JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS:
Opportunities for Early Identification and
Preventive Care of Chronic Diseases (SJR 325 – 2009)

Organizations/Individuals Submitting Comments

Three comments were received regarding the options presented to JCHC addressing Opportunities for Early Identification and Preventive Care of Chronic Diseases. The comments were submitted by:

- Becky-Bowers Lanier on behalf of AmeriHealth Mercy (an "organization of Medicaid managed care plans").
- Lisa Specter-Dunaway, President/CEO of CHIP of Virginia.
- Marcia A. Tetterton, Executive Director of the Virginia Association for Home Care and Hospice.

Policy Options

Option 1: Take no action.

Option 2: By letter of the Chairman, request that DMAS report to JCHC no later than August 2010, regarding recommended options for addressing the chronic care needs of Virginia's Medicaid and FAMIS enrollees. The options should consider at a minimum issues related to:

- whether to retain a disease management program (perhaps incorporating additional diseases and an integrated care model for Chronic Kidney Disease),
- whether to reissue a proposal for chronic care management services, and
- whether to initiate one or more demonstration projects for a patient-centered medical home.

Option 3: By letter of the Chairman, request that the Department of Human Resource Management report to JCHC regarding the feasibility and advisability of initiating a pilot program with on-site medical clinics for state employees.

Option 4: By letter of the Chairman, request that the Department of Human Resource Management report to JCHC regarding the costs and benefits of the recently implemented COVA Connect pilot program.

Summary of Comments

All three comments addressed Option 2.

Option 2: By letter of the Chairman, request that DMAS report to JCHC no later than August 2010, regarding recommended options for addressing the chronic care needs of Virginia's Medicaid and FAMIS enrollees. The options should consider at a minimum issues related to:

- whether to retain a disease management program (perhaps incorporating additional diseases and an integrated care model for Chronic Kidney Disease),
- whether to reissue a proposal for chronic care management services, and
- whether to initiate one or more demonstration projects for a patient-centered medical home.

Becky-Bowers Lanier, commenting on behalf of AmeriHealth Mercy, indicated: "We [AmeriHealth Mercy] have found that due to the complexity of health issues experienced by the Medicaid population, management of a single condition does not optimally support the participants nor does it drive improved cost efficiency. Too often, other contributing factors are not considered, such as co-morbidities, behavioral/mental health issues, safety, housing and other concerns that affect appropriate access to care. If the Commonwealth pursues the creation of a chronic disease prevention and chronic care management program for Medicaid recipients, AmeriHealth Mercy would be very interested in discussing this."

Lisa Specter-Dunaway, of CHIP of Virginia, noted "surprise at the absence of research or discussion about the prevention of chronic diseases that result from premature and/or low-birth weight, childhood asthma, or adverse events in the lives of infants and young children." Ms. Specter-Dunaway continued by saying: "There are significant data at the national and local levels highlighting opportunities for low cost chronic care models, specifically **prenatal and early childhood home visitation programs**….The Commonwealth has an opportunity to wisely invest scarce resources in proven programs that can decrease short and long term health care costs associated with chronic diseases. I urge you to consider the role home visiting programs can have in accomplishing this goal."

Marcia Tetterton of the Virginia Association for Home Care and Hospice commented in support of Option 2 with the "modification that home health also be included in the model….The Chronic Care Model (CCM)…is an accepted model of chronic care management….It has recently been suggested that this model be expanded to be a home-based chronic care model."

SUMMARY OF PUBLIC COMMENTS:
Improving Aging-at-Home Services & Support for Culture Change Initiatives

Organizations/Individuals Submitting Comments

Three comments were received regarding the options presented to JCHC addressing Improving Aging-at-Home Services & Support for Culture Change Initiatives. The comments were submitted by:

- Marcia A. Tetterton, MS; Executive Director of Virginia Association for Home Care and Hospice
- Mary Ann Bergeron, Executive Director of Virginia Association of Community Services Boards
- William L. Lukhard, AARP Virginia Executive Council and Madge Bush, Director of Advocacy for AARP Virginia

Policy Options

Option 1: Take no action.

Option 2: Introduce a joint resolution requesting that JLARC study the costs and benefits of implementing the Home and Community-Based Services state plan option.

Option 3: Introduce a budget amendment (language and funding) during the 2012 session to increase the general funds appropriated for the Virginia Department for the Aging to be allocated to the Virginia Caregiver Coalition.

Option 4: Include on the JCHC 2010 workplan a staff study of the feasibility of replicating James Madison University's Caregivers Community Network in other areas of the Commonwealth.

Summary of Comments

The general opinions of the public comments received on each Policy Option are summarized below.

Policy Option	Support	Conditional Support	Oppose
1	0	0	1
2	3	0	0
3	1	0	0
4	1	0	0

Option 1: Take no action.

In Opposition:

William L. Lukhard and Madge Bush of AARP do not support this option.

Option 2: Introduce a joint resolution requesting that JLARC study the costs and benefits of implementing the Home and Community-Based Services state plan option.

In Support:
William L. Lukhard and Madge Bush of AARP are strongly in support of this option.

Mary Ann Bergeron of Virginia Association of Community Services Boards supports this option and suggest that if JLARC is unable to conduct the study the Secretary of Health and Human Resources could be directed to work with related state agencies to determine the costs and benefits of implementing the state plan option.

Marcia A. Tetterton of Virginia Association for Home Care and Hospice is in support of this option.

Option 3: Introduce a budget amendment (language and funding) during the 2012 session to increase the general funds appropriated for the Virginia Department for the Aging to be allocated to the Virginia Caregiver Coalition.

In Support:
William L. Lukhard and Madge Bush of AARP are strongly in support of this option.

Option 4: Include on the JCHC 2010 workplan a staff study of the feasibility of replicating James Madison University's Caregivers Community Network in other areas of the Commonwealth.

In Support:
William L. Lukhard and Madge Bush of AARP are strongly in support of this option.

SUMMARY OF PUBLIC COMMENTS:
Virginia's Long-Term Care Ombudsman Program

Organizations/Individuals Submitting Comments

Three comments were received regarding the options presented to JCHC addressing Virginia's Long-Term Care Ombudsman Program. The comments were submitted by:

- Joani F. Latimer, Virginia State Long-Term Care Ombudsman, commented on behalf of her office and local ombudsmen
- Paul Lavigne, Chair commented on behalf of the Long-Term Care Ombudsman Program Advisory Committee
- William L. Lukhard, AARP Virginia Executive Council and Madge Bush, Director of Advocacy for AARP Virginia

Policy Options

Option 1: Take no action.

Option 2: Request by letter of the JCHC Chairman that VDA examine the need for additional state funding for the Office of the State Ombudsman and the local ombudsman offices.

Option 3: Introduce a budget amendment (language and funding) during the 2012 session to increase the general funds appropriated for the LTC Ombudsman Program.

Option 4: Request by letter of the JCHC Chairman that VDA study whether the state ombudsman office should have greater administrative control over resource allocation & other administrative decisions.

Summary of Comments

The general opinions of the public comments received on each Policy Option are summarized below.

Policy Option	Support	Conditional Support	Oppose
1	0	0	3
2	2	1	0
3	3	0	0
4	0	1	2

Option 1: Take no action.

In Opposition:

William L. Lukhard and Madge Bush of AARP disagree with the option of taking no action.

Paul Lavigne on behalf of the Long-Term Care Ombudsman Program Advisory Committee; Joani F. Latimer, on behalf of the Office for the State Long-Term Care Ombudsman and local ombudsmen "strongly urge the Joint Commission not to adopt Option 1." Limitations in staff place program staffing levels below the standard recommended by the Institute of Medicine and set out in the Code of Virginia. "Option 1 would also ignore the huge projected growth in the population of those over age 65…which will result in more residents of LTC facilities as well as more Virginians receiving long-term care services in the community."

Option 2: Request by letter of the JCHC Chairman that VDA examine the need for additional state funding for the Office of the State Ombudsman and the local ombudsman offices.

In Support:
Paul Lavigne and Joani F. Latimer commented in support of this option.

Conditional Support:
William L. Lukhard and Madge Bush of AARP support the intent of this option but indicate the study should be performed by an independent entity such as JCHC or JLARC.

Option 3: Introduce a budget amendment (language and funding) during the 2012 session to increase the general funds appropriated for the LTC Ombudsman Program.

In Support:
William L. Lukhard and Madge Bush of AARP support this option and indicate that it should be a high priority for the 2012 General Assembly.

Paul Lavigne and Joani F. Latimer support this option.

Option 4: Request by letter of the JCHC Chairman that VDA study whether the state ombudsman office should have greater administrative control over resource allocation & other administrative decisions.

Conditional Support:
William L. Lukhard and Madge Bush of AARP support the intent of this option but indicate the study should be performed by an independent entity such as JCHC or JLARC.

<u>In Opposition</u>:
Paul Lavigne stated, "we do believe that there is the need for new strategies and better lines of communication and input in some of these areas, which would warrant some programmatic and implementation changes…"
Joani F. Latimer indicated that "the greatest need is for additional training for the aging services network in the discrete role and functions of the program so that its unique autonomous operation within that network is better understood and supported."

SUMMARY OF PUBLIC COMMENTS:
Virginia's Health Care Workforce: Present and Future Need

Organizations/Individuals Submitting Comments

Twenty-eight comments were received regarding the options presented to JCHC addressing Virginia's Health Care Workforce. The comments were submitted by:

- Anita L. Auerbach, Ph.D., Chair of the RxP (Prescription Privledges) Task Force for the Virginia Academy of Clinical Psychologists
- Ellen Austin-Prillaman RDH, President of the American Dental Hygienists' Association
- Dr. John Ball, Ph.D., Clinical Psychologist
- Mary Ann Bergeron, Executive Director of the Virginia Association of Community Service Boards
- Catherine Bodkin, Licensed Clinical Social Worker
- Tegwyn H. Brickhouse D.D.S., Ph.D., and Chair of the Virginians for Improving Access to Dental Care
- Kay Crane, CEO of the Piedmont Access to Health Services
- James F. Dee, M.D. , President of the Northern Virginia Chapter of the Washington Psychiatric Society
- Steven T. DeKosky, M.D., Vice President and Dean of the University of Virginia School of Medicine
- Terry Dickenson, D.D.S., Executive Director of the Virginia Dental Association
- Thomas W. Eppes, Jr., M.D, President of the Medical Society of Virginia
- Baltij Gill, M.D., President of the Virginia Association of Community Psychiatrists
- Roger Hofford, M.D., Program Director of the Carilion Clinic Family Medicine Residency
- Anton Kuzel, M.D, Chair of Department of Family Medicine, Virginia Commonwealth University
- Janet McDaniel, Ph.D., M.P.H., Chair of the Workforce Council for Virginia's State Rural Health Plan
- Asha S. Mishra, MD, DFAPA, Medical Director of Chesterfield CSB and Professor of Psychiatry, VCU Health System
- J. Edwin Nieves, M.D., President of the Psychiatric Society of Virginia
- Peter J. Pagnussi, M.D., President of the Virginia College of Emergency Physicians
- Cathleen A. Rea, Ph.D., Chair of the Licensure Task Force for the Virginia Academy of Clinical Psychologists
- Karen S. Rheuban, M.D., and President of the Virginia Telehealth Network
- Debra A. Riggs, Executive Director of the Virginia Chapter of the National Association of Social Workers
- Sandra Whitley Ryals, Director of the Department of Health Professions
- Rick Shinn, Director of Public Affairs, Virginia Community Healthcare Association
- Mira Singer, Executive Director of the National Alliance on Mental Illness
- Bela Sood, M.D., President of the Virginia Chapter of the American Academy of Child and Adolescent Psychiatry

- Marcia A. Tetterton, M.S., Executive Director of the Virginia Association of Home Care and Hospice
- Dixie Tooke-Rawlins D.O., Dean and Executive. Vice President of the Via Virginia College of Osteopathic Medicine
- James L. Werth, Jr. Ph.D., Professor of Psychology and Director of the Doctor of Psychology Program in Counseling Psychology, Radford University

Workforce Policy Options Address Three Areas			
	Increase Appropriations	Review Scope of Practice	Work with Existing Organizations and Agencies
Physicians	**2, 3, 4, 5, 7**	**11**	**6, 8, 9, 10, 12, 13**
Dentists	**18**	**-**	**17**
Mental Health Professionals	**-**	**15**	**12, 13, 14, 16**
Pharmacists	**-**	**-**	**19**

Policy Options

Option 1: Take no action.

Option 2: When state revenue allows, restore funding for the State Loan Repayment Program (SLRP) & Virginia Loan Repayment Program (VLRP).

Option 3: When state revenue allows, increase dedicated funding for the EVMS, UVA and VCU Family Practice Residency Programs.

Option 4: Request by letter of the JCHC Chairman that the Department of Medical Assistance Services (DMAS) develop and report on a methodology and cost estimate for providing enhanced Direct Medical Education (DME) and Indirect Medical Education (IME) payments to graduate medical programs in Virginia that train primary care, general surgery, psychiatrists, and emergency medicine physicians. The letter would include a request that DMAS present its report to JCHC by August 30, 2011. *(Enhanced payments are expected to increase state Medicaid costs to some degree.)*

Option 5: When state revenue allows introduce a budget amendment (language and funding) to increase Medicaid reimbursement rates to match the level of Medicare reimbursement rates for primary care physicians.

Option 6: By letter of the JCHC Chairman request that the medical schools at Eastern Virginia Medical School, the University of Virginia, and Virginia Commonwealth University make efforts to increase their enrollment of medical students from rural communities in Virginia and individuals with an interest in serving underserved and minority populations.

Option 7: When state revenue allows, introduce a budget amendment (language and funding) to allow the Department of Health Professions (DHP) to develop a Continuing Medical Education course focusing on medication issues of geriatric patients targeted for primary care physicians. The objective would be for the course to be offered online and at no cost to Virginia licensed physicians.

Option 8: Request by letter of the JCHC Chairman that the Board of Medicine include and promote geriatric care issues among its online educational resources.

Option 9: Request by letter of the JCHC Chairman that the Virginia Chapter of the American College of Physicians include and promote geriatric care issues among its online educational resources.

Option 10: Request by letter of the JCHC Chairman that the Virginia Academy of Family Physicians continue to promote geriatric training among its membership.

Option 11: Include in the 2010 JCHC work plan, a study of the prevalence, distribution and scope of practice for nurse-practitioners and physician assistants in Virginia.

Option 12: Send a letter from JCHC Chairman to the Special Advisory Commission on Mandated Health Insurance Benefits to support SB1458 (Wampler) and HB2191 (Philips) which require health insurers, health care subscription plans, and health maintenance organizations provide coverage for the cost of telemedicine services.

Option 13: Request by letter of the JCHC Chairman that the Department of Human Resource Management consider and if appropriate conduct pilot programs for selected telemedicine-covered services within the state employee health insurance program. Consideration should be given to obstetric care for high-risk pregnancies, telestroke services, and telepsychiatry.

Option 14: Request by letter of the JCHC Chairman that the Department of Behavioral Health and Developmental Services (DBHDS) report regarding the Department's current and historical utilization of telemedicine and telepsychiatry services, effectiveness of such services, locations offering such services, use of telemedicine by CSB providers, and impediments to greater adoption and usage by the Department and CSBs. This letter would include a request that DBHDS present a report to JCHC by August 30, 2010.

Option 15: Introduce a joint-resolution requesting that JCHC convene a task force to review allowing qualified clinical psychologists to prescribe psychopharmacological medications and report to JCHC. The report will detail licensure and educational requirements, oversight structure, changes to licensure and regulatory oversight processes, medications that may be prescribed, requirements for physician review and/or oversight for prescribing medications. The resolution would require an interim report to JCHC in 2010 with a final report by September 1, 2011. Task force participants include:

- Board of Medicine
- Board of Pharmacy
- Board of Psychology
- Medical Society of Virginia
- Psychiatric Society of Virginia
- Virginia Psychological Association
- Virginia Pharmacists Association

Option 16: Request by letter of the JCHC Chairman that the Department of Health Professions improve the information collected and compiled about clinical psychologists which is retained in the Healthcare Workforce Data Center.

Option 17: Request by letter of the JCHC Chairman that the Department of Health Professions improve the information collected and compiled about dentists which is retained in the Healthcare Workforce Data Center.

Option 18: When state revenue allows introduce a budget amendment (language and funding) to extend basic dental benefits to adults eligible for Medicaid.

Option 19: Request by letter of the JCHC Chairman that the Virginia Pharmacists Association, the Virginia Department for the Aging, and local area agencies on Aging collaborate to provide and disseminate information about Medicare's Medication Therapy Management (MTM) program to pharmacists, prescription counselors, and Medicare beneficiaries that qualify for MTM services.

Summary of Comments

The general opinions of the public comments received on each Policy Option are summarized below.

Policy Option	Support	Conditional Support	Oppose
1	0	0	0
2	**9**	0	0
3	**8**	0	0
4	**7**	0	0
5	**6**	0	0
6	**5**	**2**	0
7	**4**	0	0
8	**2**	**1**	0
9	**1**	**1**	0
10	**3**	0	0
11	**2**	0	**2**
12	**7**	0	0
13	**5**	0	0
14	**4**	0	0
15	**2**	0	**8**
16	**3**	**1**	0
17	**3**	**1**	0
18	**6**	0	0
19	**2**	0	0

As shown, Policy Option 2 received the largest number of comments in support (9) with none opposing. Options 2-19 received at least 1 comment of unconditional support; the Options proposing an increase in appropriations

(Options 2-5, 7, 18) generally received the largest number of supportive comments and no comments in opposition. Conditional support (for Options 6, 8, 9, 16, 17) entailed three types of changes in the options: additional entities that should be included, requests to entities to promote education using the "most appropriate venue," and clarifying the data to be collected. Option 15 (to study whether to allow prescriptive authority for clinical psychologists under stipulated conditions) received the largest number of comments in opposition (8) and 2 comments in support.

Selected excerpts, particularly from comments that explained conditional support or opposition for an option, follow. In addition, for options that were opposed, the full text of the comments in support and opposition are included in Appendix A. In addition, comments which suggested new policy options are presented in Appendix B.

Excerpts from Comments for Selected Policy Options

Option 2: When state revenue allows, restore funding for the State Loan Repayment Program (SLRP) & Virginia Loan Repayment Program (VLRP).

Support: 9
Conditional Support: 0
Oppose: 0

In Support:
Rick Shinn, Virginia Community Healthcare Association commented: The loss of funding for the medical and dental loan repayment programs has had a significant and detrimental impact on the abilities of community health centers to recruit primary care physicians and dentists to work in medically underserved areas, particularly the rural areas.

Option 3: When state revenue allows, increase dedicated funding for the EVMS, UVA and VCU Family Practice Residency Programs.

Support: 8
Conditional Support: 0
Oppose: 0

In Support:
Roger Hofford, M.D., Carilion Clinic Family Medicine Residency commented: Over the last six years state funding has decreased significant[ly] to support family medicine residency training. Also occurring in the past six years was "a worsening payor mix of patients served, and decreased Federal funding for graduate medical education." In the state budget language this money can be used to pay for medical students rotations in family medicine. I would ask the Joint Commission/General Assembly look at whether these monies for students

are accomplishing the outcomes we need at the expense of our state supported family medicine residencies.

Anton Kuzel, M.D, VCUs Department of Family Medicine commented: For the past four years, we have had 78% of our residency graduates stay in state. "Yet over the past few years, we have suffered funding cuts of 25% (2003), 5% (2008), and now an additional 8% (projected, 2009). We have permanently closed one of our programs in part because of these deep cuts. Dean Strauss strongly supports making restoring the funding of the Family Medicine residencies the top priority amongst the policy options."

Option 4: Request by letter of the JCHC Chairman that the Department of Medical Assistance Services (DMAS) develop and report on a methodology and cost estimate for providing enhanced Direct Medical Education (DME) and Indirect Medical Education (IME) payments to graduate medical programs in Virginia that train primary care, general surgery, psychiatrists, and emergency medicine physicians. The letter would include a request that DMAS present its report to JCHC by August 30, 2011. *(Enhanced payments are expected to increase state Medicaid costs to some degree.)*

Support: 7
Conditional Support: 0
Oppose: 0

Option 5: When state revenue allows introduce a budget amendment (language and funding) to increase Medicaid reimbursement rates to match the level of Medicare reimbursement rates for primary care physicians.

Support: 6
Conditional Support: 0
Oppose: 0

In Support:

Janet McDaniel, Ph.D., M.P.H., Workforce Council for Virginia's State Rural Health Plan commented: It is very important to increase Medicaid reimbursement rates for primary care physicians and mid-level providers, physician assistants and nurse practitioners, because in rural areas it is difficult to recruit health providers if there is a poorer payer mix due to large numbers of residents on Medicaid.

Option 6: By letter of the JCHC Chairman request that the medical schools at Eastern Virginia Medical School, the University of Virginia, and Virginia Commonwealth University make efforts to increase their enrollment of medical students from rural communities in Virginia and individuals with an interest in serving underserved and minority populations.

Support: 5
Conditional Support: 2
Oppose: 0

In Support:

Rick Shinn, Virginia Community Healthcare Association commented: We support efforts to "grow our own" physicians, dentists, and other health care providers by encouraging young persons from rural and underserved areas to consider health careers. Encouraging our health education centers to increase their enrollments of persons from these areas will help provide a larger base of candidates that may have an interested in returning to their home communities upon graduation. We would suggest that these schools give a preference to students from these areas as a way to help combat the growing shortage and maldistribution of primary care providers.

Conditional Support:
Dixie Tooke-Rawlins D.O., Via Virginia College of Osteopathic Medicine commented: "There is a need to recruit students interested in serving rural communities that is recognized by all five schools." The option should include Virginia College of Osteopathic Medicine and Virginia Tech/Carilion School of Medicine.

Option 7: When state revenue allows, introduce a budget amendment (language and funding) to allow the Department of Health Professions (DHP) to develop a Continuing Medical Education course focusing on medication issues of geriatric patients targeted for primary care physicians. The objective would be for the course to be offered online and at no cost to Virginia licensed physicians.

Support: 4
Conditional Support: 0
Oppose: 0

Option 8: Request by letter of the JCHC Chairman that the Board of Medicine include and promote geriatric care issues among its online educational resources.

Support: 2
Conditional Support: 1
Oppose: 0

Conditional Support:
Thomas W. Eppes, Jr., M.D, Medical Society of Virginia commented: The Board of Medicine promote geriatric care issues through the most appropriate venues. The Board currently works with a variety of entities to develop and distribute educational information.

Option 9: Request by letter of the JCHC Chairman that the Virginia Chapter of the American College of Physicians include and promote geriatric care issues among its online educational resources.

Support: 1
Conditional Support: 1
Oppose: 0

Conditional Support:

Thomas W. Eppes, Jr., M.D, Medical Society of Virginia commented: Virginia Chapter of the American College of Physicians should promote geriatric issues through the most appropriate venues.

Option 10: Request by letter of the JCHC Chairman that the Virginia Academy of Family Physicians continue to promote geriatric training among its membership.

Support: 3
Conditional Support: 0
Oppose: 0

Option 11: Include in the 2010 JCHC work plan, a study of the prevalence, distribution and scope of practice for nurse-practitioners and physician assistants in Virginia.

Support: 2
Conditional Support: 0
Oppose: 2

In Support:
Janet McDaniel, Ph.D., M.P.H., Workforce Council for Virginia's State Rural Health Plan commented: In rural areas, mid-level practitioners are an important part of the health care infrastructure. As part of the research in this study, we hope that state comparisons of scopes of practice will be included. We believe other states have determined good ways to utilize and expand access to services with these practitioners.

In Opposition:
Thomas W. Eppes, Jr., M.D, Medical Society of Virginia commented: The Department of Health Professions currently has a workforce study underway which includes a focus on nurse practicioners and physician assistants. We suggest JCHC await the findings prior to beginning another study.

Option 12: Send a letter from JCHC Chairman to the Special Advisory Commission on Mandated Health Insurance Benefits to support SB1458 (Wampler) and HB2191 (Philips) which require health insurers, health care subscription plans, and health maintenance organizations provide coverage for the cost of telemedicine services.

Support: 7
Conditional Support: 0
Oppose: 0

In Support:
Karen S. Rheuban, M.D., Virginia Telehealth Network commented:
"Telemedicine is not a specialty unto itself – it is a tool to deliver care to those remote from needed services....The Commonwealth is home to at least 15 grant funded telemedicine networks located in urban and rural locations offering services across the disciplines. Ten states have adopted statutes and regulations to mandate third party private payment for telemedicine." The Virginia Telehealth Network strongly supports this option.

Option 13: Request by letter of the JCHC Chairman that the Department of Human Resource Management consider and if appropriate conduct pilot programs for selected telemedicine-covered services within the state employee health insurance program. Consideration should be given to obstetric care for high-risk pregnancies, telestroke services, and telepsychiatry.

Support: 5
Conditional Support: 0
Oppose: 0

In Support:
Janet McDaniel, Ph.D., M.P.H., Workforce Council for Virginia's State Rural Health Plan commented: "Telemedicine is of vital importance to ensuring timely and quality health care services in our rural communities. Use of telemedicine can greatly increase access to specialty care and mental health services in rural Virginia."

Option 14: Request by letter of the JCHC Chairman that the Department of Behavioral Health and Developmental Services (DBHDS) report regarding the Department's current and historical utilization of telemedicine and telepsychiatry services, effectiveness of such services, locations offering such services, use of telemedicine by CSB providers, and impediments to greater adoption and usage by the Department and CSBs. This letter would include a request that DBHDS present a report to JCHC by August 30, 2010.

Support: 4
Conditional Support: 0
Oppose: 0

In Support:
Mary Ann Bergeron, Virginia Association of Community Service Boards commented: "Telemedicine as well as telepsychiatry can help to bridge the geographic barriers to treatment faced by many of our rural CSBs."

Option 15: Introduce a joint-resolution requesting that JCHC convene a task force to review allowing qualified clinical psychologists to prescribe psychopharmacological medications and report to JCHC. The report will detail licensure and educational requirements, oversight structure, changes to licensure and regulatory oversight processes, medications that may be prescribed, requirements for physician review and/or oversight for prescribing medications. The resolution would require an interim report to JCHC in 2010 with a final report by September 1, 2011. Task force participants include:

- Board of Medicine
- Board of Pharmacy
- Board of Psychology
- Medical Society of Virginia
- Psychiatric Society of Virginia
- Virginia Psychological Association
- Virginia Pharmacists Association

Support: 2
Conditional Support: 0
Oppose: 8

In Support:
Anita L. Auerbach, Ph.D., RxP (Prescription Privledges) Task Force for the Virginia Academy of Clinical Psychologists commented: "According to government studies about 80-90% of prescriptions for mental health related drugs are provided by non-psychiatric physicians (primarily family practitioners and primary care practitioners) who have little more than 7-10 minutes per patient to try to make a diagnosis, and treat, and who have only about 7 weeks of training on the diagnosis and treatment of mental disorders" ...and "the Council on Graduate Medical Education the manpower shortage within psychiatry is projected to only get worse. Clinical psychologists already outnumber psychiatrists in Virginia by 2:1."... "Multiple studies have shown that for most mental health problems, a combination of psychotherapy and drug therapy (where indicated) is the most effective treatment."
"Prescribing Psychologists have had an average of 7 years of doctoral training (including clinical internship and residency) in the diagnosis and treatment of mental disorders, **plus** have completed an additional 3 years of training in medicine/psychopharmacology including over 400 contact hours of post-doctoral training in clinical psychopharmacology, and a year-long 100 patient internship with years more of collaborative practice with a physician. (As reported by a national association of medical schools, the average medical student receives just 99 hours of pharmacology training).

Prescribing Psychologists have been practicing independently throughout the military (Army, Navy, Air Force, Marines) for the past 15 years, and in more recent years the Public Health Service, New Mexico, Louisiana and Guam. Presently 9 more states have similar pending legislation under consideration.

Prescribing Psychologists have written tens of thousands of prescriptions including refills and the number of serious adverse outcomes or licensing board complaints: **ZERO.**
Prescribing Psychologists are already one of the most highly trained mental health professionals and are preeminently able to provide **Integrated Care** as a combination of psychotherapy and the conservative use of medication by the same doctor - shown to be the best and most cost-effective treatment for all mental disorders.

In Opposition:
James F. Dee, M.D., Northern Virginia Chapter of the Washington Psychiatric Society commented: Even in limited settings, clinical psychologist prescribing medication lowers the standard of care and endangers patient safety. Clinical psychologists are important partners to psychiatrists in mental health care but they do not have the necessary medical education and training that would enable

safe prescribing. And, abbreviated courses in pharmacology cannot provide the important prerequisite skills.

As a physician and a pharmacist, I personally find it frightening that these complex and potentially dangerous drugs could be under the authority of persons who could not treat the complications that often occur even when properly chosen and prescribed. Moreover, as psychiatric medicines rapidly advance and develop, concern about overprescribing should dissuade us from expanding prescriptive authority. In fact, we should encourage more prudent and more coordinated professional judgment rather than less in the interest of convenience.

Mira Singer, National Alliance on Mental Illness commented: "Graduate education for psychologists largely favors a social and behavioral approach that trains psychologists to conduct assessments and provide psychotherapy, not to provide medical treatment. While the social and behavioral aspects are critically important, so too is the unique medical training that psychiatrists receive in treating mental illness. Further, psychotropic medications that are used to treat mental illnesses are powerful and can cause potentially disabling side effects, and require particular expertise among those who prescribe and monitor them. The experience and expertise in monitoring complex medication interactions are critical when taking into account that over 50% of individuals with mental illnesses prescribed psychotropic medications also have other serious medical conditions requiring medications. "

Option 16: Request by letter of the JCHC Chairman that the Department of Health Professions improve the information collected and compiled about clinical psychologists which is retained in the Healthcare Workforce Data Center.

Support: 3
Conditional Support: 1
Oppose: 0

Conditional Support for Options 16 and 17:
Janet McDaniel, Ph.D., M.P.H., Workforce Council for Virginia's State Rural Health Plan commented: "Additional data on our workforce is always helpful to informing our future efforts for training, retention, and recruitment. However, we believe that there needs to be clarification about what "important information" will be collected related to clinical psychologists and how to "improve the information" about dentists. Once this has been determined, we suggest that data for all professions be reviewed and examined.

Option 17: Request by letter of the JCHC Chairman that the Department of Health Professions improve the information collected and compiled about dentists which is retained in the Healthcare Workforce Data Center.

Support: 3
Conditional Support: 1

Oppose: 0

Conditional Support:
See Janet McDaniel's comment in Option 16

Option 18: When state revenue allows introduce a budget amendment (language and funding) to extend basic dental benefits to adults eligible for Medicaid.

Support: 6
Conditional Support: 0
Oppose: 0

In Support:
Terry Dickenson, D.D.S., Virginia Dental Association commented: "With a history of seeing and treating this population via the MOM Project, it is clear that there is an immense need for these services in the adult Medicaid population. ...We certainly have become more aware of the relationship between the inflammatory response due to dental disease and certain systemic diseases, in particular diabetes, cardiovascular disease and pulmonary disease. For a population that struggles for medical care, the challenges of receiving needed dental care can be overwhelming to this population. We believe a healthier workforce, which includes oral health, is essential for healthy communities and the economics of those communities."

Option 19: Request by letter of the JCHC Chairman that the Virginia Pharmacists Association, the Virginia Department for the Aging, and local area agencies on Aging collaborate to provide and disseminate information about Medicare's Medication Therapy Management (MTM) program to pharmacists, prescription counselors, and Medicare beneficiaries that qualify for MTM services.

Support: 2
Conditional Support: 0
Oppose: 0

Appendix A

Full-text of Comments Supporting and Opposing Options 11 and 15

	Option 11	Option 15
Steven T. Dekosky, M.D., Vice President and Dean of the University of Virginia School of Medicine	Support	
Medical Society of Virginia	Oppose	Oppose
Asha S. Mishra, M.D., Medical Director of the Chesterfield Community Services Board		Oppose
National Alliance on Mental Illness		Oppose
Northern Virginia Chapter of the Washington Psychiatric Society		Oppose
Psychiatric Society of Virginia		Oppose
RxP (Prescription Privileges) Task Force for the Virginia Academy of Clinical Psychologists		Support
Dixie Tooke-Rawlins D.O., Dean and Executive Vice President of the Via Virginia College of Osteopathic Medicine	Oppose	Oppose
Virginia Chapter of the American Academy of Child and Adolescent Psychiatry		Oppose
Virginia Association of Community Psychiatrists		Oppose
Workforce Council for Virginia's State Rural Health Plan	Support	Support

UNIVERSITY of VIRGINIA HEALTH SYSTEM

VICE PRESIDENT *and*
DEAN *of the* SCHOOL *of* MEDICINE

September 29, 2009

Senator R. Edward Houck, Chair
Joint Commission on Health Care
900 E. Main Street, First Floor West
PO Box 1322
Richmond, VA 23218

Dear Senator Houck and Members of the Joint Commission on Health Care in Virginia:

Thank you for the comprehensive report, "Virginia's Health Care Workforce: Present and Future Need," and for the opportunity to respond with comments to the report. The report addresses the challenges associated with a worsening shortage and maldistribution of healthcare providers throughout the Commonwealth.

We at the University of Virginia Health System want to participate in ways that will enable us to provide excellent care to all Virginians. To address the shortage of specialty providers in Southwest Virginia, UVA faculty provide on-site physician services in the region through adult specialty clinics in neurology, pulmonology, endocrinology, mammography (radiology) and gynecology. We also provide pediatric specialty care on-site clinics in neurology, cystic fibrosis, cardiology, maxillofacial, neuro-developmental, orthopaedics, and genetics. UVA's Telemedicine program extends the ability of physicians to provide health care patients in locations throughout the Commonwealth. Its education programs offer training to help ensure a sufficient supply of compassionate and knowledgeable healthcare providers, and contribute to a practice environment that encourages healthcare providers to remain in the Commonwealth upon completion of their training.

Undergraduate Medical Education (UME)

The Undergraduate Medical Education (UME) program at the University of Virginia School of Medicine (SOM) actively has sought to address Virginia's shortage of physicians practicing geriatric care and its shortage of primary care physicians in rural areas. UME can play a pivotal role in establishing a pipeline to the health care workforce in underserved

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localities and in fostering students' engagement, interest, and opportunities in these areas. The SOM has developed special programs specifically designed to support students committed to underserved patient populations. The Generalist Scholars Program offers unique scholarly and clinical experiences focused on the practice of generalist medicine in underserved regions of the Commonwealth, and developed faculty mentors for students wishing to explore this path. The Generalist Scholars in Health Disparities Program secures clinical and field placements for students to work within disadvantaged populations, and provides academic and research opportunities concentrated on the reduction of health disparities. Both programs award some scholarship funding. All medical students receive the opportunity to participate in a one-month elective in rural Virginia localities for an extended preceptorship in Family Medicine, working one-on-one with a primary care physician. There is an additional month of general ambulatory internal medicine, and many students serve in rural physician offices. Medical students are encouraged to volunteer with the annual Remote Area Medical (RAM) clinic in Wise County, the largest source of free health care to Appalachian residents.

The SOM recognizes that UME efforts to assist these underserved populations cannot begin within the medical school curriculum. It must start earlier through the active recruitment of medical school applicants who were raised and/or currently reside in these same areas, as these students frequently wish to return to their home communities to practice. The entering class of 2009 was comprised of 143 students; of these, five students came from the very underserved counties of Lee, Montgomery, Smyth, Tazewell, and Wise.

With respect to the state's aging population, the SOM has implemented the country's first required clerkship in Geriatrics. During this two-week rotation, students actively participate in the ongoing daily care of older patients who have diverse acute and chronic illnesses and abnormal physical findings. Each student is paired with a primary geriatric physician mentor for clinical teaching and evaluation, as well as working with an interdisciplinary care team, including nurse practitioners, therapists, certified nursing assistants, and social workers. Each student also is responsible for his or her own panel of patients at a skilled nursing facility.

In terms of how best to further increase the distribution of physicians to these localities and to overall geriatric care, the SOM recommends a loan forgiveness program (Option 2) for students who elect to serve as practitioners for those populations defined as underserved and who fall under a threshold income as practicing primary care physicians. The assurance of loan repayment assistance would enable graduates to

commit to primary care without feeling pressure to instead select a specialty based simply on fiscal anxiety. Additional scholarship funds for students electing our Generalist Scholars Program also would be valuable.

Graduate Medical Education (GME)

UVA's Graduate Medical Education office oversees robust training programs in all of the areas identified by the workforce, including general surgery, emergency medicine, psychiatry (including Child and Adolescent) and Geriatrics. UVA recently expanded funding of its Geriatric Fellowship Program in recognition of the shortfall of geriatricians. UVA has fully accredited residency programs in Pharmacy and Dentistry, and outstanding programs in multiple specialties of Clinical Psychology. Each year, every program turns away many more qualified applicants than the number of open positions, largely due to restrictions in funding.

The most significant factors which affect residents' eventual choice of practice locations are 1) anticipated income in that specialty, and 2) accumulated educational debt. Any program proposed by the JCHC and enacted by the Commonwealth would need to address these critical issues. Loan repayment programs may be particularly effective in helping attract residents and fellows to underserved areas.

The University of Virginia Health System has both the clinical volume and faculty supervision to expand all of its training programs in these areas and obtain approval from the relevant accrediting institutions. However, UVA is significantly over its CMS cap for training positions. Therefore, a source of funding, either federal or state, would need to be identified before any expansion could occur. The expansion of slots may be a factor in retaining physicians in Virginia, as evidence shows that the location of a physician's residency program plays a significant role in where the physician decides to go into practice.

Regarding Graduate Medical Education Issues, we support Options 2 through 4.

Nursing Education - Undergraduate and Graduate

Healthcare workforce data projections for nursing in Virginia (Va Department of Health Professions, 2009) suggest a shortage of 22,600 nurses by 2020. Nursing Education at the University of Virginia School of Nursing (SON) includes students engaged in over 400 clinical experiences each week. Our 658 students span undergraduate baccalaureate programs, master's programs and two doctoral options: a PhD and a new

Doctor of Nursing Practice degree. We are increasing our numbers of graduates each year to meet the needs for nursing at the bedside, in the community, in primary care clinics, in underserved areas, and in growing nurse faculty for schools of nursing in the state.

The SON has several new scholarships for students this year to provide care in southwest Virginia after preparing as nurse practitioners. Just as the SOM needs to recruit students who reside in rural Virginia, the SON shares the same goal. Loan repayment plans (Option 2) for nursing students would help to ensure a dedicated workforce willing to remain in underserved areas. A new HRSA grant will allow online education to prepare nurse practitioners in mental health from southwest Virginia.

Allowing nurse practitioners to have an expanded scope of practice to better collaborate with physicians and better serve the citizens of Virginia is an important goal as described in this document. UVA is committed to educating medical and nursing students together in clinical, simulation and telehealth settings to better care for the complex needs of patients, families and communities.

We support Option 11, which recommends the inclusion of a study of the prevalence, distribution and scope of practice for nurse practitioners and physician assistants in Virginia.

Continuing Medical Education (CME)

Options 7-10 of the recommendations include integration of continuing medical education to address the need for additional training for providers in topics related to geriatric care and medication management for geriatric patients. The University of Virginia School of Medicine supports the provision of continuing medical education programs on the above that are evidence based, developed with careful needs assessment, delivered using a host of educational strategies, and which incorporate thoughtful outcomes analyses.

Telemedicine

Option 12 requests that the JCHC Chairman send a letter to the Special Advisory Commission on Mandated Health Insurance Benefits to support SB1458 (Wampler) and HB2191 (Philips), which require health insurers, health care subscription plans, and health maintenance organizations provide coverage for the cost of telemedicine services. We strongly support this recommendation. UVA has a robust telemedicine program that allows physicians providing care to patients in remote geographic locations, prisons, and other healthcare facilities to have access to UVA

specialty services with minimal delay. In particular, when immediate and emergent access to care saves lives and lowers morbidity, telemedicine can provide such access. Telemedicine provides care at a lower cost to the patient, and better service to the referring physician. Nearly all specialties at UVA can provide consultations via telemedicine, including psychiatry, dermatology, cardiology, pulmonary, geriatrics, diabetes, stroke, and high-risk pregnancy.

On behalf of my colleagues at the UVA Health System – R. Edward Howell, Vice President and CEO of the Medical Center, and Dorrie K. Fontaine, PhD, RN, FAAN, Sadie Heath Cabaniss Professor of Nursing and Dean of the School of Nursing – I express thanks for the opportunity to submit our comments. We are grateful to the Joint Commission on Health Care for consideration of these options in its analysis of the health care workforce in the Commonwealth. We hope that the Joint Commission's efforts will help to ensure equal access to quality health care services for our citizens of Virginia.

Sincerely,

Steven T. DeKosky, MD, FACP
Vice President and Dean
James Carroll Flippin Professor of Medical Science

STDeK/pek

cc: R. Edward Howell
Dorrie K.Fontaine, PhD, RN, FAAN
Sarah Collie

MSV[SM] MEDICAL SOCIETY OF VIRGINIA

September 21, 2009

The Honorable Edd Houck
Chairman
Joint Commission on Health Care
P O Box 1322
Richmond, VA 23218

Re: Joint Commission on Health Care's Report on Virginia's Health Care Workforce Present and Future Needs – Public Comment

Dear Senator Houck:

The Medical Society of Virginia (MSV) would like to take this opportunity to thank the Joint Commission on Health Care for all they do in their ongoing efforts to improve health care for the citizens of the Commonwealth of Virginia. MSV represents 8,900 physicians around the Commonwealth.

We appreciate the chance to offer comments from the physician perspective on your September 1, 2009 presentation regarding Virginia's Health Care Workforce Present and Future Needs. The MSV positions and comments on the options are as follows:

Option 2 – **Support** - Restore funding for State Loan Repayment Program and Virginia Loan Repayment Program when state revenue allows.

Option 3 – **Support** - Increase funding for Family Practice Residency Programs when state revenue allows.

Option 4 – **Support** – Request by letter of the JCHC Chairman that DMAS develop and report by August 10, 2011, on a methodology and cost estimate for providing enhanced DME and IME payments to graduate medical programs that train primary care, general surgery, psychiatrists and emergency medicine physicians.

Option 5 – **Support** - Introduction of a budget amendment (language and funding) to increase Medicaid reimbursement rates to match the level of Medicare reimbursement rates for primary care physicians. While modest increases in Medicaid reimbursement have been achieved over the past few years, physicians experienced flat reimbursement rates for 14 years.

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Option 6 – **Conditional Support - MSV only offers conditional support at this time as we recommend inclusion of the Edward Via College of Osteopathic Medicine be included in the list of medical schools in this option.** By letter of the JCHC Chairman request that the medicals schools at EVMS, UVa, VCU and ***VCOM*** make efforts to increase their enrollment of medical students from rural communities in Virginia and individuals with an interest in serving underserved and minority populations.

Option 7 – **Conditional Support - MSV only offers conditional support at this time as we believe if a CME course is developed focusing on medication issues of geriatric patients and targeted for primary care physicians, it should be developed by the *medical schools not DHP.***

Option 8 – **Conditional Support – MSV only offers conditional support at this time**. Request by letter of the JCHC Chairman that the Board of Medicine promote geriatric care issues ***through the most appropriate venues. The Board of Medicine currently works with a variety of entities to develop and distribute educational information***

Option 9 – **Conditional Support – MSV only offers conditional support at this time**. Request by letter of the JCHC Chairman that the Virginia Chapter of the American College of Physicians promote geriatric care issues ***through the most appropriate venues.***

Option 10 – **Support** – Request by letter of the JCHC Chairman that the Virginia Academy of Family Physicians continue to promote geriatric training among its membership.

Option 11 – **Oppose** – The Department of Health Professions currently has a Workforce Study underway which includes a focus on nurse practitioners as well as physician assistants. We suggest JCHC await the findings prior to beginning another study. If additional studies on workforce issues related to the prevalence, distribution and scope of practice for nurse practitioners and physician assistants in Virginia are to go forward, MSV would strongly encourage the focus be on education preparedness and clinical preparation. Virginia must take all steps necessary to not only ensure access to care but to ensure the delivery of quality care.

Option 15 – **Oppose** - MSV supports the Psychiatric Society of Virginia's (PSV) long-standing policy against prescriptive authority for clinical psychologists for the reasons PSV has outlined in its comments to JCHC. MSV also has long standing policy in opposition:

35.006 - Psychologists' Prescriptive Authority

Date: 11/4/2001

The Medical Society of Virginia opposes legislation allowing psychologists to prescribe medications.

345.006 - Non-Psychiatrist Prescribing Medicines

Date: 11/5/1994

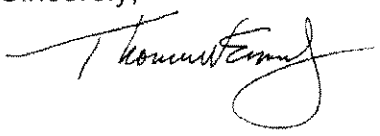
The MSV opposes the independent prescribing of medications by non-physician psychologists.

Reaffirmed 11/7/04

Option 16 – **Support** – Request by letter of the JCHC Chairman that DHP improve the information collected and compiled about clinical psychologists which is retained in the Healthcare Workforce Data Center.

As always, MSV looks forward to working with the Joint Commission on Health Care and are ready to assist in any way. If you desire additional information please contact Mike Jurgensen, MSV Senior Vice President Health Policy and Planning at 804-377-1029 or Ann Hughes 757-650-1451.

Sincerely,



Thomas W. Eppes, Jr., MD
President

Cc: Senator George L. Barker
Delegate Phillip A. Hamilton
Senator Harry B. Blevins
Delegate Clifford L. Athey, Jr.
Senator L. Louise Lucas
Delegate Robert H. Brink
Senator Ralph S. Northam
Delegate David L. Bulova
Senator Linda T. Puller
Delegate Benjamin L. Cline
Senator Patricia S. Ticer
Delegate Rosalyn R. Dance
Senator William C. Wampler, Jr.
Delegate Algie Howell
Delegate Harvey B. Morgan
Delegate David A. Nutter
Delegate John M. O'Bannon, III
Secretary Marilyn B. Tavenner
Kim Snead
Stephen W. Bowman

September 29, 2009

Senator R. Edward Houck
Chairman
Joint Commission on Health Care
P O Box 1322
Richmond, VA 23218

Dear Senator Houck:

As a Professor of Psychiatry at a medical school and the Medical Director for a community service board, I am alarmed that the Joint Commission on Health Care (JCHC) is considering a study to explore prescribing privileges for psychologists. I hope the Commission will reject this idea in favor of other policies that can address the psychiatry shortage.

Especially in public sector settings like CSB's, psychiatrists are often by default the assessors of medical status and needs of the consumers. We work with uninsured and underinsured populations who have either only the emergency rooms or other urgent care clinics for their health care needs. Psychiatrists, as fully trained medical doctors, often help patients determine when to address a wide range of physical and mental symptoms. We also do a lot of education about health issues in the context of monitoring for metabolic syndromes and co-morbidities. Certainly, one needs a comprehensive medical background to take care of our unique patients.

We are making great strides in mental health care to serve more individuals more completely. It would be a step backwards to lessen the standards of care by giving individuals with inadequate medical training the authority to prescribe powerful medications. If we make psychiatric workforce a priority, we can attract and incentivize more physicians to train and serve in Virginia.

Sincerely,

Asha S. Mishra, MD, DFAPA
Medical Director,
Chesterfield Community Services Board
Professor of Psychiatry,
Virginia Commonwealth University Health System (VCUHS)

National Alliance on Mental Illness | Virginia

PO Box 8260 ● Richmond, Virginia 23226 ● phone (804) 285-8264 ● fax (804) 285-8464 ● www.namivirginia.org

September 25, 2009

Ms. Kim Snead
Executive Director
Joint Commission on Health Care
P O Box 1322
Richmond, VA 23218

Dear Ms. Snead:

On behalf of NAMI Virginia I am contacting you about a proposed study of prescriptive authority for psychologists to address workforce shortages in Virginia as outlined in a recent staff presentation to the Joint Commission on Health Care (September 1, 2009, "Virginia Health Care Workforce: Present and Future Need").

While we acknowledge, along with other mental health advocates, that shortages exist in the mental health field and are truly appreciative of the Joint Commission for taking up the matter for further research, NAMI has concerns about proposals to expand prescribing privileges to psychologists in order to address workforce issues.

Science and medicine have made great strides in recognizing mental illness as a legitimate biologically-based illness that requires attention from specially-trained medical professionals – just like heart disease, cancer, and other forms of illness. To enable someone with lesser medical training to care for people with such illnesses contributes to a myth that mental health professionals, families, and consumers have long worked to dispel – that mental illness is psychologically and emotionally based rather than biologically-based.

Graduate education for psychologists largely favors a social and behavioral approach that trains psychologists to conduct assessments and provide psychotherapy, not to provide medical treatment. While the social and behavioral aspects are critically important, so too is the unique medical training that psychiatrists receive in treating mental illness. Further, psychotropic medications that are used to treat mental illnesses are powerful and can cause potentially disabling side effects, and require particular expertise among those who prescribe and monitor them. The experience and expertise in monitoring complex medication interactions are critical when taking into account that over 50% of individuals

with mental illnesses prescribed psychotropic medications also have other serious medical conditions requiring medications.

Such proposals also undermine the true workforce issues at hand; currently there is no evidence demonstrating that expanding prescribing privileges will address these shortages. NAMI believes that public policy on workforce shortage issues should instead focus on the underlying obstacles that prevent people from entering the mental health field and should create incentives to attract and retain qualified professionals. Recommended measures that can be considered include:

- Providing scholarships or stipends to psychiatrist trainees, psychologist trainees, and other mental health professional trainees who commit to providing services to people with mental illnesses in under-served regions or sectors;
- Establishing and expand loan forgiveness programs for psychiatrists, psychologists and other mental health professionals who serve for particular periods in under-served regions;
- Mental health insurance parity for better coverage and access to care;
- Paying adequate wages to case managers, counselors, and other important but traditionally inadequately compensated mental health professionals to retain qualified and dedicated individuals in the field; and
- Employing consumers and family members in a variety of capacities in the mental health field whenever possible, such as peer counselors, support positions, etc.

Thank you for your consideration of our concerns about expanding prescribing authority to psychologists to address workforce shortages in mental health. We sincerely thank the Joint Commission on Health Care for its research and attention to this issue and offer our assistance in the future should it be needed.

Sincerely,

Mira Signer
Executive Director

Northern Virginia Chapter – Washington Psychiatric Society

James F. Dee MD, President
7910 Andrus Road – Suite 16
Alexandria, Virginia 22306

September 29, 2009

Senator R. Edward Houck
Chairman, Joint Commission on Health Care
P O Box 1322
Richmond, VA 23218

Dear Senator Houck:

The psychiatric community in Northern Virginia strongly opposes granting prescriptive authority to clinical psychologists as a remedy for Virginia's mental health workforce shortage.

The staff report "Virginia's Health Care Workforce: Present and Future Need" includes as a policy option a study to allow psychologists to prescribe powerful psychopharmacological medications. Even in limited settings, this concept lowers the standard of care and endangers patient safety. Clinical psychologists are important partners to psychiatrists in mental health care but they do not have the necessary medical education and training that would enable safe prescribing. And, abbreviated courses in pharmacology cannot provide the important prerequisite skills.

As a physician and a pharmacist, I personally find it frightening that these complex and potentially dangerous drugs could be under the authority of persons who could not treat the complications that often occur even when properly chosen and prescribed. Moreover, as psychiatric medicines rapidly advance and develop, concern about overprescribing should dissuade us from expanding prescriptive authority. In fact, we should encourage more prudent and more coordinated professional judgment rather than less in the interest of convenience.

There are better ways to build the psychiatric workforce and expand access to mental health care. Policymakers should support robust psychiatric residency programs that will build a highly-qualified professional population. These programs should include placement requirements for residents to practice in underserved areas. Reimbursement policies should encourage use of technology and the existing workforce to expand telepsychiatry. Collaborative practice arrangements between pediatricians and psychiatrists can establish consultation networks between frontline primary care and subspecialty experts. And, public and private insurance coverage should be required to reflect the public's need and demand for psychiatric services, especially as patients seek early intervention for mental illness.

We urge the Joint Commission on Health Care to forego a study that will be an additional distraction to real psychiatric workforce development. Please focus attention and resources on programs that will maintain a high standard and not create multiple tiers of quality for Virginians in underserved areas.

Please let us know how Northern Virginia psychiatrists can assist the JCHC as you proceed.

Sincerely,

James F. Dee Pharm D, MD, FAPA

PSYCHIATRIC SOCIETY OF VIRGINIA

A District Branch of the American Psychiatric Association

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September 22, 2009

Senator R. Edward Houck
Chairman
Joint Commission on Health Care
P O Box 1322
Richmond, VA 23218

Dear Senator Houck:

On behalf of the Psychiatric Society of Virginia (PSV), I am writing to comment on the Joint Commission on Health Care (JCHC) staff presentation "Virginia's Health Care Workforce: Present and Future Need". We appreciate the extensive research that Mr. Bowman put into this study. We will comment on several of the physician and mental health workforce options but at this time we will focus on our strong opposition to a proposed study of prescriptive authority for clinical psychologists.

PSV and other mental health advocates have consistently expressed concern about the shortage of psychiatrists and other appropriately-trained professionals in Virginia, especially in rural areas. For years, psychiatrists and other physicians have supported and lobbied for programs and policies to address shortages and maldistribution. These include loan repayment, medical school funding, expanded residency, telepsychiatry, pediatric-psychiatry collaborative projects, and mental health insurance parity for better coverage. But, even as policymakers and stakeholders agree that we are underserved, many of these programs have been eliminated, reduced, or ignored. We applaud JCHC staff for including some of these items among the policy options you will consider.

We oppose, in any form, a study "to review allowing qualified clinical psychologists to prescribe psychopharmacological medications" as outlined in Policy Option 15. First of all, it presumes that, short of medical school and psychiatric residencies, there are appropriate avenues to give prescriptive authority to clinical psychologists – PSV disagrees. Our Society cannot endorse a study that would legitimize a proposal that inherently reduces the standards of quality for professionals who treat patients with psychiatric illness, disease, and addiction.

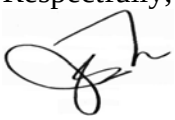
As we continue to overcome stigma and make more discoveries about these complex conditions, more people are seeking care. The providers of this care must be held to the highest standards. We are striving to have psychiatric illnesses recognized as the biological and medical conditions of

the human body that they are. Why would we demand less for our brains than we would for other organs or systems? Only psychiatrists, like other physician specialists, are completely educated and trained to address these complex brain conditions and how they affect – and are affected by – other body systems.

Public policy should respond to Virginia's need by addressing obstacles or creating incentives. Secretary Tavenner commented on our recent success with the nurse shortage. Virginia did not accept lower standards for care by enlisting lesser-trained persons. Instead, by making it a priority, we found ways to allow the supply to grow towards the demand. If psychiatrists are in great demand then why are our medical students not flocking to psychiatry and establishing practices in the Commonwealth? Let us use scarce resources to answer these questions rather than to study systems of lesser quality.

As always, PSV is prepared to work with the Joint Commission on Health Care, General Assembly, and others to improve access to high-quality mental health care. We have attached several items for your consideration as you consider ways to expand the psychiatric workforce.

Respectfully,



J. Edwin Nieves, MD, DFAPA
President

Enclosures

Cc: Members, Joint Commission on Health Care
Staff, Joint Commission on Health Care

Response of Anita L. Auerbach, Ph.D.
Chair, RxP Task Force, Virginia Academy of Clinical Psychologists

September 28, 2009

Dear Joint Commission on Health Care Members:

As Chair of the RxP (Prescription Privileges) Task Force for the Virginia Academy of Clinical Psychologists, I am writing to you in support of Option 15 (as noted in the *Staff Report: Virginia's Healthcare Workforce Present and Future Need*) to introduce "a joint-resolution requesting that JCHC convene a task force to review allowing qualified clinical psychologists to prescribe psychopharmacological medications…"

The Joint Commission Staff Report has already targeted the shortage of psychiatrists particularly in some areas within the Commonwealth of Virginia, resulting in long wait times for both the adult and pediatric populations. As part of its deliberations on Option 15, we would request that the JCHC consider the following, already reported by our counterparts in other states:

According to government studies about 80-90% of prescriptions for mental health related drugs are provided by non-psychiatric physicians (primarily family practitioners and primary care practitioners) who have little more than 7-10 minutes per patient to try to make a diagnosis, and treat, and who have only about 7 weeks of training on the diagnosis and treatment of mental disorders.

- According to government studies, the diagnostic hit rate of these physicians is rated from a low of 10% to a high of 50%. Thus, primary care physicians miss mental disorder diagnoses, such as depression and substance abuse, 50-90% of the time.

- These fine primary care physicians, who prescribe the majority of psychotropic medications, are understandably overburdened and ill-equipped to deal with mental health problems the most effectively. Further, according to the Council on Graduate Medical Education the manpower

shortage within psychiatry is projected to only get worse. Clinical psychologists already outnumber psychiatrists in Virginia by 2:1.

By contrast, Prescribing Psychologists have had an average of 7 years of doctoral training (including clinical internship and residency) in the diagnosis and treatment of mental disorders, **plus** have completed an additional 3 years of training in medicine/psychopharmacology including over 400 contact hours of post-doctoral training in clinical psychopharmacology, and a year-long 100 patient internship with years more of collaborative practice with a physician. (As reported by a national association of medical schools, the average medical student receives just 99 hours of pharmacology training).

- Multiple studies have shown that for most mental health problems, a combination of psychotherapy and drug therapy (where indicated) is the most effective treatment.

- Prescribing (Medical) Psychologists, trained in *both* behavioral and pharmacological approaches, have more options available to them. And multiple studies have shown that integrating psychotherapy and *appropriate* medication by *one provider* was the most effective treatment, and more cost-effective than splitting care between providers.

Prescribing Psychologists have been practicing independently throughout the military (Army, Navy, Air Force, Marines) for the past 15 years, and in more recent years the Public Health Service, New Mexico, Louisiana and Guam. Presently 9 more states have similar pending legislation under consideration.

- The record of safety is unparalleled: Prescribing Psychologists have written tens of thousands of prescriptions including refills – the number of serious adverse outcomes or licensing board complaints: **ZERO**

- Surveys show that prescribing psychologists 20% of the time reduce the number of psychoactive prescriptions a patient is on. For example, in Department of Defense studies, psychologists in the military with the freedom to prescribe have nevertheless been found to prescribe medications for only 10% to 30% of their patients. **The power to prescribe is also the power to unprescribe.**

Prescribing Psychologists are already one of the most highly trained mental health professionals and are preeminently able to provide **Integrated Care** as a combination of psychotherapy and the conservative use of medication by the same doctor - shown to be the best and most cost-effective treatment for all mental disorders. Psychologists serve on the faculty of almost every medical school and family practice residency in the country. Please give careful consideration to endorsing Option 15.

Respectfully submitted,

Anita L. Auerbach, Ph.D.
Chair, RxP Task Force, Virginia Academy of Clinical Psychologists
Founder/Director, Commonwealth Psychological Associates PLC
Clinical Professor, George Washington University
Diplomate, American Board of Medical Psychotherapists
Diplomate, International Academy of Behavioral Medicine

Edward Via
Virginia College of Osteopathic Medicine
Physicians & Research for the 21st Century

September 29, 2009
Joint Commission on Health Care
P.O. Box 1322
Richmond, Virginia 23218

Dear Members of the Joint Commission on Health Care,

On behalf of the Via Virginia College of Osteopathic Medicine (VCOM) I would like to respond to the policy recommendations given in Stephen Bowman's presentation to the Joint Commission on Health Care given on September 1, 2009. Thank you for the opportunity to respond to this presentation.

First I would like to complement Stephen Bowman on his hard work to bring this data together and for bringing to the attention of the Joint Commission the pending shortage of physicians for Virginia along with the increasing population, the misdistribution of physicians in regards to urban vs. rural areas, the greater need for primary care physicians (family medicine, pediatrics, and internal medicine), the growing need in the State for some specialties including surgeons, geriatricians, and emergency medicine physicians, and the lack of retention in our state of medical school graduates to primary care residencies and to Virginia generalist practices.

I also applaud Stephen Bowman's statement that the state government efforts should focus on the most essential health professional areas that are in need. The analysis of the data regarding an adequate supply of pharmacists in the future allows the JCHC to make policy recommendations that are cost/value driven.

VCOM believes however, that the report posted on line however does not offer all the policy options that should be considered. The response that follows will outline additional policy options that VCOM believes should be considered as an alternative. In preparing these suggestions, VCOM has considered the current budget restrictions, the tough decisions the General Assembly will be making, and the data from a review of reports to the JCHC and/or the legislature since 1998. The policies suggested by this response will call for a redistribution of current state funds (not an increase) to support more effective programs in increasing physicians to enter primary care in the rural and underserved regions of Virginia.

Option 1*:* ***Do nothing*** **is NOT an option**. Doing nothing will only increase the State's costs as more emergency rooms become the primary care site for patients in rural and underserved areas.

Option 2*:* ***Restore Funding for the State Loan Repayment Program and the Virginia Loan Repayment Program*** *when the state revenue allows*.

Waiting for the time "when state revenue allows" is essentially doing nothing. VCOM requests that **restoring the State Loan Repayment Program and the Virginia Loan Repayment Program begin with the Class finishing in July 2010.** It is important to provide a historical perspective to this proposal.

The scholarship program was eliminated in 2003 by Jane Woods then Secretary in order to meet a budget shortage. VCOM visited with Secretary Wood at that time and VCOM and the entering medical students were promised that the money would be placed into a loan repayment program and benefit them when they completed their residencies (2010). During the past seven years not funding the scholarship and using the money for loan repayment has saved the State a significant amount of money. In 2009 however, this loan repayment program was eliminated stating this was due to the "budget shortfalls." This money should **be restored** in time for those residents who finish in July 2010 to receive the loan repayment as they enter rural primary care practices. Finally considering the shortages for primary care that exist, **the definition of rural should be expanded to include all communities of less than 25,000 and who are over 30 miles from the nearest urban area; and the designation of underserved should expanded to include the Community Health Centers or Federally Qualified Health Centers so to reach those in most need. These changes would greatly enhance access in rural Virginia.** Although this does not match the federal definition, the federal definition does not accurately define rural in Virginia. (an example is Craig Co. which is not considered a rural medically underserved area.)

There are currently five medical schools in Virginia: VCU, EVMS, UVA, VCOM, and VTC (Carilion). The outcomes of the medical schools are outlined in the table below. (VTC is new does not have outcomes to review and VCOM's first class finishes residency in 2010).

School or College of Medicine	Class size 2009	Proposed Class size 2012	Total 4 yrs 2009	Cost to state per medical student	Total Cost to State per year	# of 2009 graduates	Current % graduates entering primary care residencies	Number and % of graduates entering primary care practices in Virginia
EVMS	115	135	445	33,786	15.1 mi.	100	48 %	12 or 10%
VCU	192	192	741	29,733	16.6 mi.	131	46%	22 or 11%
UVA	145	160	559	22,833	16.9 mi.	171	44%	28 or 20%
VCOM	189	189	680	0	0	160	57%	Unknown will complete residency in 2010
VTC	0	40	120	0	50mi. one time bond	0	unknown	unknown

To date VCOM has graduated 3 classes. In all 3 classes, VCOM HAS greater than 50% entering primary care and is listed as one of the TOP 10 MEDICAL SCHOOLS IN the US by US WORLD NEWS REPORT for graduates entering primary care. In addition VCOM has sponsored the establishment new primary care residences within Southwest and Southside Virginia (Blacksburg and Bluefield in 2008 and Danville in 2010). Additional primary care residencies are planned for SW Virginia. To date this has been done without the assistance of state funding and as a private college VCOM received no state funding for their now greater than 450 physicians that have graduated, **saving the state over 15 million dollars a year** in

producing these physicians if the average was used for what the state institutions require. This would justify restoring the scholarships that were promised to the VCOM students in 2003 when they began.

With an average of 57% of the classes entering primary care residencies, the return with primary care physicians will be great. VCOM will be the answer to Virginia's primary care shortage if the loan repayment program is re-established. If it is not re-established then they will likely go to where loan repayment exists.

OPTION 3: ***When State Revenue allows, increase funding for the UVA and VCU Family Practice Residency Programs.***

I support increasing funding to the residencies above as they enroll students from all four medical schools in the state who have graduates. I do however request that the funding provided be equally distributed to the all of the family medicine residencies throughout the state. This would include the EVMS and VCOM sponsored family medicine residency programs as well and be distributed according to the number of programs and residents.

VCOM has been in the process of establishing family practice residency programs in medically underserved communities and rural areas of the state. National Residency programs in rural areas are successful in recruitment and retention of graduates to rural areas. Of the 474 family medicine training programs that exist nationally, 143 have rural fellowships and 29 rural training tracks. Virginia should do more to support the development of rural training tracks as these programs provide a high recruitment of residents to rural areas.

As state funding is currently limited and "tough decisions" are called for by the General Assembly, re-allocation of funds to support rural residencies might be redirected from programs such as GMEC, which was established to provide a rural rotation for residents in urban primary care programs. **GMEC** which costs the State over 295,000 per year has only had 20 participating residents locate in Southwest Virginia since 1998. It would be the time to redirect the Graduate Medical Education Consortia to assist new rural primary care residency training programs or rural fellowships where retention in rural areas would be much greater.

OPTION 4 and 5: VCOM agrees with both OPTIONS.

OPTION 6: *By letter of the JCHC Chairman request that the medical schools at EVMS, UVA, and VCU make efforts to increase their enrollment of medical students from rural communities in Virginia and individuals with an interest in serving underserved areas and minority populations.*

VCOM agrees with this statement. Please recognize that there is a need to recruit students interested in serving rural and underserved communities in all five schools. A collaborative effort by the five medical schools for recruitment pipeline programs for rural and minority students is already underway.
(Please note that the policy statement should include VCOM and VTC and recognize their efforts in this area.)

OPTION 7 and 8: *When state revenue allows, introduce a budget amendment (language and funding) to allow the Department of Health Professions (DHP) to develop a Continuing Medical Education course*

focusing on medication issues of geriatric patients and targeted for primary care physicians. The objective would be for the course to be offered online and at no cost to Virginia licensed physicians.

VCOM is in favor of improving the education of the healthcare workforce in caring for Geriatric patients however this could be done **with little or no cost to the State**. All five medical schools have Geriatricians on campus and are capable of providing CME. The amendment should call for the State's Medical Schools (public and private) to provide specific hours of CME on care of the Geriatric patients. The current medical schools and allied health schools would be a greater resource in developing the programs and providing the appropriate CME credits to the participants. If the State believes that a mandate is needed to further Geriatric care then asking that the CME be submitted to the State Medical Licensing Board at the time of renewal may be warranted.

OPTION 10: *Request by letter of the JCHC Chairman that the Virginia Academy of Family Physicians continue to promote geriatric training among its membership*.

Recognize that the request should also include the **Virginia Association of Osteopathic Family Physicians** as well as they account for many family physicians throughout the state. (This suggestion has already been sent by VCOM to VAOFP).

OPTION 11: *Include in the 2010 JCHC work plan, a study of the prevalence, distribution and scope of practice for nurse practitioners and physician assistants in Virginia*.

VCOM does not believe that a study is warranted. The data on the numbers and locations of the NP and PA population exists and would therefore not be a good use of already scarce state funding.

The data **on prevalence and distribution** of nurse practitioners and physician assistants for all fifty states has been collected and recorded by the State Licensing Boards in all fifty states. The data was analyzed by NCAHD and is currently being used by AMA and at the federal level the Health and Human Resource Service Administration. Recent geospatial mapping of this data has been completed by NCAHD and a copy of the Virginia maps and summary data will be supplied to the JCHC at no cost. While no data is perfect, the data is more than sufficient to demonstrate practice locations within the state and has been deemed within an acceptable accuracy to be used by such agencies as HRSA. If improving accuracy is the reason for this suggestion, the additional money should be provided to the State Medical Licensing Board to improve the on-line data collection tool.

The scope of practice for nurse practitioners and physician assistants is well defined in the statutes and both groups are well integrated into the current primary care systems.

OPTIONS 12, 13, 14 Agree with these options.

OPTION 15. *Introduction of a joint-resolution requesting that JCHC convene a task force to review allowing qualified clinical psychologists to prescribe psychopharmacological medications and report to JCHC. The report will detail licensure and educational requirements, oversight structure, changes to licensure and regulatory oversight processes, medications that may be prescribed, requirements for physician review and/or oversight for prescribing medications. The resolution would require an interim report to JCHC in 2010 with a final report by September 1, 2011. Task force participants include:*

Psychiatric Society of Virginia, Virginia Psychological Association, Virginia Pharmacists Association, Board of Medicine, Board of Pharmacy, Board of Psychology, and Medical Society of Virginia.

VCOM does not agree with this Option. The current training for clinical psychologists does not include courses in Biochemistry, Physiology, Cell Biology, and Pharmacology that teach understanding of the mechanisms of actions, complications, side effects, and contraindications to psychopharmacologic drugs. The current training for psychologist also does not provide training on the treatment of side effects or overdoses (which are often cardiac and can be severe with overdose in this high risk group). Psychologists practicing in conjunction with psychiatrists and primary care physicians do not need prescribing rights as the physicians in the practice are available to prescribe such medications. More attention should be given to ways of expanding access through better collaboration of physicians, psychologists, and with better mental health training of the primary care workforce.

VCOM would ask that the JCHC consider when funding allows, to provide funding for a Psychiatry residency and an Addiction Medicine Fellowship in Southwest Virginia. While VCOM students have entered psychiatry programs within Virginia, many have had to leave the state to find positions. A Psychiatry Residency Program and an Addiction Medicine Fellowship in Southwest Virginia could expand services to an area in great need.

(Please note that task forces that include MSV should also include **a representative of the Virginia Osteopathic Medical Association.)**

OPTIONS 16, 17, 18, 19 VCOM agrees with these options.

Finally, regarding the statement that International Medical Graduates be considered to supply the primary care and rural needs of the state. This is not the optimal plan for Virginians. The "brain-drain" from International countries is not the way to resolve the U.S. primary care needs. As many of the International Medical Schools do not have the same accreditation standards as U.S. schools, the quality among schools vary greatly and there is currently no standard measurement for the schools, only a licensing exam for graduates. While many international graduates have supplied our rural needs in the past, there have since sprung up many overnight, on-line schools with 600 graduates a year that are not of the same quality as what we have known in the past.

In addition, the International schools bring no economic impact to the state as do the medical schools in Virginia. VCOM (without any state funding) has had an over $100 million dollar economic impact from direct monies spent (no multipliers used) over the past five years. The state medical schools have an even greater economic impact. It would be a much better plan then for the state to support programs of loan repayment for Virginia graduates, many who are from rural Virginia, and a loan repayment program would allow those students to stay within Virginia.

Thank you for allowing VCOM to respond to these issues.

Sincerely,
Dixie Tooke-Rawlins D.O.
Dean and Exec. Vice President
Via Virginia College of Osteopathic Medicine

September 22, 2009

Senator R. Edward Houck
Joint Commission on Health Care
P O Box 1322
Richmond, VA 23218

Dear Senator Houck:

The Virginia Chapter of the American Academy of Child & Adolescent Psychiatry (VA AACAP) wishes to express our deep concerns and opposition to a proposal to study prescriptive authority for clinical psychologists. Our physician members believe that allowing psychologists to prescribe medications will expose children and adolescents to inadequate care. Complete medical training is necessary to prescribe appropriate medications at a safe dosage level and avoid potentially dangerous drug interactions. This is especially true when prescribing for children and adolescents.

The human brain is at least as complex as other organ in our bodies. In developing children, mental illness is difficult to diagnose and treat. Statutes and regulations that establish high standards for physicians should be the minimum safeguards in place for prescribing powerful controlled substances. Even with current standards, we too often see the serious effects that psychotropic medications can have on a patient's entire health when drugs interact with one another or cause and adverse reaction. Let us not explore policies that could foster additional over-prescribing and inadequate ability to deal with complications.

Finally, the concept is usually advanced in the name of broader access to mental health services for the underserved. Virginia should not tolerate lesser quality for our children and adolescents. And, if the few states who have taken this route are any indication, granting psychologists prescriptive authority does not effectively address psychiatric workforce shortages in rural areas. VA AACAP and others have been frustrated by cuts to child/adolescent residency programs that were successful in attracting physicians to our specialty. In addition, with our pediatrician colleagues, we have advocated for support of collaborative arrangements that would provide primary care physicians with professional consultations for the complex cases they face in underserved regions – a model of success in other states. We have forwarded these proposals to the Secretary of Health and Human Resources and the Commissioner for Mental Health on several occasions. They have acknowledged these proposals as being viable but have not funded them citing financial shortfall in the state budget. Hence, if any funds should be appropriated, they should be made available for funding "shovel ready" proposals like the Collaborative pediatric/primary care child mental health initiatives to meet the challenges of work force shortages by training pediatricians and not studies for training non medical colleagues.

Please do not waste time and precious resources studying models that would only result in lesser quality of care for the vulnerable in our state.

Sincerely,

Bela Sood MD
President
Virginia Chapter of the American Academy of Child & Adolescent Psychiatry

Virginia Association of Community Psychiatrists

Working to provide and guide community psychiatric care in Virginia

September 23, 2009

Senator R. Edward Houck, Chairman
Joint Commission on Health Care
P O Box 1322
Richmond, VA 23218

Dear Senator Houck:

The Virginia Association of Community Psychiatrists (VACP) is a professional organization of public sector psychiatrists who work in state mental health hospitals and community services boards (CSBs). VACP wishes to express opposition to Policy Option 15 in the Joint Commission on Health Care (JCHC) staff presentation entitled "Virginia's Health Care Workforce: Present and Future Need". We oppose a study intended to expand prescriptive authority to clinical psychologists.

Community psychiatrists often provide care to the most-severely afflicted Virginians who cannot afford services elsewhere or who need intensive long-term care. Many of us provide care in underserved areas. We know firsthand that access to appropriately-trained professionals is limited in many parts of the Commonwealth. We work hard with our colleagues in primary care, psychology, social work, and counseling to use a high-quality team approach with our consumer populations.

Because we serve a growing and needy segment of mentally ill citizens, we oppose extending prescribing privileges to clinical psychologists, or any professional, who has not completed comprehensive medical education and training in pharmacology. Virginians deserve and expect professionals who treat serious mental disease and disorders to meet rigorous standards. These standards help ensure high quality medical care and should not be compromised.

We urge the Joint Commission to support policies to grow the psychiatric workforce and explore initiatives to expand access without compromising standards. Telemedicine, multi-disciplinary treatment teams and creative residency programs are just a few examples of how we can best use expertise and manpower. The increasing complexities and exciting new discoveries in mental health care make prudent and careful delivery more important than ever. Please reject a study of a more fragmented approach.

Respectfully,

Baltej Gill MD
President
Hampton

September 29, 2009

Joint Commission on Health Care
P.O. Box 1322
Richmond, Virginia 23218

Dear Members of the Joint Commission on Health Care,

On behalf of the Workforce Council for Virginia's State Rural Health Plan, I am writing to provide a response to policy recommendations given in Stephen Bowman's presentation to the Joint Commission on Health Care on September 1, 2009. Thank you for giving us the opportunity to provide you with our feedback and thoughts from the rural workforce perspective. Let me also commend Stephen for his hard work in pulling this important information together. The research is extremely helpful to the work of the Council and the implementation of our state's rural health plan.

In general, we are supportive of all the policy options suggested in the presentation except option 1 to take no action. Workforce related actions must be taken to improve access to healthcare, especially in rural Virginia. Our comments on other options are below:

Option 2: We advocate for the restoration of funding of the loan repayment program and would like to see a clarification clause to ensure midlevel providers, physician assistants and nurse practitioners, are included in this funding. These programs are extremely important in deploying health care providers to underserved communities.

Option 3: As all of the medical schools in the Commonwealth contribute to the overall workforce in the Commonwealth, we advocate for supporting all medical schools residency programs regardless of their public or private status.

Option 5: We believe it is very important to increase Medicaid reimbursement rates for primary care physicians and mid-level providers, physician assistants and nurse practitioners, because in rural areas it is difficult to recruit health providers if there is a poorer payer mix due to large numbers of residents on Medicaid.

Option 7: Caring for aging populations is a unique challenge in rural areas of our Commonwealth. In order for practitioners to take advantage of continuing education in geriatric health issues, we support ensuring Continuing Medical Education (CME) credits are obtained for this additional training. We recommend working with organizations such as the AMA and the Medical Society of Virginia to ensure that practitioners receive CME's for these courses. Mid-level providers, physician assistants and nurse practitioners, will also benefit from continuing education in this area.

Option 8: Although we support the basic intent of this option, we believe it needs further clarification. What types of geriatric health issues will be addressed, will there be a requirement for CME's, and will

there be a link on the Board of Medicine website to educational offerings? As in Option 7, the Workforce Council believes that providing CME's for the educational programs will be an incentive for health providers to complete the educational offerings.

Option 11: In rural areas, mid-level practitioners are an important part of the health care infrastructure. As part of the research in this study, we hope that state comparisons of scopes of practice will be included. We believe other states have determined good ways to utilize and expand access to services with these practitioners.

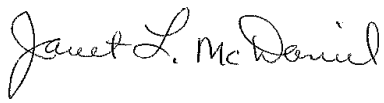
Options 12, 13, and 14: Telemedicine is of vital importance to ensuring timely and quality health care services in our rural communities. Use of telemedicine can greatly increase access to specialty care and mental health services in rural Virginia. Therefore, we support insurance reimbursement and pilot studies to examine expanding use of telemedicine. Given its sporadic use, we suggest that additional training on telemedicine be researched and provided to rural practitioners and health care institutions.

Option 15: The Workforce Council is supportive of expanding access to psychopharmacological medications, which is especially crucial in rural areas. Issues related to addressing medication problems that occur after normal business hours must be included in the study. We also suggest working with the insurance companies to reimburse for services provided by doctoral students in clinical psychology programs who are under the supervision of an appropriately credentialed mental health or medical professional. We encourage looking at how other states reimburse care provided by students who are closely supervised by licensed mental health providers (e.g. Ohio).

Option 16 and 17: Additional data on our workforce is always helpful to informing our future efforts for training, retention, and recruitment. However, we believe that there needs to be clarification about what "important information" will be collected related to clinical psychologists and how to "improve the information" about dentists. Once this has been determined, we suggest that data for all professions be reviewed and examined.

Thank you again for allowing us to submit these comments. Determining ways to better understand and improve the workforce of our Commonwealth will improve the health of all our citizens. The needs of rural Virginians are often forgotten during statewide conversations. We encourage all the members of the Joint Commission on Health Care to remember rural residents, as they are often some of the most underserved and sickest members of our Commonwealth. In addition, we encourage members to review Virginia's State Rural Health Plan that outlines recommendations to improve the health and wellbeing of our rural neighbors. The plan can be found at www.va-srhp.org.

Sincerely,



Janet McDaniel, PhD, MPH, FNP
Chair, Workforce Council

Appendix B

Public Comment: Additional Policy Options

Physician related

- Roger Hofford, M.D., Program Director of the Carilion Clinic Family Medicine Residency
- Peter J. Pagnussi, M.D., President of the Virginia College of Emergency Physicians
- Dixie Tooke-Rawlins D.O., Dean and Executive Vice President of the Via Virginia College of Osteopathic Medicine

Mental Health related

- Dr. John Ball, Ph.D., Clinical Psychologist
- Mary Ann Bergeron, Executive Director of the Virginia Association of Community Service Boards
- Catherine Bodkin, Licensed Clinical Social Worker
- James F. Dee, M.D. , President of the Northern Virginia Chapter of the Washington Psychiatric Society
- Janet McDaniel, Ph.D., M.P.H., Chair of the Workforce Council for Virginia's State Rural Health Plan
- Debra A. Riggs, Executive Director of the Virginia Chapter of the National Association of Social Workers
- Cathleen A. Rea, Ph.D., Chair of the Licensure Task Force for the Virginia Academy of Clinical Psychologists
- Mira Singer, Executive Director of the National Alliance on Mental Illness
- Bela Sood, M.D., President of the Virginia Chapter of the American Academy of Child and Adolescent Psychiatry
- James L. Werth, Jr. Ph.D., Professor of Psychology and Director of the Doctor of Psychology Program in Counseling Psychology, Radford University

Dental related

- Ellen Austin-Prillaman RDH, President of the American Dental Hygienists' Association
- Terry Dickenson, D.D.S., Executive Director of the Virginia Dental Association

Physician related

- **Roger Hofford, M.D., Program Director of the Carilion Clinic Family Medicine Residency**

  "Over the last six years our state funding has decreased significant to support family medicine residency training...with a worsening payor mix of patients served, and decreased Federal funding for graduate medical education. In the state budget language this money can be used to pay for medical students rotations in family medicine. I would ask the Joint Commission/General Assembly look at whether these monies for students are accomplishing the outcomes we need at the expense of our state supported family medicine residencies."

  Regarding DMAS reporting on an enhanced medical education funding for selected specialties (Option 4), JCHC should review how South Dakota uses their state line item funding to obtain a Federal match.

- **Peter J. Pagnussi, M.D., President of the Virginia College of Emergency Physicians**

  For the Loan Repayment programs, we request that "JCHC examine the option of adding 'emergency medicine' as one of the allowable practice areas eligible for loan repayment. Currently, emergency medicine is not included and, in light of presentation highlighting emergency medicine as a physician shortage area, we believe it should be added."

  Related to Option 5, we support introduction of a budget amendment (language and funding) "to increase Medicaid reimbursement rates for emergency physicians. Family practice physicians and emergency physicians have the lowest reimbursements in the state. And, unlike family practice physicians who can stop taking Medicaid patients, emergency physicians have to treat everyone at all times, according to the Federal EMTALA law and cannot turn anyone away."

- **Dixie Tooke-Rawlins D.O., Dean and Executive Vice President of the Via Virginia College of Osteopathic Medicine**

  Loan repayment program monies in Option 2 "should be restored in time for those residents who finish in July 2010 to receive the loan repayment as they enter rural primary care practices. Finally considering the shortages for primary care that exist, the definition of rural should be expanded to include all communities of less than 25,000 and who are over 30 miles from the nearest urban area; and the designation of underserved should expanded to include the Community Health Centers or Federally Qualified Health Centers so to reach those in most need.

These changes would greatly enhance access in rural Virginia. Although this does not match the federal definition, the federal definition does not accurately define rural in Virginia. (an example is Craig Co. which is not considered a rural medically underserved area.)"

"I support increasing funding to the residencies [referenced in Option 3] as they enroll students from all four medical schools in the state who have graduates. I do however request that the funding provided be equally distributed to the all of the family medicine residencies throughout the state. This would include the EVMS and VCOM sponsored family medicine residency programs as well and be distributed according to the number of programs and residents."

"As state funding is currently limited and "tough decisions" are called for by the General Assembly, re-allocation of funds to support rural residencies might be redirected from programs such as GMEC, which was established to provide a rural rotation for residents in urban primary care programs. GMEC which costs the State over 295,000 per year has only had 20 participating residents locate in Southwest Virginia since 1998. It would be the time to redirect the Graduate Medical Education Consortia to assist new rural primary care residency training programs or rural fellowships where retention in rural areas would be much greater."

"VCOM is in favor of improving the education of the healthcare workforce in caring for Geriatric patients however this could be done with little or no cost to the State. All five medical schools have Geriatricians on campus and are capable of providing CME. The amendment should call for the State's Medical Schools (public and private) to provide specific hours of CME on care of the Geriatric patients. The current medical schools and allied health schools would be a greater resource in developing the programs and providing the appropriate CME credits to the participants. If the State believes that a mandate is needed to further Geriatric care then asking that the CME be submitted to the State Medical Licensing Board at the time of renewal may be warranted."

Mental Health related

- **Dr. John Ball, Ph.D., Clinical Psychologist**

  Some avenues to address shortages include "protecting and even expanding state funding for the training of new mental health clinicians in programs at EVMS and elsewhere and perhaps an expanded utilization and supported healthcare reimbursement structure for telemedicine in the area of mental services to improve access to care in rural environments."

  Also, the Virginia Board of Psychology is being urged to eliminate their pre-licensure requirement of a one year post-doctoral residency in clinical psychology for new graduates who have already met both 1500 practicum training hours during graduate school and a full time in–residence clinical psychology internship. Any JCHC support of the Board of Psychology eliminating the requirement for a post-doctoral residency year as a prerequisite to licensure would be appreciated.

- **Mary Ann Bergeron, Executive Director of the Virginia Association of Community Service Boards**

  "The VACSB would be supportive of a rate increase in reimbursement for any services related to community mental health services and/or treatment."

- **Catherine Bodkin, Licensed Clinical Social Worker**

  "Licensed clinical social workers ...provide more than 50% of the mental health services, especially in rural areas and with low income families.... [Licensed clinical social workers] are a vital part of the Commonwealth's substance abuse and mental health system. No report is complete without considering their role in services and the need to support loan repayment programs similar to nurses, doctors, and clinical psychologists. I hope the Commission will request that future studies include statements about the role of licensed clinical social workers in order to be able to accurately assess the system changes that are needed."

- **James F. Dee, M.D. , President of the Northern Virginia Chapter of the Washington Psychiatric Society**

  "There are better ways to build the psychiatric workforce and expand access to mental health care [than Option 15]. Policymakers should support robust psychiatric residency programs that will build a highly-qualified professional population. These programs should include placement requirements for residents to practice in underserved areas. Reimbursement policies should encourage use of technology and the existing workforce to expand telepsychiatry. Collaborative practice arrangements between pediatricians and psychiatrists can establish

consultation networks between frontline primary care and subspecialty experts. And, public and private insurance coverage should be required to reflect the public's need and demand for psychiatric services, especially as patients seek early intervention for mental illness."

- **Janet McDaniel, Ph.D., M.P.H., Chair of the Workforce Council for Virginia's State Rural Health Plan**

  "We suggest working with the insurance companies to reimburse for services provided by doctoral students in clinical psychology programs who are under the supervision of an appropriately credentialed mental health or medical professional. We encourage looking at how other states reimburse care provided by students who are closely supervised by licensed mental health providers (e.g. Ohio)."

- **Debra A. Riggs, Executive Director of the Virginia Chapter of the National Association of Social Workers**

  "Each state determines what areas of social work practice are protected by law. It is those discrepancies that allow anyone to identify himself as a social worker despite their qualifications. As an example, fewer than 40% of child welfare workers are professional social workers. This threat to the professionalism of social has encouraged advocacy within the field for greater protection of the public through a combination of practice and title protection laws with limited exceptions or exemptions to legal requirements. Social Work practice protection refers to licensure laws that require all those who act as social workers to be licensed thus protecting the specific actions performed by social workers by ensuring that only qualified individuals carry out social work functions. A Title protection statute protects a specific social work title, such as Licensed Master Social Worker, from being used by anyone that does not meet the legal definition of a social worker for that level of licensure."

  Also NASW requests "a letter from the JCHC Chairman that the Department of Health Professions improve the information collected and compiled about clinical social workers for the Healthcare Workforce Data Center."

- **Cathleen A. Rea, Ph.D., Chair of the Licensure Task Force for the Virginia Academy of Clinical Psychologists**

  The Virginia Academy of Clinical Psychology strongly recommends that the Joint Commission formally encourage the Board of Psychology to proceed in due haste with promulgation of regulations to eliminate the requirement for a post-doctoral residency year as a prerequisite to licensure.

- **Mira Singer, Executive Director of the National Alliance on Mental Illness**

  NAMI believes that public policy on workforce shortage issues should on the underlying obstacles that prevent people from entering the mental health field and should create incentives to attract and retain qualified professionals. Recommended measures that can be considered include:

  - Providing scholarships or stipends to psychiatrist trainees, psychologist trainees, and other mental health professional trainees who commit to providing services to people with mental illnesses in under-served regions or sectors;
  - Establishing and expand loan forgiveness programs for psychiatrists, psychologists and other mental health professionals who serve for particular periods in under-served regions;
  - Mental health insurance parity for better coverage and access to care;
  - Paying adequate wages to case managers, counselors, and other important but traditionally inadequately compensated mental health professionals to retain qualified and dedicated individuals in the field; and
  - Employing consumers and family members in a variety of capacities in the mental health field whenever possible, such as peer counselors, support positions, etc.

- **Bela Sood, M.D., President of the Virginia Chapter of the American Academy of Child and Adolescent Psychiatry**

  VA AACAP with our "pediatrician colleagues, we have advocated for support of collaborative arrangements that would provide primary care physicians with professional consultations for the complex cases they face in underserved regions – a model of success in other states. We have forwarded these proposals to the Secretary of Health and Human Resources and the Commissioner for Mental Health on several occasions. They have acknowledged these proposals as being viable but have not funded them citing financial shortfall in the state budget. Hence, if any funds should be appropriated, they should be made available for funding "shovel ready" proposals like the Collaborative pediatric/primary care child mental health initiatives to meet the challenges of work force shortages by training pediatricians and not studies for training non medical colleagues."

- **James L. Werth, Jr. Ph.D., Professor of Psychology and Director of the Doctor of Psychology Program in Counseling Psychology, Radford University**

  "Typically insurance does not reimburse for services until Clinical Psychology graduate is licensed." A solution that would immediately serve to significantly increase access and availability would be to work with the insurance companies to reimburse for services provided by doctoral students in psychology programs who

are under the supervision of an appropriately credentialed mental health or medical professional.

To work through issues regarding insurance reimbursement a joint resolution requesting that JCHC convene a task force to review the implications of providing insurance reimbursement for psychology doctoral students, pre-doctoral interns, and post-doctoral residents could be introduced. The report would detail financial implications for insurers, access and availability implications for citizens, and potential likelihood of retaining psychology doctoral program students, interns, and residents in the Commonwealth through and after licensure as Clinical Psychologists. The resolution would require an interim report to JCHC by June 30, 2010 with a final report by December 31, 2010. Task force participants would include:

- Board of Psychology
- Virginia Psychological Association
- Bureau of Insurance
- Doctoral Training Program representatives
- Health insurance company representatives
- Mental Health service agencies

Dental related

- **Ellen Austin-Prillaman RDH, President of the American Dental Hygienists' Association**

  "VDHA requests that Policy Option 17 be amended to include dental hygienists. We support any effort that will help the Department of Health Professions to improve and expand the information they have on dental professionals."

  "We would also urge the Joint Commission to study and promote innovative use of technology and expanded duty dental hygienists. There are advancements in teledentistry in Texas and Alaska. Advanced dental hygiene practitioners (ADHP) are expanding access to services in states including Washington, Minnesota, and others. Virginia is fortunate to have rich resources in our dental hygiene programs - we are one of the very few states that have a Masters Degree Program in Dental "Hygiene. The programs put us in a great position to embrace the future of implementing solutions to get the most from our dental workforce."

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  "[VDA] recommend a more robust safety net via the Department of Health and its health districts- in particular, its dental segment. Dental public health is a critical and necessary part of healthy communities and its dentists serve a vital part in bringing the message of prevention to these communities. Without a sustainable dental public health system, we will continue to struggle with a workforce that doesn't meet the needs of its most vulnerable citizens."

"[VDA also] recommends the restoration of funding for the loan repayment program as we have seen excellent results in the placement of dentists in the more rural and remote areas of the state. Without this funding, we will continue to struggle to incentivize our dentists, often with heavy debt loads, to locate in communities where there are extreme needs but economies that challenge the successful business plan of a dental practice. Loan repayment programs have been shown to enhance the ability of communities to attract young dentists into moving into those areas with high dental needs. The workforce issue isn't and can't be simply about the numbers- we must continually look for ways to incentivize our young practitioners to consider practicing in communities that have these high needs, but struggle having an environment for successful businesses."

Appendix B

Public Comment: Additional Policy Options

Physician related

- Roger Hofford, M.D., Program Director of the Carilion Clinic Family Medicine Residency
- Peter J. Pagnussi, M.D., President of the Virginia College of Emergency Physicians
- Dixie Tooke-Rawlins D.O., Dean and Executive Vice President of the Via Virginia College of Osteopathic Medicine

Mental Health related

- Dr. John Ball, Ph.D., Clinical Psychologist
- Mary Ann Bergeron, Executive Director of the Virginia Association of Community Service Boards
- Catherine Bodkin, Licensed Clinical Social Worker
- James F. Dee, M.D. , President of the Northern Virginia Chapter of the Washington Psychiatric Society
- Janet McDaniel, Ph.D., M.P.H., Chair of the Workforce Council for Virginia's State Rural Health Plan
- Debra A. Riggs, Executive Director of the Virginia Chapter of the National Association of Social Workers
- Cathleen A. Rea, Ph.D., Chair of the Licensure Task Force for the Virginia Academy of Clinical Psychologists
- Mira Singer, Executive Director of the National Alliance on Mental Illness
- Bela Sood, M.D., President of the Virginia Chapter of the American Academy of Child and Adolescent Psychiatry
- James L. Werth, Jr. Ph.D., Professor of Psychology and Director of the Doctor of Psychology Program in Counseling Psychology, Radford University

Dental related

- Ellen Austin-Prillaman RDH, President of the American Dental Hygienists' Association
- Terry Dickenson, D.D.S., Executive Director of the Virginia Dental Association

Physician related

- **Roger Hofford, M.D., Program Director of the Carilion Clinic Family Medicine Residency**

"Over the last six years our state funding has decreased significant to support family medicine residency training...with a worsening payor mix of patients served, and decreased Federal funding for graduate medical education. In the state budget language this money can be used to pay for medical students rotations in family medicine. I would ask the Joint Commission/General Assembly look at whether these monies for students are accomplishing the outcomes we need at the expense of our state supported family medicine residencies."

Regarding DMAS reporting on an enhanced medical education funding for selected specialties (Option 4), JCHC should review how South Dakota uses their state line item funding to obtain a Federal match.

- **Peter J. Pagnussi, M.D., President of the Virginia College of Emergency Physicians**

  For the Loan Repayment programs, we request that "JCHC examine the option of adding 'emergency medicine' as one of the allowable practice areas eligible for loan repayment. Currently, emergency medicine is not included and, in light of presentation highlighting emergency medicine as a physician shortage area, we believe it should be added."

  Related to Option 5, we support introduction of a budget amendment (language and funding) "to increase Medicaid reimbursement rates for emergency physicians. Family practice physicians and emergency physicians have the lowest reimbursements in the state. And, unlike family practice physicians who can stop taking Medicaid patients, emergency physicians have to treat everyone at all times, according to the Federal EMTALA law and cannot turn anyone away."

- **Dixie Tooke-Rawlins D.O., Dean and Executive Vice President of the Via Virginia College of Osteopathic Medicine**

  Loan repayment program monies in Option 2 "should be restored in time for those residents who finish in July 2010 to receive the loan repayment as they enter rural primary care practices. Finally considering the shortages for primary care that exist, the definition of rural should be expanded to include all communities of less than 25,000 and who are over 30 miles from the nearest urban area; and the designation of underserved should expanded to include the Community Health Centers or Federally Qualified Health Centers so to reach those in most need. These changes would greatly enhance access in rural Virginia. Although this does not match the federal definition, the federal definition does not accurately define rural in Virginia. (an example is Craig Co. which is not considered a rural medically underserved area.)"

"I support increasing funding to the residencies [referenced in Option 3] as they enroll students from all four medical schools in the state who have graduates. I do however request that the funding provided be equally distributed to the all of the family medicine residencies throughout the state. This would include the EVMS and VCOM sponsored family medicine residency programs as well and be distributed according to the number of programs and residents."

"As state funding is currently limited and "tough decisions" are called for by the General Assembly, re-allocation of funds to support rural residencies might be redirected from programs such as GMEC, which was established to provide a rural rotation for residents in urban primary care programs. GMEC which costs the State over 295,000 per year has only had 20 participating residents locate in Southwest Virginia since 1998. It would be the time to redirect the Graduate Medical Education Consortia to assist new rural primary care residency training programs or rural fellowships where retention in rural areas would be much greater."

"VCOM is in favor of improving the education of the healthcare workforce in caring for Geriatric patients however this could be done with little or no cost to the State. All five medical schools have Geriatricians on campus and are capable of providing CME. The amendment should call for the State's Medical Schools (public and private) to provide specific hours of CME on care of the Geriatric patients. The current medical schools and allied health schools would be a greater resource in developing the programs and providing the appropriate CME credits to the participants. If the State believes that a mandate is needed to further Geriatric care then asking that the CME be submitted to the State Medical Licensing Board at the time of renewal may be warranted.

Mental Health related

- **Dr. John Ball, Ph.D., Clinical Psychologist**

  Some avenues to address shortages include "protecting and even expanding state funding for the training of new mental health clinicians in programs at EVMS and elsewhere and perhaps an expanded utilization and supported healthcare reimbursement structure for telemedicine in the area of mental services to improve access to care in rural environments."

  Also, the Virginia Board of Psychology is being urged to eliminate their pre-licensure requirement of a one year post-doctoral residency in clinical psychology for new graduates who have already met both 1500 practicum training hours during graduate school and a full time in–residence clinical psychology internship. Any JCHC support of the Board of Psychology eliminating the requirement for a post-doctoral residency year as a prerequisite to licensure would be appreciated.

- **Mary Ann Bergeron, Executive Director of the Virginia Association of Community Service Boards**

  "The VACSB would be supportive of a rate increase in reimbursement for any services related to community mental health services and/or treatment."

- **Catherine Bodkin, Licensed Clinical Social Worker**

  "Licensed clinical social workers ...provide more than 50% of the mental health services, especially in rural areas and with low income families.... [Licensed clinical social workers] are a vital part of the Commonwealth's substance abuse and mental health system. No report is complete without considering their role in services and the need to support loan repayment programs similar to nurses, doctors, and clinical psychologists. I hope the Commission will request that future studies include statements about the role of licensed clinical social workers in order to be able to accurately assess the system changes that are needed."

- **James F. Dee, M.D. , President of the Northern Virginia Chapter of the Washington Psychiatric Society**

  "There are better ways to build the psychiatric workforce and expand access to mental health care [than Option 15]. Policymakers should support robust psychiatric residency programs that will build a highly-qualified professional population. These programs should include placement requirements for residents to practice in underserved areas. Reimbursement policies should encourage use of technology and the existing workforce to expand telepsychiatry. Collaborative practice arrangements between pediatricians and psychiatrists can establish consultation networks between frontline primary care and subspecialty experts. And, public and private insurance coverage should be required to reflect the public's need and demand for psychiatric services, especially as patients seek early intervention for mental illness."

- **Janet McDaniel, Ph.D., M.P.H., Chair of the Workforce Council for Virginia's State Rural Health Plan**

  "We suggest working with the insurance companies to reimburse for services provided by doctoral students in clinical psychology programs who are under the supervision of an appropriately credentialed mental health or medical professional. We encourage looking at how other states reimburse care provided by students who are closely supervised by licensed mental health providers (e.g. Ohio)."

- **Debra A. Riggs, Executive Director of the Virginia Chapter of the National Association of Social Workers**

"Each state determines what areas of social work practice are protected by law. It is those discrepancies that allow anyone to identify himself as a social worker despite their qualifications. As an example, fewer than 40% of child welfare workers are professional social workers. This threat to the professionalism of social has encouraged advocacy within the field for greater protection of the public through a combination of practice and title protection laws with limited exceptions or exemptions to legal requirements. Social Work practice protection refers to licensure laws that require all those who act as social workers to be licensed thus protecting the specific actions performed by social workers by ensuring that only qualified individuals carry out social work functions. A Title protection statute protects a specific social work title, such as Licensed Master Social Worker, from being used by anyone that does not meet the legal definition of a social worker for that level of licensure."
Also NASW requests "a letter from the JCHC Chairman that the Department of Health Professions improve the information collected and compiled about clinical social workers for the Healthcare Workforce Data Center."

- **Cathleen A. Rea, Ph.D., Chair of the Licensure Task Force for the Virginia Academy of Clinical Psychologists**

  The Virginia Academy of Clinical Psychology strongly recommends that the Joint Commission formally encourage the Board of Psychology to proceed in due haste with promulgation of regulations to eliminate the requirement for a post-doctoral residency year as a prerequisite to licensure.

- **Mira Singer, Executive Director of the National Alliance on Mental Illness**

  NAMI believes that public policy on workforce shortage issues should on the underlying obstacles that prevent people from entering the mental health field and should create incentives to attract and retain qualified professionals.
  Recommended measures that can be considered include:

  - Providing scholarships or stipends to psychiatrist trainees, psychologist trainees, and other mental health professional trainees who commit to providing services to people with mental illnesses in under-served regions or sectors;
  - Establishing and expand loan forgiveness programs for psychiatrists, psychologists and other mental health professionals who serve for particular periods in under-served regions;
  - Mental health insurance parity for better coverage and access to care;
  - Paying adequate wages to case managers, counselors, and other important but traditionally inadequately compensated mental health professionals to retain qualified and dedicated individuals in the field; and

- Employing consumers and family members in a variety of capacities in the mental health field whenever possible, such as peer counselors, support positions, etc.

- **Bela Sood, M.D., President of the Virginia Chapter of the American Academy of Child and Adolescent Psychiatry**

  VA AACAP with our "pediatrician colleagues, we have advocated for support of collaborative arrangements that would provide primary care physicians with professional consultations for the complex cases they face in underserved regions – a model of success in other states. We have forwarded these proposals to the Secretary of Health and Human Resources and the Commissioner for Mental Health on several occasions. They have acknowledged these proposals as being viable but have not funded them citing financial shortfall in the state budget. Hence, if any funds should be appropriated, they should be made available for funding "shovel ready" proposals like the Collaborative pediatric/primary care child mental health initiatives to meet the challenges of work force shortages by training pediatricians and not studies for training non medical colleagues."

- **James L. Werth, Jr. Ph.D., Professor of Psychology and Director of the Doctor of Psychology Program in Counseling Psychology, Radford University**

  "Typically insurance does not reimburse for services until Clinical Psychology graduate is licensed." A solution that would immediately serve to significantly increase access and availability would be to work with the insurance companies to reimburse for services provided by doctoral students in psychology programs who are under the supervision of an appropriately credentialed mental health or medical professional.

  To work through issues regarding insurance reimbursement a joint resolution requesting that JCHC convene a task force to review the implications of providing insurance reimbursement for psychology doctoral students, pre-doctoral interns, and post-doctoral residents could be introduced. The report would detail financial implications for insurers, access and availability implications for citizens, and potential likelihood of retaining psychology doctoral program students, interns, and residents in the Commonwealth through and after licensure as Clinical Psychologists. The resolution would require an interim report to JCHC by June 30, 2010 with a final report by December 31, 2010. Task force participants would include:

  - Board of Psychology
  - Virginia Psychological Association
  - Bureau of Insurance
  - Doctoral Training Program representatives
  - Health insurance company representatives
  - Mental Health service agencies

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