Joint Commission on Health Care

SUMMARY OF PUBLIC COMMENTS:

Public comments were requested for the policy options included in six JCHC studies presented in September (including three studies presented during the Healthy Living/Health Services Subcommittee meeting). No comments were received for the following two studies:

- **Involuntary Admission of Persons in Need of Substance Abuse Treatment**
  HJR 682 (Delegate O'Bannon)
- **Chronic Health Care Homes**
  HJR 82 – 2010 (Delegate Hope)

Public comments were summarized for the four remaining studies:

- **Considerations in Adding Pseudoephedrine as a Schedule III Controlled Substance**
  SB 878 (Senator Reynolds)
- **Pharmacist-Regulation Legislation**
  HB 1961 and HB 1966 (Delegate Rust)
- **Eating Disorders in the Commonwealth**
  SJR 294 (Senator Puller)
- **Public Access to Vital Records**
  SB 865 (Senator Blevins)

Considerations in Adding Pseudoephedrine as a Schedule III Controlled Substance

SB 878 (Senator Reynolds)

Three comments were received regarding the policy options addressing the methamphetamine problem in Virginia presented to the Joint Commission on Health Care in September. Comments were submitted by:

- John Jones, Executive Director, on behalf of the Virginia Sheriffs' Association (VSA)
- Michael Weber
- John R. Gibson, Director of US Public Affairs & Policy, on behalf of Pfizer, Inc.

Public Comments on Policy Options

Options		In Support	In Opposition
1	Take no action.	0	0
2	Legislation to make pseudoephedrine (PSE) a prescription drug.	0	2 (Pfizer, M. Weber)
3	Legislation to use the National Precursor Log Exchange.	2 (Pfizer, VSA)	0
4	Legislation to limit PSE purchase to 9 grams within 30 days and to make exceeding the limit a misdemeanor offense.	1 (M. Weber)	0
5	Legislation to limit possession or acquiring PSE to 9 grams within 30 days.	0	0
6	Legislation to make obtaining or procuring PSE by fraud, deceit, or forgery a misdemeanor offense.	0	0

Option 1: Take no action.

Option 2: Introduce legislation to amend the *Code of Virginia* § 54.1-3450 to add pseudoephedrine to Schedule III of the Drug Control Act, which would prohibit it from being sold without a prescription. *(OAG informal opinion indicated PSE does not meet the statutory conditions.)*

Option 3: Introduce legislation to amend of the *Code of Virginia* § 18.2-248.8 to require that the log, currently required to be maintained by sellers of products containing ephedrine, pseudoephedrine, or any of their salts, isomers, or salts of isomers, must be kept by a State level law enforcement agency in electronic format, utilizing the National Precursor Log Exchange (NPLEx).

Option 4: Introduce legislation to amend the *Code of Virginia* § 18.2-248.8 to make the purchase of ephedrine and pseudoephedrine, in excess of statutorily-determined amounts, a misdemeanor offense and to establish the maximum amount of ephedrine and pseudoephedrine that can be legally sold or purchased in a 30 day period:

§ 18.2-248.8. Sale **and purchase** of the methamphetamine precursors ephedrine and pseudoephedrine; penalty.

A. The sale of any product containing ephedrine, pseudoephedrine, or any of their salts, isomers, or salts of isomers, alone or in mixture, shall be restricted when provided or sold by a retail distributor or pharmacy as follows:

1. Retail sales **and purchases** shall be limited to no more than 3.6 grams total of either ephedrine or pseudoephedrine daily and **9 grams within any 30 day period** per individual customer.

Option 5: Introduce legislation to amend Title 18.2 of the *Code of Virginia* to make it unlawful to possess, receive, or otherwise acquire more than 9 grams of ephedrine, pseudoephedrine, or any of their salts, isomers, or salts of isomers; or phenylpropanolamine in any product, mixture, or preparation within any 30 day period. (This restriction does not apply to any quantity of product, mixture, or preparation

obtained pursuant to a valid prescription drug order prescribed by a practitioner with appropriate authority.)

> Possession of more than 9 grams of ephedrine, pseudoephedrine, or phenylpropanolamine constitutes a rebuttable presumption of the intent to use the product as a precursor to methamphetamine or another controlled substance. This rebuttable presumption does not apply to:
>
> (i) A retail distributor of drug products;
> (ii) A wholesale drug distributor, or its agents;
> (iii.) A manufacturer of drug products, or its agents;
> (iv.) A pharmacist licensed by the Board of Pharmacy; or
> (v.) A licensed health care professional possessing the drug products in the course of carrying out professional duties.

Option 6: Introduce legislation to amend the *Code of Virginia* § 18.2-258.1.A to add ephedrine, pseudoephedrine, or any of their salts, isomers, or salts of isomers to the current list:

> § 18.2-258.1. Obtaining drugs, procuring administration of controlled substances, etc., by fraud, deceit or forgery. A. It shall be unlawful for any person to obtain or attempt to obtain any drug or procure or attempt to procure the administration of any controlled substance, marijuana, **or** synthetic cannabinoids, ***or ephedrine, pseudoephedrine, or any of their salts, isomers, or salts of isomers*****:** (i) by fraud, deceit, misrepresentation, embezzlement, or subterfuge; or (ii) by the forgery or alteration of a prescription or of any written order; or (iii) by the concealment of a material fact; or (iv) by the use of a false name or the giving of a false address. (Class 1 misdemeanor)

Comment Excerpts

John Jones on behalf of the Virginia Sheriffs' Association (VSA) commented in **support of Option 3**:

> "The Virginia Sheriffs" Association (VSA) supports the development of an automated NPLEX system. There are other options that will be considered by the VSA as the legislative process moves forward, but the VSA has already voted to support (as a priority) a statewide system designed to detect multiple purchases of substances used to make meth.
>
> Based on a recent survey of sheriffs, [meth production] was identified as a major and costly problem in Virginia, both as a public safety issue and as a financial burden to localities for cleaning up the labs that have been busted."

Michael Weber commented **against Option 2** and in **support of Option 4**:

> "The regulation currently in place is fine. When you go to buy this medication you must show an id - the government does not need to be involved anymore than they are with this medication. Isn't option 4 the one that is being used now? If not, I have no problem with option 4. I do not want to have to go to the doctor in the spring and fall for this sinus medication."

John R. Gibson on behalf of Pfizer, Inc. commented **against Option 2** and in **support of Option 3**:

> "While Pfizer, Inc. understands the ongoing challenges of Meth usage and production in Virginia (especially in Southwest) and many other states, the company is opposed to making Pseudoephedrine a Schedule III Drug in the Commonwealth…Reclassifying these products as schedule III will require legitimate consumers to see a doctor and get a prescription every time they have a cough, cold or allergy. It will add stress and costs onto law-abiding consumers and an already burdened healthcare system – while only marginally, if at all, decreasing meth use… Additionally, it is important to note that Pseudoephedrine by itself is NOT addictive which is certainly why Attorney General Cuccinelli's office has informally stated that it likely could not be classified as a Schedule III in the first place…we support the NPLEX tracking system that was aptly outlined in your presentation...NPLEX is a tried and true method currently in use in many states and would cost neither the state nor pharmacies any additional monies to implement... And, as you know the NPLEX system has the support of many key pharmaceutical companies and trade organizations and we believe it is the best way to achieve the results desired."

Pharmacist-Regulation Legislation – HB 1961 and HB 1966 (Delegate Rust)

Dr. Dianne Reynolds-Cane, Director of the Department of Health Professions, submitted the only comment in response to the study which addressed recusal of members of the Board of Pharmacy from disciplinary hearings. As noted below, Dr. Reynolds-Cane's comments questioned how Option 2 would be implemented and opposed Option 3.

Public Comments on Policy Options

Option 1: Send report findings to the Chairman of the House Committee on Health, Welfare and Institutions and take no further action.

Option 2: Send report findings to the Chairman of the House Committee on Health, Welfare and Institutions and include in the letter that JCHC voted:

> In support of recommending that the Board of Pharmacy record, in the minutes of any formal disciplinary hearing, a statement regarding any Board member who recused himself from participating in the hearing.

Dr. Dianne Reynolds-Cane commented:

"We are uncertain about what sort of "statement" is contemplated. *If a board member recuses himself at a formal hearing (or an informal conference), the minutes of the meeting would already include that occurrence.*…There are numerous scenarios surrounding the issue of recusal, so the Department has some concerns as to whether there is an expectation about the "statement" in the minutes apart from recording the fact of a member's recusal at the formal hearing, which would already be captured in the minutes."

Option 3: Send report findings to the Chairman of the House Committee on Health, Welfare and Institutions and include in the letter that JCHC voted:

> In support of amending the *Code of Virginia* § 54.1-2400.2(F) to change the permissive "may" to a compulsory "shall" as shown:
>
> > **"**The relevant board may [***shall***] also inform the source of the complaint or report (i) that an investigation has been conducted, (ii) that the matter was concluded without a disciplinary proceeding, (iii) of the process the board followed in making its determination, and (iv) if appropriate, the result of the proceeding including that an advisory letter from the board has been communicated to the person who was the subject of the complaint or report without the content of the letter."

Dr. Dianne Reynolds-Cane commented in opposition to Option 3:

"While it is currently discretionary, boards within the Department already do provide the information enumerated in the Code in the letter that goes to a source of a complaint. However, it would be our preference for the boards to have *authorization* to share such information with a source but to retain the current permissive language."

Option 4: Send report findings to the Chairman of the House Committee on Health, Welfare and Institutions and include in the letter that JCHC voted:

> In support of amending Title 54 of the *Code of Virginia* to extend mandatory reporting requirements (similar to requirements for health care institutions) to require pharmacists and pharmacies to report on disciplinary actions, treatment needs, and commitments and inpatient admissions related to "substance abuse or psychiatric illness that may render the….[pharmacy-related] professional a danger to himself, the public or his patients."

Eating Disorders in the Commonwealth

SJR 294 (Senator Puller)

Five comments were received regarding the policy options on eating disorders presented to the Healthy Living/Health Services Subcommittee in September. Comments were submitted by:

- Laura Collins, Executive Director, on behalf of F.E.A.S.T. (Families Empowered and Supporting Treatment of Eating Disorders)
- Lisa Gorove
- Lynn S. Grefe, Chief Executive Officer, and Lara Gregorio, STAR Program Manager on behalf of the National Eating Disorders Association (NEDA)
- Beverly Magida, LCSW, BCD
- Carol Blum Papillon, MPH, RD, President, on behalf of the Virginia Dietetic Association (VDA)

Public Comments on Policy Options

Options		In Support	In Opposition
1	Take no action.	0	0
2	Request by letter of the Chairman that DOE encourage school systems to provide approved instruction on recognizing and assisting with eating disorders.	0	0
3	Request by letter of the Chairman that DOE encourage school systems to provide instruction on healthy eating habits and positive body image during 4th, 5th, or 6th grade.	1 (VDA)	0
4	Request by letter of the Chairman that: (i) MSV encourage completion of online continuing education course on eating disorders such as 15-minute course created by AMA (ii) VNA encourage completion of online continuing education course on eating disorders such as 15-minute course created by AMA.	2 (VDA, B. Magida)	0
	Comments, that did not specifically address an option, were submitted by Lisa Gorove and on behalf of F.E.A.S.T., NEDA, and VDA.		

Option 1: Take no action.

Option 2: Request by letter of the JCHC Chairman that the Virginia Department of Education encourage local school systems to provide homeroom teachers and school nurses within each of their schools with instruction (approved by the American Psychiatric Association, the Academy for Eating Disorders or the National Eating Disorders Association) on how to recognize eating disorders and how to help youth who may be affected receive the care they need.

Option 3: Request by letter of the JCHC Chairman that the Virginia Department of Education encourage local school systems to ensure instruction (approved by the American Psychiatric Association, the Academy for Eating Disorders or the National Eating Disorders Association) on healthy eating habits and positive body image is provided to students at some point during the fourth, fifth, or sixth grade.

Option 4: Request by letter of the JCHC Chairman that:

(i) The Medical Society of Virginia encourage pediatricians and general practitioners to complete an online continuing education course on eating disorders, such as the new 15 minute, online course created by the American Medical Association.

(ii) The Virginia Nurses Association encourage nurse practitioners and nurses to complete an online continuing education course on eating disorders, such as the new 15 minute, online course created by the American Medical Association.

Comment Excerpts

Carol Blum Papillon on behalf of the Virginia Dietetic Association (VDA) commented in **support of Options 3 and 4** and requested additional options**:**

> "…In summary, the Virginia Dietetic Association does support the education of elementary school students in healthy eating imbedded within established standards of learning. We also support prevention and awareness training for medical practitioners particularly in ways that will provide them with adequate resources to both diagnose and refer patients to the appropriate treatment options.
>
> As stated in the report, treatment requires a team approach including the primary care physician, registered dietitian, and a psychotherapist knowledgeable about eating disorders. The proposed policy options do not address the current lack of treatment that exists. Therefore, we encourage further study of policy options that would enhance treatment among those afflicted within the Commonwealth and insurance coverage thereof…"

Beverly Magida commented in **support of Option 4:**

> "I am a clinician providing treatment services to Eating Disorder adolescents and adults in Northern VA. I strongly support the request for additional Eating Disorder education for nurses and doctors, as this will provide essential preventative care and maximize practitioners' knowledge of this severe illness, while assisting the client in receiving the essential care they require."

Lynn S. Grefe and Lara Gregorio on behalf of the National Eating Disorders Association (NEDA) requested **amendments to options 2, 3, and 4** and requested an **additional option**:

> "…NEDA requests that policy options 2, 3, and 4 be amended to call upon the Department of Education, the Medical Society of Virginia, and the Virginia Nurses Association to work with NEDA, and other interested parties, to implement the JCHC's directives. Further, NEDA respectfully requests that the JCHC direct staff to report back to the JCHC in 2012 on the progress made during implementation of options 2, 3, and 4 as well as any additional recommendations arising out of implementation.
>
> Additionally, NEDA respectfully requests that the JCHC adopt a fifth policy option. Building on the JCHC's Healthy Living Subcommittee's valuable discussion on September 19th, NEDA suggests a policy option be developed calling upon the Department of Health and the Department of Education to jointly develop an evidence-based program for eating disorder screenings in Virginia's schools. NEDA is excited to assist the Commonwealth of Virginia in developing this screening process. Virginia already successfully implements a scoliosis screening process in its school systems. With thoughtful development, perhaps guided by recent studies on eating disorder screening techniques by Harvard's School of Public Policy, an eating disorders screening program could provide the best defense yet for Virginia's young people. NEDA requests that staff report back to the JCHC in 2012 regarding progress made on developing an evidence-based school screening program and staff's policy recommendations for implementation."

Laura Collins on behalf of F.E.A.S.T. (Families Empowered and Supporting Treatment of Eating Disorders) commented without supporting a specific option, taking issue with the inclusion of family dynamics as one of the causal factors for eating disorders and with the lack of content on parents in the presentation. Ms. Collins wrote"

> "…Families do not cause eating disorders and family dynamics are NOT a factor in causing them. This is a myth that has been dispelled, just as it was with autism and schizophrenia, but continues to

be repeated as it is here. Not only is this myth a distraction, it causes active harm in that families need to be empowered to take assertive and challenging action to participate in care and learn all they need to know as caregivers. Family dynamics DO play a role in maintaining the symptoms BECAUSE of these myths and because of a lack of clinical support to help families intervene. Although there are many clinicians who continue to marginalize and pathologize parents and families on the basis of an ED diagnosis, the consensus in the field is that these ideas are unfounded and harmful…"

Ms. Collins also was concerned about the lack of citations and felt some were outdated.

Lisa Gorove commented without supporting a specific option by stating:

My daughter "has had over 12 inpatient hospitalizations for low heart rate, electrolyte imbalance, irregular heartbeat, enlarged liver (her heartbeat would go into the thirties), decreased respirations .. all life threatening. In addition to the residential treatment in St. Louis, she has been in Denver, CO, Logan, UT, Dominion Hospital in VA, numerous stays at Children's National Medical Center (NCMC)...Beyond that she requires 24/7 supervision of meals. The impact on her brother, my job (Federal Government), her father, her grandparents, our finances, etc. is indescribable.

PLEASE take action to inform families, teachers, pediatricians, policymakers. etc. to become more aware of how eating disorders are triggered, and how crucial it is to intervene early.

My daughter is alive - we treat her as if she has a chronic illness like cystic fibrosis - and hope that she will live as long as possible. But this disorder has a 20% mortality rate, and for kids like my daughter, who has a terrible case, death is a possibility every day. She simply may not wake up tomorrow.

She is 16 years old."