Meeting Minutes

Joint Commission on Health Care

Tuesday, October 17, 2017 – 10:00 a.m.
Pocahontas Building – Senate Committee Room

Members Present

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

Senator George L. Barker
Senator Charles W. Carrico, Sr., Chair
Senator Siobhan S. Dunnavant
Senator John S. Edwards
Senator L. Louise Lucas
Senator Glenn H. Sturtevant
Senator David R. Suetterlein

Joe Flores

This was a non-electronic meeting

Members Absent

Delegate Kaye Kory
Senator Rosalyn R. Dance, Vice Chair

Staff Present

Michele Chesser
Agnes Dymora
Paula Margolis
Andrew Mitchell
Stephen Weiss

Call to Order

Senator Carrico called the Joint Commission meeting to order, thanked everyone for coming, provided welcoming comments and turned the meeting over to the first presenter.

VHI Annual Report and Strategic Plan

Michael Lundberg began his presentation by briefly touching on the history of VHI's 25-year existence. He then spoke about the different reports that can be accessed on their websites and who would benefit from looking at them. He spoke about ConnectVirginia HIE, Emergency Department Care Coordination Program (EDCCP) and All Payer Claims Database (APCD). He also spoke about stakeholder support and healthcare reform efforts. He finished by explaining where the funding for VHI comes from.

Heroin Use in Virginia

Stephen Weiss reported on heroin use in Virginia. The study was approved during the JCHC work plan meeting in May, 2017, based on a resolution by Delegate Marshall (HJR 597) that was left in House Rules Committee.

Stephen provided information and data on heroin use and overdose; how people become addicted to heroin and the pathways that lead addiction; the cost and availability of naloxone, a medication designed to rapidly reverse opioid overdose and prevent death; what the Commonwealth is doing to address the increase in heroin use, what other state are doing and what else the Commonwealth can do to end the crisis.

Stephen reported that heroin is part of a class of drugs rooted in opium that includes morphine, methadone and prescription opioid painkillers. The report indicated that there has been a dramatic increase in heroin related overdoses and fatalities within the past few years. The literature and data reviewed for the report indicate that the increases are due to an evolving opioid crisis nationally and locally from the over prescribing of opioid painkillers to many Americans in an effort to treat non-cancer related pain. According to the National Survey of Drug Use and Health Surveys, 25,000 Virginians over the age of 12 used heroin in the last year; or approximately 0.3% of the state population. The path to heroin for many people begins with a routine injury or pain event that is treated with opioid prescription pain medicine. Opioid addiction and ultimately heroin use are highly individualistic but are more likely to occur over time based on the number of days an opioid prescription is written. According to the CDC, people who use opioid painkillers are 40-times more likely to use and become addicted to heroin. People who overdose on opioids and heroin can be revived by the administration of naloxone. In 2017 the Virginia General Assembly, like other states, approved the sale of naloxone without a prescription. The price of naloxone varies depending on the purchaser, whether they have insurance or are indigent. The Virginia State Police, emergency services, emergency rooms and the state forensic laboratory are all reporting increases in the number of heroin cases, calls, overdoses and fatalities. The Virginia Office of Chief Medical Examiner (OCME) reported an increase in heroin related fatalities of 313 between 2012 and 2016, an increase of 232% (135 to 448). The OCME also reports an increase in fentanyl found in laboratory results of fatalities along with heroin. Fentanyl is a powerful synthetic opioid pain reliever. According to OCME, 57.4% of heroin fatalities in 2016 included fentanyl. The Commonwealth is addressing the emerging heroin crisis through the Governor's Executive Leadership Team on Opioids and Addiction, the passage of at least 7 new laws and amendments to the Virginia Code, budget amendments expanding treatment alternatives, and a variety of regulatory actions by the Boards of Medicine and Dentistry.

Creation of a Registry of Abuse or Neglect Cases

Paula Margolis presented a report on the Creation of a Registry of Cases of Abuse, Neglect and Exploitation of Individuals Enrolled in the Building Independence, Family and Individual Supports, and Community Living Medicaid Home and Community-based Services and Supports Waivers.

The study was responding to a request made by four legislators to investigate options for creating a registry of individuals alleged to have committed abuse, neglect and exploitation of waiver enrollees, which include children and adults with developmental and intellectual disabilities. Avenues for reporting alleged incidents exist and are administered and operated by the Department of Aging and Rehabilitation Services (DARS), the Department of Social Services (DSS), local Social Services offices (local DSS), the Office of Human Rights (OHR) within the Department of Behavioral and Developmental Services (DBHDS) and the Department

of Health Professions (DHP), which investigates complaints against 13 licensed health professions.

Individuals working with waiver enrollees are mandated by the Code of Virginia to report suspected cases of abuse, neglect and exploitation, and the local DSS offices investigate and provide dispositions of cases. Cases may be founded or substantiated, (meaning the preponderance of the evidence supports the allegation), or unfounded/unsubstantiated (where the preponderance of the evidence does not support the allegation). Unfounded cases are purged from the databases after 1 – 3 years, depending upon circumstances. The databases administered by DARS do not allow public access. The database at DPH does allow public access but cases cannot be searched by disability type or waiver enrollment.

Approximately 23 thousand complaints were submitted to a local DSS office in 2016, of which, approximately 45% received a disposition of unfounded/unsubstantiated. The most frequent type of founded/substantiated cases was self-neglect (56%), followed by neglect (18%), financial exploitation (11%) and physical abuse (6%). The majority of cases occurred at the victim's home (62%) or another person's home (11%). Family members were the most frequent perpetrators followed by unrelated partners of parents. For cases reported to the OHR in SFY 2017, one in four (788 out of 3,019) were founded/substantiated, and 69% involved peer-to-peer incidents where one resident attacked another resident. Given the significant percentage of cases that were unfounded/unsubstantiated, creating a registry of uninvestigated complaints may pose liability issues for the state.

The Code of Virginia includes language that specifies conditions of disclosures of employment-related information (§ 8.01-46.1), preventing employment of others by a former employer (§ 40.1.27), and immunity to Sheriff Departments for disclosing information on job performance (§ 15.2-1709). A review of states found that no state maintains a registry of uninvestigated/unfounded cases due to the lack of due process for the alleged perpetrators. States use a variety of methods, including requiring that applicants provide letters of recommendation from previous employers; and, that employees sign letters of consent for past employers to divulge details of job performance.

Six policy options were offered including creating a registry of complaints; strengthening protections in current regulations; requiring employees to sign consents for employers to provide information on job performance; requiring that candidates provide letters of recommendation; and providing immunity from civil liability to past employers, similar to that provided to sheriff departments.

Medical Use and Health Effects of Cannabis

Andrew Mitchell presented a study on the medical and non-medical uses of cannabis. He first reviewed the medical use of cannabinoids (THC, THC-A and CBD), focusing on their psychoactive properties, the evidence base on their therapeutic and detrimental effects, and the landscape of medical use of cannabis across the US. He then reviewed adverse health effects of use of cannabis, including: evidence bases on cannabis use with health and social outcomes; and relationships between passage of cannabis laws for medical/non-medical uses and cannabis use, age of cannabis initiation and impaired driving. He also provided information on methods used by States and other countries to limit the illicit use of cannabis. JCHC members were presented

with 10 Policy Options, including three related to regulating psychoactivity of THC-A oil, two related to THC-A and CBD oil dispensing requirements and monitoring for Adverse Events, three related to the process for adding new qualifying conditions as an affirmative defense for use of THC-A or CBD oils, and one related to the non-medical use of cannabis.

Adjournment
The meeting was adjourned. The next Commission meeting will be held November 21, 2017 at 10 am in the Pocahontas Building.

Electronic Meeting: No
Prepared by: Agnes Dymora
Date: 9/20/2017