

JOINT COMMISSION ON HEALTH CARE



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2016 ANNUAL REPORT
JOINT COMMISSION ON HEALTH CARE

TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA



REPORT DOCUMENT #162

COMMONWEALTH OF VIRGINIA
RICHMOND
2017



JOINT COMMISSION ON HEALTH CARE

Senator Charles W. Carrico, Sr., Chair

Senator Rosalyn R. Dance, Vice Chair

June 12, 2017

The Honorable Terence R. McAuliffe
Governor of Virginia
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

Members of the Virginia General Assembly
Pocahontas Building
Richmond, Virginia 23219

Dear Governor McAuliffe and Members of the General Assembly:

Pursuant to the provisions of the *Code of Virginia* Title 30, Chapter 18 establishing the Joint Commission on Health Care and setting forth its purpose, I have the honor of submitting herewith the Annual Report for the calendar year ending December 31, 2016.

This report includes a summary of the Joint Commission's activities including legislative recommendations to the 2017 Session of the General Assembly. In addition, staff studies are submitted as written reports and made available on the Reports to the General Assembly and the Joint Commission on Health Care websites.

Respectfully submitted,

Charles W. Carrico, Sr.

Joint Commission on Health Care



The Honorable David L. Bulova
The Honorable Benjamin L. Cline
The Honorable T. Scott Garrett
The Honorable Patrick A. Hope
The Honorable Riley E. Ingram
The Honorable Kaye Kory
The Honorable John M. O'Bannon III
The Honorable Christopher K. Peace
The Honorable Christopher P. Stolle
The Honorable Roslyn C. Tyler



The Honorable Charles W. Carrico, Sr, Chair
The Honorable Rosalyn R. Dance, Vice Chair

The Honorable George L. Barker
The Honorable Siobhan S. Dunnavant
The Honorable John S. Edwards
The Honorable L. Louise Lucas
The Honorable Glen H. Sturtevant, Jr.
The Honorable David R. Suetterlein

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

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Preface

The Joint Commission on Health Care (JCHC), a standing commission of the General Assembly, was established in 1992 to continue the work of the Commission on Health Care for All Virginians. *Code of Virginia*, Title 30, Chapter 18, states in part: “The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care.” The Joint Commission’s sunset date was extended to July 1, 2022 during the 2017 General Assembly Session (Senate Bill 1043 and House Bill 1736).

The Joint Commission on Health Care is comprised of 18 legislative members, eight members of the Senate appointed by the Senate Committee on Rules and 10 members of the House of Delegates appointed by the Speaker of the House.

Senator Charles W. Carrico, Sr. served as Chair and Senator Rosalyn R. Dance served as Vice Chair in 2016. Senator Siobhan S. Dunnavant and Delegate T. Scott Garrett served as Co-Chairs of the Behavioral Health Care Subcommittee and Senator George L. Barker and Delegate Christopher P. Stolle served as Co-Chairs of the Healthy Living/Health Services Subcommittee.

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Activities

In keeping with its statutory mandate, the Joint Commission completed studies; received reports; considered comments from public and private organizations, advocates, industry representatives, citizens and other interested parties; and introduced legislation to advance the quality of health and health care services in the Commonwealth.

Joint Commission on Health Care

The full Commission met four times in 2016. These meetings were held in Senate Room A of the General Assembly Building on May 26th, September 7th, October 5th and in Senate Room B on November 9th. Meeting materials (including presentations, handouts and minutes) are posted on the website at <http://jchc.virginia.gov>.

Six staff reports were presented during the 2016 Joint Commission meetings:

- School Vaccination Requirements in the Commonwealth
- Palliative Care in the Commonwealth
- Medical Care Costs in Virginia State Prisons
- Development of Life Sustaining Treatment Guidelines
- Virginia Foundation for Healthy Youth Mission Expansion
- Expanding Access to Brain Injury Services and Barriers to Placement for Virginians with Challenging Behaviors that Result from Brain Injuries, Dementias and Post-Traumatic Stress Disorder

In addition to the staff reports, members received reports and heard presentations from a number of guest presenters:

Beth A. Bortz, President and CEO with the Virginia Center for Health Innovation, presented an update on the State Innovation Models (SIM).

Michael T. Lundberg, Executive Director, and Dr. Ibe Mbanu, President of Virginia Health Information gave a presentation of the 2016 Annual Report and Strategic Plan Update.

Christy T. Morton, Executive Director of the Virginia Rural Center, presented on the findings and recommendations of the workgroup requested by the JCHC to study the needs of rural Virginia.

The Office of the State Inspector General (OSIG) provided a letter to JCHC members soliciting recommendations for inclusion in their 2017 Annual Work Plan.

Behavioral Health Care Subcommittee

The Behavioral Health Care Subcommittee met on August 3rd and October 5th.

One staff report, “Integrating Behavioral Health and Physical Health Care Services” was presented during the 2016 Behavioral Health Care Subcommittee meetings.

Sarah Stanton discussed the mission and accomplishments of the Mental Health Services in the 21st Century Committee. She explained the number of meetings they have had and the expected outcomes of the work groups.

Mark Larsen, Director of Adult Behavioral Health Services at Mount Rogers CSB, presented information on the Mount Roger’s Alternative Transportation Pilot Program. Currently individuals with mental health problems are transported to hospitals by law enforcement in police/sheriff vehicles. That model negatively impacts the individuals and their families and places a burden on smaller and understaffed law enforcement offices. The Alternative Transportation Program has been very successful with these patients and relieving law enforcement of the transport responsibility.

Priscilla Smith presented her findings on the FY2015 Unannounced Inspection of the Commonwealth Center for Children and Adolescents. During her presentation, she highlighted data on admission and bed numbers as well as the observations and issues that were noted during the inspection such as inadequate operational programs in communities, high staff overtime hours and turnovers, and lack of master staffing plans and training. She then spoke about the Department of Behavioral Health and Developmental Services (DBHDS) updates. Mention of Department of Juvenile Justice facilities issues such as lack of funding and resources and staff recruitment problems were discussed. Daniel Herr made final comments on the research DBHDS is doing to help children and adolescents with hospital stays. A request for fiscal data and issues, for the time period of 2011-2014, was made.

Jodi Manz provided an update on Prescription Drug and Heroin Task Force initiatives. She began her presentation with data on overdose deaths from 1999 to 2016 showing a significant increase. She highlighted a program called angel wings which aides in treatment for addiction and spoke about Virginia starting similar programs. A state website which will aid in steps to take with addiction and recovery was discussed. She also spoke about suboxone and how it is used as a tool for treatment and recovery; She mentioned that counseling also needs to be provided in conjunction with suboxone. Finally, Ms. Manz summarized the focus areas of harm

BHC Subcommittee

Senator Siobhan S. Dunnivant, Co- Chair
 Delegate T. Scott Garrett, Co- Chair

Delegate David L. Bulova
 Delegate Patrick A. Hope
 Delegate Riley E. Ingram
 Delegate Kaye Kory
 Delegate John M. O’Bannon III
 Delegate Christopher P. Stolle

Senator George L. Barker
 Senator Charles W. Carrico, Sr.
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reduction, treatment, illicit use prevention, prescription abuse prevention and culture change. In conclusion, she provided upcoming task force meeting dates.

Dr. Barber, Interim Commissioner of the Department of Behavioral Health and Developmental Services (DBHDS), updated Commission members on the department’s activities. He discussed improvements to Virginia’s Behavioral Health System pertaining to hospital operations, jail waiting lists and prevention. The overall number of state hospital admissions rose 54% since 2013 due to private hospitals refusing patients with specific diagnosis. Credentials for emergency evaluators were discussed, then Dr. Barber spoke about updates on the Certified Community Behavioral Health Clinics (CCBHC) program. He presented a chart of eight participating CSBs and services they need to provide to meet CCBHC standards. He stated that in order to have all services ready in the eight CSB’s, \$6.52M would be needed and then \$38.02M to continue the operations. Virginia continues to strive to address issues of access to care, quality, consistency and accountability. He presented the STEP-VA (System Transformation, Excellence and Performance in Virginia) model as a way to improve Virginia’s behavioral health care system. Finally, Dr. Barber discussed Virginia’s Justice Involved Transformational Team.

Healthy Living/Health Services Subcommittee

The Healthy Living/Health Services Subcommittee met on August 3rd and September 7th.

Dr. Mike Royster, Vice President of the Institute for Public Health Innovation, presented information on the Community Health Workforce in Virginia. He explained that community health workers are charged with identifying and discussing social obstacles with patients and promoting health and quality of life. He spoke about several pilot projects that used community health workers and successfully decreased rates of re-admission to hospitals. He also mentioned the CHW advisory work groups and their tasks. Lastly, he discussed the legislative issues the CHW advisory group faces such as official recognition and identification in the Code.

Barbara Lowe-Fisher, National Vaccine Information Center, spoke about the legal right of parents to not vaccinate based on religious beliefs and how one-size-fits-all laws are not good for citizens. She described her own family experiences with adverse reactions to vaccines and asked that no change to be made to the current vaccine laws.

Karrie Delaney from Voices for Vaccines stated that parents who choose to vaccinate have science behind them. She then summarized concerns associated with a reduction in vaccination

HLHS Subcommittee

Senator George L. Barker, Co- Chair
 Delegate Christopher P. Stolle, Co- Chair

Delegate David L. Bulova
 Delegate T. Scott Garrett
 Delegate Patrick A. Hope
 Delegate Riley E. Ingram
 Delegate Kaye Kory
 Delegate Christopher K. Peace
 Delegate Roslyn C. Tyler

Senator Charles W. Carrico, Sr.
 Senator Rosalyn R. Dance
 Senator Siobhan S. Dunnavant
 Senator John S. Edwards
 Senator David R. Suetterlein



rates in the U.S. The loss of herd immunity can result in outbreaks in communities which may result in at-risk individuals, such as infants and the ill who cannot be vaccinated, getting vaccine-preventable diseases.

Secretary William Hazel provided an update on Health and Human Resources activities. Key behavioral health issues were discussed as well as recent progress in improving Virginia's behavioral health system. Topics included prescription, fentanyl and heroin overdoses; the Department of Justice waiver redesign; training centers; MLTSS vision and goals; Medicaid expansion; DSRIP (delivery system reform); high-cost medications; and the Health Information Exchange.

Commissioner Marissa Levine, from Virginia's Department of Health, discussed Virginia's Plan for Well-Being. Her presentation included the metrics being used for the plan, the data framework, the process for plan development, components of the plan, the Virginia Health Opportunity Index, and next steps.

Dawn Traver presented "Redesigned Waivers for Persons with Developmental Disabilities". She stated the three waivers have been amended with new services and discussed the new online system for maintaining waivers and how successful it has been functioning. Ms. Traver also spoke about the CMS final regulations on settings requirements and how DMAS will comply with them.

Lastly, Keisha Smith gave an update on the Graduate Medical Education Task Force. She spoke about the meetings that were held so far as well as the components of DMAS's residency grant program and the timeline for applications. She concluded by saying that the task force will be examining other options to improve GME in the Commonwealth.



Staff Endeavors

In 2016, JCHC staff served as members of the following organizations:

- Age Wave Plan for Greater Richmond, Leadership Committee
- Age Wave Plan for Greater Richmond, Data Subcommittee, Chair
- Children's Health Insurance Program Advisory Committee (CHIPAC)
- Lt. Governor's Commonwealth Council on Childhood Success, Child Health and Well Being Work Group
- GME Review Committee
- Rural Health Work Group

Staff gave the following presentations:

- *JCHC and Health Policy Development* in the Department of Health Administration's course, "Health Care Politics and Policy," at Virginia Commonwealth University
- *Health Policy and the Role of the JCHC* to the students and faculty at the Schroeder Center for Health Policy, College of William and Mary
- *Graduate Medical Education in Virginia*, presented at Virginia's GME Task Force meeting

Staff attended meetings for the following organizations:

- Mental Health Services in the 21st Century Subcommittee
- Geriatric Mental Health Partnership
- CHIPRA
- Virginia Brain Injury Commission
- Virginia Center for Health Innovation Presentations
- Brain Injury Data Work Group
- Mid-Atlantic Telehealth Conference
- Substance Abuse Services Counsel
- Alzheimer's Work Group
- Virginia Department of Veterans Affairs
- VHI Board of Directors
- GME Task Force

In addition, JCHC staff:

- Taught an Introduction to Health Policy course in the Virginia Commonwealth University's Department of Health Care Policy and Research
- Reviewed and evaluated the hospital EPICS and Financial data fields for the Virginia Health Information's (VHI's) Task Force
- Participated in the 19th Annual Virginia Health Law Legislative Update and Extravaganza
- Presented on the JCHC's activities as a panel member at the Virginia Quality Healthcare Network's Breakfast with the Experts event

Executive Summaries

During 2016, Commission staff conducted studies in response to requests from the General Assembly or from the Joint Commission on Health Care membership. In keeping with the Commission's statutory mandate, the following studies were completed.



School Vaccination Requirements in the Commonwealth

House Bill 1342 (Delegates Filler-Corn and Stolle) was introduced during the 2016 General Assembly session. As written, the bill amended § 32.1-46 by striking subsections D.1. and D.2. removing religious and medical exemptions and by adding "if the vaccine is medically contraindicated" as the only exemption. HB 1342 was stricken by the patron. Delegates Filler-Corn and Stolle requested that the JCHC study the requirements surrounding school vaccinations and make recommendations as to whether non-medical exemptions should be tightened for children attending public schools, private schools, child care centers, nursery schools and family day care home or developmental centers.

The study was approved at the May 26, 2016 work plan meeting.

The original study request asked the Commission to review ten issues related to the development, making, use and safety of vaccines. During the May 26, 2016 work plan approval meeting, an additional seventeen issues were added for review.

Background

Vaccination / school immunization policies are a balancing act between public health, science, personal freedoms, social responsibility, and public policy. The study explores in detail all aspects of the policies including a review of public attitudes, how vaccines are made, regulated and monitored for safety, controversies concerning vaccines and adverse reactions, other states' school vaccination requirements and a review of the current policies in Virginia.

Presentations Prior to the Study

Two presentations were heard at the beginning of the meeting. The presenters and a summary of their presentation are as follows:

Barbara Lowe-Fisher from National Vaccine Information Center spoke of the legal right of parents to not vaccinate based on religious beliefs and discussed how one-size-fits-all laws are not good for citizens. She described her own family experiences with adverse reactions to vaccines and asked that no change to be made to the current vaccine laws.

Karrie Delaney from Voices for Vaccines stated that parents who choose to vaccinate have science behind them. She then summarized concerns associated with a reduction in vaccination rates in the U.S. The loss of herd immunity can result in outbreaks in communities which may

result in at-risk individuals, such as infants and the ill who cannot be vaccinated, contracting vaccine-preventable diseases.

The Study

The study reviewed:

- Federal oversight of the development of vaccines and their approval for use by the public
- The various federal agencies charged with insuring that vaccines are safe as they are being developed, manufactured and used
- The ingredients of modern day vaccines and the controversies surrounding the ingredients, as well as the controversies surrounding the use of vaccines in general
- Federal oversight of reported adverse reactions and events and the systems in place to address them
- Herd immunity and how it is determined by disease and vaccine
- Other state laws on school vaccination policies compared to Virginia’s laws

Conclusions drawn from the study include:

- Vaccines target diseases that spread through society, some more rapidly than others and some more deadly than others.
- The U.S. Supreme Court found that individual liberties and individual religious freedoms within the context of a society can be restrained for the good of the whole (*Jacobson v. Massachusetts*, 1905).
- The statistically significant effectiveness of vaccine policies, when weighed against the nature of the diseases the vaccines are intended to prevent, support school vaccination policies.

Recommendations

1. Take no action.
2. Reintroduce legislation to amend section 22.1-271.2 and section 32.1-46 of the Virginia Code, removing religious and medical exemptions and by adding an exemption for medical contraindication as the only exemption.
3. Introduce legislation to amend section 22.1-271.2 and section 32.1-46 of the Virginia Code, eliminating the religious exemption.
4. Introduce legislation to amend section 22.1-271.2 and section 32.1-46 of the Virginia Code, eliminating the religious exemption and providing that medical exemptions can only be obtained from a licensed physician and must say what the physical condition of the child is, which vaccines are being exempted, whether the exemption is temporary or permanent and, if temporary, when the exemption will expire.
5. Introduce legislation to amend section 22.1-271.2 and section 32.1-46 of the Virginia Code, splitting the religious exemption into two parts – a religious exemption and a philosophical exemption. Both the religious and philosophical exemptions would be required to include what vaccines the person objects to base on religion or philosophical beliefs.



6. Introduce legislation to amend section 22.1-271.2 and section 32.1-46 of the Virginia Code, adding a subsection allowing physicians to file alternative vaccination plans provided that the child receives all required vaccines before Kindergarten.
7. Introduce legislation to amend Chapter 29 of Title 54.1 of the Virginia Code to improve the continuing medical education (CME) of physicians on childhood vaccinations.
8. Introduce budget amendment (language and funding) for the Virginia Department of Health to design more effective messages concerning vaccination programs for different communities and for the continuing education of physicians and other health care providers.
9. Request by letter of the JCHC Chair that the Health Department and the Department of Education work with local school divisions and private schools to improve reporting by schools and home schools to make certain that schools with low vaccination rates are filing reports properly and timely and the reports are reviewed for the reasons for low vaccination rates. A report to the Commission detailing the results of the agency efforts will be provided by October 1, 2017.

Actions Taken by the Joint Commission on Health Care

JCHC members voted to take no action.

Improving the Provision of Palliative Care in the Commonwealth

During the 2016 General Assembly Session, House Bill 473 was introduced by Delegates Filler-Corn, Krizek and Mason, and it was continued to 2017 in the House Health, Welfare and Institutions Committee. Delegate Filler-Corn subsequently requested that the JCHC study the legislation with an emphasis on the delivery and corresponding regulations of palliative care, evaluation of the need for public education on the topic, and determination of whether accessible statewide education resources exist for citizens.

The study was approved by the JCHC members during the May 26, 2016 work plan meeting.

As written, HB 473 amended § 32.1-127 and added § 32.1-371 and § 32.1-372 which required every hospital, nursing home, and licensed and certified nursing facility in the Commonwealth to establish a system for identifying patients or residents who may benefit from palliative care and provide information about and facilitate access to appropriate palliative care services for them. It also created a Palliative Care Consumer and Professional Education and Information Program within the Virginia Department of Health to maximize the effectiveness of palliative care initiatives in the Commonwealth and ensure that comprehensive and accurate information and education about palliative care is available to the public, health care providers, and health care facilities through the Department's website; and created an eight member Palliative Care and Quality of Life Advisory Council to advise the Department on the establishment, operation, maintenance, and outcomes evaluations of palliative care information and education initiatives. HB 473 had a fiscal impact statement of \$120,506 per year. The impact includes the cost of the council (\$10,000) and one professional to implement the education and information program and website (\$110,506).

Background

Historically, palliative care has been associated with hospice care as a service provided to help comfort terminally ill patients and their families during the last stages of their lives. According to the National Hospice and Palliative Care Organization, the percentage of hospice patients covered by the Medicare hospice benefit versus other payment sources was 84.1 percent in 2011. To be eligible for Medicare's hospice benefit, a beneficiary must be certified by a physician to have a life expectancy of six months or less if the illness runs its natural course and the beneficiary must sign a statement electing the hospice benefit, which means ending all treatments to cure the illness and electing to receive only comfort care - referred to as palliative care (42 CFR 418 to 418.405). Today the definition of palliative care is expanding beyond traditional hospice care and is now described to mean "comfort care" for a variety of long term, chronic and/or seriously ill patients as well as the terminally ill. The goal is to apply palliative care to any illness or disease that requires a team approach to patient care, similar to a medical home. Under this definition, a palliative care team consists of health care providers, clergy and social service programs that provide an array of services to people, and their families, who are recovering from serious illnesses and diseases that were once considered terminal.

Changing Demographics

The need for an expansion of palliative care into other areas of the health care field beyond hospice care involves the demographics of an aging population that includes people living longer due to the advancements in medical treatment. The average life expectancy in the United States in 2014 increased by 5 years since 1980; and death rates for the two most common diseases among the elderly population, cardiac disease and cancer, have declined by 64% and 15%, respectively. In addition, the number of people aged 65 and over is the fastest growing segment of the U.S. population according to the Census. Every day from now until 2030 10,000 baby-boomers will turn 65 years old. The number of people aged 65 and over grew by 23.3 percent in Virginia between the 2000 and 2010 census while the number of people aged 85 and over grew by 40.3 percent during the same period; as compared to 15.1% and 29.6% respectively for the U.S. population as a whole.

Association Positions on Palliative Care

Both the American Cancer Society and the American Heart Association have issued position papers advocating for the creation of palliative care as a way to improve treatment and patient outcomes from chronic and long term diseases.

Readmission Reduction Program

The Medicare Hospital Readmission Reduction Program reduces payments to hospitals if a person is readmitted for any cause other than a scheduled procedure within 30 days of discharge from an inpatient setting. The program only impacts the treatment of four diseases – cardiac, pneumonia, COPD and elective hip or knee replacement. All four can be addressed through a palliative care program that can help hospitals reduce readmissions and maintain their Medicare payments for inpatient procedures. In Virginia, 41 hospitals were penalized for excessive preventable readmissions for patients discharged with a diagnosis of heart attack or heart failure.

Challenges

Challenges to palliative care include the lack of knowledge about what palliative care is under an expanded definition, who the providers are and where they are located. A secret shopper program conducted by Duke University in 2016 found that cancer centers did not provide complete information on supportive services 38 percent of the time when asked whether palliative care was available. A 2014 survey of health care providers by Health Information Network (HIN) found that 48 percent of respondents indicated that physician resistance to implementing a palliative care program was a key challenge. The HIN survey also found that 80 percent of respondents said that patient/caregiver education was a key component of the program.

Virginia

In speaking to stakeholders across the state, including medical directors of palliative care programs, hospice workers, and palliative care program directors and providers, the conversations and observations about palliative care outside of hospice are similar to the findings reported in the Duke and HIN surveys. Patients and family members often do not understand what a palliative care program is or why they or their family members are on a palliative care unit. The nurse director of one palliative care program said family members and patients are often angry and confused when they enter the palliative care unit at the hospital. For them the term palliative care is associated with hospice and there is an assumption that curative treatments have ended. The director also indicated that when the program started in 2009 it took some time for the oncology physicians to support the program, viewing it as duplicative of the work they thought they were doing. The medical directors and professors of palliative care programs at Eastern Virginia Medical School, the University of Virginia, and Virginia Commonwealth University all indicate that medical schools need to do a more complete job of educating medical students about palliative care. All three indicated that the amount of time spent in the classroom or other environments where medical students are in training is insufficient to teach them how to talk to patients and family members about palliative care, death, and/or dying.

<i>General Google Search Results for Palliative Care Providers in Virginia</i>		
<i>Websites</i>	<i>Number of Hospitals / Providers Listed</i>	<i>Number of Cities</i>
<i>Getpalliativecare.org</i>	35	26
<i>National Hospice and Palliative Care Organization *</i>	13	10
<i>American Council on Surgeons Commission on Cancer *</i>	46	39
<i>Physicians</i>	<i>Number of Physicians / Nurses Listed</i>	<i>Number of Cities</i>
<i>American Board of Internal Medicine Subspecialty</i>	106	n/a
<i>American Board of Family Medicine</i>	36	24
<i>American Board of Medical Specialists</i>	81	38
<i>Certified Hospice and Palliative Nurses (CHPN)</i>	312	n/a
<i>Advanced Certified Hospice and Palliative Nurses (ACHPN)</i>	45	n/a
<i>Certified Hospice Medical Director</i>	7	7

- *The National Hospice and Palliative Care Organization website lists both palliative care specific providers and hospice provider. The only way to know if any of the hospice providers are also offering palliative care services is to follow additional detail links for each hospice provider.*
- *The American Council on Surgeons website lists 38 Commission on Cancer certified hospitals but combines several hospitals into one even though the hospitals are in different locations.*

(<https://getpalliativecare.org/providers/virginia/>); (<http://www.nhpco.org/find-hospice/pcp>); (<https://www.facs.org/search/cancer-programs?state=VA>); (http://www.gohpcc.org/certificants_map.aspx?Cert=CHPN); (http://www.gohpcc.org/certificants_map.aspx?Cert=APRN); (<http://apps.hmdcb.org/Default.aspx?TabId=356&DSResult=T&State808=VA&DirectoryFlag802=Y&AddressStatusCode795=GOOD>)

The medical director of a large palliative care program in Northern Virginia said finding providers is labor intensive. Palliative care providers do not have to be certified to be members of an organization and not all certified physicians are members of the various organizations where provider directories or lists might be found. A review of the different websites for Virginia found that the material on one website may or may not match the information on another.

Virginia Hospital and Healthcare Association Palliative Care Forum

The Virginia Hospital and Healthcare Association (VHHA) has a palliative care forum with approximately 40 members. The forum was established in 2011 and includes the Virginia Association for Hospices & Palliative Care, Honoring Choices, The Physician Orders for Scope of Treatment Group and other community groups. The forum meets four times a year with approximately 10 – 15 people in attendance at any given meeting. According to VHHA, palliative care is a part of the overall issues related to advance care planning. The forum's goals include providing an opportunity for providers to collaborate to meet the needs of communities, sharing information and best practices, supporting training and education, and credentialing of palliative care team members. Conclusion, Recommendations and Policy Options Based on the material reviewed for this study and information obtained from various stakeholders from across the Commonwealth, there may be a need for both a statewide advisory council and a website to act as a clearinghouse for information and educational material for both the general public and health care providers. During stakeholder conversations there was a strong desire to make the list of members of the advisory council more inclusive of providers that are part of a palliative care team.

The recommendations include clarifying provisions of HB 473 as follows:

1. Change House Bill 473 by removing the amendment to section §32.1-127 of the Virginia Code that requires licensed hospitals, nursing homes and certified nursing facilities to



identify and educate patients on palliative care services and continue the legislation that creates the advisory council and website by adding Title §32.1 -371 and §32.1-372 to the Virginia Code as originally written.

2. Change House Bill 473 by removing the amendment to section §32.1-127 of the Virginia Code that requires licensed hospitals, nursing homes and certified nursing facilities to identify and educate patients on palliative care services and continue the legislation that creates the advisory council and website by adding Title §32.1 -371 and §32.1-372 to the Virginia Code with language that expands the Palliative Care and Quality of Life Advisory Council within the Virginia Department of Health from eight to thirteen by adding a hospice provider, nutritionist, hospital administrator and nursing home and certified nursing facility.

Actions Taken by the Joint Commission on Health Care

Additional Member-Proposed Policy Option: Add a section to Title §32.1 of the Virginia Code requiring the Virginia Department of Health to create a website for palliative care information. Members approved this policy option.

Legislative Action

HB 1675 - Delegate Bulova/ SB 974 - Senator Lucas

Require the Department of Health to make information about and resources on palliative care available to the public, health care providers, and health care facilities on its website.

HB 1675 and SB 974 were enacted (Acts of Assembly 2017, Chapters 746 and 471 respectively).

Medical Care Provided in State Prisons – Study of the Costs

By letter to the JCHC Chair, Delegate Kory requested that the JCHC study or evaluate the costs to the state for prisoner medical care provided by the Commonwealth while inmates are incarcerated, especially costs for pharmaceutical products. The Study was approved by the JCHC members during the May 26, 2016 work plan meeting.

Background

By law the Virginia Department of Corrections (VADOC) is required to provide adequate health care to incarcerated offenders (U.S. Const. Amend. VIII; §53.1-32, Code of Virginia). Adequate health care was defined by the United States Supreme Court beginning in 1976 (*Estelle v. Gamble*, 429 U.S. 97, 97 S.Ct. 285). The definition encompasses the idea of providing incarcerated offenders with a “community standard” of care that includes a full range of services. The courts identified three rights to health care for incarcerated offenders: the right to have access to care; the right to have care that is ordered by a health care professional; and the right to professional medical judgment.

On July 12, 2012 a class action lawsuit was filed in federal court against VADOC over medical care at Fluvanna Correctional Center for Women. The lawsuit was settled through a Memorandum of Understanding on November 25, 2014 that was approved by the court in February 2016.

The agreement includes the hiring of a compliance monitor and continued court supervision of the agreement. The agreement reached between VADOC and the plaintiffs at Fluvanna is comprehensive and involves all aspects of the health care system, including mental health. Some of the issues the agreement addressed include: timely access to care and treatment; the following of national clinical guidelines for treatments and medical testing; admission and discharge planning; quality improvement compliance, security and treatment of pregnant women; accommodations for prisoners with special needs; and, compliance with the Americans with Disability Act (ADA).

Brief Description of the VADOC Health Care System

VADOC is responsible for over 30,000 incarcerated offenders on any given day in 46 prison facilities. Each prison provides health care services to incarcerated offenders and the level of health care depends on the facility. Because inmates are transferred around the system, comparing one facility to another is difficult. VADOC’s health care system for incarcerated offenders is a combination of state run and privately contracted services. VADOC provides health care services to offenders in thirty state prisons which include half of the offender population. The other half of the prison population receives health care services from Armor Correctional Health Services (fourteen state prisons that include the four infirmaries), Mediko Correctional Health Care (two state prisons), and the GEO Group (one state prison) within the context of its overall private prison contract. Offenders with complex health care needs are transported offsite to physicians, specialists, and community hospitals, including Virginia



Commonwealth University's medical center. VADOC contracts with Anthem Blue Cross Blue Shield to act as the third party administrator for all offsite health care claims. VADOC contracts with Diamond Pharmacy Services for all pharmaceutical products for the thirty state prisons it operates. Armor and Mediko also contract with Diamond for pharmaceutical products for the state prisons where they provide health care services. High cost pharmacy products for three specific diseases are carved out of the pharmacy contracts and provided to VADOC through the VCU 340B drug purchasing program. The diseases are HIV, Hepatitis C and hemophilia. Finally, hospitals submit claims to the Department of Medical Assistance Services (DMAS) directly for offenders that are admitted to a hospital as inpatient for twenty-four hours or more who qualify for Medicaid.

Findings

Overview of Management Information VADOC does not have comprehensive management tools available to monitor or accurately project health care costs. As a result, the findings in this report are based on a consolidation of information from the department and some of its vendors.

The department does not have electronic health records and cannot provide a profile of inmate health care issues. In addition, there are no routine multi-year trend analysis reports of health expenditures and reports are generated only upon request.

According to VADOC, Armor, Mediko and Geo do not share their pharmacy contractual pricing with the state – claiming the information is proprietary. As a result, under the current system, VADOC does not know if the prisons operated by Armor, Mediko or GEO are getting the best prices for the pharmacy products they purchase.

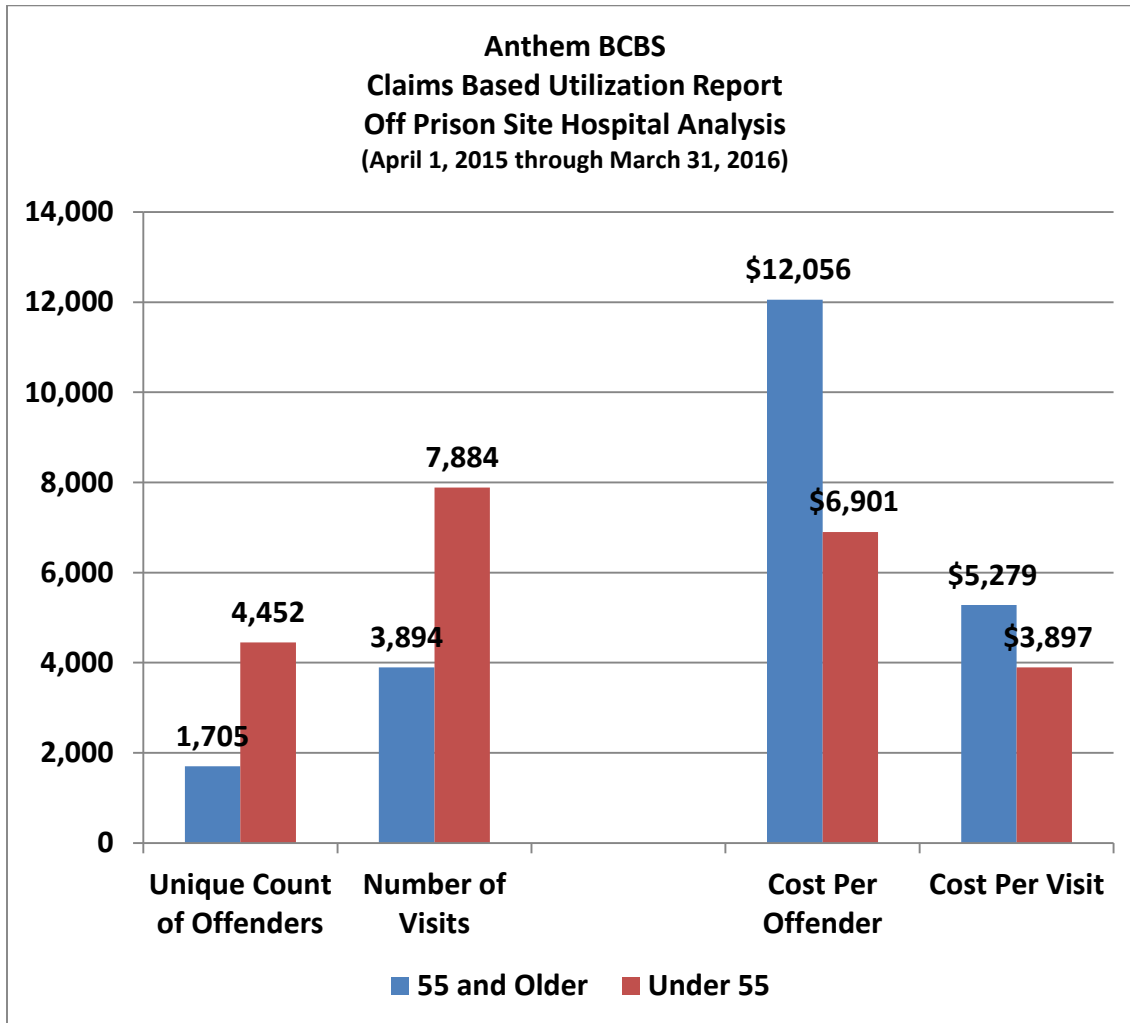
The contracts with vendors for health care services are established by facility, with each facility having its own per-member-per month capitated payment. VADOC does not generate benchmark prices that can be used for comparative purposes to insure that the Commonwealth is receiving a fair price for the services it receives from the vendors.

Offender Profile and Expenditures

A review of data provided by VADOC indicates that the offender population is aging in the state prison system. The percent of offenders aged 55 and over grew from 9.8 percent in the fourth quarter of 2012 to 12.2 percent in the fourth quarter of 2015. The data indicate that while the percent of offenders reporting alcohol use remains steady at approximately 65 percent, the number of offenders reporting drug use has grown from 35.1 to 42.9 percent. Finally, offenders screened for mental health issues grew from 22.8 to 26.0 percent.

Pharmacy reports provided to VADOC from Diamond for the offenders VADOC provides health services to reflect the health issues associated the demographics of the offender population. The top six prescriptions filled for the offenders by therapeutic class include drugs for cardiac disease, psychotropic medications and diabetes. The amount spent by therapeutic class on the top seven drugs prescribed to the VADOC offenders include bio-immuno drugs for cancer treatment, psychotropic drugs and drugs for cardiac disease.

A claims analysis performed by Anthem on the 6,157 offenders treated offsite by hospitals in 2016 found that 28 percent were aged 55 and over. These offenders accounted for 40 percent of the \$51.3 million spent on offsite inpatient or outpatient hospital care. The Anthem analysis also found that the cost per offender for those aged 55 and over was \$12,056 compared to \$6,901 for those under age 55.



Anthem’s analysis also found that 179 offenders, or 2.9 percent of the 8,317 offenders cared for offsite by all providers, accounted for 46.8 percent of the \$62.4 million for all offsite health care spending. The primary health condition for half of these offenders was identified as either cardiac disease or cancer.

Incarcerated Offender Health Care Services:

Virginia Compared to Other States

In SFY-2016 VADOC spent 16 percent of its \$1.2 billion budget on health care services. To compare Virginia to the other states, reports from the federal Bureau of Justice Statistics and the Pew Charitable Trusts were combined using the most current data available, 2011. *

Rank by % of Prison Health Spending	State	State Prison Spending 2011	Prison Health Care Spending 2011	Percent Spent on Health Care
1	California	\$8,528,335,000	\$2,137,045,000	25.1%
2	Missouri	\$683,665,000	\$142,988,000	20.9%
3	New Hampshire	\$112,666,000	\$23,564,000	20.9%
4	Mississippi	\$309,694,000	\$64,575,000	20.9%
5	Michigan	\$1,625,653,000	\$330,400,000	20.3%
6	Ohio	\$1,452,841,000	\$279,716,000	19.3%
7	Alabama	\$531,700,000	\$97,266,000	18.3%
8	North Carolina	\$1,420,666,000	\$255,125,000	18.0%
9	Delaware	\$266,666,000	\$46,094,000	17.3%
10	Nevada	\$270,381,000	\$46,593,000	17.2%
33	Virginia	\$1,193,345,000	\$149,850,000	12.6%
41	Colorado	\$871,379,000	\$102,355,000	11.7%
42	Iowa	\$329,694,000	\$38,001,000	11.5%
43	Maryland	\$1,364,884,000	\$147,856,000	10.8%
44	Rhode Island	\$181,796,000	\$19,364,000	10.7%
45	New Jersey	\$1,408,614,000	\$141,752,000	10.1%
46	Utah	\$297,609,000	\$29,529,000	9.9%
47	Illinois	\$1,513,117,000	\$144,039,000	9.5%
48	Massachusetts	\$1,050,827,000	\$95,348,000	9.1%
49	West Virginia	\$269,308,000	\$23,150,000	8.6%
50	North Dakota	\$87,671,000	\$6,350,000	7.2%
	National Average	\$46,711,103,000	\$7,679,772,001	16.4%



Other Studies of VADOC Health Care Spending

There have been three studies specifically related to VADOC health care spending and one related to high cost drugs purchased for the Commonwealth, which includes a review of VADOC's pharmacy purchasing practices. The studies are as follows:

- Report on Costs and Benefits of Current Inmate Health Care System compared to Alternative Care Management Models; 2015 Budget Bill CH 665; Item 384. P.1.
- Report on Costs and Benefits of Current Inmate Health Care System compared to alternative Care Management Models; 2015 Budget Bill CH 665; Item 384.P. and 2016 Appropriation, CH 780; Item 393.N.
- Multi Cabinet Review of High Cost Drug Purchases; 2016 Appropriation; CH 780, Item 284.B.
- Modernization of Current Data and Record Keeping Systems; 2016 Appropriation; CH 780, Item 394. A.

Conclusions

VADOC is legally responsible for providing health care services to all incarcerated offenders in the state prison system whether the prison health care services are provided by a vendor or by the state directly. While health care represents approximately 16 percent of the VADOC expenditures, costs in certain areas, such as pharmacy, have been rising. Some of the increases are due to the introduction of new prescription drugs while other health care cost increases are due to a changing prison population. The system has more offenders with mental health and substance abuse issues now than it had five years ago. There is a growing incarcerated population of elderly offenders, and their health care needs are changing much the same as the health needs of the elderly general population. VADOC can control health care costs by managing offender health care within the system through the expansion, implementation and more thorough monitoring of offender disease management programs and pharmacy management programs.

Finally, the costs of health care in the prison system need to be carefully monitored and better management tools need to be developed. The Fluvanna settlement has the potential of driving up the cost of health care in the prison system, and any efforts made by VADOC to manage those changes will be beneficial in controlling costs and complying with the settlement agreement.

Recommendations

1. Take no action.
2. Request by letter of the JCHC Chair that the Department of Corrections to prepare and submit an annual report to the Governor and the General Assembly detailing the operations and expenditures for the entire state prison system's health care system. The report should include trend analysis of expenditures, trend analysis of the prison population including disease and illness profiles, new programs and services implemented and future plans. Require the Department to report back to the Commission with results of its efforts by October, 2017.
3. Request by letter of the JCHC Chair that the Department of Corrections to implement disease management programs within all of the department's facilities for diseases where there are established best practice models available. The department should explore the



- opportunity of establishing a comprehensive peer-to-peer program for incarcerated offenders where offenders can assist each other in managing their illnesses. Require the Department to report back to the Commission with results of its efforts by October, 2017.
4. Request by letter of the JCHC Chair that the Department of Corrections to hire an independent actuary to annually establish per-member-per-month benchmark reimbursement rates for inmates where the health care is provided by a vendor. Require the Department to report back to the Commission with results of its efforts by October, 2017.
 5. Request by letter of the JCHC Chair that the Department of Corrections explore all opportunities to partner with the Department of Behavioral Health and Development Services and VCUHS for the purchasing of pharmaceutical products through the multi-state purchasing agreements already in place and/or through the use and expansion of the 340B program. Require the Department to report back to the Commission with results of its efforts by October 1, 2017.

Actions Taken by the Joint Commission on Health Care

Recommendations #2-5 were approved by Commission members.

Development of Life-Sustaining Treatment Guidelines

Study Mandate

Virginia Code §54.1-2990 regulates physician actions if a physician refuses to provide health care requested by/for a patient because the physician determines the requested treatment to be medically or ethically inappropriate. However, while the Code provides a 14-day timeframe for transferring the patient to a different provider in cases of unresolved conflict, §54.1-2990 does not address situations in which 14 days pass and the conflict remains unresolved and/or the patient is unable to be transferred. During the 2015 General Assembly, Delegate Stolle introduced HB 2153 to amend §54.1-2990 to include the language that “the physician may cease to provide care that he has determined to be medically or ethically inappropriate.” HB 2153 was tabled in the House Health, Welfare and Institutions Committee by voice vote, and in 2016, Delegate Stolle requested that the JCHC study the current legal and regulatory environment on life-prolonging care, focusing on: legal/regulatory requirements regarding disagreements over medical appropriateness of life-prolonging care; how other States address this issue, including how patients can pursue desired treatments and how providers are protected from providing medically inappropriate treatment; and recommendations for legislative changes clarifying actions after the current legal time period for patient transfer (14 days) has passed and the patient is unable to be transferred.

Background

When a patient is in need of life-sustaining treatment to remain alive, treatment decision-making conflicts between patients – or, as in almost all cases involving life-sustaining treatment decisions, an incapacitated patient’s agent – and providers are not uncommon. One driver of treatment decision making conflict occurs if a patient/patient’s agent requests life-sustaining treatment(s) that a physician believes to be inappropriate. While a patient’s/patient’s agent’s right to refuse treatment options offered by clinicians is well-established in common law, Constitutional law and statutory documents, a patient’s/patient’s agent’s right to demand any available treatment has not been similarly established. As a result, treatment decision conflicts are thought to arise in up to 50% of the Intensive Care Unit (ICU) setting admissions and are regularly identified as the single biggest ethical dilemma facing North American hospitals. Many physicians and health care institutions follow a number of process steps to prevent treatment decision conflicts before they occur, such as through clarifying goals with patients, or resolving conflicts once they arise, such as by convening ethics committee consultations, obtaining additional medical opinions and/or engaging institutional resources (e.g., palliative care specialists; patient advocates). While it is estimated that consensus is reached in the vast majority (over 95%) of cases of treatment decision conflict, many hospital and physician stakeholders in Virginia have expressed a desire for greater clarity in allowable physician actions for the minority of cases that remain unresolved.

Virginia's Health Care Decisions Act in Comparison to other States' Statutes Governing Health Care Decisions

Virginia's "Health Care Decisions Act" (§§54.1-2981-2993) regulates several aspects of patient decision making relevant to this study, including procedures relating to Advance Directives (e.g. their construction, form, and revocation), duties/authorities of a patient's agent as well as physicians, procedures if a physician refuses to honor an Advance Directive or health care decision, judicial review of decisions, and immunities. While the Health Care Decisions Act applies to any treatment decision, it is particularly relevant in the context of life-sustaining treatment decisions. Under the Health Care Decisions Act, Virginia is one of 15 States that allows physicians/facilities to decline to follow health care directives for treatments that would be medically ineffective, inappropriate and/or contrary to generally accepted health care standards. Eleven of the 15 States, including Virginia, do not define "medically" or "ethically" inappropriate treatment. Virginia is also one of the majority of States that specifies only two basic process measures to resolve treatment decision conflicts that may result: the physician must make a reasonable effort to inform the patient of reasons for refusing to provide treatment (32 States) and transfer the patient to another physician (46 States) – and one of 25 States to explicitly mandate continued provision of requested life-sustaining treatment while a transfer is sought. However, similar to most other States, if a transfer is unable to be effected, Virginia Code does not directly address allowable provider actions or legal consequences for withdrawing/withholding requested treatment. By contrast, three States permit a physician to refuse to provide treatment if transfer is unsuccessful – either unconditionally or if certain process measures are taken – while one State takes the opposite track by mandating continued provision of requested treatment if transfer is unsuccessful.

The following are three other aspects of health care decisions relevant to treatment decision making conflicts:

1. Artificially administered nutrition and hydration: Even though artificially administered nutrition and hydration is considered by the medical practice and in case law to be equivalent to any medical treatment, it is often viewed by the general public as different from other medical treatments, requiring different or specific standards regulating its use. Virginia is one of 18 States to include artificially administered nutrition and hydration in its definition of life-sustaining care, compared to 4 States that exclude artificially administered nutrition and hydration from their definition and 18 States that do not reference artificially administered nutrition and hydration one way or the other. Three States mandate continued provision of artificially administered nutrition and hydration throughout a treatment decision conflict resolution process, while the remainder of States (including Virginia) do not specifically reference artificially administered nutrition and hydration.
2. Judicial recourse/review of physician treatment decisions: Virginia is one of 15 States to identify a process for judicial recourse/review specific to the context of care provided under the Health Care Decisions Act, compared to 23 States that do not explicitly reference a process. Virginia is not one of six States to identify a judicial review process specific to the context of treatment decision conflict/patient transfers.
3. Non-discrimination in physician treatment decisions: Some stakeholders in Virginia and nationally have concerns that clinician determination of appropriateness of life-sustaining treatment will discriminate against vulnerable populations, such as the disabled or elderly, by placing a lower valuation on expected benefits for those patients and/or a higher valuation on

expected repercussions/ineffectiveness compared to other patients. There are four States, not including Virginia, that reference non-discrimination or disabilities in the context of life sustaining treatment.

The Texas Advance Directives Act is the most detailed and comprehensive State Statute to address treatment decision conflicts between patients and physicians and an instructive model to inform potential revisions to Virginia Statute. Originally enacted in 1999, its primary features are standardized facility level conflict resolution processes, including: review of physician decision by third-party ethics or medical committee; provision of information on the decision review process (written description, advance notice of meeting time, copy of registry list of providers willing to accept transfer/assist in locating provider); patient/patient agent's entitlements (attend review meeting, receive written explanation of decision/relevant portion of medical record); facility role in attempting patient transfer ("reasonable effort") and required health care pending transfer (life sustaining treatment, comfort care); patient responsibility for costs of transfer; ability of physician/health facility to cease life-sustaining treatment after 10 days, with exception of artificially administered nutrition/hydration considered ordinary care (exceptions specified for cases of artificially administered nutrition/hydration considered extraordinary care); judicial review of physician decision is limited to extending the 10-day time period if there is a "reasonable expectation" that another physician/facility will accept the patient and honor the treatment request; and exclusion of home and community support services facilities from conflict resolution process/requirements.

Recommendations

A stakeholder Working Group – with participation from 27 organizations representing patients/consumers, providers/health systems, and State agencies – was convened to generate recommendations for revisions to Virginia Code. Based on Working Group input, seven recommendations were made for "minimalist" revisions within Virginia Code §54.1-2990 to address treatment decision conflict resolution (see Appendix for recommended draft legislative revisions), and one additional non-Statute recommendation focusing on prevention of treatment decision conflicts. The eight recommendations were:

Recommendations and Notes/Rationale

1. Require hospitals to maintain written policies on life-sustaining treatment decision conflict resolution procedures
 - Transparency in facility-level policies will heighten ability of clinicians, patients/patients' agents and facilities to more effectively resolve conflicts
 - The vast majority of situations of life-sustaining treatment decision conflict take place in the hospital setting, while ability of other institutions to fulfill this (and other) recommendations varies widely
2. Require hospitals to take standard minimum steps in cases of life-sustaining treatment decision conflict:
 - A) Second medical opinion
 - B) Interdisciplinary medical review committee review of physician determination
 - C) Patient / agent / decision-maker to participate in review meeting
 - D) Written explanation of review meeting decision included in the patient's medical record

- Process standardization balanced with implementation flexibility
3. Provide qualified permission to physician to cease inappropriate treatment after 14 days:
 - A) ≥ 14 days after documentation of physician's decision in medical record to effect transfer
 - B) Mandate physician reasonable effort to effect / facilitate transfer
 - C) If transfer not effected, physician may cease to provide treatment if hospital policies/steps under recommendations 1 and 2 have been followed, except for: 1) most cases of artificially administered nutrition/hydration; and 2) comfort care
 - Clarity in legally permissible actions after 14 days emphasized by many working group stakeholders as a key aspect
 - Many Working Group participants stressed importance of additional safeguards related to provision of artificial nutrition and hydration Provide physician immunity when requirements are followed
 4. Provide physician immunity when requirements are followed
 - Ensures that physicians/hospitals are legally indemnified for ceasing treatment if mandated processes have been followed in accordance with medical standard of care
 5. Stipulate that all actions under this section must conform to federal non-discrimination standards
 - Provides additional protection to vulnerable populations and alignment with national-level norms
 6. Revise "life-sustaining care" term and definition:
 - A) Replace "care" with "treatment"
 - B) Eliminate examples (hydration, nutrition, maintenance medication, CPR)
 - "Care" is broader than medical "treatment"; revising to "treatment" eliminates potential misinterpretation / misapplication of recommendations
 - Under certain circumstances, examples specified in current language (e.g., hydration, nutrition) may be considered appropriate or inappropriate life-sustaining treatment; eliminating examples recognizes that specificities of a particular case need to guide application of § 54.1-2990 in practice
 7. Eliminate Durable Do Not Resuscitate Orders from applicable documents within § 54.1-2990
 - Addition of Durable DNR (1999) is inconsistent with § 54.1-2990 that addresses situations of physician refusal to provide medically/ethically inappropriate treatment. Durable DNRs address situations in which treatment is not desired.
 - 8. Form working group to study health care decisions more broadly, focused on preventing/improving resolution of treatment decision conflicts
 - Leverage working group formed for study to focus on recommendations/policy options for preventing and improving outcomes of treatment decision conflict
 8. Form working group to study health care decisions more broadly, focused on preventing/improving resolution of treatment decision conflicts



- Leverage working group formed for study to focus on recommendations/policy options for preventing and improving outcomes of treatment decision conflict

Actions Taken by the Joint Commission on Health Care

Include in the 2017 JCHC work plan that staff form a work group to study health care decisions more broadly, focused on preventing/improving outcomes of treatment decision conflict in Virginia, and report back to the JCHC in 2017.

Virginia Foundation for Healthy Youth Mission Expansion

Study Mandate

In 2016, Delegate O’Bannon requested via House Joint Resolution 65 that the JCHC study the benefits and costs of expanding the mission of the Virginia Foundation for Healthy Youth to include a focus on other health issues such as behavioral health, violence, hunger and diabetes. The study was included in the Joint Commission on Health Care 2016 work plan and approved by members.

Background

Created in 1999 as the Virginia Tobacco Settlement Foundation, the current mission of the Virginia Foundation for Healthy Youth (VFHY) is to prevent tobacco use by youth and reduce childhood obesity. Funding comes primarily from Master Settlement Agreement (MSA) payments (10% of total MSA payments until 2009, averaging \$14.2M in annual expenditures; 8.6% since 2010, averaging \$10.1M in annual expenditures), with the VFHY additionally able to finance activities through extra-MSA resources.

The VFHY executes its mission primarily through three platforms, as described below:

Platform	Description	Examples
Program (Grants)	<ul style="list-style-type: none"> ▪ Tobacco: Classroom-based prevention / cessation, training programs ▪ Obesity: Healthy Communities Action Teams (HCATs) 	<ul style="list-style-type: none"> ▪ Tobacco: All Stars; Project Alert; Project Toward No Drugs ▪ Obesity: see Slide 21
Marketing / Communication	<ul style="list-style-type: none"> ▪ Mass media advertising/messaging ▪ Youth engagement (tobacco prevention only) 	<ul style="list-style-type: none"> ▪ Tobacco: “Y Street” youth leaders; Down & Dirty, Fresh Empire media campaigns ▪ Obesity: “Rev your Bev” healthy drink campaign
Research (tobacco only)	<ul style="list-style-type: none"> ▪ Behavior-focused studies ▪ Basic science-focused studies ▪ Research coalition 	<ul style="list-style-type: none"> ▪ Behavior-focused: “Reducing Teen Tobacco Use Via Text Messaging” ▪ Basic Science-focused: “What Social and Molecular Factors Drive Nicotine Preference in Adolescent Mice?”

Additional activities include collaboration on youth surveillance conducted by the Virginia Department of Health (i.e., Virginia Youth Survey) and convening conferences (e.g., “Reduce Tobacco Use”; “Weight of the State”).

Epidemiology and VFHY Programming in Health Issues Under Current Mission

Tobacco

Cigarette/tobacco use by youth has declined both in Virginia and nationally over time according to self-reported data. Additionally, estimated percentages of Virginia youth using tobacco products in the early 2000s were higher than or around the national average, while most recent estimates indicate that they are below the national average (2015 CDC data) or at the national average (2014 SAMHSA data). According to one data source (CDC), almost all indicators of youth tobacco product use declined statistically significantly between 2011 and 2015, with tobacco product usage by Virginia youth among the lowest in the nation. Going forward, evidence suggests that youth use of Electronic Nicotine Delivery Systems (ENDS) is becoming a significant issue, with ENDS use in 2015 estimated to be higher than for traditional tobacco products. Evidence is still nascent on the long-term health effects of ENDS compared to traditional tobacco products, as well as whether ENDS' use facilitates cessation of tobacco products, encourages initiation, or bears no relationship.

Against this backdrop, the VFHY has funded tobacco prevention programs, marketing and research.

- **Programs:** Grantees implement classroom-based curricula drawn from a compendium of 19 programs, 18 of which are listed on the Substance Abuse and Mental Health Services (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP). Since 2009, the VFHY has awarded 107 three-year and 59 one-year grants (to CSBs, local school boards, not-for-profits, etc.), which have served between 46,380 (2014/5) and 63,071 (2009/10) youth annually.
- **Marketing:** 1) messages from anti-tobacco media campaigns reached an estimated 3.15 million youth in 2016; 2) Over 8,000 youth “Y Street” volunteers have been trained since 2004 to implement community-based campaigns, with around 4,000 actively implementing projects.
- **Research:** Since 2002, the VFHY has funded 22 research grants. Approximately 80% of funds have been directed towards behavior-focused and basic science-focused projects, and 20% directed towards a research coalition that has leveraged VFHY funds to secure approximately \$26M in outside funding.

Obesity

Percentages of overweight/obese youth did not change statistically between 2011 and 2015, while behavioral indicators that may be associated with weight (e.g., drinking sugary sodas) declined during the same period. To address youth obesity, the VFHY awards three-year grants to Healthy Community Action Teams (HCATs). HCATs implement community-based projects that are focused on increasing physical activity and/or improving nutrition and are recommended by the Institutes of Medicine (IOM).

Epidemiology of Health Issues under Consideration for Mission Expansion

Behavioral Health

Data on the epidemiology in Virginia of three behavioral health issues considered – substance use, bullying/violence, and suicide/depression – are summarized below:

Issue	Key Findings
Substance Use	<ul style="list-style-type: none"> ▪ Use of most substances among high school students <u>among lowest in nation, with the exception of prescription drugs</u> (CDC estimates); however, SAMHSA estimates of use of non-tobacco substances among 12-17 year olds are closer to national average ▪ Use of several substances among high school students declined statistically significantly between 2011 and 2015, but not for prescription drugs or marijuana (CDC estimates)
Bullying / Violence	<ul style="list-style-type: none"> ▪ Reported bullying by high/middle school students is <u>lower than the national average</u> (CDC estimates); there is no clear geographic clustering of school divisions with relatively high percentages of reported bullying (DCJS estimates) ▪ Of 18 violence-/injury prevention-related indicators tracked by the Virginia Youth Survey, 45% have decreased significantly between 2011 and 2015 and 55% have had no statistically significant change (CDC estimates)
Suicide / Depression	<ul style="list-style-type: none"> ▪ Percentages of high school students reporting suicidal ideation is <u>lower than the national average</u> (CDC estimates), although estimated 12-17 year olds with a major depressive episode is reported to be higher than the national average (SAMHSA estimates) ▪ There is no clear geographic clustering of school divisions with relatively high percentages of reported suicidal ideation (DCJS)

Literature suggests that there are well-established associations among youth of concurrent use of substances (e.g., tobacco, alcohol, illicit drugs). While there is a strong evidence base of associations among youth between other behavioral health issues under consideration (e.g., between bullying and depression; bullying and suicide; depression and suicide), evidence of associations among youth is less consistent between substance use and the other behavioral health issues.

Physical Health

Evidence of the epidemiology in Virginia of two behavioral health issues considered, childhood hunger/food insecurity and diabetes, is summarized below:

Issue	Key Findings
Food Insecurity	<ul style="list-style-type: none"> ▪ Childhood food insecurity in 2014 (16%) is <u>among the lowest in the nation</u> (FRAC estimates) ▪ Within Virginia, childhood food insecurity is clustered within southern counties (FRAC)
Diabetes	<ul style="list-style-type: none"> ▪ <u>No/Little data are available on diabetes prevalence among Virginia youth</u> ▪ Among all ages, diabetes and obesity appear to be highly correlated (CDC estimates)

Evidence on Effectiveness of Prevention Strategies

Evidence on the effectiveness of 1) program-/community-based prevention and 2) mass media/marketing prevention strategies is summarized in the tables below

Effectiveness of Program-/Community-Based Prevention Strategies

Issue	Strongest evidence of effectiveness	Caveats
Substance Use	<ul style="list-style-type: none"> Intensive programs focused on building life/social skills among middle schoolers and/or those at high-risk 	<ul style="list-style-type: none"> Effects tend to be small to modest; effects are greater in addressing social functioning/antisocial behavior rather than substance abuse alone
Bullying / Violence	<ul style="list-style-type: none"> Programs with high fidelity / implemented in homogenous cultural settings Programs targeting aggressive behavior and violence more broadly 	<ul style="list-style-type: none"> Bullying programs affect bullying knowledge and attitudes > behaviors Implementation fidelity to bullying prevention models is challenging
Depression	<ul style="list-style-type: none"> Programs can significantly reduce depression symptoms/incidence 	
Suicide	<ul style="list-style-type: none"> Programs have been shown to improve suicide-related knowledge and attitudes 	<ul style="list-style-type: none"> Programs not shown to have an effect on actual suicidal behavior
Obesity	<ul style="list-style-type: none"> Community/school-based interventions to increase physical activity (alone or with nutrition-related interventions) 	<ul style="list-style-type: none"> Dearth of physical activity/nutrition interventions consistently shown to positively affect behaviors or outcomes
Food Insecurity	<ul style="list-style-type: none"> Programs to increase quantity of food (e.g., school breakfast; Supplemental Nutrition Assistance Program (SNAP)) 	<ul style="list-style-type: none"> Programs to improve quality of food: see Obesity Caveat, above

Effectiveness of Mass Media/Marketing Prevention Strategies

Issue	Strongest evidence of effectiveness	Caveats
Substance Use	<ul style="list-style-type: none"> Tobacco cessation among adults Youth campaigns that include: multiple channels for media delivery; combined school and media components; repeated exposure to messages over multiple years; implemented as part of a comprehensive tobacco control program 	<ul style="list-style-type: none"> Evidence of effectiveness on smoking behaviors/prevention among youth is not strong Inconsistent evidence of effectiveness for illicit drugs/alcohol (apart from drunk driving)
Issue	Strongest evidence of effectiveness	Caveats
Depression / Bullying / Suicide		<ul style="list-style-type: none"> Limited data
Obesity	<ul style="list-style-type: none"> CDC's VERB (physical activity) campaign 	<ul style="list-style-type: none"> Mass media campaigns generally not successful in increasing physical activity, particularly without supporting policy, programs, environmental interventions

Cost-Effectiveness of Prevention Strategies

While the estimated annual health care and other costs of the health issues under the VFHY’s mandate and those under consideration are substantial – from \$45 billion (suicide) to \$295 billion (tobacco) – a lack of economic analyses limit evidence on the cost-effectiveness of prevention strategies. Nevertheless, the literature that does exist suggests that: 1) the most favorable cost-effectiveness ratios related to behavioral health broadly are associated with interventions targeting highest-risk youth; 2) multiple curriculum-based interventions targeting substance use/youth behaviors – several of which are currently endorsed by the VFHY for tobacco prevention – can be cost-effective; 3) structural strategies to prevent childhood obesity (e.g., sugary drink tax increase) may be substantially more cost-effective than behavioral interventions (e.g., state-level policy change to promote physical education in schools).

Virginia Stakeholder Prevention Efforts in Health Issues under Consideration

Virginia stakeholder involvement in the health issues considered is summarized below:

Issue	Policy/oversight	Programs
Substance Use	<ul style="list-style-type: none"> Coordination function by Virginia’s Office for Substance Abuse Prevention (VOSAP), Substances Abuse Services Council (SASC) 	<ul style="list-style-type: none"> DBHDS, DCJS, VDH CSBs (31 surveyed): almost all report implementing outreach
Bullying / Violence	<ul style="list-style-type: none"> VDOE issued a model bullying prevention and intervention policy in 2013 27 school divisions (~ 60 middle/high schools) use data-driven Virginia Tiered System of Support (VTSS) methodology integrating academic, behavioral and social-emotional programs 	<ul style="list-style-type: none"> 74% schools implement ≥ 1 bullying prevention program (2014) DBHDS, VDH CSBs: two-thirds implement outreach
Suicide / Depression		<ul style="list-style-type: none"> DBHDS, VDH CSBs: > 75% implement outreach
Food Insecurity	<ul style="list-style-type: none"> Commonwealth Council on Bridging the Nutritional Divide (chaired by the First Lady’s Office; VFHY participates) Governor’s 2016 introduced budget instructed agencies implementing feeding programs to develop a plan to consolidate services under one agency 	<ul style="list-style-type: none"> VDOE, VDACS, VDH (feeding programs)

Recommendations/ Rationale

- Maintain current VFHY funding levels allocated to youth tobacco prevention and obesity
 - Tobacco: Reductions to VFHY’s budget in tobacco could jeopardize gains made in reducing tobacco use and preventing ENDS use. Marketing/mass media requires longevity to sustain impact.
 - Obesity: Time is required to determine the success of current investments. Given the lack of evidence on effective prevention strategies, VFHY could consider strategic focus (e.g., reducing rates of youth diabetes/pre-diabetes)

2. Develop a tobacco research strategy designed to maximize linkages between research and impact of VFHY tobacco programs and marketing investments
 - Research strategy would systematically ensure that VFHY-funded programs/marketing are achieving highest impact at lowest cost. Examples include studies on the (cost)-effectiveness of VFHY programs/marketing on youth behaviors and the impact of policy level changes (e.g., higher cigarette tax) on youth smoking
3. Expand the scope of the VFHY’s tobacco prevention mandate to include all controlled substances
 - VFHY likely can use existing tobacco programs to impact other substances. VFHY’s work on segmentation of youth into “peer crowds” could help target programs/marketing. It will be necessary to ensure alignment prioritization methodologies of other State agency stakeholders (e.g., DBHDS, VDOE)
 - VFHY-recommended budget: \$2M (reaching 15,000 youth through programs, 362,500 youth through marketing)
4. Consider expansion of the scope of the VFHY’s mission to include up to two additional behavioral/physical health issues: Childhood hunger/food insecurity prevention; Depression/suicide prevention and/or bullying/violence prevention
 - Childhood hunger/food insecurity prevention: VFHY platforms to address youth obesity focused on nutrition are likely applicable to hunger. Focusing on increasing school breakfast participation would address a current challenge in Virginia. Given the lack of evidence of effective prevention strategies, a rigorous impact evaluation plan is needed.
 - Depression/suicide prevention and/or bullying/violence prevention: This would require extensive coordination with stakeholders
 - VFHY-recommended budget: \$2M for each issue area with same estimated youth reached as with substance use

Actions Taken by the Joint Commission on Health Care

Introduce legislation to amend the Code of Virginia to expand the VFHY mission to include prevention of other substance use by youth.

Legislative Action

HB 1751 - Delegate O'Bannon/ SB 1050 - Senator Edwards

Expand the mission of the Virginia Foundation for Healthy Youth to include the reduction and prevention of substance use by youth in the Commonwealth.

HB 1751 and SB 1050 were enacted (Acts of Assembly 2017, Chapters 109 and 60 respectively).

Expanding Access to Brain Injury Services and Barriers to Placement of Virginians with Challenging Behaviors Resulting from Traumatic and nonTraumatic Brain Injuries and Post-Traumatic Stress Disorder

In 2014, Senate Joint Resolution 80 (Senator Ruff) directed the Joint Commission on Health Care (JCHC) to determine the extent of progress made in implementing the recommendations of the 2007 Joint Legislative and Audit Review Commission report, Access to State-Funded Brain Injury Services in Virginia. In addition, in 2016, Senator Carrico instructed the JCHC to identify barriers and options for placement of individuals with traumatic brain injuries (TBI), non-traumatic brain injuries (e.g., caused by degenerative conditions, stroke or anoxic events) and Post Traumatic Stress Disorder (PTSD).

Background

Individuals with brain injuries (BI), dementias, and PTSD need medical and behavioral health services, home and community-based services and supports (HCBS), care coordination services and appropriate housing options which may change over the course of an individual's lifetime. Services that may be used by individuals with BI, dementias and PTSD can be organized into four levels of care based on needs:

- 1) Level 1 - acute, intensive behavioral and support needs
 - a) Acute Medical care
 - b) Acute Psychiatric care
- 2) Level 2 - intensive behavioral and support needs
 - a) Skilled Nursing Facility
 - b) Residential Neurobehavioral Program
- 3) Level 3- moderate to high behavioral and support needs
 - a) Residential Community-Integrated Neurobehavioral Group Homes
- 4) Level 4- Community-based low behavioral and support needs
 - a) Long-Term Supported Living
 - b) Supported Apartment
 - c) Home-Based Services

Although there are providers in Virginia at most of the service levels, gaps exist, especially for individuals whose condition leads to problematic behaviors, such as aggression, anger, acting out, noncompliance with treatment, elopement and other behaviors that pose management difficulties. For example, there are no neurobehavioral rehabilitation facilities in Virginia that accept Medicaid beneficiaries due to low payment rates, and skilled nursing facilities (SNF) refuse to admit Medicaid beneficiaries with behavioral problems due to a concern for the safety of other residents, the lack of providers with the expertise to serve these individuals, and other staffing issues. As a result, Medicaid beneficiaries needing these services are admitted to providers outside of Virginia (although the number being served outside of the state is very low).

Data on the Number of Virginians with BI, Dementias and PTSD and Related Costs

There is no one source of data on the numbers of individuals with BI, dementias and PTSD and their costs. Data are spread across multiple agencies, stored in different formats and are difficult to share. During the 2016 General Assembly Session, several state agencies were tasked with examining data sources and developing recommendations for Virginia’s data needs, and a report is due to legislators December 2016. Data from state sources are displayed below.

Chart 1: Number of Individuals with a Brain Injury by Age Group Reported by the Virginia State Trauma Registry April 2014 – March 2015: Total Number = 4,554

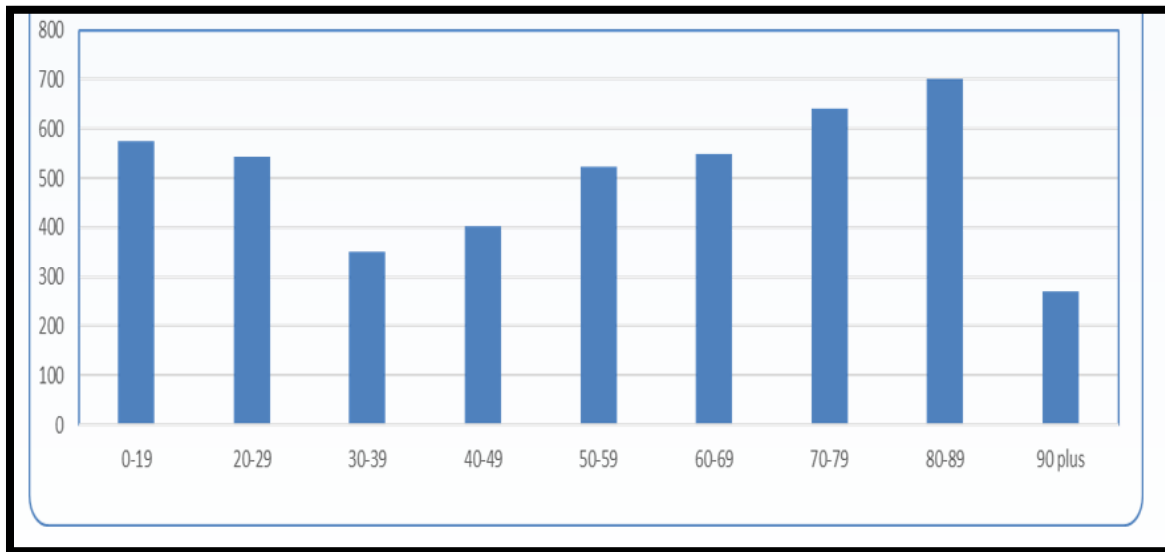


Table 1: Department of Medical Assistance Services Individuals Enrolled in Virginia Medicaid by Diagnosis State Fiscal Years 2013 - 2015

Diagnosis	SFY 2013	SFY 2014	SFY 2015
Alzheimer's & Dementia	53,618	61,674	58,997
Post-Traumatic Stress Disorder	34,688	39,098	37,425
Stroke	20,681	22,693	21,829
Traumatic Brain Injury	5,752	6,251	5,997
Grand Total	114,750	129,727	124,260
Total Medicaid Payments	\$2.8 Billion	\$3.1 Billion	\$2.9 Billion

Data Source for Table 1: Department of Medical Assistance Services fee-for-service claims, including Magellan and crossover claims, consumer directed services claims, Medicaid managed care encounter data and capitation payments made by DMAS to MCOs as of September 2, 2016

Virginia's System of Services for Individuals with BI, Dementias and PTSD Multiple state agencies and their contractors are responsible for many aspects of service delivery in Virginia. Although state agencies are providing many services, there is a degree of overlap across agencies, agencies are somewhat soloed and there is some lack of capacity needed to manage data and implement and administer programs. In addition, cross-agency coordination could be strengthened and service gaps remain.

The Department of Aging and Rehabilitative Services (DARS) is the state's lead agency for brain injury services and leads the Brain Injury Council. The Department of Health (VDH) is responsible for the Virginia State Trauma Registry (which collects inpatient data from all hospitals in Virginia on trauma¹ and the Certificate of Need program for nursing facilities. The Department of Behavioral Health and Developmental Services (DBHDS) and Community Services Boards (CSB) are responsible for public mental health and substance use services for individuals who are enrolled in Medicaid or are uninsured, and they facilitate housing for individuals with behavioral health issues who are homeless or ready for discharge from a State Mental Health Facility. The Department of Medical Assistance Services (DMAS) is the agency that administers Medicaid and obtains federal waivers, state plan authorities, and funding for Medicaid-covered services, including some services that are provided through other agencies. The Virginia Department of Social Services (DSS) administers Auxiliary grant funds that contribute to room and board for persons in assisted living facilities and performs assessments to determine eligibility for enrollment in Medicaid home and community-based services (HCBS) waivers and nursing home eligibility. The Virginia Department of Veterans Services (DVS) provides care coordination, counseling and other services for veterans and their families; and the Home and Community Development Authority provides resources for housing, clinics and other assets (see Table 2).

Service gaps include: 1) a lack of appropriate providers in acute care settings (psychiatrists, psychologists, geriatricians); 2) Medicaid Skilled Nursing Facility (SNF) and Auxiliary grant payment rates are inadequate; 3) there is a lack of appropriate supported housing options; 4) current Medicaid home and community based services (HCBS) waivers do not include some services that could help support individuals in the community; 5) there are new federal regulations related to the criteria that defines 'community-based' which impacts the ability to use Medicaid funding; and 6) a statewide system of screening, referral and treatment for individuals with dementia and cognitive decline is needed.

¹ Trauma registry data includes admission only; emergency department visits that do not result in admission are not included

Table 2: Virginia Agencies Administering Services for Individuals with BI, Dementias and PTSD

Brain Injury, Dementia and Post-Traumatic Stress Service Structures in Virginia						
DARS	DBHDS and CSBs	DMAS	VDH	Department of Veterans Services	DSS	Home & Com. Deve. Authority
<ul style="list-style-type: none"> Dementia services coordinator Direct Services Fund Neurotrauma Trust Fund Centers Indep. Living Aging and Disability Resource Centers – no wrong door Personal assistance Vocational rehabilitation Woodrow Wilson Ctr. Brain Injury Ass. of VA Brain Injury information, referral, case management, and supported living Clubhouses & day programs Virginia Supported Housing Assistive technology Behavioral Health & Supportive Services BI 1st Software System VA Alzheimer’s Disease Commission Counsel on Aging 	<ul style="list-style-type: none"> State MH Facilities Community Services Boards My Community My Life ID/DD waiver redesign, management, data warehouse & pre-admission screening Piedmont Geriatric Hospital Community Centered Behavioral Health Homes Permanent Supportive Housing 	<ul style="list-style-type: none"> Acute medical & behavioral health care payments Nursing facility and EDCD, DD, ID, Alzheimer’s Assisted Living, day support & Technology Assisted Waivers payments Commonwealth Coordinated Care Governor’s Access Plan Substance use waiver MLTSS PACE DSRIP Medicaid Works 	<ul style="list-style-type: none"> Licenses nursing facilities Statewide Trauma Registry Home Health Certificate Of Public Need Behavioral Risk Factor Surveillance Survey Minimum Data Set (nursing facility case mix) 	<ul style="list-style-type: none"> Virginia Veteran & Family Support Services Department of Veterans Affairs 	<ul style="list-style-type: none"> Nursing facility & Medicaid waiver pre-admission screening Licenses assisted living facilities & adult day services Medicaid eligibility Auxiliary grants for assisted living facilities 	<ul style="list-style-type: none"> Affordable & special needs housing Accessible housing Home modification grant funds for veterans Housing Choice Voucher Program
<p>One individual may access services administered by several agencies and be subject to different eligibility rules</p>						

Avenues for Expanding Services

There are a number of avenues that may be used to expand services for individuals with BI, dementias and PTSD in Virginia. They include options such as increasing payment rates to incent the opening of neurobehavioral rehabilitation facilities, adding new services to existing Medicaid HCBS waivers, creating new waivers, applying for new Medicaid state plan authorities, applying for demonstration and pilot programs, and creating new court dockets to divert individuals from incarceration to treatment.

Medicaid authorities can include: 1) adding new §1915(c) HCBS or §1915(b)/(c) combination waivers tailored for individuals with brain injury; 2) adding services to the current Elderly or Disabled with Consumer Direction (EDCD) waiver with mandatory enrollment in the new §1915(b)/(c) Managed Long Term Services and Supports waiver program; 3) developing a new §1115 demonstration waiver that could specifically target individuals with BI and dementias and allow individuals to be mandatorily enrolled in managed care organizations (MCO); 4) apply for state new state plan amendments including §1915(i) or §1915(k) which would provide HCBS services to eligible Medicaid enrollees without a waiver; 5) apply for the new PACE demonstration which can be an avenue to expanding services to individuals who do not meet criteria for nursing facility placement.

Any new Medicaid authority that would add new services (e.g., adding services to the EDCCD waiver), or extend existing services to new individuals (e.g., provide HCBS through a state plan

amendment to individuals who do not meet Virginia criteria for admission to a nursing facility) would likely require new budget allocations. The size of new allocations would depend on the number and cost of new services and the number of individuals who might be eligible for the new programs and/or services. Given that adding services to the EDCD waiver or expanding existing services to new populations results in deferring nursing home admission, the new costs may be offset by savings.

Due to the complexity of the issue and the fact that several state agencies and stakeholders have significant roles in providing services, one option is to request that appropriate agencies form an Interagency Implementation Team to decide which avenues to take, estimate related costs and then develop and implement the plan. Although the Virginia Brain Injury Council addresses cross-agency issues and is addressing many areas of need, the need for neurobehavioral rehabilitation units has not been addressed this year, perhaps because of funding issues. If the JCHC chooses to request the formation of an Interagency Implementation Team, the Brain Injury Council may be considered as the foundation for that effort

Table 3: Summary of Medicaid Options for Covering HCBS

Feature	State Plan Personal Care 1915(i)	HCBS Waiver 1915(c)	State Plan HCBS 1915(k)
Entitlement	<p>Cannot target services by age/diagnosis</p> <p>Must provide services to all categorically eligible individuals who meet eligibility criteria</p> <p>Must be provided statewide</p>	<p>Can target services by age/diagnosis</p> <p>Can limit the number of people</p> <p>Can limit the geographic area</p>	<p>Can target services by age/diagnosis</p> <p>Must provide services to all in an eligibility group who meet the eligibility criteria</p> <p>Must be provided statewide</p>
Financial Criteria	Beneficiaries must meet community financial eligibility standards	States may set financial eligibility criteria up to 300% of the SSI benefit	States may set financial eligibility criteria at 150% of the FPL or 300% of the SSI benefit
Eligibility Criteria	Beneficiaries must have functional limitations, specified by the state, that result in a need for the services covered	Beneficiaries must meet the minimum institutional level-of-care criteria and have a medical/ functional need for the specific service	<p>Beneficiaries under 150% of the FPL can meet functional eligibility criteria that is less stringent than institutional level-of-care criteria</p> <p>Beneficiaries under the 300% of SSI must meet institutional level-of-care</p>

Feature	State Plan Personal Care 1915(i)	HCBS Waiver 1915(c)	State Plan HCBS 1915(k)
Services	Only those specified in the Federal definition of personal care services	Can include a broad array of state-defined services, only some of which are specified in statute	Can include a very broad array of state-defined services, only some of which are specified in statute
Payment of Relatives	Relatives, other than legally responsible relatives, may be paid to provide personal care	Relatives, including those legally responsible, may be paid to provide personal care and other services determined by the state	Relatives, including those legally responsible, may be paid to provide personal care and other services determined by the state
Federal Match	Regular rate	Regular rate	Six percentage point enhanced rate for attendant services

Recommendations

1. Take no action.
2. Request by letter of the JCHC Chair that DARS, DMAS and DBHDS form an interagency implementation team (possibly made up of members from the Brain Injury Council) to ultimately implement a statewide program to serve individuals with brain injury, including determining whether, and if so, which new Medicaid authorities to be seek. The Team’s first task will be to determine program structure and costs, and report back to the JCHC by November 2017.
3. Request by letter of the JCHC Chair that DMAS determine Medicaid payment rates and methods that will incent the opening and ongoing operation of in-state neurobehavioral/nursing facility units for individuals with brain injury and dementias with challenging and aggressive behaviors; and report back to the JCHC by November 2017.
4. Request by letter of the JCHC Chair that DMAS determine a plan, including budget estimates, to add new services to the Medicaid Elderly and Disabled with Consumer Direction Waiver to provide needed long term services and supports for Medicaid beneficiaries; and report back to the JCHC by November 2017.
5. Request by letter of the JCHC Chair that DMAS determine budget estimates for applying for a Medicaid waiver specific to brain injury; and report back to the JCHC by November 2017
6. Request by letter of the JCHC Chair that DMAS determine budget estimates for applying for a state plan amendment {1915(i) or 1915(k)} to provide additional home and community based services to Medicaid recipients not enrolled in a 1915(c) HCBS waiver; and report back to the JCHC by November 2017.
7. Request by letter of the JCHC Chair that DMAS apply for the PACE Innovation Act pilot program.

8. Introduce budget amendment (language and funding) to increase state funds for the Auxiliary Grant.
9. By letter of the JCHC Chair, express support for Senate Bill 317, carried over to 2017, to create Veteran's Dockets.

Actions Taken by the Joint Commission on Health Care

JCHC members voted for recommendations numbered 2, 3, 4 and 9.



Integrating Behavioral Health and Physical Health Care Services

Preface

The objective of this study is to provide an overview of behavioral and physical health integration and activities to integrate services in Virginia and nationwide. This study was approved by the Joint Commission on Health Care members at the May, 2016 work plan meeting.

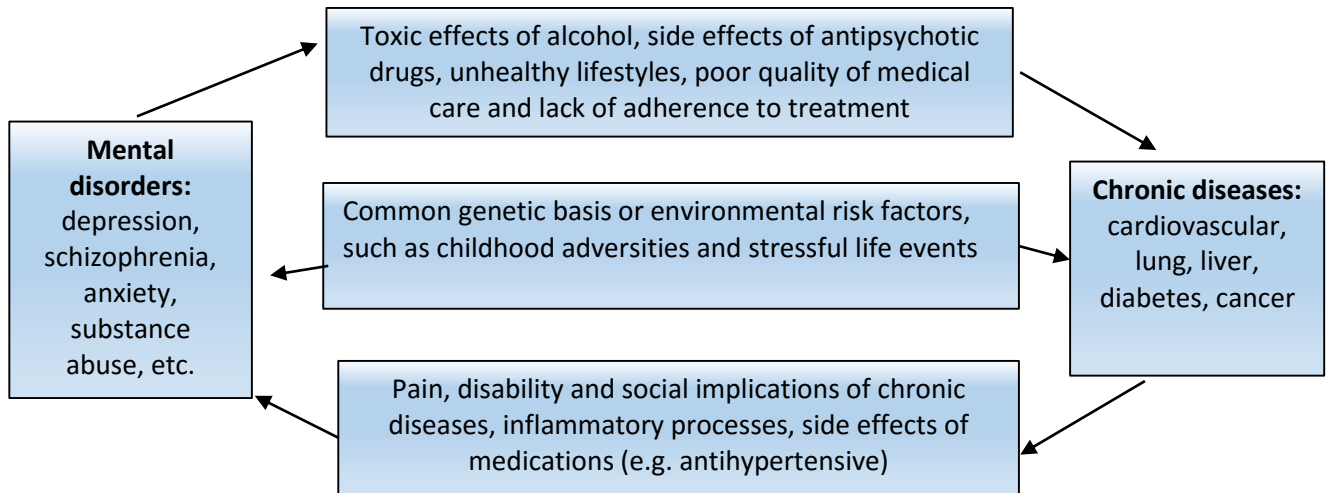
Behavioral health disorders such as depression and substance addiction often co-occur with other common chronic diseases such as diabetes and heart disease, and chronic physical diseases are frequently encountered in persons with more serious mental disorders such as schizophrenia. Mental and physical diseases may have common environmental risk factors, such as unhealthy lifestyles that increase the risk of developing another condition. Treatments for one condition may have side effects that increase the risk of another condition.

Often common behavioral health conditions go unrecognized by primary care providers, and medical conditions go unrecognized by behavioral health providers. Integrating behavioral and physical health removes barriers that prevent individuals from accessing the service they need to manage their illness, increase health and quality of life, and reduce unnecessary service utilization due to preventable medical and psychological crises.

Background

Adults with serious mental illness (SMI) have higher rates of chronic medical conditions than those without SMI, including hypertension, HIV/AIDS, and diabetes; a higher frequency of multiple general medical conditions; and a higher rate of premature mortality resulting from these conditions. Adults with serious mental illness die, on average, twenty-five years earlier than the general population. Much of the mortality is from the same preventable conditions as the general population, but individuals with SMI have higher rates of modifiable risk factors, such as smoking and obesity, experience higher rates of homelessness and poverty, and face symptoms such as disorganized thought and decreased motivation that impair compliance with self-care.

Figure 1: Why the Integration of Behavioral and Physical Health Care is Needed



Further, sixty-seven percent of individuals with a behavioral health disorder do not get treatment² and thirty percent to fifty percent of individuals who are referred to a behavioral health provider from primary care don't make the first appointment^{3,4}. Two-thirds of primary care physicians report not being able to access outpatient behavioral health services for their patients⁵ due to shortages of mental health care providers, health plan barriers, and lack of or inadequate insurance coverage. Depression goes undetected in greater than fifty percent of primary care patients⁶ and only twenty percent to forty percent of patients improve substantially in six months without specialty assistance⁷.

In the United States, mental illness is more than twice as prevalent among Medicaid beneficiaries as it is in the general population. Approximately thirty-five percent of all Medicaid enrollees have a mental health or substance use disorder, and approximately forty-nine percent of Medicaid beneficiaries with disabilities have a psychiatric illness. In 2011, fifty-four percent of Medicaid enrollees with a disability and behavioral health condition had cardiac disease, compared to thirty-eight percent of disabled Medicaid enrollees without a behavioral health problem. On average, Medicaid enrollees with a behavioral health condition had 2.7 chronic medical conditions compared to 1.7 chronic conditions among those without a behavioral health condition. And for non-disabled Medicaid enrollees, those with a behavioral health condition had 1.5 chronic medical conditions on average, compared to 0.6 conditions for non-disabled Medicaid enrollees without a behavioral health problem.

² Kessler et al., NEJM. 2005; 352:515-23
³ Fisher & Ransom, Arch Intern Med. 1997;6:324-333
⁴ Hoge et al., JAMA. 2006;95:1023-103
⁵ Cunningham, Health Affairs. 2009; 3: w490-w501
⁶ Mitchell et al. Lancet, 2009; 374:609-619
⁷ Schulberg et al. Arch Gen Psych. 1996; 53:913-919

Table 1: Non-Dually Eligible Medicaid Enrollees with Mental Health and Physical Conditions, United States

Medical Condition	Non-dually eligible Medicaid enrollees age 21-64			
	Eligibility on basis of disability		Eligibility on basis other than disability	
	Percent w/BH	Percent wo/BH	Percent w/BH	Percent wo/BH
Cardiac disease	54	38	28	13
Hypertension	41	30	17	8
Rheumatism	33	17	25	8
Kidney disease	29	18	22	10
Diabetes	22	18	8	5
Arthritis	19	11	9	3
Cancer	14	10	9	5
Asthma	14	6	10	3
Cerebrovascular disease	10	5	3	1
Chronic liver disease	5	2	2	1
Ave. conditions per enrollee	2.7	1.7	1.5	0.6

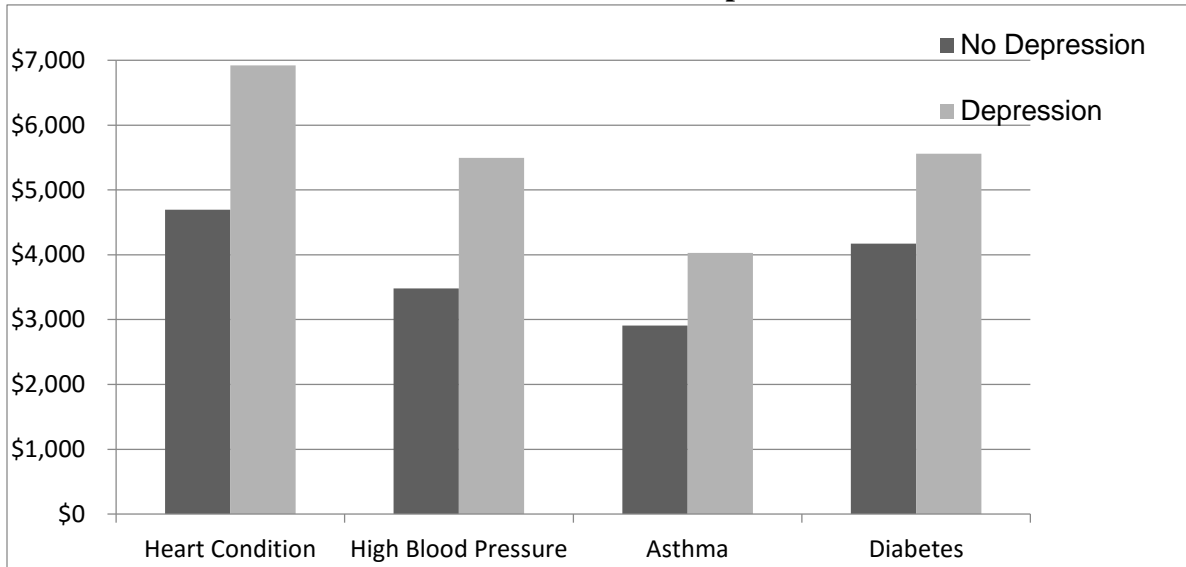
Notes: Enrollees with a behavioral health diagnosis are defined as persons who had any Medicaid fee-for-service claim or managed care encounter record where a behavioral health diagnosis was recorded (except for prescribed medicines); these claims and encounter records might have been for specific behavioral health services or for physical health or other services. Behavioral health diagnoses cover *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* codes categorized by the Chronic Illness and Disability Payment System (CDPS) payment code methodology. Partial-benefit enrollees and states with incomplete or low-quality managed care encounter data (Illinois, Maryland, Massachusetts, Mississippi, Nevada, Pennsylvania, Ohio, South Carolina, Utah, West Virginia, and the District of Columbia) have been excluded from the analysis.

Source: MACPAC analysis of 2011 Medicaid Statistical Information System (MSIS) data.

Services for physical and behavioral health care have historically been financed and delivered under separate systems. Individuals often find themselves interacting with multiple public and private agencies and receiving care from myriad providers funded from different sources. Fragmentation can impede access to care and result in poor health status, inappropriate use of services and increased costs. Annual health care costs are higher for persons with chronic diseases who have co-occurring depression. Individuals with chronic medical & behavioral health conditions combined cost forty-six percent more than those with only a chronic medical condition. Integrating physical and behavioral health has been shown to reduce fragmentation and promote patient-centered care.⁸

⁸ <https://www.macpac.gov/publication/improving-service-delivery-to-medicaid-beneficiaries-with-serious-mental-illness-themes-from-roundtable-discussion/>

Table 2: Annual healthcare costs are much greater for patients with a chronic disease and depression



The source data is from the U.S. Department of Health and Human Services 2002 and 2003 MEPS

Integrating Behavioral and Physical Health Care

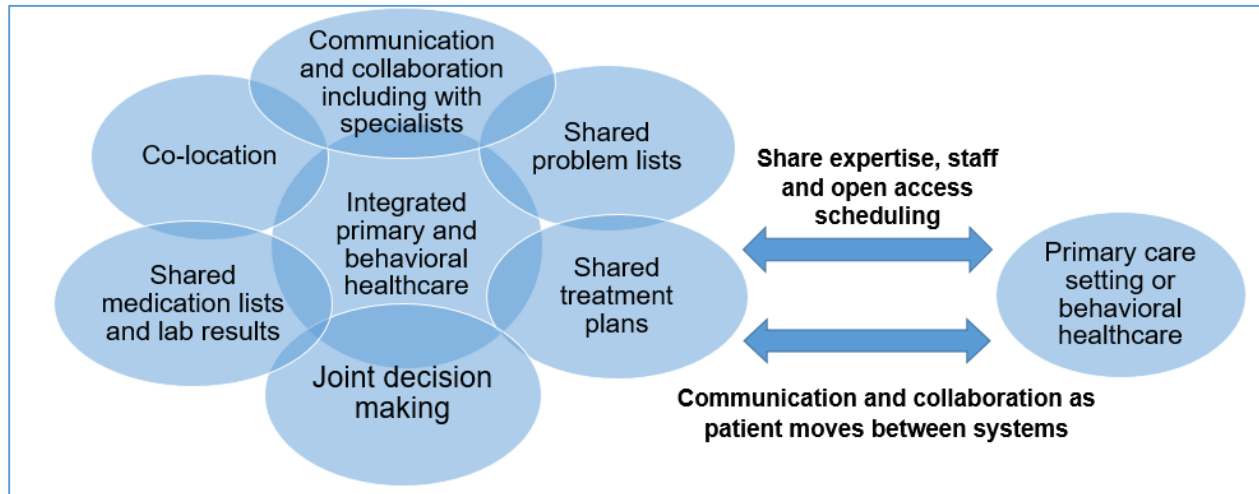
Integrated care is an omnibus concept defined in many ways and can include a mix and match of clinical and business relationships and employ a variety of payment methods. The core components of integration focus on sharing of patient information in a timely manner and addressing all the patient’s needs in the same setting to the largest extent possible. Integration can occur by bringing behavioral health care into primary care settings, or by bringing primary care into behavioral health settings, and by having on-site care coordinators to facilitate accessing off-site services.

There are three main components to integration: clinical integration, structural integration and financial integration. Clinical Integration is the extent to which patient services are coordinated across people, functions, activities and sites over time and occurs through the way service delivery and working relationships between providers are organized. Clinical integration can occur on a spectrum from enhanced referral relationships, to co-location, to staff models and fully integrated multidisciplinary care teams. Clinical integration can be difficult to achieve without financing mechanisms and structures or infrastructure that support the collaborative effort.

Structural Integration encompasses the availability and functionality of linking structures that enable and sustain clinical integration. Structural integration can occur to varying degrees from minimal collaboration between providers to fully merged practices under one administrative umbrella, including shared medical information, billing and scheduling functions. Financial Integration is the degree to which financial incentives for care systems are aligned in the service of integrated care. Financial integration can include a variety of funding and payment methods with differing levels of financial risk and incentives to providers, such as different benefit

packages, “carve-ins” and carve-outs”, shared risk pools, shared savings, global payments, partial- and full-risk capitation payments, and episode-of care or bundled payments. Characteristics of practices as they move along the continuum of integration include the degree to which information, data, and systems are shared; the degree of direct communication among providers of different disciplines; how providers are paid; and how effectively the team can manage the interplay between physical and behavioral health issues.

Figure 2: Core Components of Successful Integrated Models⁹



The ideal components of integrated care include:

- Comprehensive physical and behavioral health screening
- Electronic data system
- Clear designation of physical and behavioral health home
- Engagement of consumers at multiple levels (e.g., program design, self-management, care plan development, maintaining existing provider relationships)
- Shared development of care plans addressing physical and behavioral health
- Care coordination support for beneficiaries and providers (care homes)
- Sensitive and competent physical primary health providers with training and support to appropriately deliver medical care and change health behaviors
- Standardized protocols and evidence-based guidelines that can be tailored to individual needs
- Joint and standardized clinical and performance measures, treatment follow-up, and feedback mechanisms that are shared among providers
- Mechanisms (e.g., pay-for-performance) for rewarding quality care
- Mechanisms for sharing savings from reductions in avoidable emergency and inpatient utilization across physical and behavioral care delivery systems

⁹ M. Lardiere – National Association of Community Health Centers 12/2008

Figure 3: Conceptual Framework for Integration¹⁰

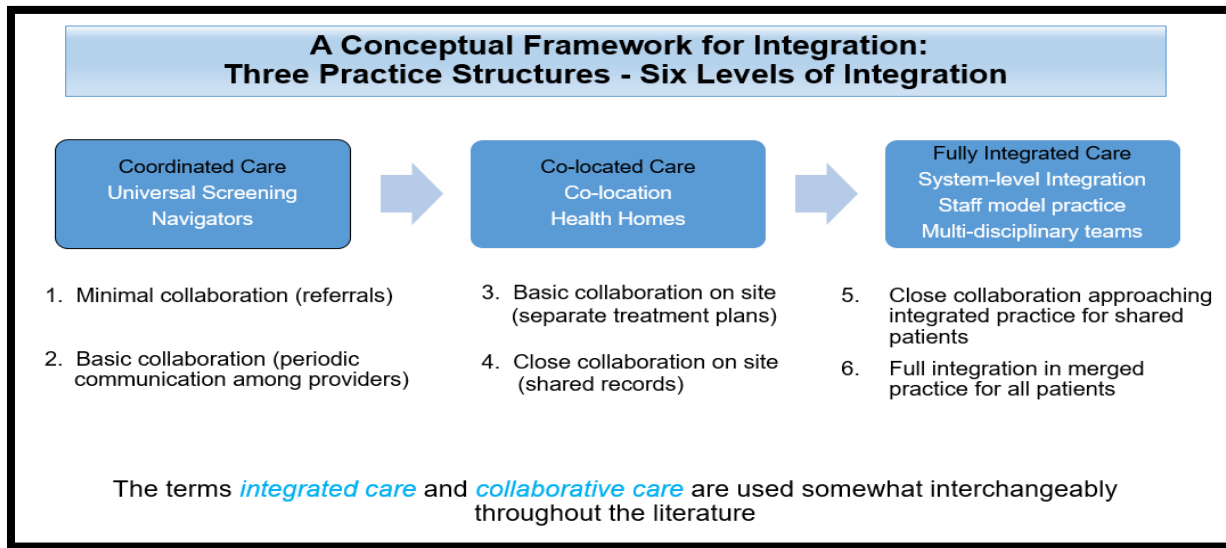


Table 3: Conceptual Framework for Integration

Level of Integration	Characteristics Achievable in Different Settings
Minimal Collaboration	<ul style="list-style-type: none"> -Separate facilities and services with rare communication -Private practices and agencies -Can handle routine medical/behavioral problems with little interplay between mental health, social and medical interactions, and few care management difficulties
Basic Collaboration at a Distance	<ul style="list-style-type: none"> -Separate facilities with period sharing on common patients -Facilities with active referral linkages -Providers view each other as resources but do not share common language -Can handle moderate interplay between mental health, social and medical interactions where management of both medical and behavioral problems are proceeding well
Basic On-Site Collaboration	<ul style="list-style-type: none"> -Shared facility but some separate systems -Regular communication on common patients, sometimes face-to-face -Managed care settings, rehabilitation centers, clinics with behavioral health specialists who primarily perform referral-oriented services -Providers appreciate each other’s roles, but do not share common language -Can handle moderate interplay between mental health, social and medical interactions and coordinate complex treatment plans

¹⁰ [http://www.integration.samhsa.gov/about-us/Mauers Behav Health Models Competerencies Infra.pdf](http://www.integration.samhsa.gov/about-us/Mauers_Behav_Health_Models_Competerencies_Infra.pdf)

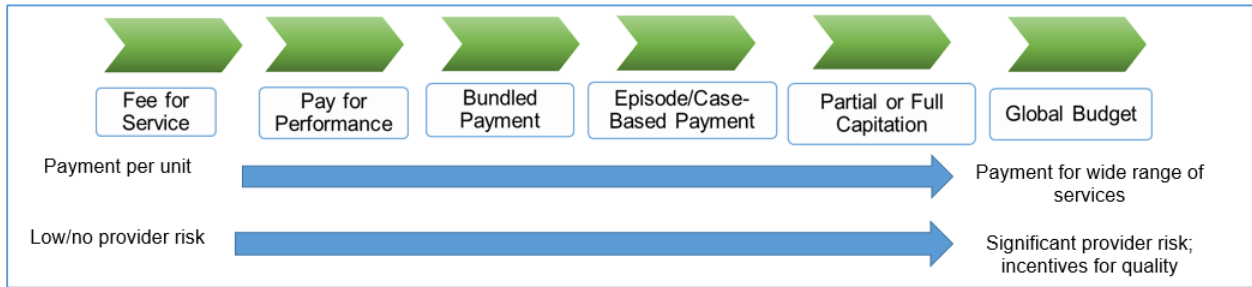
Level of Integration	Characteristics Achievable in Different Settings, Continued
Partly Integrated	<ul style="list-style-type: none"> -Shared facility and limited shared systems (e.g., scheduling, charting) -Regular face-to-face interactions, mutual consultation, coordinated treatment plans -Managed care settings, rehabilitation centers, hospice centers, family practice training programs -Providers have a shared allegiance to a physical/social/medical paradigm, but pragmatics are sometimes difficult -Can handle significant interplay between mental health, social and medical interactions and management complications
Fully Integrated	<ul style="list-style-type: none"> -Shared facility, systems, vision and seamless services -Regular team meetings to address both patient and team collaboration issues -Some hospice centers, special training and clinical programs -Providers are committed to biopsychosocial/systems paradigm, have a deep understanding of roles and cultures and make conscious effort to balance power and influence -Can handle most difficult and complex interplay between mental health, social and medical interactions with challenging management issues

Although information sharing is necessary, integration is more than sharing information. It involves creating a common vision among providers that historically operate under different paradigms, defining new work roles and workflows, and continuous monitoring of processes and outcomes.

Financial Integration

There are a variety of funding mechanisms that employ different levels of provider risk and accountability which support practice integration to varying degrees. Funding mechanisms range from no- or low-risk to full-risk, value based reimbursement. At the lower risk end is fee-for-service and pay-for-performance mechanisms and at the higher end of risk are capitation and global budgets. Shared savings programs can include up-side risk, which allows providers to receive bonuses for meeting quality of care standards, and they can include down-side risk, where providers pay penalties for failing to meet performance measures. Programs may include both up and down side risk. Global budgets can provide practices with up-front payments that can help fund structural changes needed for integration and also provide the greatest flexibility for providers to use services which may not be reimbursable but are nonetheless beneficial and may help decrease the use of costlier services.

Figure 4: Levels of Integration and Methods of Financing



Barriers to Integration

A number of barriers to integration of behavioral and physical health remain and include:

- Policies and practices that offer no incentives for or discourage integrated care, such as managed care contracts that carve out behavioral health services.
- Billing policies and restrictions, such as the Medicaid prohibition against billing for both a behavioral and physical health visit on the same day or more than one encounter per day (However, the 21st Century Cures Act, which was signed into law on December 13, 2016 has provision to allow multiple same day visits).
- Regulations on Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2) which limits information sharing of alcohol or drug abuse treatment information (The 21st Century Cures Act also address this limitation).
- Some behavioral health facilities and providers are ineligible to receive federal incentive payments for implementing electronic health records.
- Temporary funding, such as planning, implementation and demonstration grants that are time-limited; sustainability may be an issue once funding ends.
- Licensing requirements – for example, if a behavioral health organization provides physical health services, it may need to meet standards regarding exam rooms, bathrooms, drug storage, etc. If a physical health organization provides behavioral health services, it may need to meet requirements such as presence of a psychiatrist.
- Workforce shortages, especially mental health professionals.

Conclusion

The Integration of behavioral and physical health services is an emergent model developing along a continuum. In order for integration to occur, new treatment paradigms must be adopted by providers, and resources for restructuring provider systems is needed. Also, there is a need for additional behavioral health professionals in Virginia. The right incentives need to be in place and systems scaled for sustainability. Although new national legislation will help address some of the barriers to integration, integration is a process. As such, it will take several years for systems to mature and results to be achieved.

*Please note that this study did not include policy options.

Meeting Agendas 2016

Joint Commission on Health Care

May 26, 2016

Call to Order and Welcome New Members

Delegate John M. O'Bannon III, Chair

Election of Officers

Delegate John M. O'Bannon III, Chair

Comments from Elected Chair and Vice Chair

Staff Update

Michele L Chesser, Ph.D.
Executive Director

Discussion of 2016 Work Plan Proposal

Michele L Chesser, Ph.D.

September 7, 2016

Review of Public Comments on Staff Report: School Vaccination Requirements in the Commonwealth

Stephen G. Weiss, MPH
Senior Health Policy Analyst

Virginia Center for Health Innovation (VCHI) Update

Beth A. Bortz
President and CEO
Virginia Center for Health Innovation

Staff Report: Development of Life Sustaining Treatment Guidelines

Andrew Mitchell, Sc.D.
Senior Health Policy Analyst

Staff Report: Expanding Access to Brain Injury Services and Barriers to Placement for Virginians with Challenging Behaviors that Result from Brain Injuries, Dementias and Post-Traumatic Stress Disorder

Paula R. Margolis, Ph.D., MPH
Senior Health Policy Analyst

October 5, 2015

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Michele L. Chesser, Ph.D.
Executive Director

VHI Annual Report and Strategic Plan

Michael Lundberg, Executive Director Ibe Mbanu, MD, MBA, MPH, Director of Medical Affairs, Bon Secours St. Mary's Hospital

Rural Health Work Group Report

Christy Morton, Executive Director, Virginia Rural Center

Staff Report: Palliative Care in the Commonwealth

Stephen Weiss, MPA Senior Health Policy Analyst

Staff Report: Medical Care Costs in Virginia State Prisons

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Staff Report: Virginia Foundation for Healthy Youth Mission Expansion

Andrew Mitchell, Sc.D. Senior Health Policy Analyst

November 9, 2015 **Decision Matrix: Review of Policy Options and Legislation for 2017**
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August 3, 2016 **Mental Health Services in the Commonwealth in the 21st Century Subcommittee Update**

Sarah E.B. Stanton, Staff Attorney
Virginia Division of Legislative Services
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Virginia Division of Legislative Services

Overview of Mount Rogers Alternative Transportation Pilot Program

Mark Larsen, Director of Adult Behavioral Health Services
Mount Rogers Community Services Board

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Priscilla Smith, R.N., M.S., M.B.A., C.P.H.Q.
Director of Behavioral Health and Developmental Services
Office of the State Inspector General

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Jodi Manz, MSW Office of the Secretary of Health and Human Resources

Department of Behavioral Health and Developmental Services (DBHDS) Update, and Review of Certified Community Behavioral Health Clinics

Jack Barber, M.D. Interim Commissioner, DBHDS

Staff Report: Integrating Behavioral Health and Physical Health Care Services

Paula Margolis, Ph.D., MPH Senior Health Policy Analyst

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Community Health Workforce in Virginia: A Critical Link to Reducing Costs and Improving Quality and Population Health

Michael Royster, MD, MPH, FACPM, Vice President
Institute for Public Health Innovation

Considerations in Determining Vaccination Requirements by NVIC

Barbara Loe Fisher, President
National Vaccine Information Center

Considerations in Determining Vaccination Requirements by VAV

Karrie Delaney, Parent Advisory Board Member
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Stephen Weiss, Senior Health Policy Analyst

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Update on Health and Human Resources Activities

Secretary William Hazel, M.D.
Office of the Secretary of Health and Human Resources

Virginia's Plan for Well-Being

Commissioner Marissa Levine, M.D.
Virginia Department of Health

Medicaid Waiver Redesign and Final CMS Rule on Home and Community Based Services Waiver

Dawn Traver, Director of Waiver Operations
Department of Behavioral Health and Developmental Services

Graduate Medical Education Task Force Update

Keisha Smith, Director
Virginia Health Workforce Development Authority

Statutory Authority

§ 30-168. (Expires July 1, 2022) Joint Commission on Health Care; purpose.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care.

For the purposes of this chapter, "health care" shall include behavioral health care.

(1992, cc. 799, 818, §§ 9-311, 9-312, 9-314; 2001, c. 844; 2003, c. 633.)

30-168.1. (Expires July 1, 2022) Membership; terms; vacancies; chairman and vice-chairman; quorum; meetings.

The Commission shall consist of 18 legislative members. Members shall be appointed as follows: eight members of the Senate, to be appointed by the Senate Committee on Rules; and 10 members of the House of Delegates, of whom three shall be members of the House Committee on Health, Welfare and Institutions, to be appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates.

Members of the Commission shall serve terms coincident with their terms of office. Members may be reappointed. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments.

The Commission shall elect a chairman and vice-chairman from among its membership. A majority of the members shall constitute a quorum. The meetings of the Commission shall be held at the call of the chairman or whenever the majority of the members so request.

No recommendation of the Commission shall be adopted if a majority of the Senate members or a majority of the House members appointed to the Commission (i) vote against the recommendation and (ii) vote for the recommendation to fail notwithstanding the majority vote of the Commission.

(2003, c. 633; 2005, c. 758.)

§ 30-168.2. (Expires July 1, 2022) Compensation; expenses.

Members of the Commission shall receive such compensation as provided in § [30-19.12](#). All members shall be reimbursed for reasonable and necessary expenses incurred in the performance of their duties as provided in §§ [2.2-2813](#) and [2.2-2825](#). Funding for the costs of compensation and expenses of the members shall be provided by the Joint Commission on Health Care.

(2003, c. 633.)

§ 30-168.3. (Expires July 1, 2022) Powers and duties of the Commission.

The Commission shall have the following powers and duties:

1. To study and gather information and data to accomplish its purposes as set forth in § [30-168](#);
2. To study the operations, management, jurisdiction, powers and interrelationships of any department, board, bureau, commission, authority or other agency with any direct responsibility for the provision and delivery of health care in the Commonwealth;
3. To examine matters relating to health care services in other states and to consult and exchange information with officers and agencies of other states with respect to health service problems of mutual concern;

4. To maintain offices and hold meetings and functions at any place within the Commonwealth that it deems necessary;
5. To invite other interested parties to sit with the Commission and participate in its deliberations;
6. To appoint a special task force from among the members of the Commission to study and make recommendations on issues related to behavioral health care to the full Commission; and
7. To report its recommendations to the General Assembly and the Governor annually and to make such interim reports as it deems advisable or as may be required by the General Assembly and the Governor.
(2003, c. 633.)

§ 30-168.4. (Expires July 1, 2022) Staffing.

The Commission may appoint, employ, and remove an executive director and such other persons as it deems necessary, and determine their duties and fix their salaries or compensation within the amounts appropriated therefor. The Commission may also employ experts who have special knowledge of the issues before it. All agencies of the Commonwealth shall provide assistance to the Commission, upon request.
(2003, c. 633.)

§ 30-168.5. (Expires July 1, 2022) Chairman's executive summary of activity and work of the Commission.

The chairman of the Commission shall submit to the General Assembly and the Governor an annual executive summary of the interim activity and work of the Commission no later than the first day of each regular session of the General Assembly. The executive summary 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.
(2003, c. 633.)

§ 30-169. Repealed by Acts 2003, c. 633, cl. 2.

§ 30-169.1. (Expires July 1, 2022) Cooperation of other state agencies and political subdivisions.

The Commission may request and shall receive from every department, division, board, bureau, commission, authority or other agency created by the Commonwealth, or to which the Commonwealth is party, or from any political subdivision of the Commonwealth, cooperation and assistance in the performance of its duties.
(2004, c296.)

§ 30-170. (Expires July 1, 2022) Sunset.

The provisions of this chapter shall expire on July 1, 2022.
(1992, cc. 799, 818, § 9-316; 1996, c. [772](#); 2001, cc. [187](#), [844](#); 2006, cc. [113](#), [178](#); 2009, c. [707](#); 2011, cc. [501](#), [607](#).)
2014, cc. [280](#), [518](#).



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