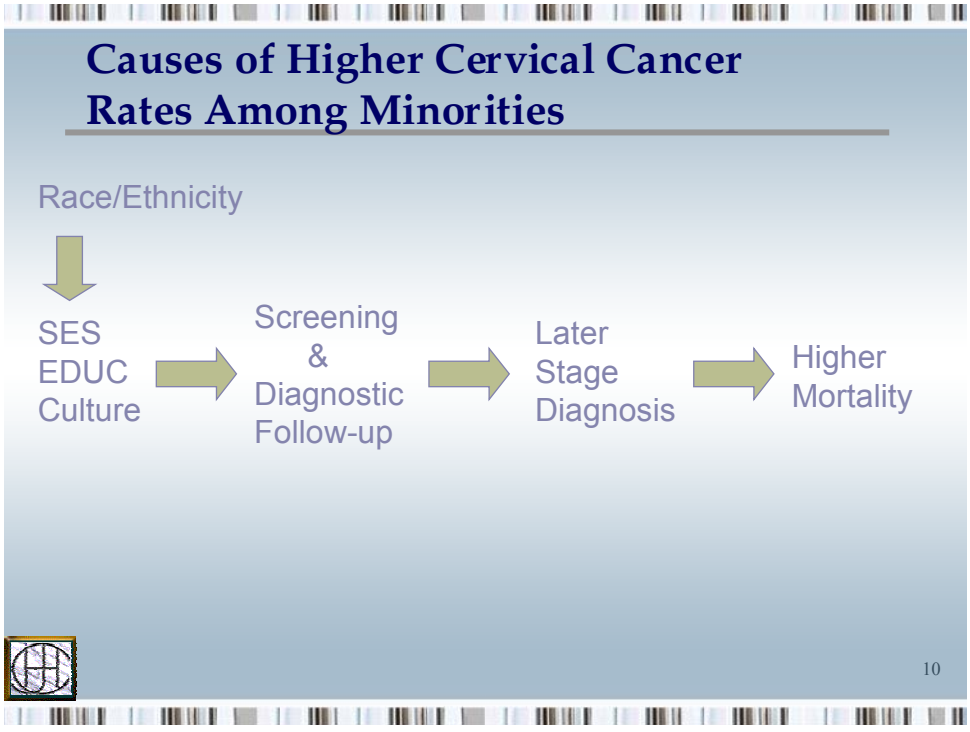
Staff Report:
Higher Rates of Cervical Cancer Among Minority Women

Introduction

- Report of the Governor's Task Force on Cervical Cancer, 2005
  - In January 2005, Governor Mark R. Warner issued Executive Directive 5, creating the task force.
  - Task force chair: Jane H. Woods, Secretary of Health and Human Resources.
  - Report completed November, 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



Conclusion

Senator Whipple, in consultation with the director of the Every Woman's Life program, plans to introduce a budget amendment to increase the number of women eligible for Medicaid funding of cervical cancer treatment.

- This will require changing Virginia's optional coverage from Option 1 to 3 of the federal Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000:
  - Option 1: Women whose clinical services were provided all or in part by the CDC program (Current option selected by Va.)
  - Option 3: Women who are screened by any provider that has been authorized by the state, as a CDC grantee to provide screening activities.
- Need to increase the number of Every Woman's Life providers in underserved health districts.
  - I.e. Northern Virginia, Piedmont, Crater (Petersburg area)
  - Funds needed for staffing these sites.
- VDH is currently investigating the problem of late diagnosis.
  - Many women go beyond the 60 days required by the CDC to receive a diagnosis after an abnormal Pap test. May be due to lack of availability of colpolists.

Options

Option 1: Take no action.

Option 2: Introduce budget amendment (amount to be determined later) to fund the staffing of Every Woman's Life (VABCCEDP) providers in underserved health districts.

Public Comments

No public comments were received for any of the policy options.

Additional Options Considering the Other Presentations:

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.

Staff Report:
Virginia Stroke Systems

Background

House Joint Resolution 635 (O'Bannon) directed JCHC to study and develop strategies that address "stroke prevention and care across the Commonwealth" and identify and propose solutions to barriers for optimal stroke care, such as:

- Public awareness initiatives
- Emergency response protocols
- Primordial, primary and secondary prevention of stroke
- Rehabilitation of stroke patients
- Continuous quality improvement initiatives, and
- Availability of public support to treat indigent and uninsured stroke victims

HJR 635 was not passed; however, JCHC agreed to the study.

Description

A stroke is loss of brain functions caused by loss of blood circulation or rupture of a vessel. There are three types of stroke hemorrhagic, ischemic, and transient ischemic attack (TIA). Hemorrhagic strokes are the most likely to be fatal and ischemic strokes represent the highest level of discharge to other institutions such as nursing facilities and rehabilitation centers.

Only 17% of Americans can accurately identify signs of stroke and recognize the need to call 911 immediately. Rapid treatment of strokes is critical.

Virginia Stroke Statistics

- 20,674 stroke patient discharges from Virginia hospitals in 2006
- 3,681 Virginians died from a stroke (2004)
- For every 100,000 Virginians, 54 died from a stroke (2004)
- For every 100,000 Black Virginians, 79 died from a stroke (2004)

Acute Stroke Treatment Coordination

Some stroke treatments such as Tissue Plasminogen Activator (TPA) must be given within three hours from onset of the stroke. The three hours would include the time the patient (or witness) becomes aware of symptoms, calls 911, EMS's arrival and transport, delivery of the patient to the hospital, a CT scan, and determination of inclusion and exclusion criteria. In short, the medical response to acute stroke patients requires great coordination and precision to meet such stringent timeframes.

Stroke Systems Workplan
A stroke systems workplan was created and approved with 28 strategy recommendations for the recommended Stroke System Task Force. The number of target strategies is denoted above each area of care.

Recommendations include: strategy description, partners, tools, resources, accomplishments, next steps, and measures.

Options

Option 1: Take no action

☑ **Option 2:** By letter of the Chairman require that VDH convene a standing Stroke Systems Task Force to address improvement in VA's Stroke Systems, meet quarterly, & focus on:

- Stroke systems work plan
- Topics referred from stroke systems workgroup
- Other stroke issues/concerns, as necessary
- Outcome analysis of interventions

Task force membership shall include:

- Neurologist
- Neuroradiologist
- Emergency care physician
- Two family practice physicians
- Licensed nurse
- Pharmacologist
- Small rural hospital administrator actively involved in stroke care
- Primary Stroke Center hospital administrator
- Office of Emergency Medical Services representative
- VDH Division of Chronic Disease Prevention representative
- Stroke survivor
- Administrator from an accredited stroke rehabilitation facility
- Stroke caregiver
- American Stroke Association representative
- Virginia Hospital & Healthcare Association representative
- Medical Society of Virginia representative
- VCU Center on Health Disparities representative
- Virginia Association of Health Plans representative
- Physical Medicine and

Option 3: Amend the *Code of Virginia* to grant the Department of Health's Commissioner the authority to designate certain hospitals to be a "Primary Stroke Center" when accredited as a "Primary Stroke Center" by the Joint Commission or similar designation by another equivalent national accrediting body (similar to trauma designations).

Option 4: Establish hospital guidelines for stroke treatment. (JCHC may support either or both)

- **4-A -** Amend the *Code of Virginia* to mandate that all hospitals establish a protocol for the rapid evaluation and subsequent admission or transfer of the stroke patient.

☑ **4-B -** Letter from JCHC chairman to VHHA requesting assistance on encouraging all hospitals to establish a protocol for the rapid evaluation and subsequent admission or transfer of the stroke patient.

☑ **Option 5:** Amend the *Code of Virginia* to require each regional EMS Council to create a uniform destination plan for prehospital stroke patients, with partners including the Office of Emergency Medical Services (OEMS) and public safety answering points (PSAPS), as well as other organizations as deemed appropriate.

☑ **Option 6:** Request by letter of the Chairman that OEMS report to JCHC in 2008 regarding progress in developing a centralized electronic medical record data collection.

☑ **Option 7:** Request by letter of the Chairman that Department of Medical Assistance Services (DMAS) investigate the option for care coordination service payments for those who have had a stroke.

☑ **Option 8:** Request by letter of the Chairman that Department of Social Services (DSS) and DMAS investigate an expedited Medicaid determination review for acute stroke patients.

Options with Public Comments

A total of 34 comments were submitted. Thirty-one support Options II-VIII. Two comments address Option V, while neither supporting nor opposing. Finally, Virginia Hospital and Health Care Association (VHHA) supports Options IV-B, 7, and 8, opposes Option 3, and addresses Options 2 and IV-A.

Option 1: Take no action
No comments in support

☑ **Option 2:** Virginia Department of Health convene a standing Stroke Systems Task Force to address improvement in Virginia's Stroke Systems. This task force will meet quarterly and focus on:

- Stroke systems work plan
- Topics referred from stroke systems workgroup

- Other stroke issues/concerns, as necessary
- Outcome analysis of interventions

Task force membership shall include:

- Neurologist
- Neuroradiologist
- Emergency care physician
- Two family practice physicians
- Licensed nurse
- Pharmacologist
- Small rural hospital administrator actively involved in stroke care
- Primary Stroke Center hospital administrator
- Office of Emergency Medical Services representative
- VDH Division of Chronic Disease Prevention representative
- Stroke survivor
- Administrator from an accredited stroke rehabilitation facility
- Stroke caregiver
- American Stroke Association representative
- Virginia Hospital & Healthcare Association representative
- Medical Society of Virginia representative
- VCU Center on Health Disparities representative
- Virginia Association of Health Plans representative
- Physical Medicine and Rehabilitation Physician

Thirty-one comments in support of this option
Additional comment:

VHHA neutrally commented regarding Option II– VHHA supports increased efforts to improve all care and will participate in the task force but find the legislative mandate "unnecessary and inappropriate."

Option 3: Amend the *Code of Virginia* to grant the Department of Health's Commissioner the authority to designate certain hospitals to be a "Primary Stroke Center" when accredited as a "Primary Stroke Center" by the Joint Commission or similar designation by another equivalent national accrediting body (similar to trauma designations).

Thirty-one comments in support of this option
One comment opposed
Additional comments:

American Heart Association (AHA) commented in support of Option III – "This option regards more than the punitive aspect of 'truth in advertising.' …. [It is] a crucial building block for establishing a full stroke system of care. This state-level designation will be important in addressing EMS destination plans for pre-hospital stroke patients, developing inter-hospital transfer protocols, and developing an accurate picture of care across the state. In addition, this designation will be an important tool for educating the public about the role of Primary Stroke Centers."

VHHA commented in opposition to Option III – Duplicating the Joint Commission (formerly JCAHO) accreditation of 'Primary Stroke Center' is "redundant and unnecessary." "In the very limited instances of which we are aware of this occurring in Virginia, simple explanation to the institution that this is inaccurate provided sufficient to correct the situation…. Option 3 appears to be a redundant solution to an infrequent problem…. If such a designating authority were granted to VDH, it would be important that hospitals that unwittingly use the title 'Primary Stroke Center' be given ample opportunity to correct innocent mistakes before being sanctioned."

Option 4: Establish hospital guidelines for stroke treatment. (JCHC may support either or both)

- **4-A** - Amend the *Code of Virginia* to mandate that all hospitals establish a protocol for the rapid evaluation and subsequent admission or transfer of the stroke patient.

Thirty-one comments in support of this option
Additional comment:

VHHA neutrally commented regarding Option IV-A- "Hospital and health systems already have protocols for the appropriate disposition of patients…. **VHHA would oppose** this option if it prescribed the content of the protocols or was accompanied by an inadequate opportunity to correct prior to enforcement or sanction." If this option is accepted, look to § 32-127 B. E. as a model for the language (protocols for obstetrical services).

☑ **4-B** - Letter from JCHC chairman to VHHA requesting assistance on encouraging all hospitals to establish a protocol for the rapid evaluation and subsequent admission or transfer of the stroke patient.

Thirty-two comments in support of this option

Additional comment for Options A and B:

AHA –"The American Stroke Association supports policies that require hospitals to have plans and protocols in place for stroke treatment. This option should not be construed to dictate the contents of the hospital plan …. including whether to provide care on site or transfer. This area has been identified by national stroke experts and the American Stroke Association as a key benchmark to building effective stroke systems and achieving quality patient care."

☑ **Option 5:** Amend the *Code of Virginia* to require each regional EMS Council to create a uniform destination plan for prehospital stroke patients, with partners including the Office of Emergency Medical Services (OEMS) and public safety answering points (PSAPS), as well as other organizations as deemed appropriate.

Thirty-one comments in support of this option

Additional comments:

AHA – "The need for standardized EMS triage and treatment plans is clearly established on a national level…" A short time frame of 3 hours for thrombolytic treatment "makes it critical for the transport system to respond through an established and organized protocol designed to minimize avoidable delays." Because of Virginia's diverse demographic and geographic issues a regional approach is supported instead of a statewide protocol.

VDH Office of Emergency Medical Services (OEMS) – "There are 11 Regional EMS Council areas …. on any given day the availability of EMS resources and personnel cannot be guaranteed. An experienced advanced life support (ALS) provider with advanced skills may be on duty today, while tomorrow an entry-level EMT with more limited patient care skills and field experience…. Also, the thrust of this option … does not adequately recognize the variable nature and availability of EMS resources. For example, to require inexperienced EMS providers to bypass a closer hospital in order to transport patients to designated Primary Stroke Center, that in many cases would be a great distance away, would place undue hardships on the resources of some if not all of the EMS regions … and might increase exposure to liability for EMS personnel."

"Enactment of this type of legislation would require contract modifications and additional funding to develop, implement and appropriately manage the proposed destination plan. Additionally, the Regional EMS Councils are non-profit organizations that function as contractors for OEMS and hold no authority to enforce a destination plan."

Michael Ashby M.D. – "A single destination hospital should not be designated until the possible effect of all stroke patients going to that destination is studied. The new hospital could be challenged with the new volume. This could have a negative impact on other emergency department patients using that emergency department."

☑ **Option 6:** Request by letter of the Chairman that OEMS report to JCHC in 2008 regarding progress in developing a centralized electronic medical record data collection.
Thirty-one comments in support of this option
Additional comment:

VDH Office of Emergency Medical Services – "if the option is directed solely at OEMS' Pre-hospital Patient Care Reporting (PPCR) system, which collects ambulance response data, then the Option should be revised to state that clearly…. OEMS has been actively pursuing approval to plan and procure a modernized electronic patient care reporting (e-PCR) system…. OEMS would be pleased to report to the JCHC on the status of this project upon request."

☑ **Option 7:** Request by letter of the Chairman that Department of Medical Assistance Services (DMAS) investigate the option for care coordination service payments for those who have had a stroke.
Thirty-two comments in support of this option
Additional comment:

VHHA comment in support of Option VII– "Virginia's Department of Medical Assistance Services should investigate the option for care coordination service payments to promote more effective and efficient treatment of all patients with acute conditions, including stroke patients."

☑ **Option 8:** Request by letter of the Chairman that Department of Social Services (DSS) and DMAS investigate an expedited Medicaid determination review for acute stroke patients.
Thirty-two comments in support of this option
Additional comment:

VHHA comment in support of Option VIII– "Increasing the speed of eligibility determinations should facilitate faster flow of resources to hospitals and health systems. In fact there may be many such disease states or conditions that should have faster eligibility reviews."

Staff Report:
Preterm Infants: Follow-Up Care and Tracking

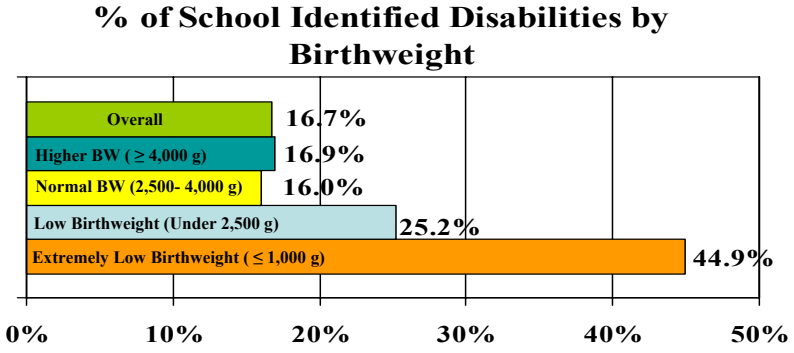
Background

In October 2005, JCHC was briefed on the importance of providing follow-up services for preterm and low-birth weight (LBW) infants. In November 2005, JCHC requested that staff determine the availability and adequacy of follow-up services and the potential need for a tracking system for preterm and LBW infants. One main theme was that "*It is difficult to determine the extent to which access to services is a problem since data that is specific to preterm and low-birth weight infants is lacking.*"

In November 2006, JCHC recommended sending a letter from the Chairman requesting that representatives from various associations and state agencies participate in a JCHC staff-convened workgroup. The focus of the workgroup was to evaluate amending existing data and tracking systems in order to strengthen tracking abilities for: i) preterm and low-birth weight infants, ii) access to services, iii) utilization of services, and iv) long-term outcomes.

Issue Overview

Preterm infants are defined as having less than 37 completed weeks of gestation and Low-Birthweight (LBW) infants are those who weigh less than 2,500 grams or 5.5 lbs. In 2004, 11,261 (10.9%) preterm births and 8,587 (8.2%) LBW infants were born in Virginia. LBW infants are at an increased risk to have a disability.



Developmental delays may not be obvious to a parent, but are often recognized once the child enters school. Types of delays relate to communication, social, motor skills and problem solving. The optimal time for providing services for the most benefit is 0-5 years of age.

Follow-Up Services

Follow-up services for these infants are very important because the brain is especially receptive to the positive effects of intervention services in the first years of a child's life. Providing follow-up services soon after birth frequently

results in increased developmental scores. If delays are undetected until attending school, there is an increased risk of academic failure, behavioral problems and socio-emotional disturbance.

Tracking Preterm and LBW Infants in Virginia

There is no State data system that specifically tracks infants or children who were born preterm or LBW. The Virginia Department of Health (VDH) is the only agency that collects LBW or preterm information on a consistent basis and that is on the birth-certificate. Preterm and LBW children may receive State services but are not identified as such.

VDH is conducting an evaluation of the Family Planning Waiver that includes merging the electronic birth certificate information and Department of Medical Assistance Services (DMAS) information which will allow for identification of LBW and preterm infants for DMAS clients.

In May 2006, a new survey was distributed by VDH – the Pregnancy Risk Assessment Monitoring System (PRAMS). Twelve-hundred mothers will be randomly surveyed each year – 600 mothers of LBW infants and 600 mothers of normal birth weight infants. Fifty surveys will be distributed monthly to each population addressing a wide range of topics. A follow-up survey is possible.

Workgroup Themes

Most state developmental services provided are based on the child's need. Virginia has limited to no ability to track state services provided to a specific child. The ability to track services provided to children across agencies needs to improve in order to determine the services that are being provided for specific children, the coordination of children's services, and the effectiveness of services provided. Obstacles for improving the ability to track these children include:

- Lack of common identifiers across agencies
- Lack of a coordinated interagency approach to be able to follow a child through different state agencies
- Family Educational Rights and Privacy Act (FERPA)

Options with Public Comments

Comments on the work group recommendations were submitted on behalf of:

- CHIP of Virginia
- Virginia Association of Community Services Boards, Inc.
- Virginia Department of Health

The number of comments received in support of each Policy Option is shown below:

Policy Option	Number of Comments in Support
1	0
2	1
3	2
4	2
5	1
6	2
7	2
8	1

Option 1: Take no action.

☑ **Option 2:** Request by letter of the Chairman that the Virginia Department of Health report to JCHC in 2008 on the status of the PRAMS follow-up survey, including the proposed timeline and information the survey results will provide regarding the type, frequency and providers of developmental services.

☑ **Option 3:** Request by letter of the Chairman that VDH and DMHMRSAS report to JCHC in 2008 on the status of an automated referral system that includes a unique identifier between the Virginia Infant Screening and Infant Tracking System (VISITS) and the Infant and Toddler Connection.

☑ **Option 4:** ~~Introduce a budget amendment that provides additional funding for~~ By letter of the Chairman, direct DMHMRSAS to make LBW and preterm information mandatory data fields when local Part C early intervention systems electronically submit a Part C eligible child's initial evaluation ~~(amount to be determined)~~.

☑ **Option 5:** Request by letter of the Chairman that VDH report to JCHC in 2008 regarding the status of the pilot for linking birth certificate information to DMAS's children's records.

Option 6: Request by letter from the JCHC Chairman that the Secretaries of Health and Human Resources, Education, and Technology in consultation with the Office of the Attorney General conduct a demonstration project to track a small group of children receiving services through state agencies and through other state-funded organizations as deemed appropriate. The purpose of this project would be to determine the Commonwealth's ability to track across agencies the services provided to specific children. The letter would include the request to report to JCHC in 2008.

Option 7: Introduce a budget amendment that provides additional funding (amount to be determined) for the DMHMRSAS Part C program to follow-up with LBW and preterm children who were not initially eligible for services.

☑ **Option 8:** Request by letter from the JCHC Chairman that VDH and DMHMRSAS explore the feasibility of VDH studying outcome data on LBW and preterm infants that receive Part C services. Restrictions on VDH's ability to access educational records protected by the Family Educational Rights and Privacy Act (FERPA) are the primary obstacle. The letter would include the request for VDH to report to JCHC in 2008.

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:

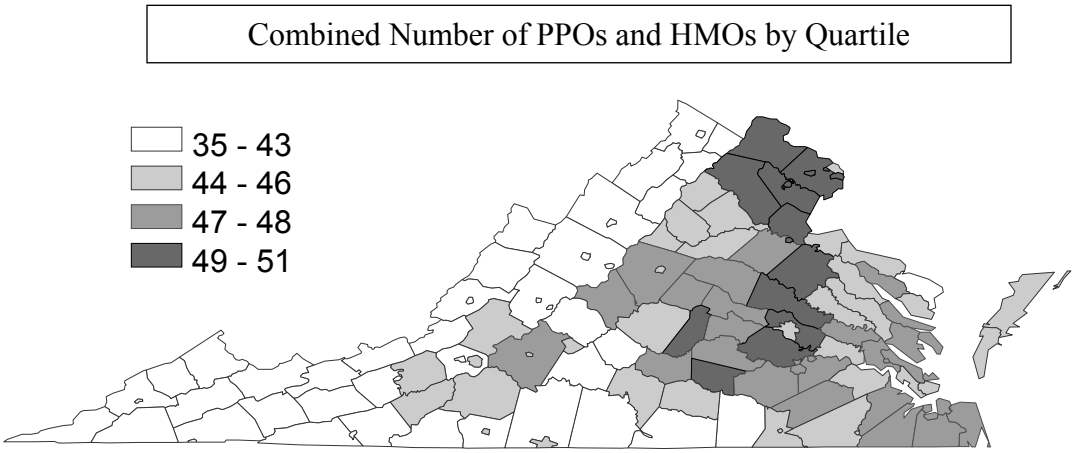
- Difficulty in establishing a network with so few health care providers
- Lack of primary care providers
- Lack of medical care specialists
- Fewer economies of scale available for insurers
- Fewer than half of small employers provide employer-sponsored coverage to employees
- Higher percentage of small 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."

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 tax incentive for health insurance carriers to offer new small group plans in targeted rural areas. (Reductions in tax liability could be based on enrollment numbers.)

Option 4: Introduce a budget amendment (funding to be determined) to provide a subsidy for small employers operating in specific rural areas of Virginia, that offer health insurance for their employees.

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