



**THE FINAL REPORT OF THE
GEORGIA HOUSE STUDY COMMITTEE ON
GEORGIANS' BARRIERS TO ACCESS TO ADEQUATE HEALTH CARE**

COMMITTEE MEMBERS

**Honorable Sharon Cooper, Chair
Representative, District 43**

**Honorable Betty Price
Representative, District 48**

**Dr. Gregory Felzien, M.D.
Citizen Member**

**Honorable Karen Bennett
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**Dr. Yolanda Graham, M.D.
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**Honorable Lee Hawkins
Representative, District 27**

**Karen Sicard, RTT
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**Honorable Rick Jasperse
Representative, District 11**

**Dr. Steve Walsh, M.D.
Citizen Member**

INTRODUCTION

The Georgia House of Representatives created the Study Committee on Georgians' Barriers to Access to Adequate Health Care through the passage of House Resolution 240. The committee was formed to evaluate the issues relating to disparities in health outcomes and publish its findings with recommendations.

The committee was chaired by Representative Sharon Cooper (43rd) and also made up of four additional members of the House and four citizen members: Representative Karen Bennett (94th); Representative Lee Hawkins (27th); Representative Rick Jasperse (11th); Representative Betty Price (48th); Dr. Gregory Felzien, M.D.; Dr. Yolanda Graham, M.D.; Dr. Steve Walsh, M.D.; and Karen Sicard, RTT. The House Budget and Research Office staff member assigned to the committee was Mr. Leonel Chancey. The Legislative Counsel staff member assigned to the committee was Ms. Lynn Whitten.

The committee held five public meetings to hear from the Georgia Department of Public Health, Morehouse School of Medicine, Emory School of Medicine, Georgia Asthma Coalition, Georgia Department of Community Health (State Health Benefit Plan), Georgia Society of the American College of Surgeons, Obesity Action Coalition, Children's Healthcare of Atlanta, Georgia Area Health Education Centers, Georgia Department of Behavioral Health and Developmental Disabilities, Georgia Association of Community Service Boards, Georgia Psychiatric Physicians Association, Georgia Department of Community Health, Infectious Disease Program at Grady Health System, HIV Epidemiology Section, Center for Disease Control and Prevention, Georgia Association of Criminal Defense Lawyers, Advisory Committee on Immunization Practices, Georgia Registry of Immunization Transaction and Services, and Harm Reduction Coalition, to discuss the emerging demand for quality health care access.

The following individuals presented testimony to the committee at the Georgia State Capitol:

September 19th, 2017 — Jean O'Connor, M.D. (Georgia Department of Public Health); Seth Walker, M.D. (Emory School of Medicine); Marilyn Foreman, M.D. (Morehouse School of Medicine); and Tracy Bridges, M.D. (Georgia Asthma Coalition).

October 5th, 2017 — Cheryl Williams, RN, CCM (Deputy Chief, State Health Benefit Plan); Joe Nadglowski (Obesity Action Coalition); Jason Broce (Children's Healthcare of Atlanta); Larry Hall (Children's Healthcare of Atlanta); Rosemarie Sales, M.D. (Georgia Department of Public Health); Chris Rustin, M.D. (Georgia Department of Public Health); and Cherie Drenzek, DVM, MS (State Epidemiologist, Georgia Department of Public Health).

October 17th, 2017 — Wendy Armstrong, MD (Medical Director of the Ponce De Leon Center, Infectious Disease Program at Grady Health System and Professor at Emory University School of Medicine); Pascale Wortley MD, MPH (Director of HIV Epidemiology Section); Dr. David Purcell JD, PhD (Center for Disease Control and Prevention); MazieLynn Causey, Esq. (Georgia Association of Criminal Defense Lawyer).

October 30th, 2017 — Judy Fitzgerald (Commissioner, Department of Behavioral Health and Developmental Disabilities); David Kidd (President, Georgia Association of Community Service Boards); Ray Kotwicki, M.D. (President, Georgia Psychiatric Physicians Association); and Joe Hood (Deputy Commissioner, Department of Community Health).

November 16th, 2017 — Shelia Lovett (Advisory Committee on Immunization Practices); (Georgia Registry of Immunization Transaction and Services); Pat O'Neal (Commissioner, Georgia Department of Public Health); Daniel Raymond (Deputy Director of Policy and Planning, Harm Reduction Coalition); and Cherie Drenzek, DVM, MS (State Epidemiologist, Georgia Department of Public Health).

BACKGROUND

The National Challenge of Health Care Access

The recognized objective of health policy in the United States is sustaining the health and well-being of all populations within rigid financial boundaries. As Congress debates the future of the Affordable Care Act (ACA), health care dollars can be utilized more efficiently. It is estimated that people with one or more chronic conditions account for more than 85 percent of health care spending in the United States.¹ The country's health care system is better at treating disease than preventing it. Families are struggling with rising health care payments; high-cost and high-need patients overwhelm health programs; prisons have become inadvertent treatment systems for drug addictions; today's neglected children are increasing more state government obligations; and the demands of an aging population increasingly add more stress to health structures.

The challenges of chronic-disease treatment and prevention are heightened for health systems by the disadvantages experienced by its enrollees. Poor diet, homelessness, environment, genetics, behavior and lack of stable employment are often major barriers to stable health care. The Federal government has the responsibility for many factors as the health challenges continue to grow. The United States Department of Health and Human Services (HHS), federal executive branch leaders, and state officials can respond to these challenges by understanding the need to provide specific guidance for federal-state health policy to improve the nation's health.

The healthcare industry is dedicated to improving a system that can achieve higher quality care at a lower cost. The formula, however, is where the challenges and debate remain, while the effort required is anything but simple. Health care systems need to know more about the patients they serve especially now since the risk for health populations is moving to medical providers. To know which strategy is best, it is important to use data analysis and scenario building that can enable good decision making. Medical experts and administrators know creating higher value contributes to significant performance and growth. However, improvements need to come more quickly to ensure health care can achieve the types of gains possible. The longer the federal government waits, the more it will cost, and the more difficult it will be to make the necessary changes that will allow health systems to complete the tasks ahead.

Health depends on more than just genetics and medical care. Everything from federal policy to community resources impact our health. State officials will have to continue collaborating with federal partners and the private-sector to accomplish a common goal: people living in healthy, thriving communities. A plan to address the challenges in public health should involve every level of society, from the community, to the individual. Actions that directly affect the societal aspects of health care can improve health equality. This would facilitate the commitment of stakeholders, business leaders, community leaders, state lawmakers, and federal policymakers to integrate health into all areas of governance.

¹ National Center for Chronic Disease Prevention and Health Promotion, Chronic disease overview, Atlanta: Centers for Disease Control and Preventions (<http://www.cdc.gov/chronicdisease/overview/>).

Rural Health Care in Georgia

Rural Georgians are more likely than Metro Atlanta residents to suffer from obesity, heart disease, diabetes, and cancer. Of Georgia's 159 counties, the majority of the population in 148 counties are likely to be uninsured or underinsured. Additionally, nearly two-thirds of the counties are below the statewide average in total doctors, primary care physicians, physician assistants, and nurses per 100,000 residents. Rural areas are struggling in recruitment and retention of primary care physicians and health specialists. "If you suffer a traumatic injury in rural Georgia as opposed to in a metropolitan area, you are more likely to die."² The healthcare workforce in the state has been described as "Two Georgias" due to the health care disparity confronting rural counties.

The 2015 Healthcare Georgia Foundation report, "Georgia Provider Policy Organizations Give Insight into Rural Health Care", highlights several statistics in the state:

- 79 counties had no OB/GYN.
- 66 counties had no general surgeon.
- 63 counties had no pediatrician.
- 31 counties had no internal medicine physician.
- 6 counties had no family medicine physician.

Many of the same theories are presented for the policy issue when asked, "What solutions can work for rural Georgia?" Suggested ideas include more loan forgiveness for those who practice in rural areas and creating more medical residency slots. Some say expanding scope of practice for mid-level practitioners can help offset the lack of primary care doctors in rural areas. Greater collaboration among the providers in a community, education in rural health awareness, expanding telehealth services, and improving transportation are other solutions.

The most significant contributions for the causes of the negative trends in rural Georgia are demographic and economic factors. Younger populations are settling in urban cities, whereas citizens in rural areas tend to be more elderly and have a greater need for vital health care services. More Georgians are self-employed in rural areas and pay more for health insurance. Many rural residents are on Medicaid, which provides medical assistance for the poor from the state/federal program. In addition, some doctors report that they do not receive reimbursement in a timely manner or for operating cost. The consequence is that physicians are leaving rural areas and rural patients are taking fewer trips to a physician's office.

Sustainable economic development decreases outmigration and guarantees a healthy, well-balanced community for current citizens and future generations.³ Federal, state, or local government share a common notion of cooperation, but there is still a persistence of rural communities in regression. To some there appears to be a missing incentive for collaborative action. Rural economic development is essential to both workforce and regional development that can foster new relationships, allowing state, regional and local policymakers to lay the groundwork for positive long-term health and economic change. Where a rural Georgian lives should not limit the access to quality health care services.

² Healthcare Georgia Foundation 2015, Providers and Policy Organization 'Listening Tour' Report, http://www.healthcaregeorgia.org/uploads/files/The_Two_Georgias_Provider_Policy_2015.pdf.

³ Foundation for Rural Service, "Rural Economic Development: Building a Sustainable Community, August 24, 2008.

COMMITTEE FINDINGS

Asthma

There are two main categories of asthma: occupational asthma and work-exacerbated asthma/work-aggravated asthma. Occupational asthma is caused by environmental exposures, such as irritants, allergens, or physical conditions (like cold weather). Some examples of asthma triggers are animal dander, insects, chlorine-based cleaning products, cigarette smoke, cockroach droppings, cold air, dust mites, indoor dampness and mold, irritant chemicals, metal dust, physical exertion, and pollen and plants. Work-related asthma, if not identified and managed early, can get worse or reduce productivity and quality of life.

In 2013, the intensity of asthma among children in Georgia was 10.8 percent and 8.4 percent among adults. Asthma was more frequent in young boys (12.6 percent) than girls (8.9 percent).⁴ In adults, asthma was higher in women (11.3 percent) than men (5.3 percent), and current asthma was also more common among adult smokers than non-smokers. Temporal trends in tobacco smoking suggest that chronic obstructive pulmonary disease (COPD) occurrence will be disadvantaged in the future. However, 10 percent of the asthma population suffers from severe asthma, and these patients could require access to biologics to adequately control the disease. The costs of being an asthmatic can lead to missed school or work, unscheduled healthcare visits, emergency room (ER) visits, prolonged hospital stays, and death.

COPD is a group of lung diseases that block airflow and make it difficult to breathe. Many people misunderstand increased breathlessness and coughing as a normal part of aging. COPD can develop for years without noticeable shortness of breath. The symptoms are usually seen in the more developed stages of the disease. During World War II, men were the predominant tobacco smoking gender with the highest rates of COPD, which peaked in the 1970s. By 2000, the number of deaths for COPD in women exceeded that of men.

Director John Howard, M.D. of the National Institute for Occupational Safety and Health (NIOSH) said, "People with work-related asthma are particularly vulnerable to pneumococcal pneumonia." This infection is caused by streptococcus pneumonia, which can trigger many types of illnesses including ear infections, meningitis, pneumonia, and bloodstream infections. Children younger than 2 years old and adults 65 years or older are most at risk for the disease. Older adults with pneumococcal pneumonia may experience confusion or low alertness, rather than the more common symptoms. In babies, meningitis may cause poor eating and drinking, low alertness, and vomiting.

Asthma treatments are largely based on inhaled therapies, commonly known as inhalers. Many asthmatics do not emphasize the difference between the two kinds of asthma treatment inhalers. The first type is a daily controller for long term management and the second is a rescue/quick relief for emergency situations. The support of a daily controller is inhaled steroids inside the inhaler. These medications lower airway inflammation and responsiveness, and prevent exacerbations of asthma. Daily controller therapies with inhaled corticosteroids is crucial to improving asthma control and reducing ER visits. Education and access to trained asthma healthcare providers and medications from pharmacies is important to monitor the severity of this disease, its signs, and symptoms.

⁴ Georgia Department of Public Health, 2016-2021 State Health Improvement Plan.

Obesity/Bariatric Treatment

The Centers for Disease Control and Prevention (CDC) acknowledges that being overweight and obese are associated with at least 13 different types of cancer. About two in three occur in adults 50-74 years old and these cancers make up 40 percent of all diagnoses. Most of these cancers increased from 2005-2014, which include:

- Meningioma (Cancer in the tissue covering brain and spinal cord).
- Thyroid.
- Breast (Post-menopausal women).
- Liver.
- Colon and rectum.
- Multiple myeloma (Cancer of blood cells).

Being overweight or obese can cause changes in the body, such as increases in levels of certain hormones and inflammation. About 55 percent of all cancers caused by obesity are diagnosed in women and 24 percent of those diagnosed in men.⁵ New cancer cases are higher among blacks and whites compared to other race and ethnic groups. There is some support for wide-ranging cancer control efforts with environmental approaches that encourage physical activity and healthier food option in communities. Testing for colorectal cancer can avoid new cases by identifying unusual growths in the colon and rectum before they turn into cancer.

Oversufficiency in calorie intake and physical inactivity trigger obesity, which is associated with some of the leading preventable chronic diseases, including cardiovascular disease, stroke, type 2 diabetes, hypertension and cancers. Among U.S. adults, the medical costs related with obesity are projected at \$147 billion.⁶ The CDC reports that in Georgia, 43 percent of adults consume fruit less than one time a day. Furthermore, only 51 percent of adults in the state achieve at least 150 minutes of moderate intensity physical activity per week.

The study committee also received an update from the Georgia Department of Community Health SHBP Bariatric Management Program. The Bariatric Surgery Pilot Program took place during 2015 and 2016. Over 1,200 people applied for the surgery and 139 surgeries were completed out of 150 participants. On average, they experienced a 23 percent weight loss six months after surgery. Nearly 75 percent of the 2015 participants were mostly or completely satisfied with their life pre-surgery compared to 100 percent of members satisfied post-surgery. Analysis shows that among participants there was a 37 percent decrease in ER visits, but an 11 percent increase in specialist visits.

The analysis also showed a decrease in common bariatric illnesses, such as 53 percent in diabetes, 42 percent in hypertension, 17 percent in coronary artery disease (CAD), 76 percent in congestive heart failure (CHF), 44 percent in chronic obstructive pulmonary disease (COPD), and 51 percent in depression. These results are correlated to pre-operative case management coaching for understanding the bariatric surgery preparation such as behavioral/lifestyle changes and network requirements. Also, members received assistance in post-operative case management including pain management, nutrition assessment plans, and physical activity plans. There were some challenges for members during post-

⁵ US Department of Health and Human Services. National Institutes of Health. Managing Overweight and Obesity in Adults: Systematic Evidence Review from the Obesity Expert Panel, 2013.

⁶ CDC 24/7: Saving Lives, Protecting People, "Cancer and Obesity", October 3, 2017.

operation as there was a gradual increase in non-adherence with agreed upon case management follow-up requirements. These include:

- Non-adherence with physician follow-up appointments.
- While member cost-share was the same for any covered elective procedure, it was a barrier for some participants.
- The number one reason for withdrawal from program was for financial reasons. (The average bariatric surgery cost per member in the 2015 and 2016 bariatric surgery pilot program was \$19,397 for surgery only).
- After surgery, members were disappointed when realizing skin removal wasn't a covered benefit.

A dedicated multi-disciplinary team of health professionals coordinate services for members and help members reach their health goals. A personal health coach individualized a care plan for development and support of health care needs for each member. Registered dietitians/exercise physiologists were provided for nutrition education to members requiring specialized diets, as they educated members on weight loss and healthy lifestyle changes. Social workers assisted with coordination of community resources and financial concerns. Pharmacists provided education pertaining to medication side effects and compliance with screening, as well as service coordination for members already diagnosed or at risk for developing depression.

Emerging Global Issues

The largest Ebola (EVD) outbreak in history occurred in West Africa (Guinea, Liberia, and Sierra Leone) during 2014-2016. A total of 28,652 cases of Ebola Virus Disease were reported cumulatively, with 11,325 deaths. Six other countries had travel-associated Ebola cases (Mali, Nigeria, Senegal, Spain, U.S., and U.K.), some resulting in localized spread to healthcare workers. Following exit and entry screening, the state conducted daily active monitoring of all travelers from West Africa in Georgia for 21 days (the incubation period of EVD). For early detection of any EVD symptoms, a trained EMS ID network provided appropriate medical evaluation and isolation at designated hospitals.

Emerging and other serious communicable diseases are only an airplane ride away. Some highly prevalent travel-associated infectious diseases include Ebola, Zika, Chikungunya, Dengue, Yellow Fever, Malaria, MERS, Plague, and others. The success of any disease prevention or containment strategy is founded upon the study and analysis of the patterns, causes, and effects of health and disease conditions in defined populations. Awareness about the epidemiology of Ebola and travel history was key to recognition, confinement, and prevention of any spread. Dressing in clothing that covers arms and legs can prevent mosquitos that carry infectious diseases.

ZIKA VIRUS

Zika is the first mosquito-borne sexually transmitted disease (STD). The Zika virus appeared in the Americas for the first time in late 2015 (in Brazil) and spread rapidly to almost 50 new countries. In the continental U.S, over 5,200 travel-associated Zika infections have been documented since 2016, (48 were sexually transmitted); 2,197 in pregnant women. Nationally, 106 Zika-related adverse pregnancy outcomes have been documented (8 pregnancy losses and 98 live born infants with birth defects). There are currently no known ongoing local transmissions.

Zika causes serious birth defects like microcephaly, other brain defects, and poor pregnancy outcomes. Since January 2016, DPH Epidemiology has tracked about 2,900 Zika clinical inquiries in Georgia. There has been no local Zika transmission in Georgia, but ten pregnant women have been documented with Zika, including two congenital infections, one pregnancy loss, and two instances of sexual transmission. Cumulatively, since January 2016, the state has documented 119 travel-related Zika infections. In 2017, Georgia had only 5 travel-associated Zika cases (the most recent one was July 20, 2017).

Travelers must be aware of warnings and areas with previous Zika transmissions, and take appropriate precautions. It is recommended by the Georgia Department of Public Health that it is best to practice strict mosquito bite prevention while traveling and when returning back to Georgia (at least for 3 weeks after travel). Other recommendations include both women and men who are returning from Zika-affected areas abstain or practice safe sex for 6 months. Although no longer an emergency, the Zika virus remains a significant public health threat, and the department's priority is still to protect pregnant women and their fetuses.

Other mosquito-borne travel-associated diseases:

- Chikungunya: causes fever and joint pain; current large outbreak in Italy; GA has 2 travel-associated cases in 2017.
- Dengue: found in tropical/subtropical areas; more severe illness; hemorrhagic. GA has 4 travel-associated cases in 2017.
- Yellow fever: endemic in parts of South America and Africa; pre-travel vaccine available (shortage this year); rare in US travelers, mostly mild illness.
- Malaria: can be severe/fatal; hundreds of millions of cases worldwide; disturbing trend of resistance to all treatment in SE Asia ("superbug"); in the US, 1,500 travel-associated cases/year (57 in GA in 2017); rare cases of transfusion-associated transmission (1 in GA in 2016).

Due to an early spring, Georgia had an early start to the mosquito season in 2016. However, an unseasonable cold in most of the state in late spring slowed mosquito production. In early summer, heavy rains increased floodwater nuisance species, while depressing container breeders. Hot weather, but relatively low humidity, led mosquitoes to harbor in cooler and more humid wooded areas, coincidentally closer to bird populations and West Nile Virus. Vector surveillance is being conducted by staff statewide and a safe precaution is to dispose of anything that can hold water.

Cleaning up containers around your home or in your neighborhood can be helpful. Dumping out containers after every rain, tip and toss containers after each rainfall, and removing saucers under your outdoor plants will curtail mosquitos. Wear repellent when outdoors, follow label directions, wear light-weight long sleeves and long pants, and be aware of mosquitoes that bite during the day. Besides travel history, it is also critical to ask patients about history of healthcare while abroad. Georgia has the habitat and climate to support Zika and other vectors. The goal of mosquito-based surveillance is to quantify human risk by determining local vector presence and abundance.

HIV/AIDS

Policy tools have the ability to enhance HIV prevention. There have been ongoing discussions whether criminal exposure laws affect behavior or transmission. Do these laws reduce transmission by encouraging disclosure or deterring high risk behavior? Do these laws possibly increase transmission by discouraging testing to avoid the law or because of perceived stigma? Do these laws have no impact on behaviors because people may not know of the laws? Ecological analysis of structural interventions such as policies and laws is a useful tool for assessing public health impacts. Criminal exposure laws had no effect on detectable HIV prevention.

In 2015, Georgia was fifth highest in the nation for both total living with HIV and new diagnoses of HIV and AIDS. In the United States and six dependent areas, the rate of diagnoses of HIV infection among adults and adolescents was 14.7 per 100,000 population. The most common barriers to HIV/AIDS treatment include:

- Access to medications.
- Push to use multiple pills instead of existing single tablet regimens (entire regimen in one pill).
- Stigma of positive status.
- Transportation to clinics.
- Failing to disclose known status.

The best practice would be for states to reform their laws to eliminate HIV-specific criminal penalties except in two distinct circumstances. First, states may wish to retain criminal liability when a person who knows he or she is HIV positive and commits a (non-HIV specific) sex crime when there is a risk of transmission (e.g., rape or other sexual assault). The second circumstance is when the individual knows he or she is HIV positive and the evidence clearly demonstrates that individual's intent was to transmit the virus and that the behavior engaged in had a significant risk of transmission, whether or not transmission occurred. The best practice would be to reform and modernize laws so that they accurately reflect the current science of risk and modes of transmission.

In 1988, at the first implementation of statutory measures criminalizing certain behaviors of citizens living with human immunodeficiency virus (HIV), the Georgia General Assembly expressed an intent to exercise the state's police power to "deal with AIDS and HIV."⁷ It seems most appropriate to interpret this intent as a desire to strive to make policies that support a reduction of HIV infection in Georgia. Unfortunately, that initial enactment, which remains part of our overall criminal law in this context today, did not require an intent to expose or transmit HIV. Instead, it broadly condemns behaviors, some with negligible risk of transmission, irrespective of the likelihood of being a vehicle for increasing the spread of HIV among Georgia's citizens. Although federal support for prosecuting the intentional, knowing exposure of another to HIV has been clearly communicated since the 1990 enactment of the Ryan White Comprehensive AIDS Resources Emergency Act,⁸ the means by which states have gone to such prosecutions has recently been questioned by both the Department of Justice (DOJ)⁹ and the CDC.¹⁰ Indeed, as noted by the CDC, from

⁷ O.C.G.A § 42-5-52.1 and § 17-10-15.

⁸ <https://history.nih.gov/research/downloads/PL101-381.pdf>, October 2, 2017.

⁹ <https://www.hivlawandpolicy.org/sites/default/files/DOJ-HIV-Criminal-Law-Best-Practices-Guide.pdf>, November 9, 2017.

¹⁰ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4019819/>, November 9, 2017.

as far back as 2010, the President’s National HIV/AIDS Strategy for the United States expressed concern about criminal HIV exposure laws concluding that “in some cases, it may be appropriate for state legislators to reconsider whether existing laws further the public interest and public health”.¹¹ Also, the 2013 Presidential Advisory Council on HIV/AIDS noted the failure of many such statutes to account for (1) the prevention measures, (2) the reality of disproportionate sentencing that often occurs, and (3) the fact that the laws are based on outdated beliefs about HIV transmission.¹²

There are two parts to Georgia’s current HIV-related criminal law incorporated into O.C.G.A. § 16-5-60 at subsections (c) and (d). The first, subsection (c) focuses on whether a person has knowledge of his/her HIV infection, rather than if there is any actual intent to transmit the virus. The only modicum of defense against the charge, as currently codified, is disclosure by the accused of such HIV infection to the other party involved in the conduct. Conviction under subsection (c) exposes the accused to between one and 10 years in prison. The second part of Georgia’s current HIV-related criminal law subsection (d) focuses on intentional behavior aimed at transmitting HIV (or hepatitis) to peace or correctional officers engaged in the performance of their official duties. Under subsection (d), also a felony, the accused faces between five and 20 years in prison.

From the earliest efforts to curb HIV transmission, the federal government’s guidance has been that the states should aim to deter high-risk behavior and protect citizens from intentional exposure to HIV. Comparison of laws aimed at similar behavior indicates the General Assembly’s attempt to provide for enhanced penalty for acts where HIV transmission or exposure could intentionally occur. For instance, consider that both prostitution and solicitation of sodomy are misdemeanors under Georgia law when the accused is not infected with HIV. These crimes only become felonies when the accused merely *knows* they are infected with HIV and fails to disclose their status. Thus, the current language in O.C.G.A. § 16-5-60(c) falls short by penalizing behavior that does not require the type of intentional behavior for which an enhanced penalty is typically reserved or the federal government has consistently highlighted for prosecution.

Scientific advances in both understanding and treating HIV infection should be accounted for in the way intentional HIV transmission is criminalized and in mitigating alleged intent. The Centers for Disease Control and Prevention (CDC) confirmed that persons living with HIV who take antiretroviral therapy (ART) daily as prescribed and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. It would be most appropriate to acknowledge these scientific advances by allowing an accused to rely on them in defense of the charge of intentionally transmitting or intentionally exposing another to HIV. Such a defense, if proven, would then negate the necessary intent to transmit HIV.

In Georgia, prosecutions of those infected with HIV whose actions fall under O.C.G.A. § 16-5-60(c) and (d) has not been limited to those code sections. In fact, there are documented cases where the state has pursued charges of aggravated assault against an accused in such situations. This inequitable disparity in prosecution of HIV-infected people should be addressed in any reforms made to these laws. O.C.G.A.

¹¹ White House. National HIV/AIDS strategy for the United States, 2010.

¹² https://www.hivlawandpolicy.org/sites/default/files/PACHA_Criminalization_Resolution%20Final%20012513.pdf, November 9, 2017.

¹³ <https://law.justia.com/cases/georgia/court-of-appeals/1990/a90a1140.html>, November 13, 2017.

§ 16-5-60(c) criminalizes behavior upon mere knowledge of status, there is fear among those living with HIV of prosecution under this statute when they are victims of a sexual assault involving behaviors outlined in this code section. To curb this fear and empower such victims to report these serious assaults, the law should be clarified to account for these scenarios by explicitly exempting such victims from prosecution.

HIV treatment is more powerful than ever, both for the health of people with HIV and as a prevention tool for sexual transmission. Recent studies found zero linked HIV infections from sexual behavior while the person with HIV was virally suppressed/undetectable. There are only three ways of HIV transmission through:

1. Blood and blood products.
2. Sexual mucosal contact including penile-vaginal contact, anal contact and possibly penile-oral contact.
3. Vertical Transmission including breast feeding.

Longitudinal data show that a majority of people in consistent care are virally suppressed, but viral load suppression is not universally maintained with 1/3 of infected not suppressed consistently and 1/5 not suppressed at last viral load test. Treatment works, but not everyone is fully benefitting from ART personally or protected from transmitting to sexual partners. Providing an environment that urges personal responsibility for sexual health, reduces stigma, encourages and facilitates testing is important for collaboration and maintenance of care. HIV diagnoses are decreasing in most groups. Prevention and treatment are working, particularly in jurisdictions that are trying to maximize the range of prevention tools.

There are biomedical preventions available and HIV-negative persons have more prevention tools than ever before. HIV medication taken daily by HIV-negative people provides very high level of protection against HIV infection. Post-exposure HIV medicine taken within 72 hours after a potential HIV exposure for a duration of 30 days is another preventative measure. A profound health care system that includes prevention benefits can provide these medications for HIV-negative patients. There are other prevention options such as abstinence, condoms, syringe services programs, choosing lower risk sexual behaviors, and partner selection strategies.

State of Mental Health in Georgia

In 2016, Georgia's suicide rate was 5.43 percent--up from 4.93 percent in 2015. According to the Department of Public Health, suicide is the 3rd highest cause of premature death in Georgia, topped only by heart disease and motor vehicle accidents. The number of poor mental health days a person experiences is a significant predictor of future adverse health events resulting in a health provider visit, hospitalization, or mortality within 30 days and within one year. In 2016, 11.2 percent of adults in Georgia experienced frequent mental distress (more than 14 days a month). According to the World Health Organization, depression is the leading cause of ill health and disability worldwide. Estimates put the economic burden of serious mental illness (nationwide) at \$317 billion, excluding incarceration, homelessness, comorbid conditions, and early mortality. Every \$1 invested in scaling up treatment for depression and anxiety leads to a return of \$4 in better health and ability to work.

The health care costs associated with opioid misuse in Georgia alone were estimated at \$447 million in 2007 with estimated per-capita costs at \$44. Given the increase in overdose deaths and misuse of opioids in Georgia over 11 years, some estimates indicate that health care costs associated with opioid misuse in Georgia have increased by 80 percent since 2007. Hospitalizations related to opioid use and misuse in the state also have skyrocketed, from about 302,000 in 2002 to about 520,000 in 2012. Similarly the cost of opioid related inpatient care more than doubled during the same time period, rising to \$15 billion in 2012.

In overall access to mental health care, Georgia ranks 47th out of 51 and in workforce availability, Georgia ranks 48th. According to Mental Health America, access is measured by insurance coverage, obtainability of treatment, quality and cost of insurance, access to special education, and workforce availability. The state has one mental health professional for every 850 individuals, one board certified psychiatrist for every 9,600 individuals, and 19.5 percent of adults with medical illness are reported with unmet needs (i.e., individuals seeking treatment and facing barriers to receiving help). According to the United Health Foundation, frequent mental distress (FMD) captures the segment of the population experiencing persistent and likely severe mental health issues, which in extreme cases poor mental health can lead to suicide.

The Georgia Association of Community Service Boards

Community Service Boards (CSB) work to improve the quality of life for the individuals they serve by treating them in the least restrictive setting possible. Thanks to the community service boards, a significant number of Georgians can live productive lives in their communities. Their services combine short-term, 24/7, walk-in crisis intervention and counseling with emergency receiving capability and crisis stabilization beds. Individuals who are experiencing behavioral health crises are provided assessment, short-term crisis counseling, supportive services and referrals for ongoing care. Staffing includes physicians, nurses, licensed clinicians and other behavioral health professionals to provide interventions designed to de-escalate crisis situations and prevent out-of-community treatment or hospitalization.

CSBs function as the disability services safety net for individuals with mental illnesses, addictive diseases, and intellectual and developmental disabilities. If individuals need a higher level of care, the attached crisis stabilization unit (CSU) allows for admissions for short-term residential treatment. 24 hour units providing stabilization to those experiencing mental health crises or needing detoxification from substances is also available. They have 25 Independent Providers located in six Regions designated by the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD). They are governed by a community board appointed by the county commissioner of each county in an individual CSB's coverage area.

Senate Bill 106 was passed during the 2017 legislative session overhauled Georgia's Prescription Drug Monitoring Program (PDMP) database in an effort to reduce duplicative prescribing and overprescribing of controlled substances — specifically opioids and benzodiazepines. However, an ensuring insurance coverage for mental health services is one solution to this epidemic in Georgia. Adding psychiatry training to medical school rotations is another solution recommended to the committee members. Finally, increasing the number of psychiatrists in the state would bring significant improvement with the current ratio being one for every 9,600 people.

Transitions to Care

Why are Medicaid benefits terminated for criminal offenders? The termination of (SSI) automatically terminates an inmate's Medicaid Coverage. The barrier exists upon their release from confinement, and the individual is reenrolled in Medicaid following their reenrollment into SSI. Unfortunately, the actual reenrollment in Medicaid may take a few months for eligibility to become effective. During these months, the individual may have medical needs that are not met. This is especially challenging for those requiring medication immediately upon release from jail. In some instances, if the medication is required to address mental health needs, the lack of access to medication may result in a return to jail due to behavior that could have been controlled by the medication.

Many adults who qualify for Medicaid do so by virtue of receiving Social Security Income (SSI) due to a disability. In Georgia, there are over 266,000 members currently with Medicaid coverage and SSI. When an individual enrolls in SSI or is terminated/suspended from SSI, a computer interface automatically enrolls or terminates the individual in Medicaid as well. The challenge arises when one of these individuals is arrested and placed in a local or county jail. The jails have agreements in place with the Social Security Administration (SSA) to allow SSA to end SSI payments when offenders are in jail for 60 days.

The Department of Community Health (DCH) is pursuing a programming change with its vendor for the Georgia Medicaid Management Information System (GAMMIS) to postpone the termination of Medicaid benefits for impacted individuals until reenrollment occurs through the Social Security Administration enrollment process. DCH is sponsoring meetings with representatives from impacted associations (Sheriffs, ACCG, and the Community Service Boards) to provide additional insight to DCH and to assure future communication to the associations occurs on the progress of the GAMMIS system changes.

Immunization

Since 2012, Georgia has seen a 200 percent increase in the total reported hepatitis C infections among those aged 18-30 years, particularly in rural areas, primarily due to ongoing opioid and heroin epidemics. More than 90 percent of acute hepatitis C infections occurred among those born after 1965 and more than 80 percent of all acute hepatitis C infections occurred among whites under 30 years of age. The correlating factors to higher hepatitis C infections are intravenous drug use and incarcerations. Additionally, about half of the young adults with hepatitis C were females of child-bearing age. As such, we have seen a 60% increase in hepatitis C infections among babies 36 months of age or younger from 2012 to 2016 in Georgia.

The success of any disease prevention or containment strategy is founded upon surveillance and epidemiology. Reliable vaccination rates are needed to provide community protection, especially children, from disease outbreaks. When a disease such as measles reaches a community of unvaccinated people, it can spread very quickly. People who are missing vaccinations can leave communities vulnerable to epidemics. A new CDC study shows that flu vaccination drastically reduced a child's risk of dying from influenza.¹⁴ The study reviewed data between 2010 and 2014 and found that flu vaccination reduced the risk of influenza related deaths by half (51 percent) among children with high-risk medical conditions.

¹⁴ Pediatrics, "Influenza Vaccine Effectiveness against Pediatric Deaths: 2010–2014," Brendan Flannery, PhD, Influenza Division, Centers for Disease Control and Prevention April 2017.

The committee heard testimony from the Georgia Registry of Immunization Transactions and Services (GRITS) which helps prevent disease outbreaks by tracking and ensuring that all residents are up-to-date on immunizations. With the use of electronic records and accurate information retrieval, GRITS helps providers follow the most up-to-date recommendations for immunization practice. They also assure quality data for schools and other organizations when facilities introduce new vaccines or changes in the vaccine schedule. Their services help protect families from vaccine-preventable diseases to ensure the correct number of shots are given without duplicating vaccinations. This helps to reduce missed opportunities to vaccinate at risk individuals and over immunization.

As of November 1, 2017 the Georgia Registry of Immunization Transactions and Services has been involved with 163.9 million total immunizations records. More than 14 million clients have been served with connection to 13,147 active provider organizations. Their system has 35,277 active users, 11,683 average logins per day, 18,149 monthly user logins, and 3.5 million monthly data exchange jobs. Providers administering vaccines in Georgia must provide appropriate information to GRITS. Their support helps create an interface between health systems that will drastically decrease data entry.

Harm Reduction and Substance Use Issues

Many circumstances influence drug-related risks and harms including choices of individuals, the setting in which they take drugs, and the laws designed to control drug use. It is also essential to review laws and policies that unintentionally reinforce risky drug using environments and reduce the harms associated with the use of psychoactive drugs in people incapable or unwilling to stop. The objective of harm reduction does not attempt to minimize or ignore the harms associated with licit and illicit drug use. It applies evidence-based interventions to reduce negative consequences of these behaviors.

Harm reduction is practical, feasible, safe and cost-effective. The lifetime cost of medical care for each new HIV infection is over \$400,000. For hepatitis C, the lifetime cost of medical care exceeds \$100,000. The equivalent amount of money spent on syringe access could prevent dozens of new infections annually. Syringe services programs (SSP) provide safer injection supplies, harm reduction counseling and education. Training and provision of naloxone is also provided to reverse opioid overdoses, screening for HIV, viral hepatitis, STDs and TB. Most harm reduction approaches are low-cost, easy to complete and have a high effect on community health.

The exchange is normally located in a building that could be a storefront, an office, or other similar space. They can provide shelter from street-based activities, room for other services such as medical care, referrals, and psychosocial. With the ability to be out of view of local residents and businesses, there is privacy for exchange participants. Mobile/street based vehicle exchange is also available to conduct via a van or RV that drives to exchange sites and neighborhoods. Participants can call a phone number to arrange delivery of services, which can be done in their home or at another agreed upon site.

Formal working agreements based on approved policy between police departments and local programs/health departments can begin harm reduction in any community. Accentuating public health and human rights, harm reduction programs deliver vital health information and services while respecting individual dignity and independence. In 2015, the North Carolina Harm Reduction Coalition (NCHRC) successfully advocated for the passage of HB 712 allowing four counties in the state to participate in a bio-hazard pilot project that collects and safely disposes of used needles and began decreasing their exposure to harm, HIV and hepatitis C.

COMMITTEE RECOMMENDATIONS

Individual responsibility is important for each woman, man, and family to have optimal health and health care. Consumer awareness and effective health communication improves individual health and population health. Recognition of the importance of health behaviors, language, and health/financial literacy of diverse consumers and communities will lead to better health outcomes. Involvement by communities can improve health care services by bringing their experiences and prevailing social norms that can influence the health system and build healthy communities. Increasing health promotion and disease prevention programs in addressing the social determinants of health can reduce risk behaviors hence reduce the risk of developing chronic disease. The focus should be on keeping individuals, communities and the population healthy.

Chronic diseases are responsible for seven out of every 10 deaths in the US and account for about 75% of the nation's health spending. Chronic diseases such as diabetes, COPD, heart disease, HIV and others may be preventable through prevention services such as screenings, sexual health education, nutrition counseling, smoking cessation programs, cancer screening, exercise, and having a health care provider. Staying healthy, avoiding or delaying the onset of disease and keeping diseases that they may already have from becoming debilitating will allow Georgians to lead productive lives and reduce the financial cost of care. Georgia has among the highest levels of cardiovascular disease risk factors in the nation. Diabetes and hypertension are 2 of the top 10 leading causes of premature death in Georgia. Both are preventable and treatable conditions that contribute significantly to the state disease burden.

Primary care visits should provide clinical health risk assessment, health education and preventive care services. Community health centers and other Federally Qualified Health Centers (FQHC) can be a key advantage to implementing policies for improve health. FQHCs can provide primary care services for those Georgians who are underinsured or uninsured. Also, in addition to risk screening, professional guidelines should include health promotion and counseling related to reproductive health risks. Best practices and clinical practice guidelines should be followed in providing care.

Interventions for identified risks must increase follow-ups to health valuations and focusing on high priority interventions, but also make sure patients are obtaining their proper prescriptions and following medical orders. Quality case management and timely interventions for certain conditions can significantly improve health outcomes. Certain women and men could require additional healing and interventions. For example, women who have conditions treated with medications that are known teratogens that can disturb the development of an embryo or fetus should to change prescriptions. Also, women who take mental health prescriptions or have HIV should not be compelled to take breastfeeding courses.

Eventually, increase in public and private health insurance coverage for citizens with low incomes can improve access to adequate health care. Affordability of health insurance is a major concern especially for women. Data from the Kaiser Family Foundation reports that roughly 17 million women do not have health insurance and are more likely to delay or go without care. However, increased potential savings and prevention can develop if more provided coverage is increased for additional prevention, health promotion, and interventions, resulting in greater extents of wellness.

Immunization

- Add school requirement for Meningitis vaccination second dose at 12th grade (ancillary benefit would be opportunity to assess other healthcare needs during this visit at 16-18 years of age).
- Require residential healthcare facilities (hospitals, nursing homes, etc.) to educate and offer shingles, flu, and pneumococcal conjugate vaccines in accordance with ACIP recommendations.
- Increase state funding for the viral hepatitis program at DPH by \$1,000,000 for additional staff and screenings.
- Require Department of Juvenile Justice and Corrections facilities to check vaccination records and vaccinate according to ACIP Recommendations.
- Increase education to physicians and facilities on registry and requirement to report (Georgia Registry of Immunization Transaction and Services).
- Create legislation to allow for a Georgia Harm Reduction Programs.

HIV/AIDS

- Repeal O.C.G.A. § 16-5-60(d) relating to the scientific evidence of transmitting HIV. State Laws should focus on the intent to transmit rather than knowledge of infection.
- Recognize the role of risk reduction measures and encourage uniform prosecution.
- Acknowledge HIV sex assault victims and ensure continuous access to HIV treatment regimens. Open access (no restrictions) to HIV medicines in Medicaid fee-for-service and Medicaid managed care plans need to be available.
- Increase access to testing, especially in communities with health disparities. Increase funding to the Department of Public Health to strengthen their testing programs and encourage all state-funded programs (Medicaid, state employees) to increase HIV testing-linkage to care.
- Limit cost sharing in commercial plans.
- Make HIV Viral Load Suppression available (National Quality Forum measure, which is included in the Adult Medicaid Core Set).
- Increase Prescription of Antiretroviral Therapy (National Quality Forum measure) Retention in care.

Diabetes

- Provide for diabetes screening as a required and covered cost of primary care visits among the DPH recommended screening population.

Wellness and Nutrition

- Restore bariatric benefits to State Health Benefit Plan (SHBP).
- Create a state diabetes action plan to support pilot programs in the counties with the highest incidence of the diseases.

Medicaid

- In keeping up with criminal justice reform, propose policy that postpones the termination of Medicaid benefits, moving towards suspension rather than termination, especially in county jail systems.
- Continuing Medicaid benefits, provide a framework for continuity of care and improve inmate transitional plans.

Asthma/COPD

- Require development or extension of comprehensive state COPD/asthma plan. The current asthma state plan expires in 2018. The state should look at creating a new plan that addresses all chronic respiratory disease. This would capture the patients with asthma, severe asthma and COPD.
- Education on signs and symptoms, medication administration and self-management plans are key to improved quality of life resulting in fewer return visits to the hospital(s). Links to COPD Foundation, Asthma with all good information can set up DPH website.
- Screening is underused for diagnosis of COPD population. A simple 5 question screen at any point of healthcare assistance can guide care to further testing to confirm COPD diagnosis and begin education with self-management plans to improve life style and quality.

Mental Health

- Expand core funding for community service boards in keeping up with the long-term objectives of the Georgia Department of Behavioral Health and Developmental Disabilities.
- Additional funding for 24 psychiatric residency slots to expand mental health treatment.
- Before enacting any legislation, review analysis of the Georgia Prescription Drug Monitoring Program until July 1, 2018.
- Support e-prescriptions for opioid medications in order to reduce fraud and abuse of opioid medications.