Decision Matrix

Policy Options for 2015 General Assembly Session

TABLE OF CONTENTS

Decision Matrix

PURPOSE OF DOCUMENT

- To review and discuss findings, policy options, and public comments regarding staff reports and other issues that came before the Commission in 2014.
- To approve various actions including the introduction of legislation and budget amendments for the 2015 General Assembly Session.

Annual Reporting by Virginia's Health Conversion Foundations

October 18, 2013 Letter Request from the Virginia Consortium for Health Philanthropy

Kim Snead, Executive Director
Allyson Wiley, Health Policy Extern
William and Mary Law School

The Virginia Consortium for Health Philanthropy (VCHP) requested, in a letter submitted October 18, 2013, "a review by the Joint Commission on Health Care (JCHC) regarding the need for Virginia's health conversion foundations to continue providing a joint annual report regarding their charitable activities." These annual reports have been provided since 1998 as requested in House Joint Resolution 179 of that year, introduced by Delegate Alan A. Diamonstein on behalf of JCHC.

Reviews and Actions Concerning Hospital Conversions in the Late 1990s

During the 1990s, a number of not-for-profit hospitals converted to for-profit status. The U.S. General Accounting Office (GAO) issued a report in December 1997 which concluded:

> "Concerns about the conversion of not-for-profit hospitals and the transfer of millions of dollars in charitable assets still exist, because they are carried out essentially privately between boards of the selling hospitals and management of the purchasing for-profit companies. These conversions are not routinely subject to any disclosure requirements, which leave little opportunity for community involvement outside of the community members who serve on the not-for-profit hospitals' boards. A growing number of states are recognizing that the public interest is at stake and, as a result, are becoming more involved in overseeing the conversion process and monitoring the terms of such transactions. This increased state oversight may address some questions and concerns related to obtaining fair value for charitable assets, obtaining public disclosure and community input, and ensuring that the proceeds of the transaction are used for appropriate charitable purposes." [1]

The GAO report also noted that as of August 1997, 24 states including Virginia had enacted some form of legislation regarding conversions.

House Bill 2335 Authorized Role for the Attorney General of Virginia. HB 2335, enacted during the 1997 Session, amended Title 55 of the *Code* establishing a process to monitor conversion activities; the legislative provisions:

- Required any nonprofit hospital, health services plan, or health maintenance organization planning a transaction which would dispose of or change control of its assets, to provide written notification to the Attorney General at least 60 days before the proposed transaction.
- Required the Attorney General, within 10 days of the notification, to place "a public notice of the transaction to be published in a newspaper in which legal notices may be published in that jurisdiction."
- Allowed the Attorney General to "exercise his common law and statutory authority over the activities of these organizations."[2]

[1] GAO/HEHS-98-24, *Not-For-Profit Hospitals: Conversion Issues Prompt Increased State Oversight,* Dec. 1997, p. 31.
[2] *1997 Virginia Acts of Assembly*, Chapter 615.

Senate Joint Resolution 298 Requested JCHC Study of Indigent and Uninsured Populations. In completing the study requested by SJR 298 (1997), the impact of hospital conversions on the provision of care was examined. JCHC study findings included:

- Hospital conversions often resulted in the establishment of conversion foundations to continue the not-for-profit mission.
  - Federal law included strict rules regarding how assets could be used following conversion from not-for-profit to for-profit status.
  - Most of the newly-established health foundations had been created through hospital conversions and some "non-profit leaders and state regulators believe the…assets [should] provide care for indigent and uninsured persons in their communities."
- As of 1997, five hospitals in Virginia had converted from not-for-profit to for-profit status and established foundations with assets ranging from $4 million to $140 million; in addition three hospitals created foundations in disposition of assets to another not-for-profit organization. The newness of most of the conversions meant that the impact on the provision of care could not be determined.[3]

Based on the review of hospital conversions, JCHC members voted to introduce the resolution that resulted in the annual reporting request (House Joint Resolution 179 – 1998).

Annual Reporting and Other Present-Day Requirements

Currently there are 14 health conversion foundations in Virginia; eight of the foundations "are the result of sales and/or lease to for-profit entities" and are therefore subject to JCHC's annual reporting request. The Virginia Consortium for Health Philanthropy (VCHP), an informal association of health foundations, has submitted a joint annual report on behalf of the health conversion foundations within its membership for the last 16 years. (The Greensville Memorial Foundation was not listed as a VCHP member and did not have information included in the FY 2012 or FY 2013 annual report. The Harvest Foundation was not listed as a VCHP member and did not have information included in the FY 2013 annual report.)

VCHP contracts with a consultant to assemble and compile information from each of the reporting health foundations; four foundations that were not "required" to submit information chose to do so for the 2013 report.

Foundation	Total Assets*	Grant Awards*
The Alleghany Foundation	$67.2 million	$3.1 million
The Cameron Foundation (Petersburg)	$122.3 million	$5.6 million
Danville Regional Foundation	$215.0 million	$10.3 million
Greensville Memorial Foundation (Emporia)	$12.3 million – FY 2011	$313,324 – FY 2011
The Harvest Foundation (Martinsville)	$197.4 million – FY 2012	$13.7 million – FY 2012
Jenkins Foundation (Richmond)	$47.5 million	$2.3 million
John Randolph Foundation (Hopewell)	$40.4 million	$758,013
Wythe-Bland Foundation (Wytheville)	$51.0 million	$2.5 million
*As reported in the 2013 Report or previous reports of Virginia's Conversion Health Foundations, if otherwise indicated.		

[3] JCHC *Study of the Indigent/Uninsured Pursuant to SJR 298*, SD No. 43 – 1998, pp. II-21-22.

The 2013 report indicated that Virginia's conversion foundations serve specific geographic areas which cover "34% of Virginia's cities and counties….The largest proportion of health and human services grants was awarded for projects related to access to health services ($11.6 million; 44%) – a continuing priority for the foundations. This general category includes access to medical, dental and mental health (as well as substance abuse) services….The conversion foundations are making a significant contribution to improving the health status of residents in the communities they serve. They are dedicated to strengthening existing community-based nonprofits and helping to establish new organizations that may be needed to address pressing health needs. There is tremendous long-term potential for these foundations to assist in bringing lasting and positive change to the health of Virginia's residents."[4]

Request for JCHC Review of Continued Need for Annual Report. As previously noted, in October 2013 VCHP requested a JCHC-review of the continued need for health conversion foundations to submit annual reports of their charitable activities. Mary Fant Donnan, Executive Director of the Alleghany Foundation and Jeanne Zeidler, President of the Williamsburg Health Foundation attended the JCHC meeting in June 2014 to speak to the VCHP request. Ms. Zeidler made the following comments in observing that much "has changed since 1998:

- Health conversion foundations were relatively new then and there were only a few. Their value and impact was unknown. Those who were around at the time remember your predecessors' interest in monitoring the activity of these new entities to ensure that their resources would be put to good use within their communities.
    - Virginia now has 14 health conversion foundations. Most have existed for more than five years. All have stellar records of using their resources to enhance their communities and improve the health status of those who live in their service areas. All of us also have a record of transparency and regular reporting to our communities….[O]ur communication vehicles appropriately include annual reports to our communities, press releases, websites, community presentations, and social media such as FACE BOOK and Twitter….none of these social media tools were available 16 years ago….
- Since 1998 there have been several other mechanisms created that also help ensure the accountability and transparency of conversion foundations.
    - For example, our federally mandated 990 tax reports are now required to be publicly available. Most of us post them on the national Guidestar website, which is known as the place to go to learn about any nonprofit tax-exempt organization. In addition, these 990 forms contain much more detail than those that existed 16 years ago.
    - There is now an official process for the Attorney General to review the circumstances and charter of any new conversion foundations, a process that is not exist in 1998.
- For these reasons, we find ourselves wondering if the report we produce for you may have outlived its usefulness and may be redundant….The letter we sent to your leadership last October, indicated our willingness to continue to produce the report if you think there is a compelling reason to do so.
- Our question to you today is, 'With all the excellent communication vehicles that we have available today, is the report still useful, or is it an artifact of the past?'"[5]

[4] *Virginia's Conversion Health Foundations 2013 Report to the Joint Commission on Health Care*, September 26, 2014, pp. ii-iii.

[5] Transcript of comments made by Jeanne Zeidler, President and CEO of the Williamsburg Health Foundation representing the Virginia Consortium for Health Philanthropy, during June 11, 2014 meeting of JCHC.

Policy Options and Public Comment

Option 1: Take no action, which would leave the expectation that an annual joint report will continue to be submitted by Virginia's health conversion foundations.

Option 2: Discontinue the request for and expectation that an annual joint report will be submitted by Virginia's health conversion foundations.

Public Comments Received

Jeanne Zeidler, Virginia Consortium for Health Philanthropy

Ms. Zeidler provided the one public comment received regarding the proposal to discontinue the reporting requirement; Ms. Zeidler in commenting in support of the proposal, noted "much has changed since the requirement for the report was initiated by JCHC in 1998 in HJR 179. Health conversion foundations were relatively new then and there were only a few. Their value and impact was unknown. At that time, there was interest in ensuring these entities' resources would be used to benefit those within their communities and this report was a way to demonstrate this impact. Today, however there are many ways in which foundations can be transparent about their community investments and impact….I can assure you that we are committed to effectively communicating our charitable work to you and all who are interested. However, I'm sure you can understand our desire to avoid an unnecessary expenditure of time, effort, and financial resources. If there is no compelling reason for us to continue to produce a joint report, VCHP would be pleased to reduce duplication."[6]

[6] Public comment in the form of a letter dated July 14, 2014 from Jeanne Zeidler, President and CEO of the Williamsburg Health Foundation in support of the request made by the Virginia Consortium for Health Philanthropy.

Viral Hepatitis in the Commonwealth

House Joint Resolution 68 – Delegate Hodges and Delegate O'Bannon

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

During the 2014 General Assembly Session, House Joint Resolution 68 (Delegate Hodges and Delegate O'Bannon) directed the Joint Commission on Health Care to conduct a two-year study of viral hepatitis in the Commonwealth. The study objectives were to identify resources for, and factors limiting, the testing, treatment and prevention of viral hepatitis and to identify opportunities for integration of viral hepatitis treatment within new or existing HIV treatment programs.

Background

Viral hepatitis, which is an inflammation of the liver caused by a virus, claims the lives of 12,000 to 18,000 Americans each year. It is estimated that between 3.2 and 5.3 million Americans are living with viral hepatitis, and up to 75 percent do not know they are infected. In 2007, annual deaths in the U.S. due to viral hepatitis outpaced deaths due to HIV for the first time. While a number of viruses can cause hepatitis, hepatitis A (HAV), hepatitis B (HBV) and hepatitis C (HCV) are the most common in the United States. Hepatitis B and C may result in chronic hepatitis, potentially causing cirrhosis, liver failure and liver cancer. In fact, chronic hepatitis is the most common cause of liver cancer and liver transplants in America.

Hepatitis A and B

Each year, there are 17,000 new hepatitis A infections and 18,800 new hepatitis B infections in the United States. A vaccine is available for both hepatitis A and B; and hepatitis A usually clears on its own without treatment. However, hepatitis B can result in a chronic infection with the likelihood of progression from acute to chronic hepatitis B based on the age at which the virus was acquired. Hepatitis B becomes chronic in over 90 percent of infants, 25 to 50 percent of children one to five years of age and six to ten percent of older children and adults. For the 90 percent of newborns infected with hepatitis B who develop chronic infection, up to 25 percent will die of cirrhosis, liver failure or liver cancer later in life. However, the standard of care for pregnant women now includes hepatitis B testing during pregnancy since interventions are now available to prevent transmission to the infant during birth.

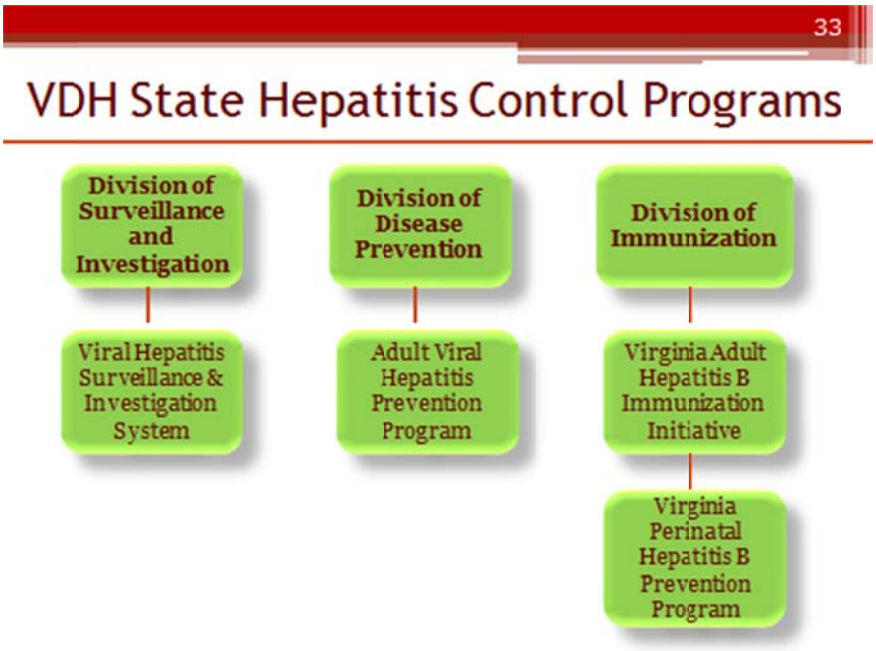
Hepatitis C

There are approximately 20,000 new hepatitis C infections each year in the United States; and for every 100 people infected with the hepatitis C virus, 75 to 80 will develop a chronic infection, 60 to 70 will develop chronic liver disease, five to 20 will develop cirrhosis and one to five will die of cirrhosis or liver cancer. The Centers for Disease Control and Prevention (CDC) and the U.S. Preventive Services Task Force (USPSTF) recommend that all high risk adults be screened for hepatitis C, which includes current or former drug users, recipients of clotting factor concentrates before 1987, recipients of blood transfusions or donated organs before July 1992, long-term hemodialysis patients, health care and public safety workers at risk of percutaneous blood exposure, HIV infected persons and infants born to infected mothers. Given that 75 percent of hepatitis C cases are baby boomers, primarily due to the lack of blood supply screening prior to 1987, the CDC and USPSTF also recommend that health care professionals offer one-time screening to adults born in 1945 to 1965.

While there is no vaccine for hepatitis C, treatment is available.[7] However, prior to 2013, HCV was treated with an interferon-based anti-viral regimen with long treatment durations (lasting up to one year), significant side effects, complicated dosing schedules and modest cure rates. Given these treatment problems and the fact that it can take years for chronic hepatitis to result in liver damage, many infected individuals chose to delay treatment until better medication was available, resulting in significant pent-up demand. Last year, two new drugs, sofobuvir (Sovaldi) and simeprevir (Olysio), were approved by the Food and Drug Administration (FDA) as part of a combination anti-viral treatment regimen. These drugs still must be taken with at least one of the traditionally used anti-virals that can cause side effects; however, both sofosbuvir and simeprevir based treatment regimens offer significantly higher cure rates than traditional regimens and a shorter treatment duration of 12 to 24 weeks.[8] Treatment costs of regimens utilizing the new medications are significant. A 12-week supply is $84,000 for Sovaldi and $66,360 for Olysio. Combined with the cost of the other drugs used in the regimen, a 12-week treatment for hepatitis C can cost as much as $116,910. On October 13, the FDA approved a new drug (Harvoni) for the treatment of Hepatitis C. It is the first all-oral regimen and is expected to cost $95,000 for a 12 week treatment.

Factors Limiting the Prevention and Care of Viral Hepatitis in Virginia

The Virginia Department of Health's (VDH) Office of Epidemiology includes a number of programs that focus on viral hepatitis prevention, immunization and/or surveillance.



While these programs provide important viral hepatitis tracking and care services, addressing both the lack of dedicated funding streams for testing and the limitations of the State's surveillance system would allow VDH to more effectively prevent the spread of viral hepatitis in the Commonwealth.

[7] A vaccine currently is in development and may be available as early as next year.
[8] It is important to note that there is some debate regarding the accuracy and range of cure rates for sofosbuvir and simeprevir based regimens.

Lack of Dedicated Funding for Testing. In Virginia, the only HCV testing-specific funds are from a limited grant of $240,000 for testing and care linkage for injection drug users which ends March 31, 2015; and this funding cannot be used for HCV testing of persons in other populations. State departments do not receive categorical federal funding to support HCV testing. As a result, much of the leveraged funding is not available from year to year and is pulled from other program areas like HIV prevention. In Virginia, approximately $86,000 of HIV prevention program funds are used for HCV testing each year.

Limitations of the State Surveillance System. VDH surveillance data is used to track the incidence of infection and guide development and evaluation of programs and policies designed to prevent viral hepatitis and minimize the public health impact of the disease. Currently, VDH receives no federal or State funding for viral hepatitis surveillance and investigation activities and, as a result, there is insufficient surveillance at the local and State levels. With limited resources for the investigation/quality checking of infection reports by providers and for the data entry of cases, many reports received by the agency lack information on linkage to care, risk data and demographic information. Of the incidence reports received by VDH, thousands still have not been entered into a database due to a lack of dedicated data entry staff. In fact, the entering of reports is being done primarily by HIV hotline staff between phone calls. This inability to fully investigate and document reports results in the undercounting of cases and, in general, poor data quality. As a result, it is currently impossible to estimate the true burden of disease caused by viral hepatitis in Virginia.

Policy Options and Public Comment

No comments were received regarding the policy options addressing viral hepatitis in the Commonwealth.

Policy Options	
1	Take no action.
2	Introduce a budget amendment (language and funding) for $615,000 GFs for VDH for viral hepatitis surveillance
3	Introduce a budget amendment (language and funding) for $660,000 GFs for VDH for strategic viral hepatitis interventions ▫ HCV testing of 11,000 people per year ▫ Public and clinician education to increase awareness of the importance of HCV testing among high-risk populations and baby-boomers ▫ Assistance with linkage to care for persons with HCV.
4	Introduce a budget amendment (language and funding) for $65,000 to increase funding for the Virginia HIV/AIDS Resource and Consultation Centers to provide information and training to HIV providers on HIV/HCV co-infection, including the addition of a consulting hepatologist.
5	Request by letter of the JCHC Chair that the Medical Society of Virginia encourage physicians to complete online CME course on viral hepatitis ▫ Free CME resources are available at: http://www.cdc.gov/hepatitis/Resources/Professionals/TrainingResources.htm.

Dental Safety Net Capacity and Opportunities for Improving Oral Health

Senate Joint Resolution 50 – Senator George L. Barker

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

In 2012, Senate Joint Resolution 50 (Senator Barker) directed JCHC to conduct a two-year study of the fiscal impact of untreated dental disease in the Commonwealth. The study resulted in a policy option to include in the 2014 JCHC work plan a targeted study of the dental capacity of Virginia's oral health care safety net providers, an option that was approved by JCHC members.

The approved policy option specifically requested that JCHC conduct "a targeted study of the dental capacity *and educational priorities* of Virginia's *oral health care* safety net providers – *to include an in depth look at ways to more proactively divert patients from ERs to dental resources within their communities and to include discussion on alternative settings where additional providers (such as registered dental hygienists) can practice to access additional patient populations that are not being reached. The study and its objectives should be led by the many and diverse stakeholder in the oral health community:* The Virginia Department of Health, Virginia Association of Free and Charitable Clinics, Virginia Community Healthcare Association, *the Virginia Dental Hygienists' Association, the Virginia College of Emergency Physicians,* Virginia Dental Association, *Virginia Commonwealth University School of Dentistry,* Virginia Health Care Foundation, *Old Dominion Dental Society*, Virginia Oral Health Coalition, *Virginia Health Care Associatio*n, and Virginia Rural Health Association will be asked to work with JCHC staff in determining the need for any *additional funding and resources to take care of Virginia's most vulnerable citizens. Furthermore, the group would be charged with taking a longer view of resources needed to improve education, awareness and proactivity for changing oral hygiene habits. The group would also collaborate with the Department of Education and other education stakeholders to expand oral health education in public schools."*
(The approved option includes additional text, in italics, proposed during the public comment period by the Virginia Dental Association, the Virginia Dental Hygienists' Association, the Virginia Board for People with Disabilities, and the Virginia College of Emergency Physicians.)

Background

Many Virginians do not have dental insurance and cannot afford regular dental services. These individuals lack preventive care and often develop serious dental problems, with negative consequences for their overall physical health and their ability to thrive as productive members of society. Dental disease, and the chronic pain that it often causes, affects a person's ability to eat, sleep and perform regular daily activities, including going to school or work. In addition, bacteria and inflammation from oral disease have negative effects on conditions such as diabetes, cardiovascular disease, respiratory infection and osteoporosis; and can result in adverse pregnancy outcomes.

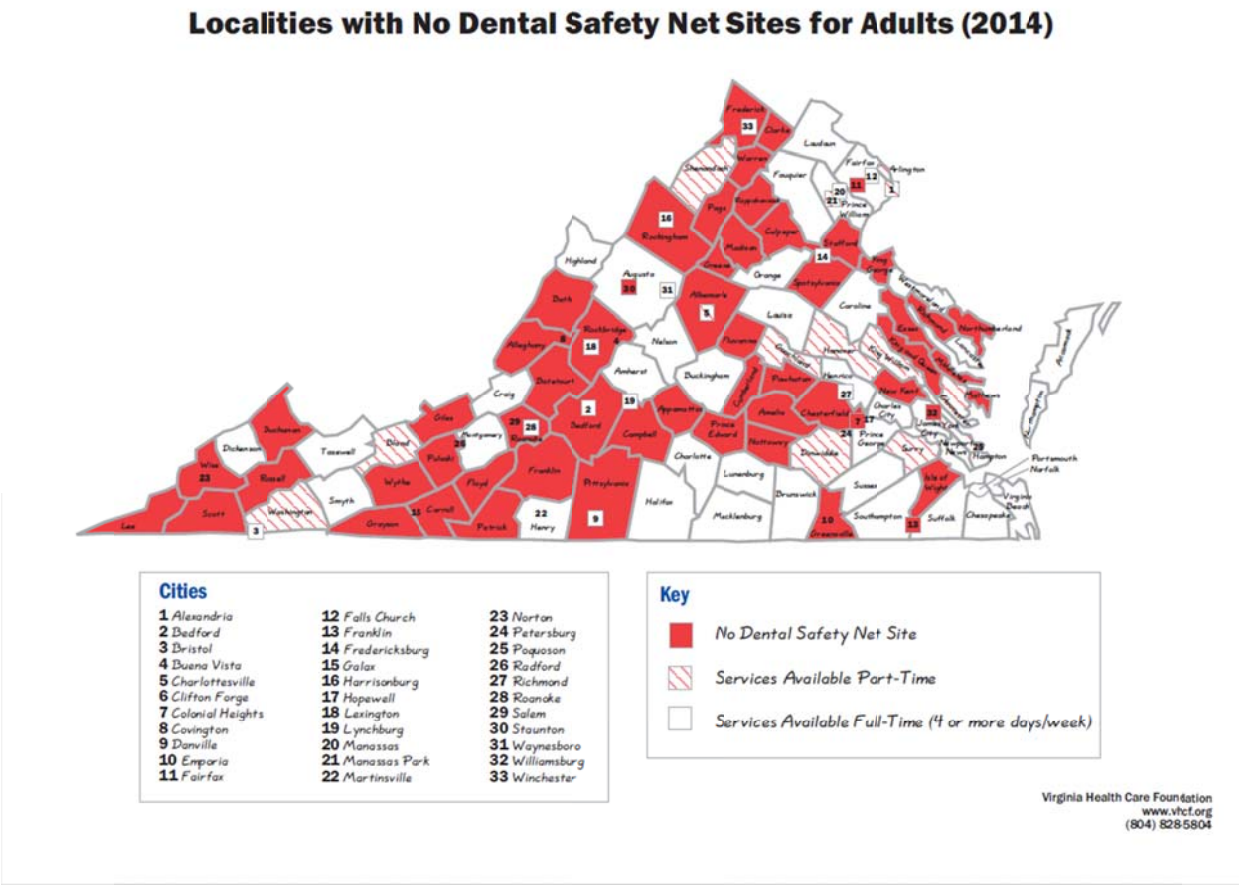
JCHC staff convened a work group of approximately 30 individuals representing a broad range of stakeholders. During the first work group meeting, it was decided to create five subcommittees to address the following issues identified as most relevant to the study:

1. Dental safety net capacity
2. Development of an emergency department diversion plan
3. Potential expansion of the Remote Supervision of Dental Hygienists model
4. Education and prevention
5. Teledentistry

The full work group and subcommittees each met twice to review information and formulate ideas, for a total of 12 meetings.

Dental Safety Net Capacity

Uninsured, low-income Virginians go without dental care or rely on hospital emergency departments, safety net providers and/or charitable weekend dental fairs, such as Missions of Mercy (MOM), for their dental needs. Unfortunately, all of these providers are limited in their ability to meet the needs of the large number of individuals with dental problems that cannot afford dental services offered in the private sector. Only 66 of 134 localities in Virginia have a dental safety net provider, and of those, many are only part-time. Last year a total of 44,789 patients received dental care at a safety net facility. This represents 7.4 percent of the estimated 607,000 adults in Virginia, aged 19-64, who do not have health insurance and have incomes below 200 percent of the federal poverty level.



The dental safety net is comprised of the Virginia Health Care Foundation, community health centers, free and charitable clinics, and dental practitioners who provide free or very low cost services in their community.

Virginia Health Care Foundation. The VHCF supports dental care for uninsured Virginians in a number of ways, including providing $10.7 million in dental grants which helped establish or expand 46 of Virginia's 81 dental safety net clinics, and by partnering with a dental company to

enable providers serving the uninsured to receive a substantial discount on dental equipment and supplies, maintenance and repair, and dental practice management software.

With an additional $1 million in funding, VHCF would be able to expand the number of dental safety net sites in the State through grant funding to clinics for the purchase of operatories (dental chairs and equipment).

Community Health Centers. Community health centers are nonprofit organizations, located in medically underserved areas, that provide comprehensive primary health care to anyone seeking services regardless of ability to pay. There are over 130 health center sites in Virginia, serving more than 300,000 patients. CHCs provide a wide range of services to patients, including medical, dental, pharmaceutical, behavioral health and prevention. As Federally Qualified Health Centers (FQHCs), CHCs receive federal grant funding under Section 330 of the Public Health Service Act and qualify for enhanced reimbursement from Medicare and Medicaid.

Dental-Service Sites	Staffing	Patients Served 2013	Estimated Need
44 sites/150 operatories 44 of 130 CHC sites	56 dentists 5 reg. dental hygienists ~ 80 dental assistants	42,380 total patients est. cost of $19.9 million (including 25,852 uninsured patients est. cost $12.2 million)	$6.1 million: (est. cost of treating uninsured not covered by other sources: self pay, federal funding, grants, and donations)

The Virginia Community Healthcare Association estimates that 61 percent of patients do not have dental insurance, requiring the centers to shift funding from other areas in order to cover the cost of providing dental services. An estimated $6.1 million of additional funds would be needed to create a more sustainable dental care program.

The Virginia Association of Free and Charitable Clinics. The Association has 60 member-clinics providing care to the uninsured; of the 30 clinics which provide dental services: 25 members provide on-site dental care and 5 provide off-site dental care by partnering with community dentists who render services at their offices.

Dental-Service Sites	Staffing	Patients Served 2013	Estimated Need
95 operatories at 25 on-site/5 community dental offices serve 30 of 60 clinics	462 volunteer dentists 142 volunteer dental hygienists	14,500 patients with $5 million budget	$3.3 million to expand in currently operating clinics

While these clinics are able to provide dental care to a significant number of Virginians in need, most are not able to meet the high demand for services in their community. Many have long wait lists and/or have stopped accepting new dental patients; and some are only able to treat for pain. With additional funding of $3.3 million, the dental clinics already providing dental care would be able to treat 15,474 additional patients per year—twice the number that currently can be seen.

Development of an Emergency Department Diversion Plan

Lack of access to dental care often means people with dental problems seek care in emergency departments (EDs) which typically are only able to provide an antibiotic and/or pain medication, and at a significantly higher cost. Data obtained this year from five Virginia hospitals indicate

that the proportion of ED visits that are dental related mirrors the national estimate of 1 to 2 percent. In addition, study results, from VCU's ED diversion pilot program and data from Memorial Hospital of Martinsville and Henry County regarding their efforts to divert patients to a community dental clinic, indicate that ED diversion plans can be effective in helping individuals find the oral health care they need in a more appropriate setting. However, these programs are only possible in localities in which there is a dental school or full-time community dental clinic to receive the diverted patients. Significant portions of the State lack a dental safety net facility; and in the localities with a safety net provider, many have waiting lists and/or lack the resources to care for all who are in need of services. It is unlikely that successful ED diversion can occur without additional funding for dental safety net providers.

Potential Expansion of the Remote Supervision of Dental Hygienists Model

In 2009, the General Assembly enacted legislation to reduce the dentist oversight requirement for hygienists employed by the Virginia Department of Health (VDH) in areas designated as dentally underserved. In these areas, dental hygienists are allowed to work under the remote, rather than general or direct, supervision of a dentist. Under remote supervision "a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but such dentist may not have done an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided" (*Code* § 54.1-2722). Under remote supervision, VDH hygienists may perform an initial examination of teeth and surrounding tissues, charting existing conditions; administer prophylaxis of natural and restored teeth; conduct scaling using hand instruments and ultrasound devices; provide dental sealant, assessment, maintenance and repair; apply topical fluorides; and provide educational services, assessment, screening or data collection for the preparation of preliminary records for evaluation by a licensed dentist.

While the remote supervision program initially was limited to services provided in schools, additional legislation was passed in 2012 allowing a dental hygienist employed by VDH to practice throughout the Commonwealth. The program has "improved access to preventive dental services for those at highest risk of dental disease, as well as reduced barriers and costs for dental care for low-income individuals" (*Report on Services Provided by Virginia Department of Health Dental Hygienists Pursuant to a "Remote Supervision" Practice Protocol, 2013*,RD No. 30 - 2014). The Board of Health Professions is currently considering expanding the model to include dental hygienists not employed by VDH and in a potentially broader range of settings. The options to expand the model include allowing non-VDH dental hygienists to practice via remote supervision in safety net facilities, hospitals, nursing homes or all dental sites, including the private sector, in order to provide access to a greater portion of Virginia's underserved population.

The JCHC work group subcommittee on remote supervision considered the range of expansion options and the majority of members support an incremental approach with initial expansion to safety net facilities only. Further, it was suggested that a work group of primary stakeholders – including Virginia Dental Association, Virginia Dental Hygienists' Association, Virginia Department of Health, Virginia Association of Free and Charitable Clinics, Virginia Community Healthcare Association, Virginia Oral Health Coalition, Virginia Board of Dentistry, Old Dominion University's School of Dental Hygiene, and Virginia Commonwealth University's School of Dentistry – be created to develop a pilot program for the expansion of the remote

supervision model, giving stakeholders the chance to be involved in determining the bounds and scope of the model and the specific protocol.

Education and Prevention

The JCHC work group subcommittee on education and prevention focused on improving oral health education in the Virginia school system. Currently, the topic of oral health is only covered in the kindergarten and first grade Standards of Learning (SOLs). The subcommittee, including members from VDH and the Virginia Department of Education, recommended inclusion of oral health education in the SOLS for all school-grades, along with the curriculum "Saving Smiles Series" developed by VDH for kindergarten through 10th grade. Curriculum information can be found at http://www.vdh.virginia.gov/OFHS/childandfamily/dental/ohe/.

Teledentistry

Questions remain regarding the range of appropriate uses for teledentistry and various obstacles that may need to be addressed in order to facilitate teledentistry in Virginia. The *Code of Virginia* includes a section on reimbursement for telemedicine but teledentistry is not specifically authorized. As a result, it is unclear whether, and what types of teledentistry can be billed for reimbursement. In September 2013, the Virginia Oral Health Coalition created a teledentistry work group which is currently investigating these issues. The JCHC work group members recommended encouraging the efforts of the Coalition's work group and suggested a report of its findings be submitted to JCHC by October 2015.

Policy Options and Public Comment

Nine comments were received regarding the policy options addressing the dental safety net capacity and ways to improve oral health in Virginia. Comments were submitted by:

- Kelli Swanson Jaecks, MA, RDH, **American Dental Hygienists' Association (ADHA)**
- Andre Hinterman, Chairman, **Piedmont Regional Dental Clinic (PRDC)**
- Jeremiah K. O'Shea, MD, FACEP, President, **Virginia College of Emergency Physicians (VCEP)**
- Rick Shinn, **Virginia Community Healthcare Association (VCHA)**
- Michael J. Link, DDS, President, **Virginia Dental Association (VDA)**
- Michelle McGregor, RDH, BS, M.Edu, **Virginia Dental Hygienists' Association (VDHA)**
- Deborah Oswalt, **Virginia Health Care Foundation (VHCF)**
- Sarah Bedard Holland, Executive Director; Robin Haldiman, Chair; Tegwyn Brickhouse, DDS, PhD, Legislative Committee Chair, **Virginia Oral Health Coalition (VOHC)**
- Susan F. O'Connor, DDS

	Policy Options	**Support**
1	Take no action.	0
2	Introduce budget amendments to increase funding for the following safety net providers for dental services • $3.3 million for the Virginia Association of Free and Charitable Clinics member clinics • $6.1 million for Community Health Centers • $1 million for the Virginia Health Care Foundation for the creation of additional dental safety net sites.	5 PRDC VCEP VCHA VDA VOHC

3	Introduce a budget amendment for $7,563,750 GFs and $7,563,750 NGFs in FY 2016 to expand Medicaid to include preventive dental coverage for adults.	4 PRDC VCEP VCHA VOHC
4	Introduce a budget amendment for $30,255,000 GFs and $30,255,000 NGFs in FY 2016 to expand Medicaid to include full dental coverage for adults.	4 PRDC VCEP VCHA VOHC
5	Introduce a budget amendment for $400,000 GFs to allow the Virginia Department of Health to establish an Oral Health Workforce Fund.	3 PRDC VCHA VOHC
6	Request by letter of the JCHC Chair, that a representative of the Virginia Oral Health Coalition's Teledentistry Work Group report on their efforts to JCHC by October 2015.	2 VCHA VOHC
7	Request by letter of the JCHC Chair, that a work group of primary stakeholders, including Virginia Dental Association, Virginia Dental Hygienists' Association, Virginia Department of Health, Virginia Association of Free and Charitable Clinics, Virginia Community Healthcare Association, Virginia Oral Health Coalition, Virginia Board of Dentistry, Old Dominion University's School of Dental Hygiene, and Virginia Commonwealth University's School of Dentistry, be created to develop a pilot program to expand the remote supervision of dental hygienists model to safety net facilities. The work group should report to JCHC by October 2015.	5 ADHA PRDC VCHA VDHA VOHC

Comment Excerpts:

Kelli Swanson Jaecks, MA, RDH, American Dental Hygienists' Association (ADHA): "…The American Dental Hygienists' Association (ADHA) urges the Commission to support expanding the remote supervision of dental hygienists to include safety net facilities…Dental hygienists work in a host of settings to deliver clinical care and work under varying levels of supervision, depending on the state practice act. States, like Virginia, are increasingly recognizing the importance of increasing direct access to dental hygiene services. Thirty-seven states have policies that allow dental hygienists to work in community-based settings (like public health clinics, schools, and nursing homes) to provide preventive oral health services without the presence or direct supervision of a dentist. These states recognize that dental hygienists are primary care providers who are an essential entry point to the health care system…"

Andre Hinterman, Chairman, Piedmont Regional Dental Clinic (PRDC): "…I have learned several things about the dental safety net program in Virginia I wish to share with the Commission: [1] It is far more expensive to set up a dental safety net practice than a medical free clinic by at least a factor of 10. PRDC spent approximately $500,000 to equip our nine-operatory Clinic. [2] The greatest single thing the Legislature could do to improve the oral health of our patients is pass Medicaid expansion. [3] Please be aware that dental safety net clinics use a variety of operational models. The majority of us are not eligible for State support

through the Association of Free and Charitable Clinics because we receive Smiles for Children and Medicaid reimbursement. We ask the Commission to remain cognizant that no single channel of funding reaches all dental safety net clinics (except the Virginia Health Care Foundation without whom our Clinic would not exist). [4] Low income veterans are an underserved population with particularly acute needs. We recommend allowing uninsured, low income veterans to participate in Medicaid up to 138% of the federal poverty level…"

Jeremiah K. O'Shea, MD, FACEP, President, Virginia College of Emergency Physicians (VCEP): "…When we see [dental] patients in the emergency department, there is often nowhere for us to refer them to due to a lack of dental resources in the community. As a result, they return to the emergency department when their dental problems have become medical emergencies. The best way to divert these patients from the emergency department is to ensure they receive preventative dental care and dental services. We need to expand the capacity of safety net providers to see and treat these patients. Therefore, we support [options 2, 3 and 4]…"

Rick Shinn, Virginia Community Healthcare Association (VCHA): "…The Virginia Community Healthcare Association supports Option 2. We would note that the funding would assist safety net dental providers in their efforts to stabilize current operations and assist in providing basic dental services to those in need. We estimate that 61% of dental patients at community health centers are uninsured for dental services. It is simply financially unsustainable for health centers to provide dental services without financial support to offset costs incurred for treating the uninsured…. The Virginia Community Healthcare Association supports Option 5. We would note that there already exists a loan repayment program in place for this funding, and that the funds should be used specifically for providing dental services in underserved areas or to underserved populations of the Commonwealth… The Virginia Community Healthcare Association supports Option 7. We would express our support for the Virginia Dental Association and the Virginia Dental Hygienist Association to develop acceptable and agreed upon parameters for any scope of practice issues that may impede common agreement for this option to advance…"

Michael J. Link, DDS, President, Virginia Dental Association (VDA): "…While we agree with the purpose of [the] budgetary options, we also realize the reality of the current financial constraints faced by the Commonwealth. We do, however, feel that if anything can be done from a budgetary perspective, we would encourage the JCHC to consider the option that refers to additional funding for the Virginia Health Care Foundation. They have demonstrated over a period of 15 years that dentistry is an important part of overall health and have invested heavily into that sector of health care. Their investment into the oral health of populations that struggle for care are well documented and we would encourage additional funding for their dental safety net initiatives…We [VDA] are launching a pilot program in our quest to promote oral health to underserved population, as well as navigate people into a dental home. A Community Dental Health Coordinator (CDHC) is a 'connector' between populations of patients and dental care. Their successful efforts to connect people to care through patient navigation, community based education and prevention have been documented both in a three year pilot program conducted by the American Dental Association and in several sabbaticals that have been done across the country. These professionals will complete a program and internship which typically lasts a little over a year. CDHCs comply with the state dental practice act and work under the supervision of a dentist. CDHCs may be assistants, dental hygienists, or other health professionals. Their duties may involve delivery of preventive services, such as dental sealants and fluoride varnish,

but experience over three years has shown that case management and navigation are significant areas where CDHCs have shown tremendous value. Our leadership is in the early stages of forming a task force to develop the plan to fully implement utilization of CDHCs in the Commonwealth of Virginia. We anticipate partnering with other stakeholders on this program and look forward to updating legislators on our progress moving forward…Ultimately, the VDA membership believes that 1) encouraging and maintaining the number of Medicaid/CHIP providers; 2) increasing the oral-health literacy of families already covered under Medicaid/CHIP; and 3) the rollout of the CDHC model are the most cost-effective ways to increase access and utilization…"

Michelle McGregor, RDH, BS, M.Edu, Virginia Dental Hygienists' Association (VDHA): "The VDHA overwhelmingly supports Policy Option 7… The October 2014 Virginia Department of Health Technical Report on "Remote Supervision Hygienists" reveals: As this and previous reports indicate, the remote supervision model offers an effective alternative method of delivery for safety net dental program services with increased access for underserved populations…This effort has improved access to preventive dental services for those at highest risk of dental disease, as well as reducing barriers and costs for dental care for low-income individuals…Across the State, "remote supervision" hygienists are making a significant contribution to the oral health of their communities, not only through direct services but through education, raising awareness of local dental challenges, capturing oral health status data, partnering with providers and linking children to the services they need (Quoted from the VDH report). The VDH has already documented improved oral health care outcomes using the remote supervision model for dental hygienists. The VDHA supports expansion of this program to include the utilization of registered dental hygienists' in safety net facilities across the state. Using this model will enable dental hygienists to utilize their education and training to their full capacity."

Deborah Oswalt, Virginia Health Care Foundation (VHCF): "…The data and evidence the staff has provided demonstrate that the need for affordable oral health care is tremendous among low-income working Virginians. As Commission members noted last month, the financing of dental services has traditionally been much different than medical care. Dental services are sold much like a commodity with people often paying for dental care themselves. While about half of all Virginians have dental insurance, it is typically limited to a modest amount of annual coverage. Uncovered services must be underwritten by the patient. Those without dental insurance must pay for all charges themselves. For uninsured, low-income Virginians, regular visits to a dentist are a luxury many can't afford. As they carefully weigh priorities when determining how to spend their limited incomes, a trip to the dentist for routine maintenance often loses out to more immediate needs, such as food, rent, or a child's winter coat. Much attention has been paid to the long lines of people who wait through the night to get needed dental care at the Mission of Mercy (MOM) project in Wise County each summer. What many don't realize is that the same long lines exist in every locality that has a MOM project – Roanoke, Orange County, Northern Virginia, Gloucester County to name a few. It is not exaggeration to predict that long lines of people who can't afford dental care would assemble in any locality that has a MOM. For many, it's their only hope of getting relief from the throbbing pain of a toothache or of maintaining good oral hygiene. At the Virginia Health Care Foundation (VHCF) we're acutely aware of this problem and have worked diligently to address it. Over the past 15 years, we've helped establish 46 dental safety net clinics where dental care is low cost and affordable for low-income Virginians. There are still 66 localities that do not have one,

however. We are currently engaged in a $1 million dental safety net challenge grant campaign made possible by the Delta Dental of Virginia Foundation. It will ultimately yield a total of $2 million to expand Virginia's dental safety net. While this will make an impact, we will still have many localities without a dental safety net organization. We realize that budget cuts are dominating current state fiscal discussions. Should revenues improve, however, we ask you to keep the need for availability of affordable dental care top of mind, and become a partner in expanding accessibility to oral health care for low-income Virginians."

Sarah Bedard Holland, Executive Director; Robin Haldiman, Chair; Tegwyn Brickhouse, DDS, PhD, Legislative Committee Chair, Virginia Oral Health Coalition (VOHC): "…Oral health access issues are complex, as reflected in the report. These issues can result from too few dental providers in areas of high need, lack of insurance coverage or resources to cover the cost of care, and an inadequate understanding of the importance of oral health. As such, it will take a multi-faceted approach to address these issues. The Coalition appreciates the challenging fiscal realities the Commonwealth currently faces and the need to optimize Virginia's resources. Before you are policy options that will improve the health of Virginians by expanding access to care. We respectfully ask that as you consider the options you are mindful of the long term financial and health returns of small investments in Medicaid and the safety net and that you support the development of delivery models that have proven to reduce Medicaid costs in other states and have enhanced access to dental services. Policy options two through five will enable more Virginians to access oral health services they desperately need by: [1] Expanding the capacity of existing safety net clinics (option two); [2] Facilitating the development of new dental safety net sites (option two); [3] Providing Medicaid dental coverage for preventive oral health services that will improve health, diminish pain and decrease avoidable emergency department visits (options three and four); [4] Providing an additional revenue source for safety net clinics who are currently subsiding the care for uninsured adults (options three and four); and, [5] Providing an incentive for dentists to practice in dental shortage areas (option five)…[Also] we are pleased to see that the report provides two options (six and seven) that have no fiscal impact to the Commonwealth but provide an avenue for efficiencies, cost savings and better access to care.

Susan F. O'Connor, DDS: While no specific policy options were mentioned, Dr. O'Connor, a dentist who volunteers at the Galax Free Clinic, stated, "Need is exceptional in the south and west of Virginia. Money is the main issue. Free clinics need to be established and funded. Dentists are volunteering in a manner I believe to be much more than ordinary in many other states, but fees for Medicaid dentistry need to be increase."

Minor Consent Requirement for Voluntary Inpatient Psychiatric Treatment

Senate Bill 184 - Senator McWaters and House Bill 1097 - Delegate LeMunyon

Stephen W. Bowman
Senior Staff Attorney/Methodologist

During the 2014 General Assembly Session, Senate Bill 184 and House Bill 1097 were introduced to amend the minor consent requirement for inpatient psychiatric treatment. While the bills approaches differed, both bills would eliminate the requirement to receive the consent of a minor who is 14 years of age or older for inpatient psychiatric treatment on a voluntary basis. SB 184 was passed by indefinitely by the Senate Committee on Courts of Justice with a letter from the Clerk of the Senate referring the bill's subject matter to the Joint Commission on Health Care for review. HB 1097 was left in the House Committee on Courts of Justice and referred to JCHC by letter of the Committee Chair for review.

Inpatient Psychiatric Treatment and Available Beds

Parental admission of minors for inpatient psychiatric treatment involves interests of parents, children, and government. Sections 16.1-338 and 16.1-339, of the *Code of Virginia,* provide procedures for parental admission of minor children for inpatient treatment that may be provided in psychiatric inpatient facilities and for certain residential treatment services. In terms of a continuum of treatment alternatives, residential and inpatient psychiatric treatment are the most intensive, costly, and disruptive to home-based family life. There is no statewide data available regarding the frequency in which minors are involved in voluntary admissions, voluntary admission over objection, or court cases involving objecting minors.

Private hospitals and residential facilities are not required to provide mental health care and in certain areas of the State there are relatively few inpatient psychiatric beds. In addition, there are instances in which an open bed exists but a facility may not accept the minor for patient- or facility-related reasons. Patient-related reasons may include gender, violent behavior, status as a sex offender, or a medical condition that cannot be managed. Facility-related reasons may include the demands of the current unit population or that staff may not have the training to treat certain individuals.

Virginia's Current Law

The admission process for minors younger than 14 years of age and consenting minors 14 and older is defined in *Code* § 16.1-338. The requirements for admission are: 1) parental consent, 2) application for admission, 3) willing facility, and 4) minor's consent if over 14 years of age. Within 48 hours of admission, a qualified evaluator is required to conduct a personal examination of the minor and make the following written findings:

"1. The minor appears to have a mental illness serious enough to warrant inpatient treatment and is reasonably likely to benefit from the treatment; and

2. The minor has been provided with a clinically appropriate explanation of the nature and purpose of the treatment; and

3. If the minor is 14 years of age or older, that he has been provided with an explanation of his rights under this Act as they would apply if he were to object to admission, and that he has consented to admission; and

4. All available modalities of treatment less restrictive than inpatient treatment have been considered and no less restrictive alternative is available that would offer comparable benefits to the minor."

If admission is sought to a State facility "the community services board serving the area in which the minor resides shall provide…a preadmission screening report conducted by an employee or designee of the community services board." For admission to a private facility, a qualified evaluator conducts the examination; the evaluator can be the facility medical director.

The admission process for a minor 14 years of age or older who (i) objects to admission, or (ii) is incapable of making an informed decision is defined in *Code* §16.1-339, which specifies the opportunity for judicial review. A minor under this section may be admitted to a willing facility upon the application of a parent and within 24 hours will be examined by a qualified evaluator designated by the community services board that serves the area the facility is located. As noted below, the evaluator must determine whether the minor meets the criteria for admission, which is a much-higher standard than the voluntary commitment required in *Code* §16.1-338.

"The evaluator shall prepare a report that shall include written findings as to whether:

1. Because of mental illness, the minor (i) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control;

2. The minor is in need of inpatient treatment for a mental illness and is reasonably likely to benefit from the proposed treatment; and

3. Inpatient treatment is the least restrictive alternative that meets the minor's needs. The qualified evaluator shall submit his report to the juvenile and domestic relations district court for the jurisdiction in which the facility is located."

When an objecting minor or one that is incapable of making an informed decision is initially admitted under *Code* §16.1-339, the facility files "a petition for judicial approval no sooner than twenty-four hours and no later than ninety-six hours.…Upon receipt of the petition, the judge appoints a guardian ad litem for the minor and counsel to represent the minor.…The court and the guardian ad litem shall review the petition and evaluator's report and shall ascertain the views of the minor, the minor's consenting parent, the evaluator, and the attending psychiatrist." The court may order the facility to release the minor, authorize continued hospitalization for up to 90 days on the basis of the parent's consent, or schedule a commitment hearing.

Approaches Taken by Other States

State laws vary significantly and can be classified into three basic groups: very protective of parents' rights, very protective of minors' rights, or intermediate approaches.

States that Are Very Protective of Parents' Rights. These states provide no judicial review requirement for parental admission of a minor. An independent examiner, usually the facility's medical director, makes the determination of whether a minor meets the criteria for admission. The typical criteria for admission are the minor will benefit from treatment and that the treatment cannot feasibly take place in a less restrictive setting. Examples of these states include Arizona, Missouri, Minnesota, Ohio, Oklahoma, Oregon, and Texas.

States that Are Very Protective of Minors' Rights. These states require a judicial hearing for an objecting minor and most have no "holding period" until the hearing. In some of these states, the criteria for admission when a minor objects are the same as their involuntary commitment standards. Examples of these states include Florida, Hawaii, Iowa, and New York.

States with an Intermediate Approach to Parental Admissions. Most of the states that take an intermediate approach set a minimum age at which the minor may object to his admission (12, 14, 15, or 16). The maximum "holding period" after admission but before judicial review varies widely, from three to 21 days. All of these states require a hearing for an objecting minor while some require the court to determine that the minor meets the criteria for involuntary commitment. Examples of these states include Colorado, Connecticut, Illinois, Kentucky, Louisiana, Michigan, New Jersey, North Carolina, South Dakota, Virginia, Washington, and West Virginia.

Policy Options and Public Comment

Twelve comments were received regarding the policy options addressing the minor consent requirement for inpatient psychiatric treatment. Comments were submitted by:

- Heather Davies
- Sandra Eichorn
- Jessie Georges
- Jacquelin McKisson
- Bryan Niles
- Lisa Ross
- Denise Thompson
- Aisha Huertas Michel, **American Civil Liberties Union of Virginia**
- Colleen Miller, **disAbility Law Center of Virginia**
- Mira Signer, **National Alliance on Mental Illness Virginia**
- Jennifer Faison, **Virginia Association of Community Services Boards**
- Susan Ward, **Virginia Hospital and Healthcare Association**

Option 1: Provide a written report of study findings and JCHC recommendations to the Senate and House Courts of Justice Committees.

Option 2: Introduce legislation to amend *Code of Virginia* §§ 16.1-338 and 16.1-339 to remove the minor consent requirement for voluntary inpatient psychiatric treatment. The current admission criteria for voluntary admission of a minor are used.

- Substantive policy of House Bill 1097

8 comments in support:
Heather Davies Sandra Eichorn
Jessie Georges Jacquelin McKisson
Bryan Niles Lisa Ross
Denise Thompson
National Alliance on Mental Illness Virginia – with caveat that "a method for due process for youth" is included

Option 3: Introduce legislation to amend *Code of Virginia* §§ 16.1-338 and 16.1-339 to remove the minor consent requirement for voluntary inpatient psychiatric treatment with an option for judicial review for minors who are 14 years of age or older who object to admission. When judicial review occurs, the current admission criteria for voluntary admission of an objecting minor are used.

- Substantive policy of Senate Bill 184

In Support: National Alliance on Mental Illness Virginia

Option 4: Introduce legislation to amend *Code of Virginia* §§ 16.1-338 and 16.1-339 to change the minimum age a minor may object to psychiatric inpatient treatment from 14 years of age to:

A. 15 years of age B. 16 years of age C. 17 years of age

Option 5: Introduce legislation to amend *Code of Virginia* § 16.1-339 to increase the time allowed before a petition for judicial approval is filed from 96 hours (4 days) to:

A. 120 hours (5 days) B. 144 hours (6 days)

Option 6: Include in the JCHC work plan for 2015 that staff convene a workgroup to study the idea of establishing an advance directive for mental health conditions for use by minors.

(*Code* § 37.2-805.1 sets out a process for adults to be admitted under an advance directive for mental health conditions to an inpatient facility. However, no comparable statutory framework exists for minors under Virginia law.)

The following groups and individuals would be invited to participate in the workgroup, as well as other interested parties:

- American Civil Liberties Union
- Attorney General of Virginia
- Department of Behavioral Health and Developmental Services
- disAbility Law Center of Virginia
- JustChildren of the Legal Aid Justice Center
- National Alliance on Mental Illness Virginia
- Parents of minors with mental health conditions who may need inpatient psychiatric treatment
- UVA Institute of Law, Psychiatry and Public Policy
- Virginia Association of Community Services Boards
- Virginia Hospital and Healthcare Association
- Voices for Virginia's Children

In Support: Heather Davies and Virginia Association of Community Services Boards

Option 7: By letter of the JCHC Chair, request that the Institute of Law, Psychiatry and Public Policy review and describe current practices regarding admission of minors for inpatient psychiatric treatment in Virginia and report to JCHC when findings and conclusions are available.

***In Support*:** Virginia Association of Community Services Boards and Virginia Hospital and Healthcare Association

Option 8: Introduce legislation to amend *Code of Virginia* § 16.1-338 to allow a minor 14 years of age or older to consent to voluntary inpatient psychiatric treatment without the consent of the minor's parent.

Option 9: Introduce legislation to amend *Code of Virginia* § 16.1-338.D to require that the mental health facility notify the consenting parent immediately if a minor 14 or older objects at any time to further treatment. In addition, the parent shall be informed of the avenues available to request continued admission under *Code* §§ 16.1-339, 16.1-340.1, or 16.1-345.

In Support: National Alliance on Mental Illness Virginia

Option 10: Introduce legislation to amend *Code of Virginia* § 16.1-339 to make consistent the mental health criteria for admission of an objecting minor with the existing mental health criteria for a voluntary admission of a consenting minor in *Code* § 16.1-338.

In Support: National Alliance on Mental Illness Virginia

Current mental health criteria in Code § 16.1-339:

"1. Because of mental illness, the minor (i) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control;

2. The minor is in need of inpatient treatment for a mental illness and is reasonably likely to benefit from the proposed treatment; and

3. Inpatient treatment is the least restrictive alternative that meets the minor's needs."

Proposed mental health criteria from Code § 16.1-338:

"The minor appears to have a mental illness serious enough to warrant inpatient treatment and is reasonably likely to benefit from the treatment; and

… All available modalities of treatment less restrictive than inpatient treatment have been considered and no less restrictive alternative is available that would offer comparable benefits to the minor."

Option 11: Include in the JCHC work plan for 2015, a staff review of the implications of allowing a minor to consent for inpatient treatment at a mental health facility without the consent of the minor's parent. The review shall include consideration of 1) amending *Code* § 16.1-338 to allow a minor 14 years of age or older to consent for voluntary inpatient mental health treatment without the consent of the minor's parent, 2) creating a judicial review regarding release under *Code* § 16.1-339 when the minor desires to continue inpatient treatment and consent for continued admission is withdrawn by the parent who consented to the minor's admission, and 3) reimbursement issues for services provided when a minor receives inpatient mental health treatment without the consent of the minor's parent.

In Support: Virginia Association of Community Services Boards - would support the study "on its own or after option #7 is executed."

Policy Options		Support
1	Provide a written report of study findings and JCHC recommendations to the Senate and House Courts of Justice Committees.	None
2	Introduce legislation to amend *Code of VA* §§ 16.1-338 and 16.1-339 to remove the minor consent requirement for voluntary inpatient psychiatric treatment. The current admission criteria for voluntary admission of a minor are used. *Substantive policy of House Bill 1097*	H. Davies, S. Eichorn, J. Georges, J. McKisson, B. Niles, L. Ross, D. Thompson; NAMI VA **if** "a method for due process for youth" is included
3	Introduce legislation to amend *Code of VA* §§ 16.1-338 and 16.1-339 to remove the minor consent requirement for voluntary inpatient psychiatric treatment with an option for judicial review for minors who are 14 years of age or older who object to admission. When judicial review occurs, the current admission criteria for voluntary admission of an objecting minor are used. *Substantive policy of Senate Bill 184*	NAMI Virginia
4	Introduce legislation to amend *Code of VA* §§ 16.1-338 and 16.1-339 to change the minimum age a minor may object to psychiatric inpatient treatment from 14 to: A. 15 years of age B. 16 years of age C. 17 years of age	None
5	Introduce legislation to amend *Code of Virginia* § 16.1-339 to increase the time allowed before a petition for judicial approval is filed from 96 hours (4 days) to: A. 120 hours (5 days) B. 144 hours (6 days)	None
6	Include in the JCHC work plan for 2015 that staff convene a workgroup to study the idea of establishing an advance directive for mental health conditions for use by minors. (*Code* § 37.2-805.1 sets out a process for adults only.)	H. Davies VACSB
7	By letter of the JCHC Chair, request that the Institute of Law, Psychiatry and Public Policy review and describe current practices regarding admission of minors for inpatient psychiatric treatment in Virginia and report to JCHC when findings and conclusions are available.	VACSB VHHA
8	Introduce legislation to amend *Code of Virginia* § 16.1-338 to allow a minor 14 years of age or older to consent to voluntary inpatient psychiatric treatment without the consent of the minor's parent.	None
9	Introduce legislation to amend *Code of Virginia* § 16.1-338.D to require that the mental health facility notify the consenting parent immediately if a minor 14 or older objects at any time to further treatment. In addition, the parent shall be informed of the avenues available to request continued admission under *Code* §§ 16.1-339, 16.1-340.1, or 16.1-345.	NAMI Virginia
10	Introduce legislation to amend *Code of Virginia* § 16.1-339 to make consistent the mental health criteria for admission of an objecting minor with the existing mental health criteria for a voluntary admission of a consenting minor in *Code* § 16.1-338.	NAMI Virginia
11	Include in the JCHC work plan for 2015, a staff review of the implications of allowing a minor to consent for inpatient treatment at a mental health facility without the consent of the minor's parent. The review shall include consideration of 1) amending *Code* § 16.1-338 to allow a minor 14 years of age or older to consent for voluntary inpatient mental health treatment without the consent of the minor's parent, 2) creating a judicial review regarding release under *Code* § 16.1-339 when the minor desires to continue inpatient treatment and consent for continued admission is withdrawn by the parent who consented to the minor's admission, and 3) reimbursement issues for services provided when a minor receives inpatient mental health treatment without the consent of the minor's parent.	VACSB would support the study"on its own or after option #7 is executed."

ATTACHMENT
Compendium of Study Requests

Mary Washington Healthcare
Mary Washington Hospital Foundation

October 18, 2013

Senator Linda T. Puller, Chair
Delegate John M. O'Bannon, III, Vice-Chair
Joint Commission on Health Care
P.O. Box 1322
Richmond, VA 23218

Dear Senator Puller and Delegate O'Bannon:

The Virginia Consortium of Health Philanthropy (VCHP) is an informal association of health foundations in Virginia which meet periodically for the purpose of improving the effectiveness of health philanthropy through collaboration, cooperation and communication among and between health foundations and other key stakeholders. Membership includes most of Virginia's local conversion foundations.

We respectfully request a review by the Joint Commission on Health Care (JCHC) regarding the need for Virginia's health conversion foundations to continue providing a joint annual report regarding their charitable activities. This report was requested in 1998 by House Joint Resolution No. 179, which requested *"foundations formed in Virginia as a result of hospitals converting from not-for-profit to for-profit status to annually update the JCHC on their charitable activities"*.

HJR 179 was passed at a time when conversion foundations were new and members of the JCHC wanted a mechanism for monitoring their activities. The VCHP has contracted annually with a consultant to retrieve the information needed from each conversion foundation, compile it, and report it to the JCHC.

A lot has happened in the past 15 years to ensure accountability and transparency of health conversion foundations. Each must file the new Form 990 annually with the Internal Revenue Service, providing in-depth information regarding its finances and disbursements. This new form was instituted by Congress several years ago and requires much more detail than the Form 990 which existed in 1998. In addition, there is now an official process in place where the Attorney General reviews the circumstances and charter of new conversion foundations. This did not exist when HJR 179 was passed. Finally, conversion foundations are more commonplace now, their charitable activities are very visible and they publicize them through annual reports to the community and on their websites.

If there is a compelling reason for us to continue to produce a joint annual report, VCHP is happy to continue providing it. In the spirit of good stewardship and eliminating duplication, however, we are raising the question of whether such a report has outlived its usefulness.

If there is an interest in having all of the information in one place, perhaps you could consider allowing each conversion foundation to send its annual report to the JCHC rather than creating a separate report?

Thank you for your consideration of this request. If you have any questions, please contact me at 540-741-1492

Sincerely,

Kimberly C. Smart, Convener
Virginia Consortium of Health Philanthropy

ENROLLED

HOUSE JOINT RESOLUTION NO. 68

Directing the Joint Commission on Health Care to study viral hepatitis within the Commonwealth. Report.

Agreed to by the House of Delegates, February 5, 2014
Agreed to by the Senate, February 25, 2014

WHEREAS, over four million Americans are infected with viral hepatitis, which is a major public health problem that causes chronic liver diseases, such as cirrhosis, liver failure, and liver cancer; and

WHEREAS, populations at risk of viral hepatitis infection within the Commonwealth include recipients of blood transfusions prior to 1992, Vietnam veterans, HIV-positive individuals, children born to mothers infected with viral hepatitis, and health care providers exposed to communicable viral hepatitis; and

WHEREAS, significant pharmaceutical developments have created expanded treatment options for viral hepatitis; and

WHEREAS, the Centers for Disease Control and Prevention and the United States Preventive Services Task Force have recently issued new guidance for testing, treatment, and prevention of viral hepatitis; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care be directed to study viral hepatitis within the Commonwealth.

In conducting its study, the Joint Commission on Health Care shall (i) identify resources available, and those needed, for testing, treatment, and prevention of viral hepatitis; (ii) ascertain any financial, workforce, legislative, or regulatory factors limiting testing, treatment, and prevention of viral hepatitis; (iii) identify opportunities for integration of viral hepatitis treatment within new or existing HIV-positive treatment programs; and (iv) consult with representatives of the Commonwealth's health care providers, pharmaceutical sector, military community, and other appropriate stakeholders.

Technical assistance shall be provided to the Joint Commission on Health Care by the Department of Health, the Department of Health Professions, the Department of Veterans Services, and the Department of Corrections. All agencies of the Commonwealth shall provide assistance to the Joint Commission on Health Care for this study, upon request.

The Joint Commission on Health Care shall complete its meetings for the first year by November 30, 2014, and for the second year by November 30, 2015, and the chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the next Regular Session of the General Assembly for each year. Each executive summary shall state whether the Joint Commission on Health Care intends to submit to the General Assembly and the Governor a report of its findings and recommendations for publication as a House or Senate document. The executive summaries and reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

12105380D

SENATE JOINT RESOLUTION NO. 50

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Rules
on February 10, 2012)

(Patron Prior to Substitute—Senator Barker)

Directing the Joint Commission on Health Care to study the fiscal impact to the Commonwealth that results from untreated dental disease. Report.

WHEREAS, it is a well-accepted principle that there is a direct correlation between oral health care and overall health care, including the adverse effects of lack of preventive oral health care; and

WHEREAS, there are numerous chronic and acute health maladies that are related to poor access to oral health care, including but not limited to diabetes, cardiovascular disease, premature births, and low birth weight babies; and

WHEREAS, these maladies not only have severe adverse impacts on the well-being of the residents of the Commonwealth, they also result in (i) major costs to the Commonwealth in the form of payments to treat general health maladies and severe dental disease that could have been prevented through preventive oral health care at a fraction of the cost; (ii) lost work and school hours related to pain and disease; and (iii) expense to the Commonwealth in the form of uncompensated care; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to study the fiscal impact to the Commonwealth that results from untreated dental disease.

In conducting its study, the Joint Commission on Health Care shall estimate (i) the payments made by Virginia's Medicaid program to hospital emergency departments for dental-related diagnoses; (ii) the amount of uncompensated care provided by hospital emergency departments for dental-related diagnoses; and (iii) the number of dental patients treated and the overall value of the dental-related services provided by Virginia's safety net providers, including but not limited to Free Clinics, Community Health Centers, and local health departments.

All agencies of the Commonwealth shall provide assistance to the Joint Commission for this study, upon request.

The Joint Commission on Health Care shall complete its meetings for the first year by November 30, 2012, and for the second year by November 30, 2013, and the Chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the next Regular Session of the General Assembly for each year. Each executive summary shall state whether the Joint Commission on Health Care intends to submit to the General Assembly and the Governor a report of its findings and recommendations for publication as a House or Senate document. The executive summaries and reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

14102065D

SENATE BILL NO. 184

Offered January 8, 2014

Prefiled January 2, 2014

A BILL to amend and reenact §§ 2.2-3705.5, 16.1-337, 16.1-338, 16.1-339, 16.1-341, 16.1-342, and 16.1-345 of the Code of Virginia, relating to admission of minors to mental health facility for inpatient treatment.

Patron—McWaters

Referred to Committee for Courts of Justice

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-3705.5, 16.1-337, 16.1-338, 16.1-339, 16.1-341, 16.1-342 and 16.1-345 of the Code of Virginia are amended and reenacted as follows:

§ 2.2-3705.5. Exclusions to application of chapter; health and social services records.

The following records are excluded from the provisions of this chapter but may be disclosed by the custodian in his discretion, except where such disclosure is prohibited by law:

1. Health records, except that such records may be personally reviewed by the individual who is the subject of such records, as provided in subsection F of § 32.1-127.1:03.

Where the person who is the subject of health records is confined in a state or local correctional facility, the administrator or chief medical officer of such facility may assert such confined person's right of access to the health records if the administrator or chief medical officer has reasonable cause to believe that such confined person has an infectious disease or other medical condition from which other persons so confined need to be protected. Health records shall only be reviewed and shall not be copied by such administrator or chief medical officer. The information in the health records of a person so confined shall continue to be confidential and shall not be disclosed by the administrator or chief medical officer of the facility to any person except the subject or except as provided by law.

Where the person who is the subject of health records is under the age of 18, his right of access may be asserted only by his guardian or his parent, including a noncustodial parent, unless such parent's parental rights have been terminated, a court of competent jurisdiction has restricted or denied such access, or a parent has been denied access to the health record in accordance with § 20-124.6. In instances where the person who is the subject thereof is an emancipated minor, a student in a public institution of higher education, or is a minor who has consented to his own treatment as authorized by § ~~16.1-338~~ ~~or~~ 54.1-2969, the right of access may be asserted by the subject person.

For the purposes of this chapter, statistical summaries of incidents and statistical data concerning abuse of individuals receiving services compiled by the Commissioner of Behavioral Health and Developmental Services shall be open to inspection and copying as provided in § 2.2-3704. No such summaries or data shall include any information that identifies specific individuals receiving services.

2. Applications for admission to examinations or for licensure and scoring records maintained by the Department of Health Professions or any board in that department on individual licensees or applicants. However, such material may be made available during normal working hours for copying, at the requester's expense, by the individual who is the subject thereof, in the offices of the Department of Health Professions or in the offices of any health regulatory board, whichever may possess the material.

3. Reports, documentary evidence and other information as specified in §§ 51.5-122, 51.5-141, and 63.2-104.

4. Investigative notes; proprietary information not published, copyrighted or patented; information obtained from employee personnel records; personally identifiable information regarding residents, clients or other recipients of services; other correspondence and information furnished in confidence to the Department of Social Services in connection with an active investigation of an applicant or licensee pursuant to Chapters 17 (§ 63.2-1700 et seq.) and 18 (§ 63.2-1800 et seq.) of Title 63.2; and records and information furnished to the Office of the Attorney General in connection with an investigation or litigation pursuant to Article 19.1 (§ 8.01-216.1 et seq.) of Chapter 3 of Title 8.01 and Chapter 9 (§ 32.1-310 et seq.) of Title 32.1. However, nothing in this section shall prohibit disclosure of information from the records of completed investigations in a form that does not reveal the identity of complainants, persons supplying information, or other individuals involved in the investigation.

5. Information and records collected for the designation and verification of trauma centers and other specialty care centers within the Statewide Emergency Medical Services System and Services pursuant to Article 2.1 (§ 32.1-111.1 et seq.) of Chapter 4 of Title 32.1.

6. Reports and court documents relating to involuntary admission required to be kept confidential

pursuant to § 37.2-818.

7. Data formerly required to be submitted to the Commissioner of Health relating to the establishment of new or the expansion of existing clinical health services, acquisition of major medical equipment, or certain projects requiring capital expenditures pursuant to former § 32.1-102.3:4.

8. Information required to be provided to the Department of Health Professions by certain licensees pursuant to § 54.1-2506.1.

9. Information and records acquired (i) during a review of any child death conducted by the State Child Fatality Review team established pursuant to § 32.1-283.1 or by a local or regional child fatality review team to the extent made confidential by § 32.1-283.2; (ii) during a review of any death conducted by a family violence fatality review team to the extent made confidential by § 32.1-283.3; or (iii) during a review of any adult death conducted by the Adult Fatality Review Team to the extent made confidential by § 32.1-283.5.

10. Patient level data collected by the Board of Health and not yet processed, verified, and released, pursuant to § 32.1-276.9, to the Board by the nonprofit organization with which the Commissioner of Health has contracted pursuant to § 32.1-276.4.

11. Records of the Health Practitioners' Monitoring Program Committee within the Department of Health Professions, to the extent such records may identify any practitioner who may be, or who is actually, impaired to the extent disclosure is prohibited by § 54.1-2517.

12. Records submitted as a grant application, or accompanying a grant application, to the Commonwealth Neurotrauma Initiative Advisory Board pursuant to Article 12 (§ 51.5-178 et seq.) of Chapter 14 of Title 51.5, to the extent such records contain (i) medical or mental health records, or other data identifying individual patients or (ii) proprietary business or research-related information produced or collected by the applicant in the conduct of or as a result of study or research on medical, rehabilitative, scientific, technical or scholarly issues, when such information has not been publicly released, published, copyrighted or patented, if the disclosure of such information would be harmful to the competitive position of the applicant.

13. Any record copied, recorded or received by the Commissioner of Health in the course of an examination, investigation or review of a managed care health insurance plan licensee pursuant to §§ 32.1-137.4 and 32.1-137.5, including books, records, files, accounts, papers, documents, and any or all computer or other recordings.

14. Records, information and statistical registries required to be kept confidential pursuant to §§ 63.2-102 and 63.2-104.

15. All data, records, and reports relating to the prescribing and dispensing of covered substances to recipients and any abstracts from such data, records, and reports that are in the possession of the Prescription Monitoring Program pursuant to Chapter 25.2 (§ 54.1-2519 et seq.) of Title 54.1 and any material relating to the operation or security of the Program.

16. Records of the Virginia Birth-Related Neurological Injury Compensation Program required to be kept confidential pursuant to § 38.2-5002.2.

17. Records of the State Health Commissioner relating to the health of any person or persons subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.1; this provision shall not, however, be construed to prohibit the disclosure of statistical summaries, abstracts or other information in aggregate form.

18. Records containing the names and addresses or other contact information of persons receiving transportation services from a state or local public body or its designee under Title II of the Americans with Disabilities Act, (42 U.S.C. § 12131 et seq.) or funded by Temporary Assistance for Needy Families (TANF) created under § 63.2-600.

§ 16.1-337. Inpatient treatment of minors; general applicability; disclosure of records.

A. A minor may be admitted to a mental health facility for inpatient treatment only pursuant to § 16.1-338~~, 16.1-339,~~ or 16.1-340.1 or in accordance with an order of involuntary commitment entered pursuant to §§ 16.1-341 through 16.1-345. The provisions of Article 12 (§ 16.1-299 et seq.) of Chapter 11 of this title relating to the confidentiality of files, papers, and records shall apply to proceedings under this article.

B. Any health care provider, as defined in § 32.1-127.1:03, or other provider rendering services to a minor who is the subject of proceedings under this article, upon request, shall disclose to a magistrate, the juvenile intake officer, the court, the minor's attorney, the minor's guardian ad litem, the qualified evaluator performing the evaluation required under §§ 16.1-338, 16.1-339, and 16.1-342, the community services board or its designee performing the evaluation, preadmission screening, or monitoring duties under this article, or a law-enforcement officer any and all information that is necessary and appropriate to enable each of them to perform his duties under this article. These health care providers and other service providers shall disclose to one another health records and information where necessary to provide care and treatment to the person and to monitor that care and treatment. Health records disclosed to a law-enforcement officer shall be limited to information necessary to protect the officer,

the minor, or the public from physical injury or to address the health care needs of the minor. Information disclosed to a law-enforcement officer shall not be used for any other purpose, disclosed to others, or retained.

Any health care provider providing services to a minor who is the subject of proceedings under this article may notify the minor's parent of information which is directly relevant to such individual's involvement with the minor's health care, which may include the minor's location and general condition, in accordance with subdivision D 34 of § 32.1-127.1:03, unless the provider has actual knowledge that the parent is currently prohibited by court order from contacting the minor.

Any health care provider disclosing records pursuant to this section shall be immune from civil liability for any harm resulting from the disclosure, including any liability under the federal Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.), as amended, unless the person or provider disclosing such records intended the harm or acted in bad faith.

C. Any order entered where a minor is the subject of proceedings under this article shall provide for the disclosure of health records pursuant to subsection B. This subsection shall not preclude any other disclosures as required or permitted by law.

§ 16.1-338. Parental admission of minors.

A. A minor ~~younger than 14 years of age~~ may be admitted to a willing mental health facility for inpatient treatment upon application and with the consent of a parent~~. A minor 14 years of age or older may be admitted to a willing mental health facility for inpatient treatment upon the joint application and consent of the minor and the minor's parent.~~

B. Admission of a minor under this section shall be approved by a qualified evaluator who has conducted a personal examination of the minor within 48 hours after admission and has made the following written findings:

1. The minor appears to have a mental illness serious enough to warrant inpatient treatment and is reasonably likely to benefit from the treatment; ~~and~~

2. The minor has been provided with a clinically appropriate explanation of the nature and purpose of the treatment; ~~and~~

3. If the minor is 14 years of age or older, that he has been provided with an explanation of his ~~rights under this Act as they would apply~~ *right to judicial approval of his admission under § 16.1-339* if he were to object to admission~~, and that he has consented to admission~~; and

4. All available modalities of treatment less restrictive than inpatient treatment have been considered and no less restrictive alternative is available that would offer comparable benefits to the minor.

If admission is sought to a state hospital, the community services board serving the area in which the minor resides shall provide, in lieu of the examination required by this section, a preadmission screening report conducted by an employee or designee of the community services board and shall ensure that the necessary written findings have been made before approving the admission. A copy of the written findings of the evaluation or preadmission screening report required by this section shall be provided to the consenting parent and the parent shall have the opportunity to discuss the findings with the qualified evaluator or employee or designee of the community services board.

C. Within 10 days after the admission of a minor under this section, the director of the facility or the director's designee shall ensure that an individualized plan of treatment has been prepared by the provider responsible for the minor's treatment and has been explained to the parent consenting to the admission and to the minor. The minor shall be involved in the preparation of the plan to the maximum feasible extent consistent with his ability to understand and participate, and the minor's family shall be involved to the maximum extent consistent with the minor's treatment needs. The plan shall include a preliminary plan for placement and aftercare upon completion of inpatient treatment and shall include specific behavioral and emotional goals against which the success of treatment may be measured. A copy of the plan shall be provided to the minor and to his parents*, and to the guardian ad litem and counsel if appointed under subsection B of § 16.1-339*.

D. If the parent who consented to a minor's admission under this section revokes his consent at any time, ~~or if a minor 14 or older objects at any time to further treatment,~~ the minor shall be discharged within 48 hours to the custody of such consenting parent unless the minor's continued hospitalization is authorized pursuant to § 16.1-339, 16.1-340.1, or 16.1-345. If the 48-hour time period expires on a Saturday, Sunday, legal holiday or day on which the court is lawfully closed, the 48 hours shall extend to the next day that is not a Saturday, Sunday, legal holiday or day on which the court is lawfully closed. *If a minor 14 or older objects at any time to further treatment, the facility shall file a petition for judicial approval within 24 hours after the minor's objection with the juvenile and domestic relations district court for the jurisdiction in which the facility is located, and a judicial determination regarding further treatment shall be made pursuant to subsection B of § 16.1-339.*

E. Inpatient treatment of a minor hospitalized under this section may not exceed 90 consecutive days unless it has been authorized by appropriate hospital medical personnel, based upon their written

findings that the criteria set forth in subsection B of this section continue to be met, after such persons have examined the minor and interviewed the consenting parent and reviewed reports submitted by members of the facility staff familiar with the minor's condition.

F. ~~Any minor admitted under this section while younger than 14 and his consenting parent shall be informed orally and in writing by the director of the facility for inpatient treatment within 10 days of his fourteenth birthday that continued voluntary treatment under the authority of this section requires his consent.~~

~~G.~~ Any minor 14 years of age or older ~~who joins in an application and consents to admission pursuant to subsection A,~~ shall, in addition to his parent, have the right to access his health information. The concurrent authorization of both the parent and the minor shall be required to disclose such minor's health information.

~~H.~~ *G.* A minor who has been hospitalized while properly detained by a juvenile and domestic relations district court or circuit court shall be returned to the detention home, shelter care, or other facility approved by the Department of Juvenile Justice by the sheriff serving the jurisdiction where the minor was detained within 24 hours following completion of a period of inpatient treatment, unless the court having jurisdiction over the case orders that the minor be released from custody.

§ 16.1-339. Judicial approval required for admission of an objecting minor 14 years of age or older.

A. ~~A minor 14 years of age or older who (i) objects to admission, or (ii) is incapable of making an informed decision may be admitted to a willing facility for up to 96 hours, pending the review required by subsections B and C of this section, upon the application of a parent. If admission is sought to a state hospital, the community services board serving the area in which the minor resides shall provide the preadmission screening report required by subsection B of § 16.1-338 and shall ensure that the necessary written findings, except the minor's consent, have been made before approving the admission.~~

~~B. A~~ *If a* minor *14 years of age or older* admitted under ~~this section~~ *§ 16.1-338 objects to his admission, he* shall be examined within 24 hours of his admission by a qualified evaluator designated by the community services board serving the area where the facility is located. *If a minor who was under the age of 14 years when he was first admitted under § 16.1-338 objects to his admission after turning 14 years of age, he shall be examined within 24 hours of his objection by a qualified evaluator designated by the community services board serving the area where the facility is located.* If the 24-hour time period expires on a Saturday, Sunday, legal holiday or day on which the court is lawfully closed, the 24 hours shall extend to the next day that is not a Saturday, Sunday, legal holiday or day on which the court is lawfully closed. The evaluator shall prepare a report that shall include written findings as to whether:

1. Because of mental illness, the minor (i) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control;

2. The minor is in need of inpatient treatment for a mental illness and is reasonably likely to benefit from the proposed treatment; and

3. Inpatient treatment is the least restrictive alternative that meets the minor's needs. The qualified evaluator shall submit his report to the juvenile and domestic relations district court for the jurisdiction in which the facility is located.

~~C.~~ *B.* Upon admission of ~~a~~ *an objecting* minor ~~under this section~~, the facility shall file a petition for judicial approval no sooner than 24 hours and no later than 96 hours after admission with the juvenile and domestic relations district court for the jurisdiction in which the facility is located. To the extent available, the petition shall contain the information required by § 16.1-339.1. A copy of this petition shall be delivered to the minor's consenting parent. Upon receipt of the petition and of the evaluator's report submitted pursuant to subsection ~~B~~ *A*, the judge shall appoint a guardian ad litem for the minor and counsel to represent the minor, unless it has been determined that the minor has retained counsel. A copy of the evaluator's report shall be provided to the minor's counsel and guardian ad litem. The court and the guardian ad litem shall review the petition and evaluator's report and shall ascertain the views of the minor, the minor's consenting parent, the evaluator, and the attending psychiatrist. The court shall conduct its review in such place and manner, including the facility, as it deems to be in the best interests of the minor. Based upon its review and the recommendations of the guardian ad litem, the court shall order one of the following dispositions:

1. If the court finds that the minor does not meet the criteria for admission specified in subsection ~~B~~ *A*, the court shall issue an order directing the facility to release the minor into the custody of the parent who consented to the minor's admission. However, nothing herein shall be deemed to affect the terms and provisions of any valid court order of custody affecting the minor.

2. If the court finds that the minor meets the criteria for admission specified in subsection ~~B~~ *A*, the

court shall issue an order authorizing continued hospitalization of the minor for up to 90 days ~~on the basis of the parent's consent~~ *pursuant to § 16.1-338*.

~~Within 10 days after the admission of a minor under this section, the director of the facility or the director's designee shall ensure that an individualized plan of treatment has been prepared by the provider responsible for the minor's treatment and has been explained to the parent consenting to the admission and to the minor. A copy of the plan shall also be provided to the guardian ad litem and to counsel for the minor. The minor shall be involved in the preparation of the plan to the maximum feasible extent consistent with his ability to understand and participate, and the minor's family shall be involved to the maximum extent consistent with the minor's treatment needs. The plan shall include a preliminary plan for placement and aftercare upon completion of inpatient treatment and shall include specific behavioral and emotional goals against which the success of treatment may be measured.~~

3. If the court determines that the available information is insufficient to permit an informed determination regarding whether the minor meets the criteria specified in subsection ~~B~~ *A*, the court shall schedule a commitment hearing that shall be conducted in accordance with the procedures specified in §§ 16.1-341 through 16.1-345. The minor may be detained in the hospital for up to 96 additional hours pending the holding of the commitment hearing.

~~D. A~~ *C. An objecting* minor ~~admitted under this section~~ *14 years of age or older* who rescinds his objection may be retained in the hospital pursuant to § 16.1-338.

~~E. If the parent who consented to a minor's admission under this section revokes his consent at any time, the minor shall be released within 48 hours to the parent's custody unless the minor's continued hospitalization is authorized pursuant to § 16.1-340.1 or 16.1-345. If the 48-hour time period expires on a Saturday, Sunday, legal holiday or day on which the court is lawfully closed, the 48 hours shall extend to the next day that is not a Saturday, Sunday, legal holiday or day on which the court is lawfully closed.~~

~~F. A minor who has been hospitalized while properly detained by a juvenile and domestic relations district court or circuit court shall be returned to the detention home, shelter care, or other facility approved by the Department of Juvenile Justice by the sheriff serving the jurisdiction where the minor was detained within 24 hours following completion of a period of inpatient treatment, unless the court having jurisdiction over the case orders that the minor be released from custody.~~

§ 16.1-341. Involuntary commitment; petition; hearing scheduled; notice and appointment of counsel.

A. A petition for the involuntary commitment of a minor may be filed with the juvenile and domestic relations district court serving the jurisdiction in which the minor is located by a parent or, if the parent is not available or is unable or unwilling to file a petition, by any responsible adult, including the person having custody over a minor in detention or shelter care pursuant to an order of a juvenile and domestic relations district court. The petition shall include the name and address of the petitioner and the minor and shall set forth in specific terms why the petitioner believes the minor meets the criteria for involuntary commitment specified in § 16.1-345. To the extent available, the petition shall contain the information required by § 16.1-339.1. The petition shall be taken under oath.

If a commitment hearing has been scheduled pursuant to subdivision *B* 3 ~~of subsection C~~ of § 16.1-339, the petition for judicial approval filed by the facility under subsection ~~C~~ *B* of § 16.1-339 shall serve as the petition for involuntary commitment as long as such petition complies in substance with the provisions of this subsection.

B. Upon the filing of a petition for involuntary commitment of a minor, the juvenile and domestic relations district court serving the jurisdiction in which the minor is located shall schedule a hearing which shall occur no sooner than 24 hours and no later than 96 hours from the time the petition was filed or from the issuance of the temporary detention order as provided in § 16.1-340.1, whichever occurs later, or from the time of the hearing held pursuant to subsection ~~C~~ *B* of § 16.1-339 if the commitment hearing has been conducted pursuant to subdivision ~~C~~ *B* 3 of § 16.1-339. If the 96-hour period expires on a Saturday, Sunday, legal holiday or day on which the court is lawfully closed, the 96 hours shall be extended to the next day that is not a Saturday, Sunday, legal holiday or day on which the court is lawfully closed. The attorney for the minor, the guardian ad litem for the minor, the attorney for the Commonwealth in the jurisdiction giving rise to the detention, and the juvenile and domestic relations district court having jurisdiction over any minor in detention or shelter care shall be given notice prior to the hearing.

If the petition is not dismissed or withdrawn, copies of the petition, together with a notice of the hearing, shall be served immediately upon the minor and the minor's parents, if they are not petitioners, by the sheriffs of the jurisdictions in which the minor and his parents are located. No later than 24 hours before the hearing, the court shall appoint a guardian ad litem for the minor and counsel to represent the minor, unless it has determined that the minor has retained counsel. Upon the request of the minor's counsel, for good cause shown, and after notice to the petitioner and all other persons

receiving notice of the hearing, the court may continue the hearing once for a period not to exceed 96 hours.

Any recommendation made by a state mental health facility or state hospital regarding the minor's involuntary commitment may be admissible during the course of the hearing.

§ 16.1-342. Involuntary commitment; clinical evaluation.

A. Upon the filing of a petition for involuntary commitment, the juvenile and domestic relations district court shall direct the community services board serving the area in which the minor is located to arrange for an evaluation by a qualified evaluator, if one has not already been performed pursuant to subsection ~~B~~ *A* of § 16.1-339. All such evaluations shall be conducted in private. In conducting a clinical evaluation of a minor in detention or shelter care, if the evaluator finds, irrespective of the fact that the minor has been detained, that the minor meets the criteria for involuntary commitment in § 16.1-345, the evaluator shall recommend that the minor meets the criteria for involuntary commitment. The petitioner, all public agencies, and all providers or programs which have treated or who are treating the minor, shall cooperate with the evaluator and shall promptly deliver, upon request and without charge, all records of treatment or education of the minor. At least 24 hours before the scheduled hearing, the evaluator shall submit to the court a written report which includes the evaluator's opinion regarding whether the minor meets the criteria for involuntary commitment specified in § 16.1-345. A copy of the evaluator's report shall be provided to the minor's guardian ad litem and to the minor's counsel. The evaluator, if not physically present at the hearing, shall be available for questioning during the hearing through a two-way electronic video and audio or telephonic communication system as authorized in § 16.1-345.1. When the qualified evaluator attends the hearing in person or by electronic communication, he shall not be excluded from the hearing pursuant to an order of sequestration of witnesses.

B. Any evaluation conducted pursuant to this section shall be a comprehensive evaluation of the minor conducted in-person or, if that is not practicable, by a two-way electronic video and audio communication system as authorized in § 16.1-345.1. Translation or interpreter services shall be provided during the evaluation where necessary. The examination shall consist of (i) a clinical assessment that includes a mental status examination; determination of current use of psychotropic and other medications; a medical and psychiatric history; a substance use, abuse, or dependency determination; and a determination of the likelihood that, because of mental illness, the minor is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control; (ii) a substance abuse screening, when indicated; (iii) a risk assessment that includes an evaluation of the likelihood that, because of mental illness, the minor presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats; (iv) for a minor 14 years of age or older, an assessment of the minor's capacity to consent to treatment, including his ability to maintain and communicate choice, understand relevant information, and comprehend the situation and its consequences; (v) if prior to the examination the minor has been temporarily detained pursuant to this article, a review of the temporary detention facility's records for the minor, including the treating physician's evaluation, any collateral information, reports of any laboratory or toxicology tests conducted, and all admission forms and nurses' notes; (vi) a discussion of treatment preferences expressed by the minor or his parents or contained in a document provided by the minor or his parents in support of recovery; (vii) an assessment of alternatives to involuntary inpatient treatment; and (viii) recommendations for the placement, care, and treatment of the minor.

§ 16.1-345. Involuntary commitment; criteria.

After observing the minor and considering (i) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available, (ii) any past actions of the minor, (iii) any past mental health treatment of the minor, (iv) any qualified evaluator's report, (v) any medical records available, (vi) the preadmission screening report, and (vii) any other evidence that may have been admitted, the court shall order the involuntary commitment of the minor to a mental health facility for treatment for a period not to exceed 90 days if it finds, by clear and convincing evidence, that:

1. Because of mental illness, the minor (i) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control;

2. The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment; and

3. If the court finds that inpatient treatment is not the least restrictive treatment, the court shall consider entering an order for mandatory outpatient treatment pursuant to § 16.1-345.2.

Upon the expiration of an order for involuntary commitment, the minor shall be released unless he is

involuntarily admitted by further petition and order of a court, which shall be for a period not to exceed 90 days from the date of the subsequent court order, or the minor or his parent rescinds the objection to inpatient treatment and consents to admission pursuant to § 16.1-338 or subsection ~~D~~ *C* of § 16.1-339 or the minor is ordered to mandatory outpatient treatment pursuant to § 16.1-345.2.

A minor who has been hospitalized while properly detained by a juvenile and domestic relations district court shall be returned to the detention home, shelter care, or other facility approved by the Department of Juvenile Justice by the sheriff serving the jurisdiction where the minor was detained within 24 hours following completion of a period of inpatient treatment, unless the court having jurisdiction over the case orders that the minor be released from custody. However, such a minor shall not be eligible for mandatory outpatient treatment.

In conducting an evaluation of a minor who has been properly detained, if the evaluator finds, irrespective of the fact that the minor has been detained, that the minor meets the criteria for involuntary commitment in this section, the evaluator shall recommend that the minor meets the criteria for involuntary commitment.

If the parent or parents with whom the minor resides are not willing to approve the proposed commitment, the court shall order inpatient treatment only if it finds, in addition to the criteria specified in this section, that such treatment is necessary to protect the minor's life, health, safety, or normal development. If a special justice believes that issuance of a removal order or protective order may be in the child's best interest, the special justice shall report the matter to the local department of social services for the county or city where the minor resides.

Upon finding that the best interests of the minor so require, the court may enter an order directing either or both of the minor's parents to comply with reasonable conditions relating to the minor's treatment.

If the minor is committed to inpatient treatment, such placement shall be in a mental health facility for inpatient treatment designated by the community services board which serves the political subdivision in which the minor was evaluated pursuant to § 16.1-342. If the community services board does not provide a placement recommendation at the hearing, the minor shall be placed in a mental health facility designated by the Commissioner of Behavioral Health and Developmental Services.

When a minor has been involuntarily committed pursuant to this section, the judge shall determine, after consideration of information provided by the minor's treating mental health professional and any involved community services board staff regarding the minor's dangerousness, whether transportation shall be provided by the sheriff or may be provided by an alternative transportation provider, including a parent, family member, or friend of the minor, a representative of the community services board, a representative of the facility at which the minor was detained pursuant to a temporary detention order, or other alternative transportation provider with personnel trained to provide transportation in a safe manner. If the judge determines that transportation may be provided by an alternative transportation provider, the judge may consult with the proposed alternative transportation provider either in person or via two-way electronic video and audio or telephone communication system to determine whether the proposed alternative transportation provider is available to provide transportation, willing to provide transportation, and able to provide transportation in a safe manner. If the judge finds that the proposed alternative transportation provider is available to provide transportation, willing to provide transportation, and able to provide transportation in a safe manner, the judge may order transportation by the proposed alternative transportation provider. In all other cases, the judge shall order transportation by the sheriff of the jurisdiction where the minor is a resident unless the sheriff's office of that jurisdiction is located more than 100 road miles from the nearest boundary of the jurisdiction in which the proceedings took place. In cases where the sheriff of the jurisdiction in which the minor is a resident is more than 100 road miles from the nearest boundary of the jurisdiction in which the proceedings took place, it shall be the responsibility of the sheriff of the latter jurisdiction to transport the minor.

If the judge determines that the minor requires transportation by the sheriff, the sheriff, as specified in this section shall transport the minor to the proper facility. In no event shall transport commence later than six hours after notification to the sheriff or alternative transportation provider of the judge's order.

14101971D

HOUSE BILL NO. 1097

Offered January 9, 2014

A BILL to amend and reenact §§ 16.1-336, 16.1-337, 16.1-338, 16.1-340, 16.1-340.1, 16.1-341, 16.1-342, 16.1-345, 16.1-345.2, and 16.1-345.5 of the Code of Virginia and to repeal § 16.1-339 of the Code of Virginia, relating to psychiatric treatment of minors.

Patron—LeMunyon

Referred to Committee for Courts of Justice

Be it enacted by the General Assembly of Virginia:

1. That §§ 16.1-336, 16.1-337, 16.1-338, 16.1-340, 16.1-340.1, 16.1-341, 16.1-342, 16.1-345, 16.1-345.2, and 16.1-345.5 of the Code of Virginia are amended and reenacted as follows:

§ 16.1-336. Definitions.

When used in this article, unless the context otherwise requires:

"Community services board" has the same meaning as provided in § 37.2-100. Whenever the term community services board appears, it shall include behavioral health authority, as that term is defined in § 37.2-100.

"Consent" means the voluntary, express, and informed agreement to treatment in a mental health facility ~~by a minor 14 years of age or older and~~ by a parent or a legally authorized custodian *of a minor*.

"Designee of the local community services board" means an examiner designated by the local community services board who (i) is skilled in the assessment and treatment of mental illness, (ii) has completed a certification program approved by the Department of Behavioral Health and Developmental Services, (iii) is able to provide an independent examination of the minor, (iv) is not related by blood, marriage, or adoption to, or is not the legal guardian of, the minor being evaluated, (v) has no financial interest in the admission or treatment of the minor being evaluated, (vi) has no investment interest in the facility detaining or admitting the minor under this article, and (vii) except for employees of state hospitals and of the U.S. Department of Veterans Affairs, is not employed by the facility.

"Employee" means an employee of the local community services board who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by the Department of Behavioral Health and Developmental Services.

"Incapable of making an informed decision" means unable to understand the nature, extent, or probable consequences of a proposed treatment or unable to make a rational evaluation of the risks and benefits of the proposed treatment as compared with the risks and benefits of alternatives to the treatment. Persons with dysphasia or other communication disorders who are mentally competent and able to communicate shall not be considered incapable of giving informed consent.

"Inpatient treatment" means placement for observation, diagnosis, or treatment of mental illness in a psychiatric hospital or in any other type of mental health facility determined by the Department of Behavioral Health and Developmental Services to be substantially similar to a psychiatric hospital with respect to restrictions on freedom and therapeutic intrusiveness.

"Investment interest" means the ownership or holding of an equity or debt security, including shares of stock in a corporation, interests or units of a partnership, bonds, debentures, notes, or other equity or debt instruments.

"Judge" means a juvenile and domestic relations district judge. In addition, "judge" includes a retired judge sitting by designation pursuant to § 16.1-69.35, substitute judge, or special justice authorized by § 37.2-803 who has completed a training program regarding the provisions of this article, prescribed by the Executive Secretary of the Supreme Court.

"Least restrictive alternative" means the treatment and conditions of treatment which, separately and in combination, are no more intrusive or restrictive of freedom than reasonably necessary to achieve a substantial therapeutic benefit or to protect the minor or others from physical injury.

"Mental health facility" means a public or private facility for the treatment of mental illness operated or licensed by the Department of Behavioral Health and Developmental Services.

"Mental illness" means a substantial disorder of the minor's cognitive, volitional, or emotional processes that demonstrably and significantly impairs judgment or capacity to recognize reality or to control behavior. "Mental illness" may include substance abuse, which is the use, without compelling medical reason, of any substance which results in psychological or physiological dependency as a function of continued use in such a manner as to induce mental, emotional, or physical impairment and cause socially dysfunctional or socially disordering behavior. Intellectual disability, head injury, a

learning disability, or a seizure disorder is not sufficient, in itself, to justify a finding of mental illness within the meaning of this article.

"Minor" means a person less than 18 years of age.

"Parent" means (i) a biological or adoptive parent who has legal custody of the minor, including either parent if custody is shared under a joint decree or agreement, (ii) a biological or adoptive parent with whom the minor regularly resides, (iii) a person judicially appointed as a legal guardian of the minor, or (iv) a person who exercises the rights and responsibilities of legal custody by delegation from a biological or adoptive parent, upon provisional adoption or otherwise by operation of law. The director of the local department of social services, or his designee, may stand as the minor's parent when the minor is in the legal custody of the local department of social services.

"Qualified evaluator" means a psychiatrist or a psychologist licensed in Virginia by either the Board of Medicine or the Board of Psychology, or if such psychiatrist or psychologist is unavailable, (i) any mental health professional licensed in Virginia through the Department of Health Professions as a clinical social worker, professional counselor, marriage and family therapist, psychiatric nurse practitioner, or clinical nurse specialist, or (ii) any mental health professional employed by a community services board. All qualified evaluators shall (a) be skilled in the diagnosis and treatment of mental illness in minors, (b) be familiar with the provisions of this article, and (c) have completed a certification program approved by the Department of Behavioral Health and Developmental Services. The qualified evaluator shall (1) not be related by blood, marriage, or adoption to, or is not the legal guardian of, the minor being evaluated, (2) not be responsible for treating the minor, (3) have no financial interest in the admission or treatment of the minor, (4) have no investment interest in the facility detaining or admitting the minor under this article, and (5) except for employees of state hospitals, the U.S. Department of Veterans Affairs, and community services boards, not be employed by the facility.

"Treatment" means any planned intervention intended to improve a minor's functioning in those areas which show impairment as a result of mental illness.

§ 16.1-337. Inpatient treatment of minors; general applicability; disclosure of records.

A. A minor may be admitted to a mental health facility for inpatient treatment only pursuant to § 16.1-338~~, 16.1-339,~~ or 16.1-340.1 or in accordance with an order of involuntary commitment entered pursuant to §§ 16.1-341 through 16.1-345. The provisions of Article 12 (§ 16.1-299 et seq.) of Chapter 11 of this title relating to the confidentiality of files, papers, and records shall apply to proceedings under this article.

B. Any health care provider, as defined in § 32.1-127.1:03, or other provider rendering services to a minor who is the subject of proceedings under this article, upon request, shall disclose to a magistrate, the juvenile intake officer, the court, the minor's attorney, the minor's guardian ad litem, the qualified evaluator performing the evaluation required under §§ 16.1-338~~, 16.1-339,~~ and 16.1-342, the community services board or its designee performing the evaluation, preadmission screening, or monitoring duties under this article, or a law-enforcement officer any and all information that is necessary and appropriate to enable each of them to perform his duties under this article. These health care providers and other service providers shall disclose to one another health records and information where necessary to provide care and treatment to the person and to monitor that care and treatment. Health records disclosed to a law-enforcement officer shall be limited to information necessary to protect the officer, the minor, or the public from physical injury or to address the health care needs of the minor. Information disclosed to a law-enforcement officer shall not be used for any other purpose, disclosed to others, or retained.

Any health care provider providing services to a minor who is the subject of proceedings under this article may notify the minor's parent of information which is directly relevant to such individual's involvement with the minor's health care, which may include the minor's location and general condition, in accordance with subdivision D 34 of § 32.1-127.1:03, unless the provider has actual knowledge that the parent is currently prohibited by court order from contacting the minor.

Any health care provider disclosing records pursuant to this section shall be immune from civil liability for any harm resulting from the disclosure, including any liability under the federal Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.), as amended, unless the person or provider disclosing such records intended the harm or acted in bad faith.

C. Any order entered where a minor is the subject of proceedings under this article shall provide for the disclosure of health records pursuant to subsection B. This subsection shall not preclude any other disclosures as required or permitted by law.

§ 16.1-338. Parental admission of minors.

A. A minor ~~younger than 14 years of age~~ may be admitted to a willing mental health facility for inpatient treatment upon application and with the consent of a parent. ~~A minor 14 years of age or older may be admitted to a willing mental health facility for inpatient treatment upon the joint application and consent of the minor and the minor's parent.~~

B. Admission of a minor under this section shall be approved by a qualified evaluator who has conducted a personal examination of the minor within 48 hours after admission and has made the following written findings:

1. The minor appears to have a mental illness serious enough to warrant inpatient treatment and is reasonably likely to benefit from the treatment; ~~and~~

2. The minor has been provided with a clinically appropriate explanation of the nature and purpose of the treatment; and

3. ~~If the minor is 14 years of age or older, that he has been provided with an explanation of his rights under this Act as they would apply if he were to object to admission, and that he has consented to admission; and~~

~~4.~~ All available modalities of treatment less restrictive than inpatient treatment have been considered and no less restrictive alternative is available that would offer comparable benefits to the minor.

If admission is sought to a state hospital, the community services board serving the area in which the minor resides shall provide, in lieu of the examination required by this section, a preadmission screening report conducted by an employee or designee of the community services board and shall ensure that the necessary written findings have been made before approving the admission. A copy of the written findings of the evaluation or preadmission screening report required by this section shall be provided to the consenting parent and the parent shall have the opportunity to discuss the findings with the qualified evaluator or employee or designee of the community services board.

C. Within 10 days after the admission of a minor under this section, the director of the facility or the director's designee shall ensure that an individualized plan of treatment has been prepared by the provider responsible for the minor's treatment and has been explained to the parent consenting to the admission and to the minor. The minor shall be involved in the preparation of the plan to the maximum feasible extent consistent with his ability to understand and participate, and the minor's family shall be involved to the maximum extent consistent with the minor's treatment needs. The plan shall include a preliminary plan for placement and aftercare upon completion of inpatient treatment and shall include specific behavioral and emotional goals against which the success of treatment may be measured. A copy of the plan shall be provided to the minor and to his parents.

D. If the parent who consented to a minor's admission under this section revokes his consent at any time, ~~or if a minor 14 or older objects at any time to further treatment,~~ the minor shall be discharged within 48 hours to the custody of such consenting parent unless the minor's continued hospitalization is authorized pursuant to § ~~16.1-339,~~ 16.1-340.1~~,~~ or 16.1-345. If the 48-hour time period expires on a Saturday, Sunday, legal holiday or day on which the court is lawfully closed, the 48 hours shall extend to the next day that is not a Saturday, Sunday, legal holiday or day on which the court is lawfully closed.

E. Inpatient treatment of a minor hospitalized under this section may not exceed 90 consecutive days unless it has been authorized by appropriate hospital medical personnel, based upon their written findings that the criteria set forth in subsection B of this section continue to be met, after such persons have examined the minor and interviewed the consenting parent and reviewed reports submitted by members of the facility staff familiar with the minor's condition.

F. Any minor admitted under this section while younger than ~~14~~*18* and his consenting parent shall be informed orally and in writing by the director of the facility for inpatient treatment within 10 days of his fourteenth birthday that continued voluntary treatment under the authority of this section requires his consent.

G. Any minor 14 years of age or older ~~who joins in an application and consents to admission pursuant to subsection A,~~ shall, in addition to his parent, have the right to access his health information. The concurrent authorization of both the parent and the minor shall be required to disclose such minor's health information.

H. A minor who has been hospitalized while properly detained by a juvenile and domestic relations district court or circuit court shall be returned to the detention home, shelter care, or other facility approved by the Department of Juvenile Justice by the sheriff serving the jurisdiction where the minor was detained within 24 hours following completion of a period of inpatient treatment, unless the court having jurisdiction over the case orders that the minor be released from custody.

§ 16.1-340. Emergency custody; issuance and execution of order.

A. Any magistrate shall issue, upon the sworn petition of a minor's treating physician or ~~parent or, if the parent is not available or is unable or unwilling to file a petition, by~~ any responsible adult, including the person having custody over a minor in detention or shelter care pursuant to an order of a juvenile and domestic relations district court, or upon his own motion, an emergency custody order when he has probable cause to believe that (i) because of mental illness, the minor (a) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats, or (b) is experiencing a serious deterioration of his ability to care for himself in a

developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control; and (ii) the minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment. Any emergency custody order entered pursuant to this section shall provide for the disclosure of medical records pursuant to subsection B of § 16.1-337. This subsection shall not preclude any other disclosures as required or permitted by law. To the extent possible, the petition shall contain the information required by § 16.1-339.1.

When considering whether there is probable cause to issue an emergency custody order, the magistrate may, in addition to the petition, consider (1) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available, (2) any past actions of the minor, (3) any past mental health treatment of the minor, (4) any relevant hearsay evidence, (5) any medical records available, (6) any affidavits submitted, if the witness is unavailable and it so states in the affidavit, and (7) any other information available that the magistrate considers relevant to the determination of whether probable cause exists to issue an emergency custody order.

B. Any minor for whom an emergency custody order is issued shall be taken into custody and transported to a convenient location to be evaluated to determine whether he meets the criteria for temporary detention pursuant to § 16.1-340.1 and to assess the need for hospitalization or treatment. The evaluation shall be made by a person designated by the community services board serving the area in which the minor is located who is skilled in the diagnosis and treatment of mental illness and who has completed a certification program approved by the Department.

C. The magistrate issuing an emergency custody order shall specify the primary law-enforcement agency and jurisdiction to execute the emergency custody order and provide transportation. However, in cases in which the emergency custody order is based upon a finding that the minor who is the subject of the order has a mental illness and that, as a result of mental illness, the minor is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control, the magistrate may authorize transportation by an alternative transportation provider, including a parent, family member, or friend of the minor who is the subject of the order, a representative of the community services board, or other transportation provider with personnel trained to provide transportation in a safe manner, upon determining, following consideration of information provided by the petitioner; the community services board or its designee; the local law-enforcement agency, if any; the minor's treating physician, if any; or other persons who are available and have knowledge of the minor, and, when the magistrate deems appropriate, the proposed alternative transportation provider, either in person or via two-way electronic video and audio or telephone communication system, that the proposed alternative transportation provider is available to provide transportation, willing to provide transportation, and able to provide transportation in a safe manner. When transportation is ordered to be provided by an alternative transportation provider, the magistrate shall order the specified primary law-enforcement agency to execute the order, to take the minor into custody, and to transfer custody of the minor to the alternative transportation provider identified in the order. In such cases, a copy of the emergency custody order shall accompany the minor being transported pursuant to this section at all times and shall be delivered by the alternative transportation provider to the community services board or its designee responsible for conducting the evaluation. The community services board or its designee conducting the evaluation shall return a copy of the emergency custody order to the court designated by the magistrate as soon as is practicable. Delivery of an order to a law-enforcement officer or alternative transportation provider and return of an order to the court may be accomplished electronically or by facsimile.

Transportation under this section shall include transportation to a medical facility as may be necessary to obtain emergency medical evaluation or treatment that shall be conducted immediately in accordance with state and federal law. Transportation under this section shall include transportation to a medical facility for a medical evaluation if a physician at the hospital in which the minor subject to the emergency custody order may be detained requires a medical evaluation prior to admission.

D. In specifying the primary law-enforcement agency and jurisdiction for purposes of this section, the magistrate shall order the primary law-enforcement agency from the jurisdiction served by the community services board that designated the person to perform the evaluation required in subsection B to execute the order and, in cases in which transportation is ordered to be provided by the primary law-enforcement agency, provide transportation. If the community services board serves more than one jurisdiction, the magistrate shall designate the primary law-enforcement agency from the particular jurisdiction within the community services board's service area where the minor who is the subject of the emergency custody order was taken into custody or, if the minor has not yet been taken into custody, the primary law-enforcement agency from the jurisdiction where the minor is presently located to execute the order and provide transportation.

E. The law-enforcement agency or alternative transportation provider providing transportation

pursuant to this section may transfer custody of the minor to the facility or location to which the minor is transported for the evaluation required in subsection B, G, or H if the facility or location (i) is licensed to provide the level of security necessary to protect both the minor and others from harm, (ii) is actually capable of providing the level of security necessary to protect the minor and others from harm, and (iii) in cases in which transportation is provided by a law-enforcement agency, has entered into an agreement or memorandum of understanding with the law-enforcement agency setting forth the terms and conditions under which it will accept a transfer of custody, provided, however, that the facility or location may not require the law-enforcement agency to pay any fees or costs for the transfer of custody.

F. A law-enforcement officer may lawfully go or be sent beyond the territorial limits of the county, city, or town in which he serves to any point in the Commonwealth for the purpose of executing an emergency custody order pursuant to this section.

G. A law-enforcement officer who, based upon his observation or the reliable reports of others, has probable cause to believe that a minor meets the criteria for emergency custody as stated in this section may take that minor into custody and transport that minor to an appropriate location to assess the need for hospitalization or treatment without prior authorization. A law-enforcement officer who takes a person into custody pursuant to this subsection or subsection H may lawfully go or be sent beyond the territorial limits of the county, city, or town in which he serves to any point in the Commonwealth for the purpose of obtaining the assessment. Such evaluation shall be conducted immediately. The period of custody shall not exceed four hours from the time the law-enforcement officer takes the minor into custody. However, upon a finding by a magistrate that good cause exists to grant an extension, the magistrate shall issue an order extending the period of emergency custody one time for an additional period not to exceed two hours. Good cause for an extension includes the need for additional time to allow (i) the community services board to identify a suitable facility in which the minor can be temporarily detained pursuant to § 16.1-340.1 or (ii) a medical evaluation of the person to be completed if necessary.

H. A law-enforcement officer who is transporting a minor who has voluntarily consented to be transported to a facility for the purpose of assessment or evaluation and who is beyond the territorial limits of the county, city, or town in which he serves may take such minor into custody and transport him to an appropriate location to assess the need for hospitalization or treatment without prior authorization when the law-enforcement officer determines (i) that the minor has revoked consent to be transported to a facility for the purpose of assessment or evaluation and (ii), based upon his observations, that probable cause exists to believe that the minor meets the criteria for emergency custody as stated in this section. The period of custody shall not exceed four hours from the time the law-enforcement officer takes the minor into custody. However, upon a finding by a magistrate that good cause exists to grant an extension, the magistrate shall issue an order extending the period of emergency custody one time for an additional period not to exceed two hours. Good cause for an extension includes the need for additional time to allow ~~(a)~~ *(i)* the community services board to identify a suitable facility in which the minor can be temporarily detained pursuant to § 16.1-340.1 or ~~(b)~~ *(ii)* a medical evaluation of the person to be completed if necessary.

I. Nothing herein shall preclude a law-enforcement officer or alternative transportation provider from obtaining emergency medical treatment or further medical evaluation at any time for a minor in his custody as provided in this section.

J. The minor shall remain in custody until a temporary detention order is issued, until the minor is released, or until the emergency custody order expires. An emergency custody order shall be valid for a period not to exceed four hours from the time of execution. However, upon a finding by a magistrate that good cause exists to grant an extension, the magistrate shall extend the emergency custody order one time for a second period not to exceed two hours. Good cause for an extension includes the need for additional time to allow (i) the community services board to identify a suitable facility in which the minor can be temporarily detained pursuant to § 16.1-340.1 or (ii) a medical evaluation of the person to be completed if necessary. Any family member, as defined in § 37.2-100, employee or designee of the community services board, treating physician, or law-enforcement officer may request the two-hour extension.

K. If an emergency custody order is not executed within six hours of its issuance, the order shall be void and shall be returned unexecuted to the office of the clerk of the issuing court or, if such office is not open, to any magistrate serving the jurisdiction of the issuing court.

L. Payments shall be made pursuant to § 37.2-804 to licensed health care providers for medical screening and assessment services provided to minors with mental illnesses while in emergency custody.

§ 16.1-340.1. Involuntary temporary detention; issuance and execution of order.

A. A magistrate shall issue, upon the sworn petition of a minor's treating physician or ~~parent or, if the parent is not available or is unable or unwilling to file a petition, by any~~ *other* responsible adult,

including the person having custody over a minor in detention or shelter care pursuant to an order of a juvenile and domestic relations district court, or upon his own motion and only after an evaluation conducted in-person or by means of a two-way electronic video and audio communication system as authorized in § 16.1-345.1 by an employee or designee of the local community services board to determine whether the minor meets the criteria for temporary detention, a temporary detention order if it appears from all evidence readily available, including any recommendation from a physician or clinical psychologist treating the person, that (i) because of mental illness, the minor (a) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats, or (b) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control; and (ii) the minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment. The magistrate shall also consider the recommendations of the minor's parents and of any treating or examining physician licensed in Virginia if available either verbally or in writing prior to rendering a decision. To the extent possible, the petition shall contain the information required by § 16.1-339.1. Any temporary detention order entered pursuant to this section shall be effective until such time as the juvenile and domestic relations district court serving the jurisdiction in which the minor is located conducts a hearing pursuant to subsection B of § 16.1-341. Any temporary detention order entered pursuant to this section shall provide for the disclosure of medical records pursuant to subsection B of § 16.1-337. This subsection shall not preclude any other disclosures as required or permitted by law.

B. When considering whether there is probable cause to issue a temporary detention order, the magistrate may, in addition to the petition, consider (i) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available, (ii) any past actions of the minor, (iii) any past mental health treatment of the minor, (iv) any relevant hearsay evidence, (v) any medical records available, (vi) any affidavits submitted, if the witness is unavailable and it so states in the affidavit, and (vii) any other information available that the magistrate considers relevant to the determination of whether probable cause exists to issue a temporary detention order.

C. A magistrate may issue a temporary detention order without an emergency custody order proceeding. A magistrate may issue a temporary detention order without a prior evaluation pursuant to subsection A if (i) the minor has been personally examined within the previous 72 hours by an employee or designee of the local community services board or (ii) there is a significant physical, psychological, or medical risk to the minor or to others associated with conducting such evaluation.

D. An employee or designee of the community services board shall determine the facility of temporary detention for all minors detained pursuant to this section. The facility of temporary detention shall be one that has been approved pursuant to regulations of the Board of Behavioral Health and Developmental Services. The facility shall be identified on the preadmission screening report and indicated on the temporary detention order. Except for minors who are detained for a criminal offense by a juvenile and domestic relations district court and who require hospitalization in accordance with this article, the minor shall not be detained in a jail or other place of confinement for persons charged with criminal offenses and shall remain in the custody of law enforcement until the minor is either detained within a secure facility or custody has been accepted by the appropriate personnel designated by the facility identified in the temporary detention order.

E. Any facility caring for a minor placed with it pursuant to a temporary detention order is authorized to provide emergency medical and psychiatric services within its capabilities when the facility determines that the services are in the best interests of the minor within its care. The costs incurred as a result of the hearings and by the facility in providing services during the period of temporary detention shall be paid and recovered pursuant to § 37.2-804. The maximum costs reimbursable by the Commonwealth pursuant to this section shall be established by the State Board of Medical Assistance Services based on reasonable criteria. The State Board of Medical Assistance Services shall, by regulation, establish a reasonable rate per day of inpatient care for temporary detention.

F. The employee or designee of the local community services board who is conducting the evaluation pursuant to this section shall determine, prior to the issuance of the temporary detention order, the insurance status of the minor. Where coverage by a third party payor exists, the facility seeking reimbursement under this section shall first seek reimbursement from the third party payor. The Commonwealth shall reimburse the facility only for the balance of costs remaining after the allowances covered by the third party payor have been received.

G. The duration of temporary detention shall be sufficient to allow for completion of the examination required by § 16.1-342, preparation of the preadmission screening report required by § 16.1-340.4, and initiation of mental health treatment to stabilize the minor's psychiatric condition to avoid involuntary commitment where possible, but shall not exceed 96 hours prior to a hearing. If the 96-hour period herein specified terminates on a Saturday, Sunday, or legal holiday, the minor may be detained, as

herein provided, until the close of business on the next day that is not a Saturday, Sunday, or legal holiday. The minor may be released, pursuant to § 16.1-340.3, before the 96-hour period herein specified has run.

H. If a temporary detention order is not executed within 24 hours of its issuance, or within a shorter period as is specified in the order, the order shall be void and shall be returned unexecuted to the office of the clerk of the issuing court or, if the office is not open, to any magistrate serving the jurisdiction of the issuing court. Subsequent orders may be issued upon the original petition within 96 hours after the petition is filed. However, a magistrate must again obtain the advice of an employee or designee of the local community services board prior to issuing a subsequent order upon the original petition. Any petition for which no temporary detention order or other process in connection therewith is served on the subject of the petition within 96 hours after the petition is filed shall be void and shall be returned to the office of the clerk of the issuing court.

I. For purposes of this section a healthcare provider or an employee or designee of the local community services board shall not be required to encrypt any email containing information or medical records provided to a magistrate unless there is reason to believe that a third party will attempt to intercept the email.

J. The employee or designee of the local community services board who is conducting the evaluation pursuant to this section shall, if he recommends that the minor should not be subject to a temporary detention order, inform the petitioner and an on-site treating physician of his recommendation.

K. Each community services board shall provide to each juvenile and domestic relations district court and magistrate's office within its service area a list of employees and designees who are available to perform the evaluations required herein.

§ 16.1-341. Involuntary commitment; petition; hearing scheduled; notice and appointment of counsel.

A. A petition for the involuntary commitment of a minor may be filed with the juvenile and domestic relations district court serving the jurisdiction in which the minor is located by ~~a parent or, if the parent is not available or is unable or unwilling to file a petition, by~~ any responsible adult, including the person having custody over a minor in detention or shelter care pursuant to an order of a juvenile and domestic relations district court. The petition shall include the name and address of the petitioner and the minor and shall set forth in specific terms why the petitioner believes the minor meets the criteria for involuntary commitment specified in § 16.1-345. To the extent available, the petition shall contain the information required by § 16.1-339.1. The petition shall be taken under oath.

~~If a commitment hearing has been scheduled pursuant to subdivision 3 of subsection C of § 16.1-339, the petition for judicial approval filed by the facility under subsection C of § 16.1-339 shall serve as the petition for involuntary commitment as long as such petition complies in substance with the provisions of this subsection.~~

B. Upon the filing of a petition for involuntary commitment of a minor, the juvenile and domestic relations district court serving the jurisdiction in which the minor is located shall schedule a hearing which shall occur no sooner than 24 hours and no later than 96 hours from the time the petition was filed or from the issuance of the temporary detention order as provided in § 16.1-340.1, whichever occurs later~~, or from the time of the hearing held pursuant to subsection C of § 16.1-339 if the commitment hearing has been conducted pursuant to subdivision C 3 of § 16.1-339~~. If the 96-hour period expires on a Saturday, Sunday, legal holiday or day on which the court is lawfully closed, the 96 hours shall be extended to the next day that is not a Saturday, Sunday, legal holiday or day on which the court is lawfully closed. The attorney for the minor, the guardian ad litem for the minor, the attorney for the Commonwealth in the jurisdiction giving rise to the detention, and the juvenile and domestic relations district court having jurisdiction over any minor in detention or shelter care shall be given notice prior to the hearing.

If the petition is not dismissed or withdrawn, copies of the petition, together with a notice of the hearing, shall be served immediately upon the minor and the minor's parents~~, if they are not petitioners,~~ by the sheriffs of the jurisdictions in which the minor and his parents are located. No later than 24 hours before the hearing, the court shall appoint a guardian ad litem for the minor and counsel to represent the minor, unless it has determined that the minor has retained counsel. Upon the request of the minor's counsel, for good cause shown, and after notice to the petitioner and all other persons receiving notice of the hearing, the court may continue the hearing once for a period not to exceed 96 hours.

Any recommendation made by a state mental health facility or state hospital regarding the minor's involuntary commitment may be admissible during the course of the hearing.

§ 16.1-342. Involuntary commitment; clinical evaluation.

A. Upon the filing of a petition for involuntary commitment, the juvenile and domestic relations district court shall direct the community services board serving the area in which the minor is located to

arrange for an evaluation by a qualified evaluator~~, if one has not already been performed pursuant to subsection B of § 16.1-339~~. All such evaluations shall be conducted in private. In conducting a clinical evaluation of a minor in detention or shelter care, if the evaluator finds, irrespective of the fact that the minor has been detained, that the minor meets the criteria for involuntary commitment in § 16.1-345, the evaluator shall recommend that the minor meets the criteria for involuntary commitment. The petitioner, all public agencies, and all providers or programs which have treated or who are treating the minor, shall cooperate with the evaluator and shall promptly deliver, upon request and without charge, all records of treatment or education of the minor. At least 24 hours before the scheduled hearing, the evaluator shall submit to the court a written report which includes the evaluator's opinion regarding whether the minor meets the criteria for involuntary commitment specified in § 16.1-345. A copy of the evaluator's report shall be provided to the minor's guardian ad litem and to the minor's counsel. The evaluator, if not physically present at the hearing, shall be available for questioning during the hearing through a two-way electronic video and audio or telephonic communication system as authorized in § 16.1-345.1. When the qualified evaluator attends the hearing in person or by electronic communication, he shall not be excluded from the hearing pursuant to an order of sequestration of witnesses.

B. Any evaluation conducted pursuant to this section shall be a comprehensive evaluation of the minor conducted in-person or, if that is not practicable, by a two-way electronic video and audio communication system as authorized in § 16.1-345.1. Translation or interpreter services shall be provided during the evaluation where necessary. The examination shall consist of (i) a clinical assessment that includes a mental status examination; determination of current use of psychotropic and other medications; a medical and psychiatric history; a substance use, abuse, or dependency determination; and a determination of the likelihood that, because of mental illness, the minor is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control; (ii) a substance abuse screening, when indicated; (iii) a risk assessment that includes an evaluation of the likelihood that, because of mental illness, the minor presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats; (iv) ~~for a minor 14 years of age or older, an assessment of the minor's capacity to consent to treatment, including his ability to maintain and communicate choice, understand relevant information, and comprehend the situation and its consequences; (v)~~ if prior to the examination the minor has been temporarily detained pursuant to this article, a review of the temporary detention facility's records for the minor, including the treating physician's evaluation, any collateral information, reports of any laboratory or toxicology tests conducted, and all admission forms and nurses' notes; ~~(vi)~~ *(v)* a discussion of treatment preferences expressed by the minor or his parents or contained in a document provided by the minor or his parents in support of recovery; ~~(vii)~~ *(vi)* an assessment of alternatives to involuntary inpatient treatment; and ~~(viii)~~ *(vii)* recommendations for the placement, care, and treatment of the minor.

§ 16.1-345. Involuntary commitment; criteria.

After observing the minor and considering (i) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available, (ii) any past actions of the minor, (iii) any past mental health treatment of the minor, (iv) any qualified evaluator's report, (v) any medical records available, (vi) the preadmission screening report, and (vii) any other evidence that may have been admitted, the court shall order the involuntary commitment of the minor to a mental health facility for treatment for a period not to exceed 90 days if it finds, by clear and convincing evidence, that:

1. Because of mental illness, the minor (i) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control;

2. The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment; and

3. If the court finds that inpatient treatment is not the least restrictive treatment, the court shall consider entering an order for mandatory outpatient treatment pursuant to § 16.1-345.2.

Upon the expiration of an order for involuntary commitment, the minor shall be released unless he is involuntarily admitted by further petition and order of a court, which shall be for a period not to exceed 90 days from the date of the subsequent court order, or ~~the minor or~~ his parent rescinds the objection to inpatient treatment and consents to admission pursuant to § 16.1-338 ~~or subsection D of § 16.1-339~~ or the minor is ordered to mandatory outpatient treatment pursuant to § 16.1-345.2.

A minor who has been hospitalized while properly detained by a juvenile and domestic relations district court shall be returned to the detention home, shelter care, or other facility approved by the Department of Juvenile Justice by the sheriff serving the jurisdiction where the minor was detained within 24 hours following completion of a period of inpatient treatment, unless the court having

jurisdiction over the case orders that the minor be released from custody. However, such a minor shall not be eligible for mandatory outpatient treatment.

In conducting an evaluation of a minor who has been properly detained, if the evaluator finds, irrespective of the fact that the minor has been detained, that the minor meets the criteria for involuntary commitment in this section, the evaluator shall recommend that the minor meets the criteria for involuntary commitment.

If the parent or parents with whom the minor resides are not willing to approve the proposed commitment, the court shall order inpatient treatment only if it finds, in addition to the criteria specified in this section, that such treatment is necessary to protect the minor's life, health, safety, or normal development. If a special justice believes that issuance of a removal order or protective order may be in the child's best interest, the special justice shall report the matter to the local department of social services for the county or city where the minor resides.

Upon finding that the best interests of the minor so require, the court may enter an order directing either or both of the minor's parents to comply with reasonable conditions relating to the minor's treatment.

If the minor is committed to inpatient treatment, such placement shall be in a mental health facility for inpatient treatment designated by the community services board which serves the political subdivision in which the minor was evaluated pursuant to § 16.1-342. If the community services board does not provide a placement recommendation at the hearing, the minor shall be placed in a mental health facility designated by the Commissioner of Behavioral Health and Developmental Services.

When a minor has been involuntarily committed pursuant to this section, the judge shall determine, after consideration of information provided by the minor's treating mental health professional and any involved community services board staff regarding the minor's dangerousness, whether transportation shall be provided by the sheriff or may be provided by an alternative transportation provider, including a parent, family member, or friend of the minor, a representative of the community services board, a representative of the facility at which the minor was detained pursuant to a temporary detention order, or other alternative transportation provider with personnel trained to provide transportation in a safe manner. If the judge determines that transportation may be provided by an alternative transportation provider, the judge may consult with the proposed alternative transportation provider either in person or via two-way electronic video and audio or telephone communication system to determine whether the proposed alternative transportation provider is available to provide transportation, willing to provide transportation, and able to provide transportation in a safe manner. If the judge finds that the proposed alternative transportation provider is available to provide transportation, willing to provide transportation, and able to provide transportation in a safe manner, the judge may order transportation by the proposed alternative transportation provider. In all other cases, the judge shall order transportation by the sheriff of the jurisdiction where the minor is a resident unless the sheriff's office of that jurisdiction is located more than 100 road miles from the nearest boundary of the jurisdiction in which the proceedings took place. In cases where the sheriff of the jurisdiction in which the minor is a resident is more than 100 road miles from the nearest boundary of the jurisdiction in which the proceedings took place, it shall be the responsibility of the sheriff of the latter jurisdiction to transport the minor.

If the judge determines that the minor requires transportation by the sheriff, the sheriff, as specified in this section shall transport the minor to the proper facility. In no event shall transport commence later than six hours after notification to the sheriff or alternative transportation provider of the judge's order.

§ 16.1-345.2. Mandatory outpatient treatment; criteria; orders.

A. After observing the minor and considering (i) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available, (ii) any past actions of the minor, (iii) any past mental health treatment of the minor, (iv) any evaluation of the minor, (v) any medical records available, (vi) the preadmission screening report, and (vii) any other relevant evidence that may have been admitted, the court shall order that the minor be admitted involuntarily to mandatory outpatient treatment for a period not to exceed 90 days if it finds, by clear and convincing evidence, that:

1. Because of mental illness, the minor (i) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control;

2. The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment;

3. Less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his condition have been investigated and are determined to be appropriate;

4. The minor~~, if 14 years of age or older,~~ and his parents (i) have sufficient capacity to understand the stipulations of the minor's treatment, (ii) have expressed an interest in the minor's living in the

community and have agreed to abide by the minor's treatment plan, and (iii) are deemed to have the capacity to comply with the treatment plan and understand and adhere to conditions and requirements of the treatment and services; and

5. The ordered treatment can be delivered on an outpatient basis by the community services board or a designated provider.

Less restrictive alternatives shall not be determined to be appropriate unless the services are actually available in the community and providers of the services have actually agreed to deliver the services.

B. Mandatory outpatient treatment may include day treatment in a hospital, night treatment in a hospital, or other appropriate course of treatment as may be necessary to meet the needs of the minor. The community services board serving the area in which the minor resides shall recommend a specific course of treatment and programs for the provision of mandatory outpatient treatment. Upon expiration of an order for mandatory outpatient treatment, the minor shall be released from the requirements of the order unless the order is continued in accordance with § 16.1-345.5.

C. Any order for mandatory outpatient treatment shall include an initial mandatory outpatient treatment plan developed by the community services board serving the area in which the minor resides. The plan shall, at a minimum, (i) identify the specific services to be provided, (ii) identify the provider who has agreed to provide each service, (iii) describe the arrangements made for the initial in-person appointment or contact with each service provider, and (iv) include any other relevant information that may be available regarding the mandatory outpatient treatment ordered. The order shall require the community services board to monitor the implementation of the mandatory outpatient treatment plan and report any material noncompliance to the court.

D. No later than five business days after an order for mandatory outpatient treatment has been entered pursuant to this section, the community services board that is responsible for monitoring compliance with the order shall file a comprehensive mandatory outpatient treatment plan. The comprehensive mandatory outpatient treatment plan shall (i) identify the specific type, amount, duration, and frequency of each service to be provided to the minor, (ii) identify the provider that has agreed to provide each service included in the plan, (iii) certify that the services are the most appropriate and least restrictive treatment available for the minor, (iv) certify that each provider has complied and continues to comply with applicable provisions of the Department of Behavioral Health and Developmental Services' licensing regulations, (v) be developed with the fullest involvement and participation of the minor and his parents and reflect their preferences to the greatest extent possible to support the minor's recovery and self-determination, (vi) specify the particular conditions with which the minor shall be required to comply, and (vii) describe how the community services board shall monitor the minor's compliance with the plan and report any material noncompliance with the plan. The minor shall be involved in the preparation of the plan to the maximum feasible extent consistent with his ability to understand and participate, and the minor's family shall be involved to the maximum extent consistent with the minor's treatment needs. The community services board shall submit the comprehensive mandatory outpatient treatment plan to the court for approval. Upon approval by the court, the comprehensive mandatory outpatient treatment plan shall be filed with the court and incorporated into the order of mandatory outpatient treatment. Any subsequent substantive modifications to the plan shall be filed with the court for review and attached to any order for mandatory outpatient treatment.

E. If the community services board responsible for developing the comprehensive mandatory outpatient treatment plan determines that the services necessary for the treatment of the minor's mental illness are not available or cannot be provided to the minor in accordance with the order for mandatory outpatient treatment, it shall notify the court within five business days of the entry of the order for mandatory outpatient treatment. Within five business days of receiving such notice, the judge, after notice to the minor, the minor's attorney, and the community services board responsible for developing the comprehensive mandatory outpatient treatment plan, shall hold a hearing pursuant to § 16.1-345.4.

F. Upon entry of any order for mandatory outpatient treatment, the clerk of the court shall provide a copy of the order to the minor who is the subject of the order, his parents, his attorney, his guardian ad litem, and the community services board required to monitor his compliance with the plan. The community services board shall acknowledge receipt of the order to the clerk of the court on a form established by the Office of the Executive Secretary of the Supreme Court and provided by the court for this purpose.

G. After entry of any order for mandatory outpatient treatment if the court that entered the order is not the juvenile and domestic relations district court for the jurisdiction in which the minor resides, it shall transfer jurisdiction of the case to the court where the minor resides.

§ 16.1-345.5. Continuation of mandatory outpatient treatment order.

A. At any time within 30 days prior to the expiration of a mandatory outpatient treatment order, the community services board that is required to monitor the minor's compliance with the order may file with the juvenile and domestic relations district court for the jurisdiction in which the minor resides a motion for review to continue the order for a period not to exceed 90 days.

B. The court shall grant the motion for review and enter an appropriate order without further hearing if it is joined by ~~(i)~~ the minor's parents ~~and the minor if he is 14 years of age or older, or (ii) the minor's parents if the minor is younger than 14 years of age~~. If the minor's parents ~~and the minor, if necessary,~~ do not join the motion, the court shall schedule a hearing and provide notice of the hearing in accordance with subsection A of § 16.1-345.4.

C. Upon receipt of the motion for review, the court shall appoint a qualified evaluator who shall personally examine the minor pursuant to § 16.1-342. The community services board required to monitor the minor's compliance with the mandatory outpatient treatment order shall provide a preadmission screening report as required in § 16.1-340.4.

D. After observing the minor, reviewing the preadmission screening report, and considering the appointed qualified evaluator's report and any other relevant evidence referenced in § 16.1-345 and subsection A of § 16.1-345.2, the court may make one of the dispositions specified in subsection D of § 16.1-345.4. If the court finds that a continued period of mandatory outpatient treatment is warranted, it may continue the order for a period not to exceed 90 days. Any order of mandatory outpatient treatment that is in effect at the time a motion for review for the continuation of the order is filed shall remain in effect until the court enters a subsequent order in the case.

E. For the purposes of this section, the "court" shall not include a special justice as authorized in § 37.2-803.

2. That § 16.1-339 of the Code of Virginia is repealed.

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