Decision Matrix

Policy Options for the 2013 General Assembly Session

November 7, 2012

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Decision Matrix

STAFF REPORTS

ADDITIONAL REPORTS

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 2012.
B. To develop legislative recommendations for the 2013 General Assembly Session.

Cost Sharing and Specialty Tier Pricing of Prescription Medications
House Joint Resolution 579 (2011) – Delegate O'Bannon

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

HJR 579, introduced by Delegate O'Bannon in 2011, directed the Joint Commission on Health Care to conduct a two-year study to determine the impact of cost sharing, coinsurance and specialty tier pricing on access to prescription medications for chronic health disorders; and to identify and evaluate options for reducing any negative impacts of cost sharing, coinsurance and specialty tier pricing, including but not limited to statutory limitations on cost sharing obligations for prescription medications.

Background

In the U.S., 88% of covered workers have a tiered cost-sharing formula for prescription drugs. Traditionally, formularies consisted of only three tiers or less; however, an increasing number of plans have created a fourth tier of drug cost sharing, often referred to as a specialty tier, primarily for expensive drugs. Originally developed as part of Medicare Part D, specialty tiers are now utilized by the majority of commercial plans.

Tier 1: Generic
Tier 2: Preferred Brand
Tier 3: Non-Preferred Brand
Tier 4: Specialty Drugs

Cost-sharing structures vary among health plans, but most require enrollees to pay a set co-payment for drugs in tiers 1-3 and a percentage of the drug's cost (ranging from 10 to 40 percent) for those in the fourth/specialty tier. Each individual insurer or payer determines whether a drug is placed on a specialty tier.

While no standard definition exists for specialty drugs, most are biologics (derived from living organisms, in contrast being made from chemical compounds); used to treat complex conditions; administered by injection, infusion, inhalation, or orally; and very expensive. On average, the monthly cost for a specialty drug is $1200; and while specialty tier drugs are prescribed for only 1% of commercial health plan enrollees, they account for 12-16% of commercial pharmacy benefit drug spending.

The primary factors for consideration include:

1. The original intent of drug tiers, to provide incentives for consumers to consider costs when making health care decisions, is not applicable for specialty drugs for which there are no suitable, less expensive alternatives. Instead, drug tiering has created a structure where those who are most sick are required to pay more.
2. Specialty tier pricing may not be cost effective for employers in the long run due to increased medical costs that can result from decreases in treatment adherence.
3. The number of conditions that can be treated with specialty drugs—and thus the number of patients eligible for treatment with these high-cost drugs—are both expected to increase significantly over the next ten years and beyond.
4. Biosimilars are expected to reduce drug costs, but their impact will not be seen for many years. Innovator products are granted 12 years of market exclusivity and often are protected by patents lasting longer; and the new FDA approval process is expected to be rigorous and lengthy.

5. Biosimilars will not reduce drug costs as much as conventional generic drugs. Due to the complexity of the manufacturing process, biosimilars likely will still be far more expensive than most conventional drugs.

Policy Options and Public Comment

Ten comments were received regarding the policy options addressing cost-sharing and specialty tier pricing prescription medications. Comments were submitted by:

- Susan Keitt
- Philip Posner, Ph.D.
- Susan Teabout
- Keenan Caldwell, State Government Relations Director, **American Cancer Society Cancer Action Network (ACS CAN)**
- Ashley Chapman, Virginia Statewide Advocacy Manager, **National Multiple Sclerosis Society** – Central Virginia Chapter **(NMSS)**
- Jen Johns, MPH, Associate Director, State Government Relations, **National Patient Advocate Foundation (NPAF)**
- James Romano, Director of Government Relations, **Patient Services Incorporated (PSI)**
- Becky Bowers-Lanier on behalf of the **Virginia Alliance of Medication Affordability and Access (VAMAA)**. (VAMAA represents: Virginia Hemophilia Foundation – Hemophilia Association of the Capital Area, National Multiple Sclerosis Society, Virginia Organization Responding to AIDS, Patient Services Incorporated, Health HIV, and Arthritis Foundation Mid-Atlantic Region.)
- Doug Gray, Executive Director, **Virginia Association of Health Plans (VAHP)**
- Susan R. Rowland, MPA, Executive Director, **Virginia Organization Responding to AIDS (VORA)**

	Options	**In Support**	
1	Take no action.	1	VAHP
2	Include study in the JCHC 2013 work plan in order to review the effects of PPACA, if retained, on cost-sharing and specialty tier pricing of prescription medications.	7	ACS CAN/NMSS NPAF/PSI VAMAA/VORA VAHP/or Opt. 1
3	Request by letter of the JCHC chair that the Virginia Association of Health Plans (VAHP) encourage health insurance carriers to offer monthly payment plans for enrollees who are required to purchase multiple months of a high-cost prescription at one time.	6	ACS CAN/NMSS NPAF/PSI VAMAA/VORA
4	Introduce legislation or budget language to prohibit coinsurance (i.e., percentage cost of the prescription) as the basis for cost sharing for outpatient prescription drug benefits, and limit a health insurance enrollee's co-payment for each outpatient prescription drug to $150 per one-month supply or its equivalent for prescriptions for longer periods, adjusted for inflation over time.	8	ACS CAN/NMSS NPAF/PSI VAMAA/VORA Philip Posner, Ph.D. Susan Teabout
5	Introduce legislation requiring qualified health plans to allow individuals who are expected to incur costs in excess of the cost sharing limits set by the ACA the option of paying their capped out-of-pocket amount in 12 equal installments over the course of the year.	8	ACS CAN/NMSS NPAF/PSI VAMAA/VORA Susan Keitt Philip Posner, Ph.D.
6	*Introduce legislation to require qualified health plans to notify individuals in writing at least 60 days prior to a change in the tier status of their medications.*	*3*	*ACS CAN* *PSI* *VAMAA*

Comment Excerpts:

Three individuals (Susan Keitt, Philip Posner, Ph.D., and Susan Teabout) who require specialty prescription medication to treat their multiple sclerosis offered public comments regarding their experiences.

Ms. Susan Teabout explained her hope that the out-of-pocket costs of specialty tier prescription drugs will be limited by writing, in part:

> "At the time of diagnosis [in December 2002], I was President of Delta Connection Academy, a subsidiary of Delta Air Lines. I managed 5 pilot training locations and contracts for airline pilot training with airlines throughout the world….My Multiple Sclerosis progressed and by September of 2005, I left Delta Air Lines due to my disabling condition. Life is made of defining moments and leaving my dream career due to Multiple Sclerosis was clearly one of those 'moments.' I was amazed at the number of people who came forward telling me they suffered from Multiple Sclerosis or had a close friend or family member who suffered from the disease. One very common and sad theme emerged. Most could not afford the high cost of the MS disease-modifying drugs, which fall into the "specialty tier pricing" category and cost over $40,000 annually. As a result, they are not on any MS therapy and their disease most likely will progress faster. While "specialty tier pricing" may have seemed like a solution, I can tell you both personally and professionally, it is the wrong approach and it simply does not work….my insurance provider, paid $46,810.98 on my behalf in 2011. My 2011 out of pocket costs were significantly lower than 2010 because I began to take the MS drug only 2 times a week versus the 3 recommended. Unfortunately, this decision means my MS will progress faster. I simply could not afford my medical costs exceeding $15,000 annually, as the cost of the MS drugs continue to escalate. For 2012, I continued to take my MS drug...two times a week and I began taking an additional MS drug…which costs over $1,000 monthly.
>
> …Having run a division of a large company, I understand first-hand the tremendous pressure to cut spending. My hope is that Legislators will ask themselves before any vote, 'Would I hold the same position, if tomorrow I knew a close family member or myself would need to take a "specialty tier drug" that exceeds $40,000 annually?' Trust me…. I never imagined in a million years as a world-class athlete, a pilot, and ranked in top 30 fastest women motorcycle racers, that I would need to take a "specialty tier drug" that was financially unaffordable to slow the disease progression of become fully disabled. My hope is Legislators will take a much closer look at 'specialty tier pricing' and limit the out-of-pocket cost of prescription drugs. I sincerely appreciate the Joint Commission's efforts to study and communicate their findings regarding cost sharing and specialty tier pricing of prescription drugs more than you will ever know."

Representatives of the American Cancer Society Cancer Action Network, National Patient Advocate Foundation and the Virginia Alliance of Medication Affordability and Access (which represents the Virginia Hemophilia Foundation – Hemophilia Association of the Capital Area, National Multiple Sclerosis Society, Virginia Organization Responding to AIDS, Patient Services Incorporated, Health HIV, Arthritis Foundation Mid-Atlantic Region), wrote in support of Options 2 through 5.

In addition, several of these organizations commented in support of an Option 6 to require qualified health plans to notify individuals in writing at least 60 days prior to a change in the tier status of their medications. At the time of the study, it was thought that this Option would not be

needed if federal health reform were to be retained. However, in subsequent discussions, U.S. Department of Labor staff clarified that proposed health reform regulations do not address these types of notifications.

Doug Gray on behalf of the Virginia Association of Health Plans commented, in part:

> "If the ACA out-of-pocket limits remain in effect and there are very few Virginians who have 4th tier drug benefits that treated specialty drugs differently from other prescriptions, VAHP sees no need for further state action unless federal action is determined to be inadequate.
>
> Policy suggestions to spread out a member's payments for coinsurance and deductibles may not be workable or of assistance to the patient.
>
> Maximum out-of-pocket limits help protect members from unlimited risk and costs. When these limits are spread out further, the member takes longer to reach his/her limit, exposing him/her to more risk longer. Delaying meeting the out-of-pocket limit is not helpful to the member.
>
> Payment collection of coinsurance and deductibles is a provider function. These are amounts due to the provider not the health plan. Health plans are not in the position to address provider payment responsibilities. These are between the patient and his/her provider.
>
> VAHP commends the JCHC on its research on cost sharing and specialty tier pricing of prescription drugs. However, since concerns with cost-sharing are addressed by the ACA and there are very few individuals covered under 4-tier drug benefits, VAHP recommends either Option 1 – take no action or Option 2 – to review the effects of the ACA on cost sharing and specialty tier pricing of prescription medications."

Rural Obstetrical Care in Virginia

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

By letter request, Delegate Nutter and Senator Northam asked that JCHC update the recommendations from the Governor's 2004 Working Group on Rural Obstetric Care on behalf of the Access Council of Virginia's State Rural Health Plan. The study objectives were to assess the level of maternal and infant health in rural populations of the Commonwealth, determine the factors influencing access to and utilization of obstetrical services in these areas and identify programs that have the potential to address barriers to access and utilization of obstetrical services in the State's rural areas.

Background

The infant mortality rate in Virginia has decreased from 7.4/1000 live births in 2004 to 6.8/1000 in 2010. However, infant mortality rates, as well as low birth weight and prematurity rates, remain higher in rural areas of the State. Further, while 82 percent of pregnant women in Virginia begin receiving prenatal care in the first trimester of their pregnancy, fewer women in rural areas do so; Scott County (26.1%) and the city of Bristol (31.3%) have the lowest percentages. Late onset of prenatal care and poorer birth outcomes are associated with barriers to access and utilization in rural areas, including hospital obstetrical unit closures, OB/GYN health practitioner shortages, difficulty establishing and maintaining birth centers, and demographic factors (such as poverty and low education levels). There are a number of ways to address these barriers, such as enabling birth centers to be reimbursed by Medicaid, expanding UVA's prenatal telehealth program, encouraging more health practitioners to practice in rural areas, and supporting prenatal education programs.

Birth Centers. A pilot project to establish birth centers in the Northern Neck and Emporia encountered difficulties primarily due to the inability to receive Medicaid reimbursement. The Northern Neck Family Maternity Center closed in 2011 after 14 months of operation and the opening of the Women's Health and Birthing Center in Emporia has been delayed indefinitely. To receive Medicaid reimbursement for the cost of operating the facility, the birth center must be licensed or recognized as being accredited by an approved national organization. If Virginia were to either license or recognize freestanding birth centers, it may improve the financial viability of centers in rural areas that rely heavily on Medicaid payments.

Perinatal Telehealth Program. In 2009, UVA established the High-Risk Obstetrics Telehealth Program to improve access to specialized prenatal care for women with high-risk pregnancies in communities that do not have a maternal-fetal medicine specialty unit. After three years of operation, the program already has shown a range of positive outcomes, including a 25 percent reduction in preterm deliveries. Expanding the program to include Danville, Pittsylvania County and Washington County, and developing ultrasound services at the Culpeper and Staunton Health Department telemedicine sites would provide greater access to prenatal care for a larger number of women with high-risk pregnancies.

Scholarship/Loan Repayment and Prenatal Education Programs. In addition to improving the viability of birth centers and the expansion of telemedicine, access to care can be increased by encouraging health care professionals to practice in underserved areas through the expansion of scholarship and loan repayment programs and by providing greater support for programs, such as

Text4Baby and Baby Basics, that provide prenatal health information for pregnant women and training for healthcare providers to improve patient understanding and coordination of prenatal care.

Policy Options and Public Comments

A total of 28 comments, regarding the proposed policy options, were submitted including:

Eight Baby Basics participants:

- Michael Barker, Baby Basics participant
- Haiqing Chen, Baby Basics participant
- Selena Hale, Baby Basics participant
- Linda Harriger, Baby Basics Mom's Club Facilitator
- Andrew and Rebekah McGrady, Baby Basics participants
- Jessica Moriarty, Baby Basics participant
- Morgan Novotny, Baby Basics participant

Sixteen health practitioners, advocates, and associations:

- Denise Arrington, Labor and Delivery Registered Nurse
- Lisa A. Dooley, RN, IBCLC, Lactation Consultant
- Linda Hudgins RN, BSN, Roanoke City Health Department
- Alisa Johnson, Community Care Partner, Tennessee Volunteer State Health Plan
- Angela Kinzie, IBCLC, LCCE, ICCE, CD
- Doreen Lancaster, RN, Labor and Delivery and Newborn Care
- Ellen McConnell, RN, BSN, CTL, Roanoke Carilion OB Clinic
- Tiffany McCoy, Volunteer Coordinator/Community Educator, Abuse Alternatives
- Brooks Michael, Adolescent Health Educator, Carilion Clinic Children's Hospital
- Sharon Parker, RN, BSN, LCCE, Perinatal Outreach Education Coordinator, Carilion Clinic
- Mercedes E. Quinones, Carilion Clinic
- Kelly Jo Sexton, BSN, RNC-OB, C-EFM; Associate Clinical Leader/Nurse Educator, Wellmont Bristol Regional Medical Center, New Life Birthing Center
- Julie Taylor, RN, IBCLC, Lactation Consultant
- Tara West, Coordinator of Regional Perinatal Council Projects, Southwest Virginia Perinatal Council
- Cleo S. Williams, RNC, Director of Women's Services and Surgical Care Unit, Carilion New River Valley Medical Center
- Katharine M. Webb, Senior Vice President, **Virginia Hospital and Healthcare Association**

Two business representatives:

- Terry Ahrens, K-VA-T Food Stores, Inc.
- Scott Ferrell, Service Manager, Toyota of Bristol

Two individuals provided comments anonymously via email.

	Options	In Support
1	Take no action.	**0**
2	Request by letter of the JCHC Chair that VDH and DMAS review the potential for licensing or recognition of freestanding birth centers, for the purpose of Medicaid facility reimbursement, and report to the Joint Commission by October 1, 2013.	**0**
3	Introduce a budget amendment (language and funding) for the Virginia Department of Health to provide funding of $867,600 GFs to expand the Perinatal Telehealth Network in Virginia to include Danville, Pittsylvania County, and Washington County; and to initiate ultrasound services at the Culpeper and Staunton Health Department telemedicine sites.	**0**
4	Introduce legislation to amend the *Code of Virginia* to expand the Nurse Practitioner and Nurse Midwife Scholarship Program to include loan repayments as well.	**0**
5	Introduce a budget amendment (language and funding) for the Virginia Department of Health to increase funding by an additional $150,000 for the Nurse Practitioner and Nurse Midwife Scholarship (and Loan Repayment) Program with requirements that the additional awards be granted to nurse practitioners specializing in OB/Women's Health and to nurse midwives.	**0**
6	Introduce a budget amendment (language and funding) for the Virginia Department of Health to provide additional funding of $75,000 to allow for customization and advertisement of the Text 4 Baby Program.	**0**
7	Request by letter of the Joint Commission Chair that, as part of the maternal and child health strategic plan, VDH give due consideration to the Baby Basics curriculum as a tool to improve patient education and standardize health messages for pregnant women and mothers.	**27**

Comment Excerpts:

Katharine M. Webb, Senior Vice President of the Virginia Hospital and Healthcare Association, commented without taking a position on any specific option. Ms. Webb wrote:

> "We believe the report accurately reflects current challenges in providing obstetrical care in Virginia's rapidly changing health care delivery system."

Alisa Johnson, Community Care Partner with Tennessee's Volunteer State Health Plan commented:

> "I am writing to express my excitement about the role Baby Basics has played with Medicaid members in the State of Tennessee over the past couple of years and encourage you to seriously consider making it a priority in Virginia as well. As a collaborative partner in the Baby Basics Moms Club which was implemented a few years ago in Bristol, Tennessee I have seen such a positive impact on our moms who are recipients of TennCare. It has helped with health literacy, self-confidence, and decision-making skills they need to be in charge of their health as well as that of their child. My hope would be that all those who have access to this valuable resource would embrace all it offers to the citizens of their localities."

Twelve health practitioners commented about the benefits that the Baby Basics program provides to pregnant women and their families, including:

Ellen McConnell, at Roanoke's Carilion OB Clinic commented that,

> "The Baby Basics program has really been benefiting our OB patients since it was established this year in the Roanoke, VA area. Our clinic OB patients are in great need of education and support for their pregnancy, from health eating, exercise, preparation for the labor/delivery experience, breastfeeding, and baby care. The workload of nurses has increased over the years, leaving less time for nurses to provide the education our patients need and deserve for healthy pregnancy outcomes. I have been a nurse for 25 years. This program is a great resource for nurse's to offer to

assist with patients questions and concerns about their pregnancy and baby care. Patients are very receptive of the program due to participation with peers in a more relaxed atmosphere. I feel expanding this program statewide would help improve the health of many other pregnant moms and newborns through the education and support this program provides."

Linda Hudgins of the Roanoke Health Department wrote about the importance of both the home visiting and Mom's Club components of the Baby Basics program in her area, commenting in part:

"We have very few referral sources that we have available to further support the prenatal education that is provided one-on-one in the home setting…The Moms Club is a wonderful resource that adds an increased level of knowledge for our pregnant women. The Club uses quality curriculum, brings in knowledgeable guest speakers and provides infant care demonstrations…This Club is worthy of replication throughout the state!"

Denise Arrington discussed how beneficial Baby Basics Mom's Club has been to her both professionally and personally, writing in part:

"I am a RN who works on labor and delivery. I am and have always been very pro education and take every opportunity I can to teach my patients. I went to the classes in all honesty not expecting to gain much knowledge due to my occupation. I was very wrong! I thoroughly enjoyed all of the classes and gained as much knowledge from the other moms as I did from the classes themselves. From a professional perspective it was nice to tell my patients about this program and know they would be gaining the knowledge to empower them to have the healthiest pregnancy possible."

Cleo Williams, Director of Women's Services and Surgical Care Suite, stated in part:

"This program is truly unique in that it reaches out to populations that traditionally do not attend a childbirth class. Please let our legislators know how important this program is."

Kelly Jo Sexton commented, in part:

"These club members include populations of patients that would never feel comfortable attending a traditional child birth education class…The physicians love it when their patients attend the BBMC [Baby Basics Mom's Club]…The BBMC book is written in such an organized way, low literacy level and easy to understand…."

Seven individuals who participated in the Baby Basics Mom's Club as expecting parents commented about their positive experiences in the program, including:

One woman, who did not sign her email, wrote:

"I am a new mother so I knew nothing about parenting until I joined moms club. Moms club has truly been a great opportunity for me. I learned things I never had any knowledge about at all. I would like to thank moms club for teaching me and other moms how to be the greatest parent you can be."

Jessica Moriarty commented, in part:

"As a first time mother, these classes have been a great opportunity for me. I have learned a lot about what to expect when our child arrives…I hope to see this program continue and grow in our area."

Expansion of the Health Practitioners' Monitoring Program
Senate Bill 634 – Senator Vogel/House Bill 1289 – Delegate Jones

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

SB 634 (Senator Vogel) and HB 1289 (Delegate Jones) would amend § 54.1-2515 of the *Code of Virginia* relating to the type of impairments that allow a health practitioner to qualify for voluntary participation in the Health Practitioners' Monitoring Program (HPMP). Both bills were continued to 2013 and referred to JCHC for study.

Background

The Health Practitioners' Monitoring Program was established by the General Assembly in 1997 and is operated by VCU's Department of Psychiatry under a Memorandum of Agreement with the Department of Health Professions (DHP). The program has an annual budget of $1.8 million, funded by professional licensure fees; and 579 practitioners were enrolled in September, 2012.

HPMP provides confidential services (including intake, referrals for assessment and/or treatment, monitoring, and alcohol and drug toxicology screens) for the health practitioner who may be impaired by any physical or mental disability, or who suffers from chemical dependency. The program encourages early identification and referral to appropriate treatment, allows valuable professionals to return to practice following treatment with ongoing monitoring, and improves practitioner's prognosis for recovery.

Senate Bill 634 and House Bill 1289 would amend the definition of impairment in *Code* § 54.1-2515 to include mismanagement of countertransference, which is when a patient unconsciously transfers feelings and attitudes from a person or situation in the past onto their therapist and the therapist responds to the patient's feelings inappropriately. (HB 1289 was amended to add that mismanagement specifically involves "sexual misconduct.")

Supporters of the proposed legislation argue:

1. Mismanagement of countertransference involving sexual misconduct is an impairment.
2. The current system does not adequately address the problem.

   (a) When the therapist's license is revoked, he/she can continue to practice as an unlicensed behavioral consultant, life coach or in an exempt setting without Board monitoring. Five years after the therapist's license expires, the disciplinary case can no longer be found in the DHP's public database of disciplinary cases, which may be a public safety issue.

   (b) When the therapist's license is not revoked, he/she may be required to undergo therapy, but the therapy is not adequately monitored by a Board. In rural areas, it can be difficult to find a practitioner trained in treating practitioners who have engaged in mismanagement of countertransference involving sexual misconduct.
3. A change in the law would allow: (a) eligible practitioners to be monitored within the HPMP and be screened to determine which practitioners should continue in the profession and which are unsafe and should have their license revoked; (b) the establishment of an educational service to instruct practitioners on boundaries, cognitive distortions and ethics; (c) possible use of required event-specific polygraph testing to ensure compliance with HPMP contract; and (d) establishment of a systematic protocol for dealing with all behavioral science practitioners who have engaged in mismanagement of countertransference involving sexual misconduct.

Opponents of the proposed legislation argue:

1. Sexual misconduct is not an impairment. It is a failure of professional judgment resulting from a lack of training, knowledge or character; and it is an egregious violation of professional ethical code and Board regulations. If SB 634 is enacted, Virginia would be the only state to legally define mismanagement of countertransference involving sexual misconduct as an impairment, which could provide a defense for sexual misconduct, resulting in therapist-perpetrators being held less accountable for sexual offenses.
2. Not all sexual misconduct is the result of mismanagement of countertransference. It can be intentional predatory behavior.
3. Mismanagement of countertransference is a theoretical construct referring to thoughts and feelings inferred from behaviors that are subject to multiple interpretations.
4. Unlike substance abuse, mismanagement of countertransference cannot be objectively measured, lacks a consistent definition and accurate assessment measures, and is not a disorder listed in the DSM IV. In fact, since 2009, the Boards no longer make findings of mismanagement of countertransference in disciplinary cases because it is not a provable violation.
5. Funding would be needed to expand the current HPMP.
6. There is no viable mechanism for this type of monitoring within the current HPMP structure. VCU case managers are not trained to monitor management of boundary issues, therefore, expansion to include mismanagement of countertransference involving sexual misconduct would require either training existing staff or hiring new case managers.
7. It is estimated that only 3-5 practitioners per year would be eligible for the program (given the historically small number of sexual misconduct cases identified by the Behavioral Science Boards). Consequently, expansion would not be cost effective.
8. Placing practitioners with mismanagement of countertransference involving sexual misconduct in the HPMP is not a significant deviation from current board sanctioning. The Behavioral Science Boards' current system of disciplinary action includes:
    - an evaluation to determine whether the practitioner should be allowed to continue in the profession or is unsafe and should have his/her license revoked;
    - the use of license suspension (until practitioner is considered safe to practice) combined with therapy;
    - a monitoring system which includes required quarterly reports from the practitioner, his/her therapist and, if allowed to practice while on probation, supervisor;
    - all treatment therapists must be approved by the Board and maintain consistent communication with the Board; and
    - if applicable, the practitioner may be required to receive additional training/education on boundary maintenance, ethics, etc.
9. DHP is currently considering a change in policy to retain records in the practitioner database involving the revocation, suspension or surrendering of a license for longer than 5 years.

Policy Options and Public Comment

Four comments were received regarding the policy options.

Joseph Lynch, Board Member of the Virginia Society for Clinical Social Work, commented in support of Options 2, 3 and 4.

Dianne Reynolds-Cane, Director of the Department of Health Professions, commented without supporting any particular option.

Becky Bowers-Lanier, from B2L Consulting, commented on behalf of the Virginia Counselors Association in support of Options 1 and 4.

Debra Riggs, Executive Director, and Mary Sasser, President, of the National Association of Social Workers commented in support of Option 4.

Option 1: Provide a written report to the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions without taking further action.

Option 2: Provide a written report to the Senate Committee on Education and Health with a letter indicating that the Joint Commission voted in support of SB 634.

Option 3: Provide a written report to the House Committee on Health, Welfare and Institutions with a letter indicating that the Joint Commission voted in support of HB 1289.

Option 4: By letter of the JCHC Chair, encourage the Department of Health Professions to change agency policy to allow records related to revocation, suspension or surrendering a license to be retained for a significantly longer period of time.

Comment Excerpts

Joseph Lynch and Dianne Reynolds-Cane provided written comments reiterating their positions which were covered in the presentation; and offered the following additional points:

Joseph Lynch (Virginia Society for Clinical Social Work):

- Concerns over the term "Mismanagement of Countertransference"
  The term "Mismanagement of Countertransference" was selected for this legislation because it was the most frequent term used in the licensing board orders when addressing the problem of sexual misconduct by therapist. The study revealed that the licensing boards stopped using this term in 2009. There is no need to be committed to this term if it is not the language that is now being used to best describe the sexual misconduct by therapist. This term can be replaced by "violating the boundaries of the professional relationship by sexual misconduct" if this is more specific and clear language that identifies the problem that we all stakeholders agree is an egregious ethical violation and harmful to clients.
- It is important to note that if the legislature informs the Director of DHP to include therapist perpetrators in the definition of impaired practitioners then the regulations can easily be adapted to comply with the will of the legislature and the change in the statute. The Code of Virginia **§54.1-2516**. *Program established; practitioner participation; disciplinary action stayed under certain conditions,* (see below) allows for the HPMP regulations to be changed by the Director of DHP and the change implemented quickly.
  - **§54.1-2516** *Program established; practitioner participation; disciplinary action stayed under certain condition,* A. The Director of the Department of Health Professions shall maintain a health practitioners' monitoring program that provides an alternative to disciplinary action for impaired health practitioners. The Director shall promulgate such regulations as are necessary for the implementation of this program after consulting with the various health regulatory boards.

Dianne Reynolds-Cane (Department of Health Professions):

- All boards and all professions regulated by the Department would be affected by a change in the proposed definition of impairment – not just the three behavioral sciences boards, as is stated by the proponent. Other boards have laws and/or regulations prohibiting sexual misconduct and have had disciplinary cases involving practitioners including physicians, nurses, chiropractors, dentists, physical therapists, optometrists, etc.

- Specifically, in response to the proponent's argument for changing the definition of impairment to include sexual misconduct for eligibility in the Health Practitioner Monitoring Program (HPMP):
  - The HPMP does not include an educational service to instruct practitioners on any issues; it is a monitoring program operated under a contract with VCU-MCV.
  - Boards already have the authority to order psychological or mental assessments or screening; it is not necessary to change the definition of impairment for that purpose.
  - Whether a practitioner has his license revoked or is enrolled in the HPMP, he would still be able to use an unregulated title, such as "life coach." The legislation would not affect that possibility.
  - A change in the definition of impairment would have no effect on the information available through the Department's License Lookup system…The current policy of having all licensure information drop off the on-line system after five years from the time the license is no longer current is already being re-examined by the Department.

Becky Bowers-Lanier (Virginia Counselors Association) expressed concern about the proposed legislation, stating:

> "…We agree with your statement that there is no real evidence to support sexual boundary issues as a manifestation of the mismanagement of countertransference. Further, our Code of Ethics clearly and emphatically prohibits sexual or romantic counselor-client interactions or relationships with current clients, their romantic partners, and their family members. Counselors who violate this standard do not belong in an impaired professionals' monitoring program. They do require disciplinary sanctions and treatment with possible return to the profession, but not until such time as they are deemed eligible for a return to practice. Including such individuals while they are receiving treatment would require monitoring that is not likely to be practicable. Further, we believe that clients' safety and health could be jeopardized if these individuals were permitted to continue to practice while undergoing treatment…"

Debra Riggs and Mary Sasser (National Association of Social Workers) also expressed their concerns, commenting in part:

> "These bills sought to add the "mismanagement of countertransference" to the definition of "impairment" as a part of the Virginia Health Practitioners' Monitoring Program (VAHPMP). The concern was, if their professional license was taken, these individuals could practice under the guise of an unlicensed profession and pose a threat to the public. By allowing them to keep their license, the theory being posed is that board will somehow maintain control over the individual's ability to practice. We believe this is not the most effective way to address the issue at hand and could have harmful unintended consequences…we do not believe the proposed language in HB 1289 and SB 534 is the best solution to this problem. In fact, we are concerned that this could cause unintended negative consequences and put the public at an even higher risk. Countertransference is not something that can be objectively measured or proven. It would not be possible to accurately determine whether a practitioner engaged in sexual misconduct due to countertransference versus another motivating factor. By allowing practitioners who commit these violations to participate in the VAHPMP, we could be providing every practitioner who commits this act a plausible defense, without a way to determine whether the cause was actually the mismanagement of countertransference as opposed to predatory behavior."

Regulation of Surgical Assistants and Surgical Technologists
Senate Bill 313 – Senator Blevins

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

SB 313 (Senator Blevins) was continued in Senate Education and Health to 2013 and referred to JCHC for study. SB 313 would establish requirements for Board of Medicine licensure of surgical assistants and certification of surgical technologists. (SB 313 provided exceptions from regulation in three instances involving: i) students in approved education programs practicing under direct supervision, ii) individuals who had completed "approved training within the uniformed services" and iii) individuals practicing as surgical assistants or surgical technologists during the six months prior to July 2012.)

2010 Study by the Board of Health Professions

Currently, there are no regulatory requirements placed on individuals who perform as surgical assistants or surgical technologists in Virginia.

The Board of Health Professions initiated an exhaustive review as requested by surgical assistants and surgical technologists and as part of the Board's ongoing review regarding regulation of "emerging health professions." The Board's findings on degree of risk included:

- "The unregulated practice of **surgical assistants** poses a high risk of harm to patients which is directly attributable to the nature of the practice…. Although surgical assistants practice with surgeons, the nature of their work requires independent judgment, knowledge and competence. Therefore **licensure** is the least restrictive means of protecting the public and ensuring the minimum qualifications of surgical assistants."

- "The unregulated practice of **surgical technologists** poses a moderate potential harm….attributable to the nature of certain advanced tasks, and the inherent hazards and patient vulnerability associated with surgery and infection….While much of the work…is supervised…the nature of the risks and tasks require independent competence and judgment" such that **mandatory certification** should be required for surgical technologists. (VA Board of Health Professions Study, July 2010, pp. iv-v.)

The Board of Health Professions recommended, in part, that the Board of Medicine should:

- "establish a license for surgical assistants."
- "require mandatory certification for surgical technologists."
    - Mandatory certification requires employers and practitioners to ensure that practitioners have the credentials required by the Board of Medicine.
- "identify training programs and military occupational specialties that impart the necessary skills, knowledge and competence and allow military-trained surgical technologists and surgical assistants to practice in Virginia."

Regulation in Other States

Two states (Illinois and Texas) and the District of Columbia license surgical assistants, although Texas exempts from licensure those surgical assistants who are employed by hospitals and practice under the delegated authority of a physician. Kentucky is the only state that has certification requirements for surgical assistants, although surgical assistants who are employed

by hospitals and practice under the direct supervision of a registered nurse are exempt from the certification requirements. Colorado is the only state that requires surgical assistants to register.

Six states (Illinois, Indiana, New Jersey, South Carolina, Tennessee, and Texas) have certification requirements for surgical technologists. Colorado and Washington require surgical technologists to register.

Policy Options and Public Comment

Sixty-one comments were received regarding the three policy options addressing the regulation of surgical assistants and surgical technologists. Comments were submitted by:

- **Surgical technology students and instructors from Sentara College of Health Sciences**
- **Physicians and surgical technologists from the University of Virginia Health System**
- Catherine Sparkman, Director of Public and Government Affairs, **Association of Surgical Technologists**
- Karen Ludwig, **Association of Surgical Assistants**
- Paul Collicott, **American College of Surgeons**
- Mary Catherine Flynn, CST, Secretary of the **Virginia Commonwealth State Assembly of Surgical Technologists**
- Calvin Bailey, **Professional Development Specialist for STs and SAs at Mary View Medical Center**
- Linda Starks, **Program Director, Fortis College**
- J. Craig Merrell, MD, President, **American Society of Plastic Surgeons**
- David Jeanette, CSA, President, **Virginia Association of Surgical Assistants and the National Association of Surgical Assistants**
- Virginia Rawls, **CST, Program Director, Riverside School of Health Careers**
- **CSTs, CSAs and MDS from Centrahealth Lynchburg General and Virginia Baptist**
- Dedra Parrish, **Director of ST, ECPI University**
- **Private physicians**
- Katherine Webb, Senior Vice President, **Virginia Hospital and Healthcare Association**

	Policy Options	In Support
1	**Provide a written report** to the Senate Committee on Education and Health **without taking further action**.	**1** VHHA
2	**Provide a written report** to the Senate Committee on Education and Health **with a letter indicating that the Joint Commission voted in support of certification of surgical technologists** as outlined in SB 313.	**60**
3	**Provide a written report** to the Senate Committee on Education and Health **with a letter indicating that the Joint Commission voted in support of licensure of surgical assistants** as outlined in SB 313.	**60**

Comment Excerpts

The 60 letters written in support also included 300 signatures from physicians who had indicated their support for the regulation of surgical technologists and surgical assistants when the Virginia Department of Health Professions completed a study in 2010. The majority of letters in support touched on similar themes:

- Surgical technologists and surgical assistants are the only members of the operating room team that have no minimum educational or training requirements and patients expect everyone in the surgery room to have a minimum level of training and education.
- Because surgical technologists are currently unregulated, hospitals determine the level of credentialing necessary for a surgical technologist's employment. This results in a hodgepodge of different requirements that are confusing for individuals who wish to practice as surgical technologists.
- Given the tasks surgical technologists perform in the operating room, there is a risk to Virginia's patients.
- The Virginia Department of Health Professions conducted a thorough study and recommended regulation.
- Physicians rely on surgical technologists and surgical assistants, and they also rely on hospitals for staffing. As such and because they are ultimately legally responsible, they want to feel confident that every member of the operating room has been properly educated and trained.
- Other professions, such as manicurists and massage therapists, pose less risk to Virginia consumers are regulated.
- There is no fiscal impact to the Commonwealth of Virginia or Virginia's hospitals.

Katherine Webb, Senior Vice President of the Virginia Hospital and Healthcare Association submitted a letter in opposition to the regulation of surgical assistants and surgical technologists. Ms. Webb stated that "regulation of these practitioners is unnecessary, raising obstacles to care delivery that increase health care costs and restrict workforce flexibility without enhancing patient safety or care quality.

- Staff qualifications, training, performance and quality of care in hospital surgical services are regulated by The Joint Commission, the Centers for Medicare & Medicaid Services' Condition of Participation, and Virginia's hospital licensure regulations enforced by the State Board of Health.
- Surgical assistants and surgical technologists practice under the supervision of licensed surgical staff. They do not engage in autonomous practice.
- There is no documented evidence of patient harm in Virginia hospitals supporting regulation of these practitioners.
- …the hospital and its licensed surgical staff are legally and professionally responsible for the practice and actions of surgical assistants and surgical technologists, and therefore they have strong incentive to ensure that the assistants and technologists they hire and supervise have the necessary qualifications and skills. Doing otherwise exposes the hospital and licensed surgical staff to significant legal liability.
- …Hospitals are engaged in increasingly comprehensive and transparent patient safety programs that measure and disclose outcomes and quality. These efforts increase hospitals' incentives to use highly competent professionals in surgical settings.…"

Opt-Out Program for Organ, Eye, and Tissue Donation
House Joint Resolution 19 – Delegate O'Bannon

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

HJR 19 introduced by Delegate O'Bannon, directed JCHC to study options for establishing an opt-out program for organ, eye, and tissue donation in the Commonwealth.

Background

There is a need to increase the availability of organs for donation. According to Donate Life America:

- As of July 2012, there were 114,712 patients waiting for an organ donation.
- Every 10 minutes another name is added to the national organ transplant waiting list.
- Approximately 6,000 people die waiting for a transplant each year.
- While 90% of Americans say they support donation, only 30% know the essential steps to become a donor.

Virginia operates by an opt-in, or voluntary consent, organ donation process. In recognition of individual rights and voluntarism, the process is governed by the Uniform Anatomical Gift Act which provides:

- Any person older than 18 can make a gift, effective upon death, of all and any part of his/her body.
- When the deceased has not expressly made a gift or expressly objected to donation during his/her lifetime, the deceased's family can make a gift.
- Expressly allows gifts to be made by will, effective immediately upon death, or by donor card, and can be revoked at any time.

To be an organ, eye or tissue donor in Virginia, an individual can either:

- Register to be an organ, eye, or tissue donor on the Virginia Registry – DonateLifeVirginia.org.
- Say "yes" to donation at the Department of Motor Vehicles which will place the individual on the DonateLifeVirginia.org registry.
    - However, to remain on the donor registry, individuals must check "yes" to donation every time they renew their driver's licenses or state identification cards.

Presumed Consent

Because the need for organ, eye, and tissue donations surpasses the supply, some argue for a presumed consent donation system which presumes a person has consented to organ, eye, and tissue recovery if he/she has not registered a refusal. Advocates indicate such a system would:

- Improve efficiency and increase supply.
- Reflect the opinion of the vast majority who favors organ donation.
- Maintain individual autonomy in the ability to opt-out, while focusing more on the needs of those on the donation waiting list.

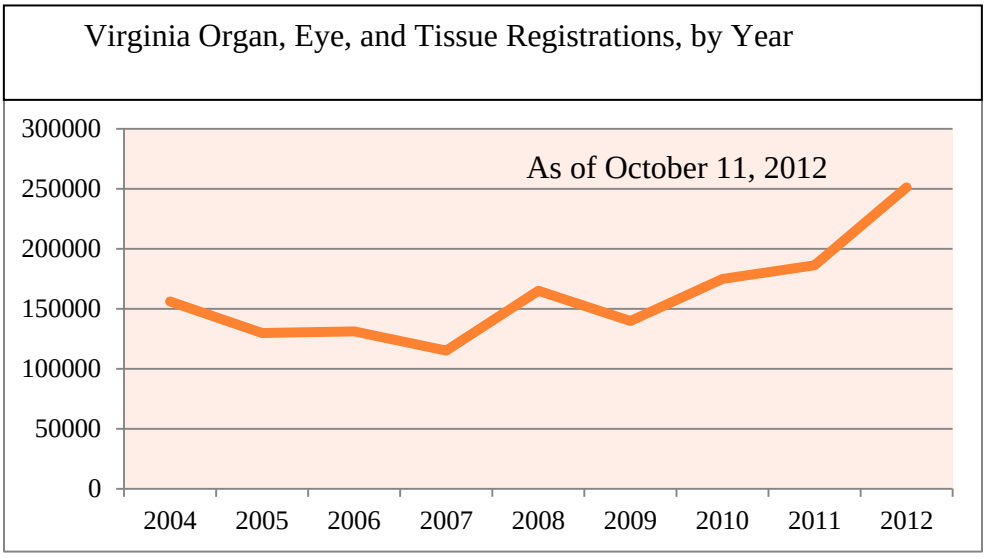
A number of European countries (Austria, Belgium, Denmark, France, and the Netherlands) have implemented a presumed consent system. After these countries implemented a presumed consent system, the supply of organs did increase; however, research is unclear as to whether other factors played a bigger role than the policy of presumed consent. For example, in many

countries these laws are rarely enforced and family consent is always or often required before organs are extracted.

A recent study conducted by the Association of Organ Procurement Organizations indicates that the United States already has higher donation rates than any of the countries with presumed consent systems. It should be noted that while Spain is often cited as a presumed consent country, it in fact operates a voluntary consent system. The top 11 countries are shown below:

Country	Consent Practice	Donors/Million Pop
Spain	Voluntary Consent	34.4
United States	Voluntary Consent	25.4
Belgium	Presumed Consent	25.3
France	Presumed Consent	24.7
Austria	Presumed Consent	23.0
Italy	Voluntary Consent	21.3
United Kingdom	Voluntary Consent	15.5
Germany	Voluntary Consent	14.9
Denmark	Presumed Consent	13.9
Sweden	Voluntary Consent	13.8
Netherlands	Presumed Consent	12.8

Furthermore, organ, eye, and tissue registrations in the United States and specifically, in Virginia, continue to increase.



Opposition to Presumed Consent

If Virginia were to switch to a presumed consent system, it would be the first state in the country to do so. To date, presumed consent legislation, considered by other states (including Colorado, Delaware, Illinois, Pennsylvania, and New York) has not been enacted. Presumed consent

donation efforts have been opposed by Donate Life California and other organizations whose primary goal is to increase organ donation and recovery rates.

Opposition to presumed consent in the United States has been based on the opinion that the current system seems to be working well. Public opinion favors organ donation and registrations continue to increase. Furthermore, because the majority of U.S. citizens favor individual autonomy, there is a fear that moving to a presumed consent system would result in a decrease in organ donations:

- Individuals would act out of fear or protest and decide not to donate.
- The political environment and the majority public opinion do not favor a change.
- Faith in the current system could be undermined negating the progress made over the last couple of decades.
- There is no hard data to indicate that moving to an opt-out donation program would increase donation and recovery rates.

Policy Options

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

Option 2: Provide a written report to the House Committee on Health, Welfare and Institutions with a letter from the JCHC Chair indicating that the Joint Commission voted in support of pursuing an opt-out organ donation program in Virginia.

Option 3: Provide a written report to the House Committee on Health, Welfare and Institutions with a letter from the JCHC Chair indicating that the Joint Commission voted in opposition to pursuing an opt-out organ donation program in Virginia.

No public comments were received regarding these policy options.

Mandatory Outpatient Treatment for Substance Use Disorder

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

A 2011 JCHC staff study examined the use of involuntary commitment procedures in treating chronic substance use disorder (HJR 682 – Delegate O'Bannon). Study findings included:

- The *Code of Virginia* currently allows for the use of involuntary commitment procedures for persons in need of substance abuse treatment.
- Involuntary commitment procedures are not often used for this purpose for a variety of reasons.
- Involuntary commitment to inpatient treatment in most cases is better suited to compel treatment for mental illness; however, mandatory outpatient treatment is potentially a better disposition for persons with chronic substance use disorder.

JCHC members voted to include in the 2012 work plan, a study of whether mandatory outpatient treatment can be structured to address more effectively the needs of persons in need of substance abuse treatment.

Background

In general, the option of mandatory outpatient treatment (MOT) is used infrequently (in less than 1% of involuntary commitment hearings in 2012) and very rarely used to address substance abuse. One exception to this general rule is the community services board (CSB) in Prince William County which has had success using MOT.

308 MOTs were issued from July 2008 – June 2012
78 MOTS (25.3%)
in Prince William County

Approximately one-third of the clients, placed on MOT in Prince William County, were required to receive substance abuse treatment services as well as services for mental illness. The MOT was found to meet the needs of clients who "fall somewhere in between inpatient care and dismissal" and the clients generally were very cooperative with treatment. Prince William County CSB representatives indicated that two aspects of their civil commitment process made MOT more feasible:

- They waited a full 48 hours before initiating the involuntary commitment hearing to give clients more time to consider and agree to treatment on an outpatient basis; and
- A second evaluation was completed immediately prior to the hearing to give the client another opportunity to express a willingness to participate in outpatient treatment.

Representatives of the Department of Behavioral Health and Developmental Services and other CSBs noted that the success of court-mandated treatment for such criminal acts as driving under the influence as evidence that MOT can work. However, there are challenges including: a common substance abuse assessment tool has not been adopted, the participants would need to agree to treatment, and there are few penalties for noncompliance. Furthermore, limited treatment resources, including access to detoxification and residential treatment, compromises the continuum of care for those with substance use disorder and are significant factors limiting the use of MOT. However, MOT could be used more effectively if, at the least:

- A common substance abuse assessment tool were adopted and used, and
- The temporary detention order (TDO) period could be increased to 72 hours, or at a minimum, allow at least 24 hours to pass before the involuntary commitment hearing is held.

Additional Discussion Regarding Temporary Detention Orders

Richard Bonnie of the UVA School of Law, in discussing the proposal to increase the maximum time for a TDO, made the following points:

- Virginia's 48-hour limitation is the shortest timeframe in the U.S.
- Increasing the maximum timeframe was recommended by the Virginia Tech Review Committee, the Office of the Inspector General, and the Commission on Mental Health Law Reform in 2007.
- Legislation, introduced in 2010 (HB 307 - O'Bannon/SB 85 - Howell) in order to extend the maximum TDO period to 72 hours, was unsuccessful due to a projected fiscal impact of more than $2.7 million per year.

A study, undertaken by Mr. Bonnie and Dr. Tanya Wanchek and published in *Psychiatric Services* examined 500 cases in which Medicaid paid for TDO hospitalizations and found that longer TDO periods were correlated with:

- More dismissals
- Fewer involuntary commitments
- Fewer post-TDO hospitalizations
- Shorter post-TDO hospital stays (when hospitalization was ordered).

Mr. Bonnie asserted that when these factors are considered: the fiscal impact, (on the involuntary commitment fund) of extending the maximum time period for a TDO to 72 hours (Option 2), actually would be modest. Based on conservative assumptions (e.g., that no hearing would be held after 72 hours), Mr. Bonnie estimated that the net number of additional days of hospitalization would be less than 1,000 (actual number is 873), resulting in a fiscal impact of no more than $600,000. In addition, increasing the minimum period of time to at least 24 hours (Option 3) may offset the additional cost altogether, leading to a net savings. Furthermore, Mr. Bonnie pointed out that the number of TDOs and hearings has decreased over the last two years and assuming this trend continues, this would further reduce the fiscal impact of increasing the maximum duration of the TDO period.

Policy Options

Option 1: Take no action.

Option 2: Introduce legislation to amend Titles 19.2 and 37.2 of the *Code of Virginia* to increase the maximum time period for a temporary detention order to 72 hours.

Option 3: Introduce legislation to amend Titles 19.2 and 37.2 of the *Code of Virginia* to require that at least 24 hours elapse between execution of the temporary detention order and the commitment hearing for involuntary admission.

No public comments were received regarding these policy options.

Regulation of Naturopaths
House Bill 2487 (2011) – Delegate Kilgore

Stephen W. Bowman
Senior Staff Attorney/Methodologist

HB 2487, introduced by Delegate Terry G. Kilgore in 2011, was left in the House Committee of Health, Welfare, and Institutions and referred to JCHC for study. HB 2487 would require the Board of Medicine to license and regulate naturopaths as independent practitioners.

Background

Currently, there are no regulatory requirements placed on individuals who perform as naturopaths in Virginia. Since 2005, five bills have been introduced to regulate naturopaths in Virginia; none of the bills were approved by the originating Committee.

TYPES OF NATUROPATHS PRACTICING IN VIRGINIA

Traditional Naturopaths (TNs)

- No standard professional educational requirements.
- Training programs vary from non-degree certificate program to doctoral programs.
- Role is to educate and support the health of clients through non-invasive means.
  - TNs do not diagnose, treat conditions, or perform surgery.
- Titles used: Naturopath, Classical Naturopath, Nature Care Practitioner
- Number practicing in Virginia: 100s perhaps >1000

Naturopathic Physicians (NaPs)

- Graduates of a four-year, graduate-level naturopathic medical school accredited by an organization recognized by the U.S. Department of Education.
  - 2 years of Graduate Level Didactic
  - 2 years Graduate Level Clinical
  - Average Clinical – 2,800 Hours
  - A residency is not required
- Statutes in other states define NaP role in various ways ranging from primary care to promoting wellness.
- Titles used: Naturopath, Medical Naturopath, Naturopathic Doctor, or Doctor of Naturopathy
- Estimated number in Virginia: 24

NaP Regulation: 16 States License NaPs

Typical licensure requirements include graduating from an accredited four-year, residential naturopathic medical school and passing a postdoctoral board examination (NPLEX). :

SCOPE OF PRACTICE LAWS AMONG THE REGULATING STATES VARY

Most states allow NaPs to address:	Some states also allow NaPs to address:
Dietetics	Obstetrics
Hydrotherapy	X-ray
Physiotherapy	Minor surgery
Electrotherapy (medical therapy using electric currents)	Prescriptive authority

HB 2487 Provision Highlights

Naturopathic Physician requirements for licensure:

- Graduation from a naturopathic medical education program that offers graduate-level, full-time didactic and supervised clinical training
- Successful completion of a competency-based national naturopathic medicine licensing examination administered by an agency recognized by the Board.

Restricts practice of naturopathy to only licensed NaPs

- Exceptions: TN practice activities would be limited to "providing information" about vitamins and herbs.

Restricts the ability for non-licensed individuals to use the term "naturopath"

TYPES OF NATUROPATHS PRACTICING IN VIRGINIA

Proponent Arguments for Regulation

- NaPs can help remedy Virginia's shortage of primary care physicians.
- NaPs complete a 4-year accredited medical school.
- NaPs emphasize prevention, which can be a cost-effective type of health care.
- Without regulation, NaPs are not allowed to practice up to their level of training.
- Naturopathy is unregulated in Virginia and any individual can present himself/herself as a "naturopath."

Opponent Arguments Against Regulation

- NaPs do not have the requisite education and training to provide the same level and quality of care as a physician to practice independently.
  - NaPs are not required to participate in a supervised residency program, like MDs and DOs.
- NaPs are not sufficiently trained to prescribe medications.
- Medical efficacies of the treatment modalities by NaPs are unproven.
- The practice of traditional naturopathy could become illegal without a NaP license.
- The term "naturopath" could be reserved only for NaPs.
- If NaPs are regulated, it may negatively impact the market that traditional naturopaths serve.

In 2005, the Board of Health Professions initiated an exhaustive review of the regulation of naturopaths. The Board found that the "risk of harm" criterion for licensure was not met.

Policy Options and Public Comment

A total of 409 written comments were received regarding this study.[1] Ninety-six percent (391 of 409) of the respondents appear to live in Virginia and 13 practitioner-organizations commented. Except for the Virginia Association of Naturopathic Physicians, all practitioner-organizations recommended taking no action. The public comments submitted by individuals varied in support or opposition to licensure. Fifty-two percent of the comments (215 of 409) recommended NaP

[1] In instances in which individuals or organizations provided multiple comments only the most recent comment was incorporated in the public comment counts presented. Please note that some individuals recommended more than one option.

licensure as set forth in Option 2, whereas 35 percent (143 of 409) recommended taking no action (Option 1). Most commenters who elaborated on whether to license NaPs made arguments similar to those listed above, with one exception. Some commenters supporting NaP licensure discussed positive treatment experiences working with an NaP. The following public comment summary highlights the number of public comments received for each option and any practitioner-organization that supported the option. The practitioner-organization comments are included in their entirety in a separate document.

Option 1: Take no action.

In Support: **143 comments, including 12 practitioner-organizations:**

American Naturopathic Medical Association
Medical Society of Virginia
National Registry of Naturopathic Practitioners
Psychiatric Society of Virginia (PSV)
Virginia Academy of Family Physicians
Virginia Academy of Physician Assistants
Virginia Chapter of American Academy of Pediatrics
Virginia College of Emergency Medicine
Virginia Orthopaedic Society (VOS)
Virginia Society of Eye Physicians and Surgeons (VSEPS)
Virginia Society of Otolaryngology (VSO)
Virginians for Health Freedom

Option 2: Introduce legislation amending Title 54.1, Chapter 29 of the *Code of Virginia* to direct the Board of Medicine to promulgate regulations for the licensure of the "naturopathic physician" as an independent practitioner.

- Includes the scope of practice and prescriptive authority as defined in HB 2487.
- Limits unlicensed individuals from:
  - Claiming to be a "naturopath," and
  - Practicing naturopathy.

In Support: **215 comments, including:**

Virginia Association of Naturopathic Physicians (1st choice)

Option 3: Introduce legislation amending Title 54.1, Chapter 29 of the *Code of Virginia* to direct the Board of Medicine to promulgate regulations for the licensure of the "naturopathic physician" as an independent practitioner.

1. Licensure:
   a. Graduate from an accredited four-year residential naturopathic medical school
   b. Pass postdoctoral board examination (NPLEX)
   c. Meet continuing education requirements (30 hours annually)
2. Includes the scope of practice and prescriptive authority as defined in HB 2487.

In Support: **102 comments, including:**

Virginia Association of Naturopathic Physicians (2nd choice)

Option 4: Introduce legislation amending Title 54.1, Chapter 29 of the *Code of Virginia* to direct the Board of Medicine to promulgate regulations for licensure of the "medical naturopath." The regulations would include requirements for:

1. Licensure:
   - Graduate from an accredited four-year residential naturopathic medical school
   - Pass postdoctoral board examination (NPLEX)
   - Meet continuing education requirements (30 hours annually)
2. Supervision
   - Medical naturopaths (MNs) are required to practice under the direct supervision of a licensed Doctor of Medicine or Osteopathic Medicine.
3. Scope of Practice

   Supervising physician works with the medical naturopath to establish the MN's scope of practice.
   - Delegated in a manner consistent with sound medical practice and the protection of the health and safety of the patient, including recommending non-prescription drugs.
   - Set forth in a written practice supervision agreement and may include health care services which are educational, diagnostic, therapeutic, preventive or involve treatment.

In Support: **48 comments**

Note: HB 2487 addressed issues other than "naturopathic physician" licensure. Options 3 & 4 are limited to only NaP licensure and scope of practice. These options are not intended to address unlicensed NaPs or TNs.

Therefore, both options include specific allowances for the continuation of:

1. Unlicensed individuals claiming to be a "naturopath" and
2. Unlicensed NaPs or TNs continuing to legally practice as they have been.

Telehealth: A Tool for the 21st Century

Karen S. Rheuban M.D.
Virginia Telehealth Network
Center for Telehealth, UVA

Dr. Rheuban, President of the Virginia Telehealth Network, addressed the Healthy Living/Health Services Subcommittee and offered the following remarks and policy recommendations.

"Telemedicine" is the use of medical information exchanged from one site to another via electronic communications to support: medical diagnosis, ongoing patient care, and remote patient monitoring. "Telehealth" encompasses a broader definition of remote health care (such as health-related distance learning) that does not always involve clinical services.

Telehealth Services in Virginia

Public and private Virginia organizations have underscored the value of telehealth through research, partnering and funding commitments. Telehealth seeks to benefit patients, health professionals, and communities.

- Patients are benefited through timely access to services that are unavailable locally, relief from the burden and cost of transportation, and improvement in quality of care.
- Health professionals working in shortage areas can access consultative services and continuing education, in some cases helping to increase the area's provider community.
- Communities are benefited as 90 percent of patients remain in the local setting, expanding locally-available medical services; often enhancing a community's health care and economic prospects.

Virginia is considered to be a leader in telehealth; the UVA telehealth program includes 40 different specialties supporting more than 27,000 patient encounters which saved 7.2 million miles in patient travel. Dr. Rheuban presented opportunities to expand telehealth applications as noted in the policy options that follow.

Policy Options

Option 1: Take no action.

Option 2: Introduce a budget amendment (language and funding) for $25,000 in State general funds to advance statewide education programs regarding emergency stroke care through the Virginia Stroke Systems Task Force.

Stroke is the 3rd leading cause of death in Virginia. Although tissue plasminogen activator (tPA) can reduce damage if administered within 3 hours of most ischemic strokes, only 1.5% of acute stroke patients are treated with tPA in Virginia. Telestroke programs can facilitate immediate access to high-quality specialty stroke neurology care and triage.

Option 3: Include in the 2013 work plan for JCHC, a study of various avenues to expand access to mental health services through telemedicine, including potential public-private partnerships.

UVA tele-mental health services have supported more than 11,000 patient encounters including child and adolescent services and emergency consultations in community hospitals' emergency departments.

Option 4: By letter of the JCHC Chair, request that the Virginia Department of Health, Department of Medical Assistance Services, Department of Education, and the academic health centers collaborate regarding how to expand services for children in the Commonwealth.

If current barriers are resolved, school-based telehealth services could help address reductions in funding for school nurses, higher rates of chronic diseases in children, and limited service access for many children including to behavioral health services.

Option 5: By letter of the JCHC Chair, request that the Department of Medical Assistance Services consider funding for chronic disease management programs in the home setting using remote patient monitoring and care coordination in the Medicaid program.

Remote monitoring and home telehealth can be effective tools for chronic disease management and in addressing proposed penalties for hospital readmissions. Virginia Care Coordination and Home Telehealth demonstrated a 19% reduction in readmissions for the same diagnosis and a 53% reduction in hospital days.

A proposed option to fund an expansion of a high-risk obstetrics telehealth program has been included as Option 3 in the summary for Rural Obstetric Care in Virginia on page 7.

Preliminary data, on 305 high-risk obstetrical patients served through telemedicine from March 2009 through mid-May 2012, showed a reduction of pre-term delivery by 25 percent.

Quality Collaborative Care Through Interprofessional Education

Dorrie K. Fontaine, Ph.D., RN, FAAN
Sadie Heath Cabaniss Professor of Nursing and Dean
Valentina Brashers, M.D., FACP, FNAP
CoChair, Interprofessional Education Initiative
University of Virginia

Dr. Brashers provided an "overview of the evidence that collaborative care and interprofessional education (IPE) are essential to healthcare quality" and a description of UVA's interprofessional education initiative.

Background

The importance of collaborative practice has been underscored by the Institute of Medicine in reports related to quality of care (including the landmark 1999 report, *To Err is Human: Building a Safer Health System*) and in establishing its five core competencies of health professionals. If health professionals do not learn to work together more effectively the results will be: poor patient outcomes; diagnostic, treatment, prevention, and communication errors; and higher costs and attrition.

The World Health Organization defines IPE as when students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes and as preparing a "collaborative practice-ready" health workforce.

UVA's Interprofessional Education Initiative

The UVA IPE program builds on a strong foundation which includes simulation, telehealth, basic skills training, and global health partnerships, and UVA is now recognized as a national leader in IPE:

- 25 IPE programs in undergraduate, graduate, and professional education
- Numerous grants of more than $800,000 in support of IPE at UVA
- National dissemination of IPE scholarship and leadership, including presentations at national meetings.

There is a great deal of interest in IPE including inquiries from public and private medical programs regarding how they might incorporate IPE in their programs. It would be useful to survey baccalaureate medical, nursing, and pharmacy programs in the Commonwealth to determine the levels of integration and interest as a first step in planning to facilitate the development of IPE.

Policy Options

Option 1: Take no action.

Option 2: Include in the 2013 work plan for JCHC, a collaborative survey (conducted by staff of the Joint Commission and the University of Virginia) of the baccalaureate medical, nursing, and pharmacy programs in the Commonwealth to determine the levels of integration and interest in interprofessional education.

Expedited Partner Therapy: An Innovative Strategy
House Joint Resolution 147 – Delegate Herring

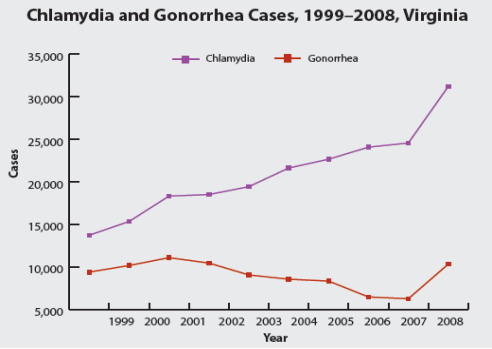
Robin L. Hills, MS, WHNP-BC, CNE
Clinical Assistant Professor
VCU School of Nursing

House Joint Resolution 147 (Delegate Herring) directed the Joint Commission on Health Care to study options for implementing expedited partner therapy in the Commonwealth. Although the resolution was laid on the table in House Rules Committee, JCHC members voted to complete the two-year study.

Becky Bowers-Lanier and Robin Hills contacted the JCHC Chair regarding making a presentation this year, possibly in lieu of further study by JCHC staff. The following remarks and policy proposals were included in the presentation.

Background

Chlamydia and gonorrhea are serious, often asymptomatic, conditions that affect both men and women. In women, they can cause permanent damage to the fallopian tubes, uterus, and surrounding tissues, resulting in infertility, tubal pregnancy, and chronic pelvic pain. In men, gonorrhea can result in infertility. These effects are more closely linked to re-infection than to initial infection; therefore, it is important that both partners be treated with antibiotics to prevent re-exposure.



While incidence rates in Virginia for both chlamydia and gonorrhea are lower than the national average, the number of new cases of chlamydia continues to increase each year; and after initially decreasing from 2000-2007, incidence rates for gonorrhea are rising in the State. Further, the standard approach of treating the patient with an antibiotic regimen and requesting that he/she notify the partner so that they may be treated is considered to be inadequate due to stigma and denial that often prevent the partner from seeking treatment. Given the increasing incident rates and treatment adherence problems, the Centers for Disease Control and Prevention recommended in 2006 that expedited partner therapy be used to facilitate partner management among heterosexual men and women and, as of 2012, expedited partner therapy is permitted in 32 states.

Expedited Partner Therapy

Expedited partner therapy is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner. Along with medication, expedited partner therapy would be accompanied by information that advises recipients to seek personal health care in addition to expedited partner therapy. Studies have found this treatment to be more effective than the standard approach and the potential for adverse side effects of the medications are low. Expedited partner therapy is considered to be an

additional strategy for partner management that is not intended to replace other strategies, such as standard patient referral, when available. Since 2006, the American Bar Association, American Medical Association, Society for Adolescent Health and Medicine, American Academy of Pediatrics, and American Congress of Obstetricians and Gynecologists have stated their support for expedited partner therapy as an option for treating chlamydia and gonorrhea and reducing rates of infection. Medico-legal concerns regarding liability would need to be investigated prior to policy implementation.

Policy Options

Option 1: Take no action.

Option 2: Include in the JCHC 2013 work plan, a staff study of options for implementing expedited partner therapy in the Commonwealth.

Option 3: Introduce legislation to amend and reenact § 54.1-3303 of the *Code of Virginia* to allow a medical practitioner to prescribe antibiotic therapy to the sexual partner of a patient diagnosed with a sexually transmitted disease without the physical examination normally required.

Why Is Respite Important for Caregivers?

Courtney Tierney, Director
Prince William Area Agency on Aging

Ms. Tierney made the following remarks, regarding the importance of providing respite care for caregivers, during the September meeting of the Healthy Living/Health Services Subcommittee.

Background

The majority of informal caregivers are "related by blood or marriage, but partners, friends, and neighbors are also caregivers." Informal caregivers allow many Virginians to avoid or delay nursing facility care which save millions in Medicaid costs. An AARP Public Policy Institute study estimated that in 2009, more than 1.1 billion hours of care had been provided in Virginia for a total value of $11.7 million in public savings. (Lynn Feinberg, Susan C. Reinhard, and Rita Choula, *Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving*, Insight on the Issues #51 (Washington, DC: AARP Public Policy Institute, June 2011)

While caregiving is often very meaningful and rewarding; it can be very stressful, socially isolating, and it takes time from work and other family responsibilities. The health of caregivers often suffers over time; several studies have reported that family caregivers can suffer from serious depression and the type of extreme stress which has been shown to cause premature aging. Respite care includes such services as adult day health care, companion and personal care services in the home, and institutional respite care (overnight or for longer periods of time). The provision of respite care enables someone else to provide care allowing the caregiver to relax or take care of personal, family, or work responsibilities.

Virginia Respite Care Initiative

The Virginia Respite Care Initiative was established in 1988 to provide care for Virginians who are elderly (60 and older) or suffer from Alzheimer's disease or related dementias. To qualify for assistance, the applicant must have a 24-hour caregiver; respite care is limited to 35 hours per month.

In FY 2012:

- 290 caregivers received respite care
- Cost of $456,209 in State GFs
  - An average of $1,573 per client for the year.

This presentation focused on the Virginia Respite Care Initiative. There is also a federal program, the National Family Caregiver Support Program (Title III-E), which was established in 2000.

In 2011, Virginia received $3.1 million in Title III-E funding (which required a match of $2.3 million via local, State, and private funding); a variety of services were provided to 4,044 caregivers and 1,704 received respite care.

Title III-E funding can be unpredictable as it is subject to sequestration and other federal budgetary actions.

In requesting that the Initiative appropriation be doubled, Ms. Tierney indicated that the $1 million would save State funding by delaying and in some cases avoiding nursing facility admission and by supporting families so they can continue to provide care.

Policy Options

Option 1: Take no action.

Option 2: Introduce a budget amendment (language and funding) to increase FY 2014 funding for the Virginia Respite Care Initiative by $543,791 for a total of $1 million GFs.

Eating Disorders Follow-Up

A 2011 JCHC-staff study on eating disorders, requested by Senator Puller in SJR 294 (2011), included several policy options that were approved by Joint Commission members. The approved options included a request that the Departments of Education and Health determine the resources that are available in public schools and collaborate with the National Eating Disorders Association to "study an evidence-based eating disorder screening program for potential implementation in Virginia's school systems."

2012 Activities and Findings

Dr. Patricia Wright, the Superintendent of Public Schools, reported on work group findings regarding JCHC's request in a letter dated September 26, 2012.

With regard to the recommendation:

"Encourage school divisions to provide homeroom teachers and school nurses in all secondary schools with instruction or information approved by the American Medical Association (AMA) or the National Eating Disorders Association (NEDA) on how to recognize eating disorders and how to help youth who may be affected get care they need."

Work group members found there are a number of resources available to school personnel:

- Videos on eating disorders were distributed to school nurses several years ago.
- An eating disorder workshop for school nurses was offered at the Summer Institute for School Nursing this past year.
- DOE school health specialists who provide technical assistance for school nurses on an ongoing basis "will provide additional resources on eating disorders."
- Eating disorder resources aligned with Virginia's standards of learning are available on the Health Smart Virginia website http://healthsmartva.pwnet.org and "promoted to all school personnel."
- Healthy eating habits and positive self-image are addressed in the school curricula and the NEDA toolkit for teachers.

With regard to implementing evidence-based screening instruments, several tools were examined by the work group including the SCOFF questionnaire, an "evidence-based, short screening interview…

S: Do you make yourself **S**ick because you feel uncomfortably full?
C: Do you worry that you have lost **C**ontrol over how much you eat?
O: Have you recently lost more than **O**ne stone (14 lbs.) in a 3-month period?
F: Do you believe yourself to be **F**at when others say you are too thin?
F: Would you say that **F**ood dominates your life?"

The specific recommendations submitted on behalf of the work group are included in **Option 2**.

Lara Gregorio, LCSW, STAR Program Manager for NEDA, sent a letter asking JCHC to "adopt policy options to improve education, awareness, and treatment of eating disorders in Virginia through an evidence-based school screening method." The specific recommendation submitted by NEDA is included in **Option 3**.

"Less than 45% of affected individuals seek treatment…up to 20%...will die without treatment …eating disorder on-set often occurs during middle to high school age."

Policy Options and Public Comment

Although no formal request for public comments was made, 50 comments were received in support of the NEDA's preferred policy option to add an eating disorder screening program in public schools. Comments were submitted by eating disorder sufferers and parents of children with eating disorders as well as by Laura Collins, Executive Director of Families Empowered and Supporting Treatment of Eating Disorders (F.E.A.S.T.); Felicia Kolodner. LPC, NCC, Director of Reflections Treatment Center, and Hunter W. Jamerson on behalf of the National Eating Disorders Association.

Option 1: Take no action.

Option 2: By letter of the JCHC chair, encourage the Virginia Department of Health and the Virginia Department of Education to implement the work group recommendations to:

- Conduct training within the clinical community, such as physicians and nurse practitioners, in recognizing and treating eating disorders since this is a complex disorder and is extremely sensitive and clinical in nature;
- Continue efforts to raise awareness of school personnel regarding the signs and symptoms of eating disorders and appropriate referral;
- Increase awareness of the Health Smart Virginia Website with ready-made lesson plans for healthy eating habits and positive body image aligned with Virginia SOL; and
- Provide information on the SCOFF questionnaire to school nurses, school psychologists, and school social workers for use in evaluating the need for referral to a health care provider.

Option 3: Introduce legislation during the 2013 Session to add eating disorder screenings to the list of screenings for public school students in Title 22.1, Chapter 14 of the *Code of Virginia*. Specifically, the legislation would require the Board of Education to promulgate regulations for implementation of an annual screening for eating disorders for public school pupils in grades five through 10 with provisions for the parents of such students to exclude their children from participating in such screening.

50 comments were received in support of this option:

Cynthia Arnold
Kaitlin Amsperger
Diana Ausderau
Najla Bayram
Tamy Brady
Charlotte Chapman
Marie Chu
Nicholas Coleman
Laura Collins of F.E.A.S.T.
Amy Corbett
Lewis Cornell
Pamela Cornell
Aileen Elsaesser
Tanja Ely
Melanie Fischer
Christine Floyd
Christy Fondren
Valerie Garcia
Richard Greer
Ashley Grizzard
Katherine Vatalaro Hill
Catherine Horowitz
Kristen Hostetter
Marea Hyman
Hunter Jamerson for NEDA
Alexandra Kaghan
Felicia Kolodner, Reflections Treatment Center
Stephanie Kurtz
Rebecca Mcconnell
Jeanne Mitcho
Joan Mizrahi
Lisa Nava, Ph.D., Licensed Clinical Psychologist
Anne Partlett
Christy Plumly
Debbie Rackham
Kelly Raetzsch
Linda Rittenhouse
Eric Rosenfeld
Ronna Saunders
Douglas Schueler
Gwen Seiler
Sarah Shannon
Kimberley Shaver
Liz Smith
Dr. Joy Spiekermann
Katie Vassar
Annie Watson
Martha Watson
Jane Williams
Kaitlyn Zupka

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The Honorable John M. O'Bannon, III, Vice-chair

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The Honorable George L. Barker
The Honorable Harry B. Blevins
The Honorable Charles W. Carrico, Sr.
The Honorable L. Louise Lucas
The Honorable Stephen H. Martin
The Honorable Jeffrey L. McWaters
The Honorable Ralph S. Northam

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The Honorable Robert H. Brink
The Honorable David L. Bulova
The Honorable Benjamin L. Cline
The Honorable Roslyn R. Dance
The Honorable T. Scott Garrett
The Honorable Algie T. Howell, Jr.
The Honorable Riley E. Ingram
The Honorable Christopher K. Peace
The Honorable Christopher P. Stolle

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

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