Virginia's Overdose Epidemic Response

State Executive Council

June 20, 2019

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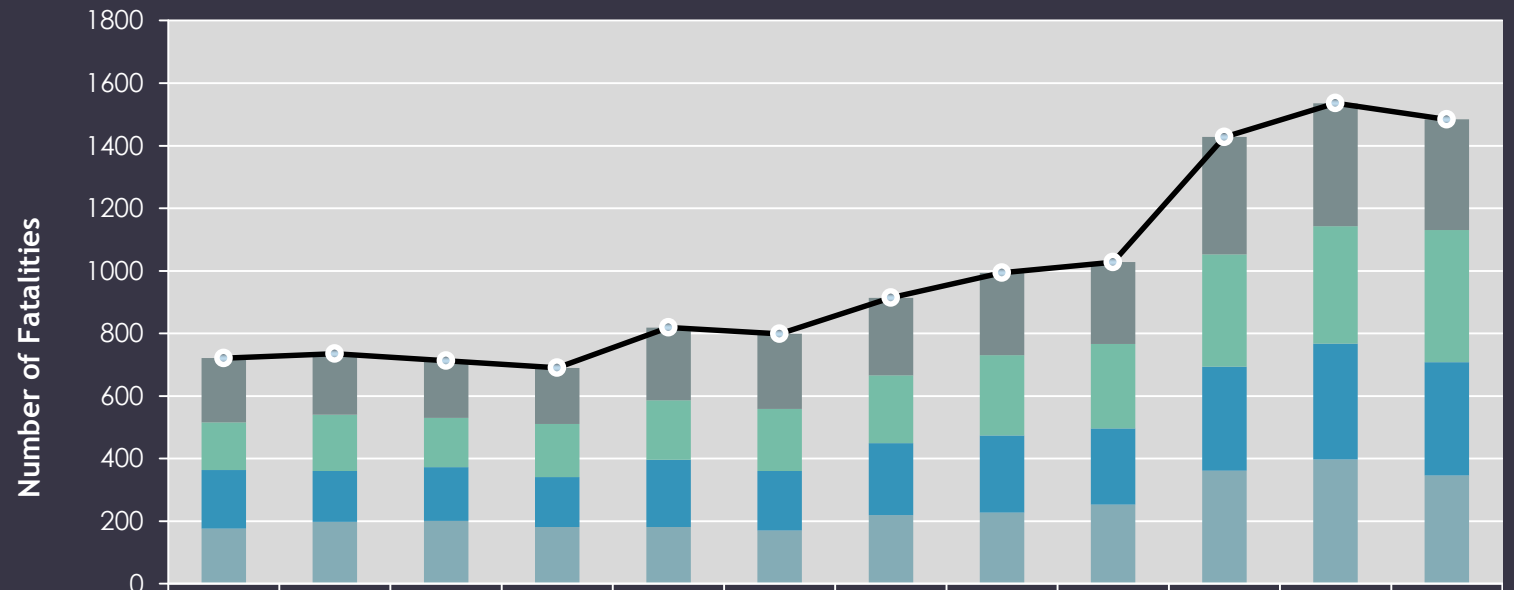
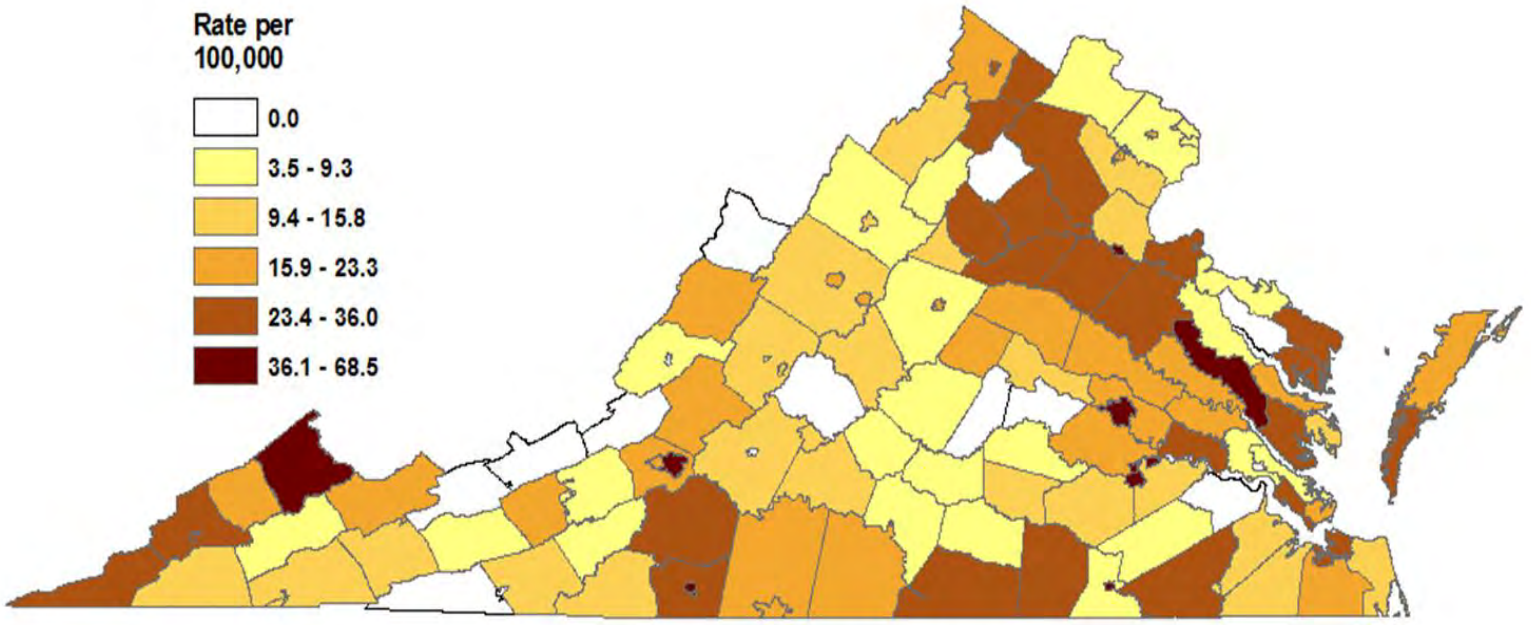
Total Drug Overdose Deaths, 2007 - 2018



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Q4	205	195	183	179	232	240	248	263	262	375	393	353
Q3	152	180	157	170	191	199	217	257	270	359	375	423
Q2	188	162	172	159	215	190	230	246	243	332	371	362
Q1	176	198	201	182	181	170	219	228	253	362	397	346
Total Fatalities	721	735	713	690	819	799	914	994	1028	1428	1536	1484

Substance Use Disorder Crisis

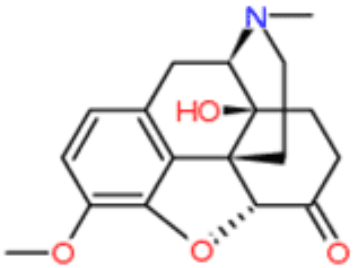


Opiate Versus Opioid

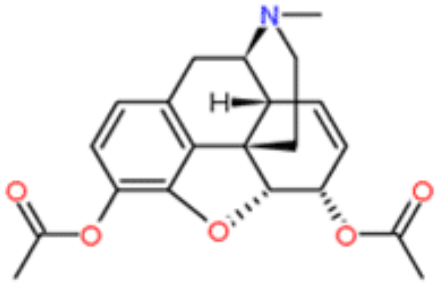
Natural	Semi-synthetic	Synthetic
codeine	hydrocodone	methadone
morphine	oxycodone	fentanyl
*heroin	meperidine	tramadol
	hydromorphone	
	oxymorphone	
	buprenorphine	

Your body makes its own opioids, which are called "endorphins."

Similarities between Heroin and Prescription Opioids



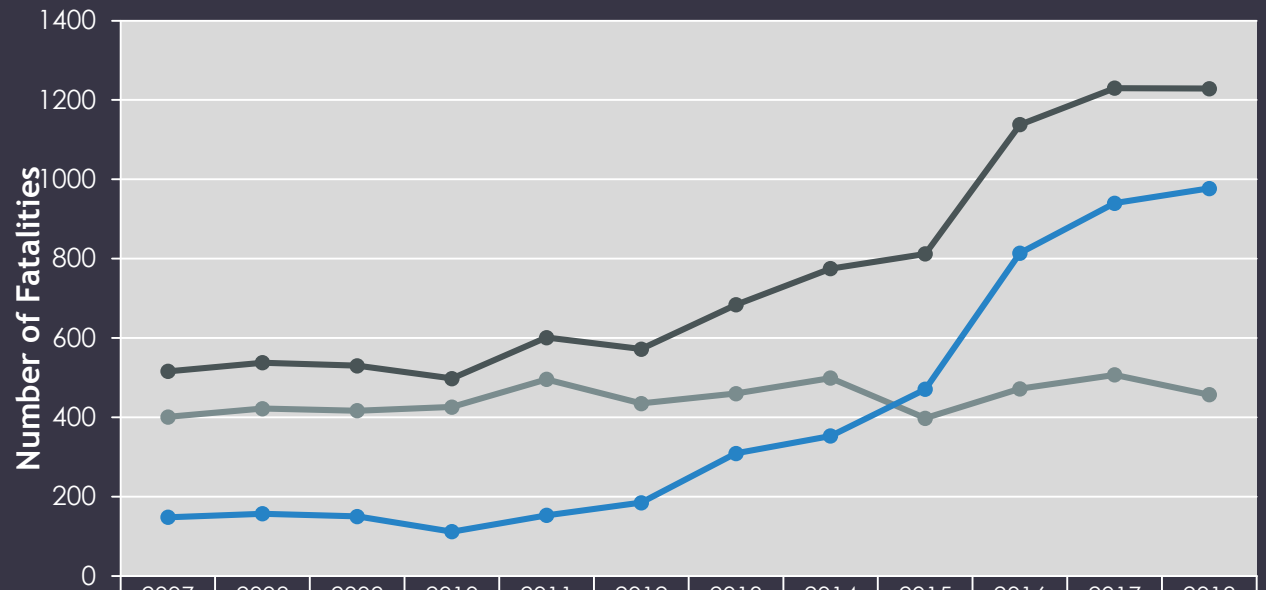
OXYCONTIN (OXYCODONE)



HEROIN

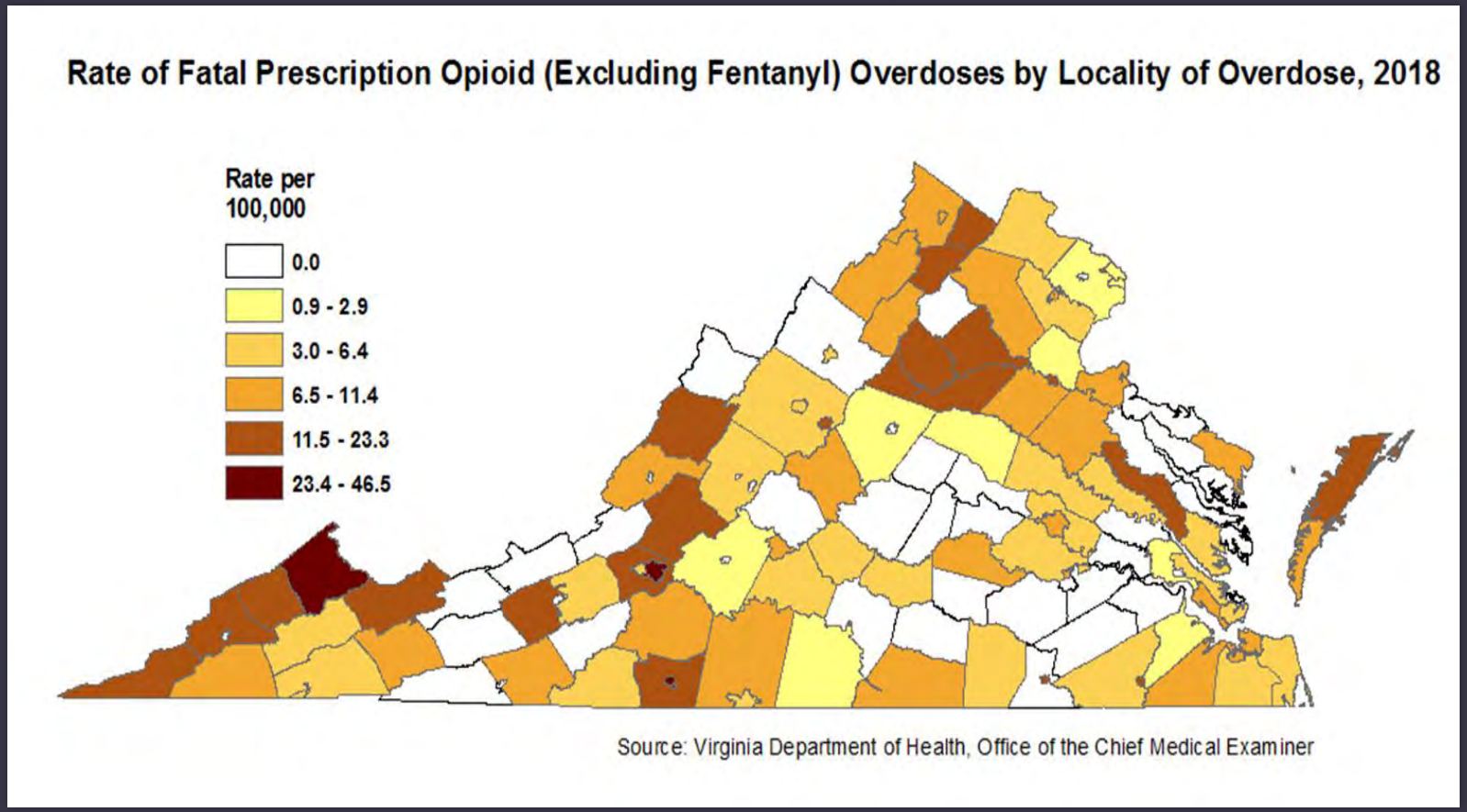
- Opiates can depress breathing by changing neurochemical activity in the brain stem, where automatic body functions are controlled.
- Opiates can change the limbic system, which controls emotions, to increase feelings of pleasure.
- Opiates can block pain messages transmitted through the spinal cord from the body.

Drivers of Opioid Overdose Death

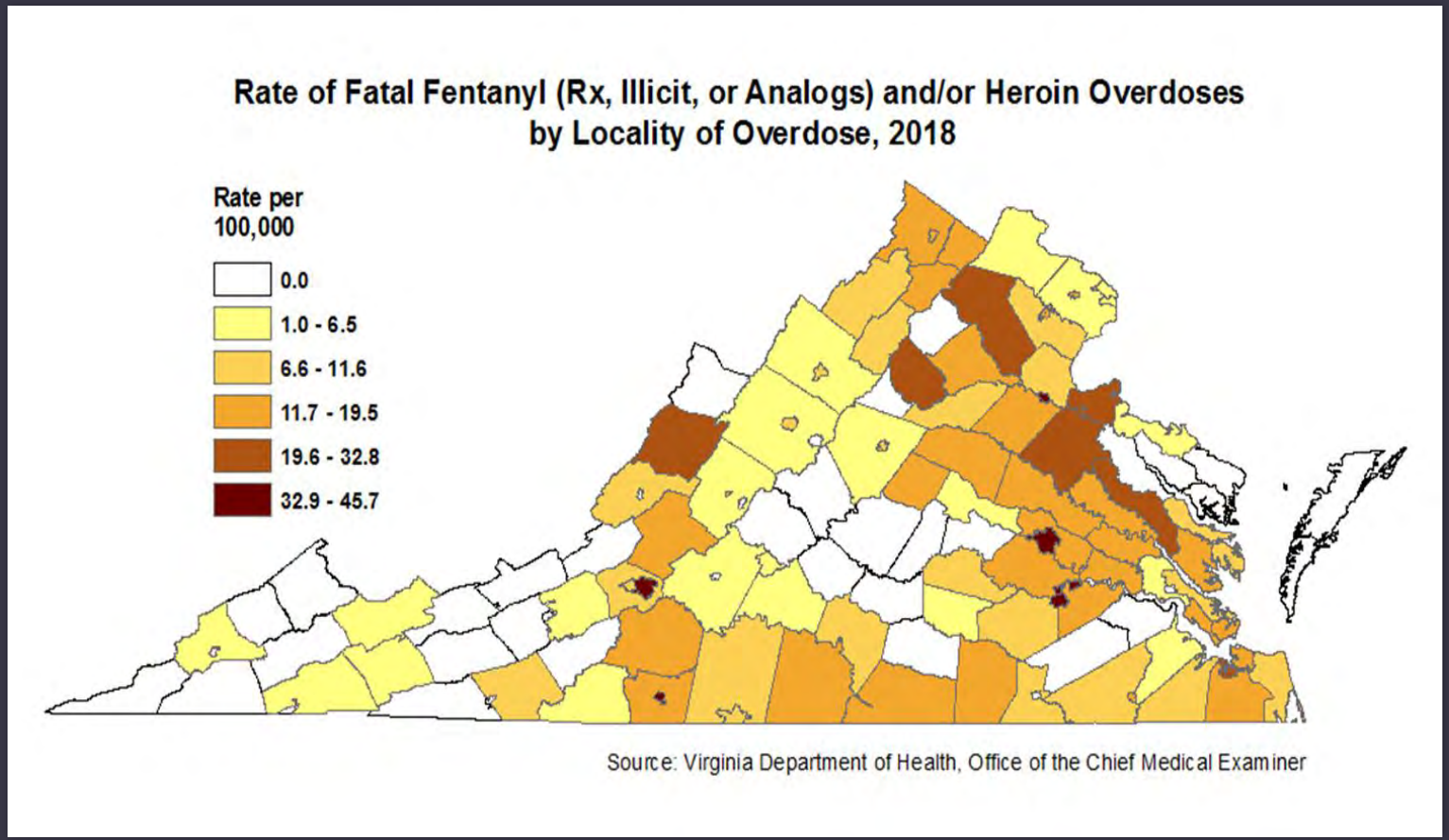


	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All Opioids	516	538	530	498	601	572	684	775	812	1138	1230	1229
Prescription Opioids (excluding fentanyl)	401	422	417	426	496	435	460	499	398	472	507	457
Fentanyl and/or Heroin	148	157	150	112	153	185	309	353	471	814	940	977

Rx Opioid-related Overdose Deaths: Rural Concentration



Fentanyl and Heroin Overdose Deaths: Urban and Suburban Concentration



Virginia's Organizational Approach

- **2015** Governor's Task Force on Prescription Drug and Heroin Abuse
- **2016** Commissioner of Health declared a public health emergency
- **2016 – pres** Coordinating body: Governor's Executive Leadership Team on Opioids and Addiction
  - Co-chaired by Secretary of Health and Human Resources and Secretary of Public Safety and Homeland Security
  - Supplemented by **Governor's Commission** (stakeholders)
  - Led by 5 work groups to facilitate interagency work

Governor's Executive Leadership Team on Opioids and Addiction

- Abuse/Misuse Prevention
- Supply Prevention
- Treatment and Recovery
- Harm Reduction
- Justice-Involved Interventions

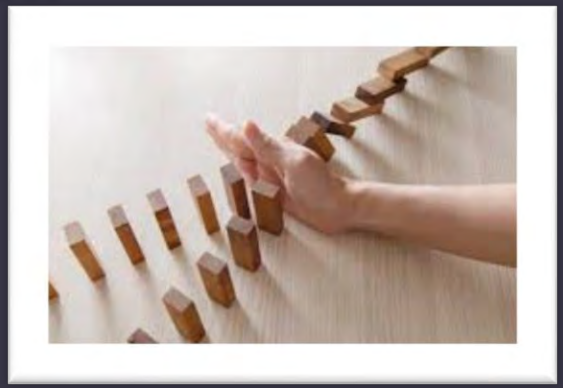
Responding to the Federal Response

Leveraging and aligning funding opportunities from SAMHSA, CDC, USDA, HRSA, BJA, DOL, NIH

- Dismantle **stigma** that poses barriers to prevention and treatment
- Reduce **impacts** of addiction (reduce deaths)
- Build i**nfrastructure** to prevent and treat addiction through workforce supports and development

Abuse and Misuse Prevention

- Led by Department of Behavioral Health and Developmental Services (DBHDS)
- Build the capacity of Virginia's communities through CSBs to address the addiction epidemic through community mobilization and coalition development
  - CCOVA support for coalition development
  - Partnering among local government offices
- Additional objectives
  - REVIVE! Naloxone trainings
  - GF dollars toward prevention
  - Developing ACE-prepared communities



Importance of Youth Prevention

- 40-70% of a person's risk for developing SUD is genetic
- The parts of the brain that control judgment and decision-making remain in development until early or mid-20s, limiting adolescent ability to accurately assess the risks of drug experimentation and makes young people more vulnerable to peer pressure
- Because the brain is still developing, using drugs at this age has more potential to disrupt brain function in areas critical to motivation, memory, learning, judgment, and behavior control.
- If first use of alcohol happens under 15 years old, an individuals is 4 times more likely to develop AUD later in life
- Nearly 70% of those who try illicit drug before the age of 13 develop a SUD
  - Compare with 27% of people who first try after the age of 17 y.o.
  - **Key: Preventing or even just delaying young people from trying substances is important for reducing the likelihood SUD in adulthood**

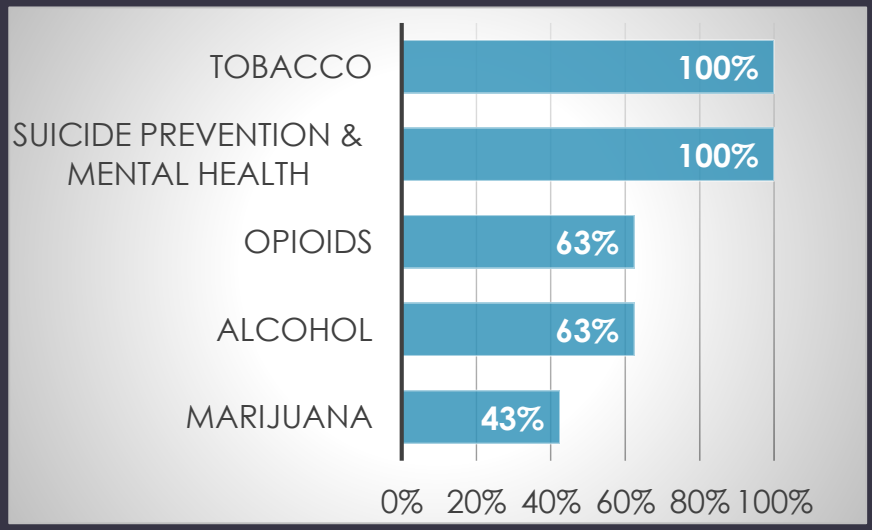
Trauma Lens: Substances as Coping Strategies

- Substances offer a coping strategy when others are not accessible or apparent.
  - SUD are not substance-specific, as all substances provide distortion of reality.
  - Individuals with an ACE score of 4 are twice as likely to be smokers and seven times more likely to have alcohol addiction.
  - Childhood trauma also correlates to chronic pain diagnoses and more Rx drug use
    - Individuals with an ACE score of 5 are three times more likely to misuse prescription pain medications.
- Risk of substance use increases in times of transition
- One physician's perspective: Addiction shouldn't be called "addiction," but rather "ritualized compulsive comfort-seeking." – Dr. Daniel Sumrok, TN

CSB Prevention Priorities

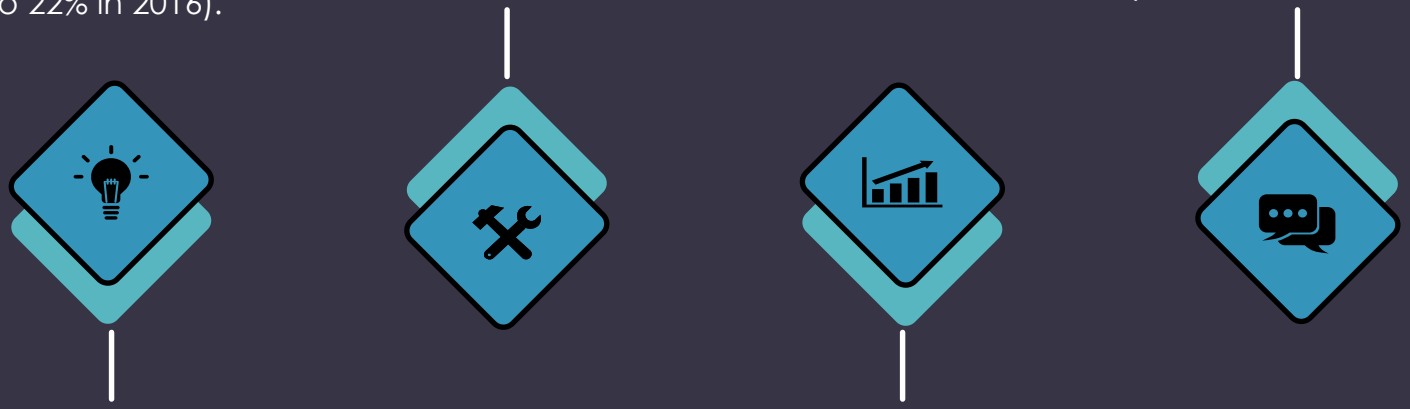
Each CSB set its own prevention priority areas based on local data and needs assessment results. All 40 CSBs are working toward outcomes in the areas of tobacco and suicide prevention and mental health. Opioids, alcohol, and marijuana are also being addressed by a large portion of CSBs.

Percentage of CSBs with targeted outcomes in each area:



Building Prevention Capacity

PFS funding has strengthened the prevention workforce. By 2018, two thirds of communities felt they had enough staff with the right skills to successfully implement PFS strategies (compared to 22% in 2016).



PFS communities collaborate with more than a dozen coalitions. These coalitions are highly engaged and remain critical components of PFS success.

PFS communities report significantly more capacity now than they did at the beginning of the PFS grant.

From 2016 to 2018, there was a 45% increase in the number of active stakeholders in PFS communities.

Prevention Partners

Community partnerships have been key to achieving implementation success.

Medical Community *Hospitals, practitioners, pharmacists*	**Faith Community** *Churches, faith leaders*
Law Enforcement *Local police departments*	**Health Department** *Local public health officials*
Fire Departments and Paramedics *First responders, emergency personnel*	**Libraries** *Library leadership/staff*
Criminal Justice *Prison or jail leadership/staff*	**Community Organizations** *Family support, behavioral health, youth*
Youth Groups *School groups, faith groups, youth councils*	**Realtors** *Realtor professionals hosting open houses*
Elected Officials *City councils, county commissioners*	**Media Organizations** *Marketing firms, radio and television stations*

Supply Prevention

- Led by Department of Health Professions
- Limit availability of prescription opioids for misuse.
  - Drug take-back sites
    - 63 existing drop boxes + 32 CVS sites + 5 private pharmacies + 20 law enforcement offices = 120 operating drop boxes
  - 2017 Prescribing regulations have significantly reduced supply available for diversion
    - Regs DO NOT make all opioid prescribing illegal or impossible

Supply Prevention

- Additional objectives – EDUCATION!
  - Addiction treatment education (waivers)
    - ~ 1600 waivered, not all prescribing
  - Alternative pain management education
  - Education with emerging medical and allied health professions
    - Governor's Grand Rounds
    - Core Curricula development

Treatment and Recovery

- Led by DBHDS
- Establish pathways to treatment and recovery supports in Virginia
  - Increase number of CSBs providing evidence-based treatment*
  - Increase number of FQHCs providing evidence-based treatment (3)
  - Increase number of Emergency Room to outpatient continuum programs
- Additional objectives
  - Treatment workforce development (waivers)
  - Increase addiction treatment capacity (actual prescribing and psycho-social interventions)
  - Recovery in the community
    - workplace
    - collegiate
    - housing

Medicaid Addiction and Recovery Treatment (ARTS) benefit

- Medicaid Addiction Recovery and Treatment Services (ARTS) benefit through 1115 waiver
  1. Expand short-term SUD inpatient detox to all Medicaid /FAMIS members
  2. Expand short-term SUD residential treatment to all Medicaid members
  3. Increase rates for existing Medicaid/FAMIS SUD treatment services
  4. Add Peer Support services for individuals with SUD and/or mental health conditions
  5. Require SUD Care Coordinators at DMAS contracted Managed Care Plans
  6. Organize Provider Education, Training, and Recruitment Activities
- Implemented Medicaid prescribing guidelines building on ARTS momentum and collaboration

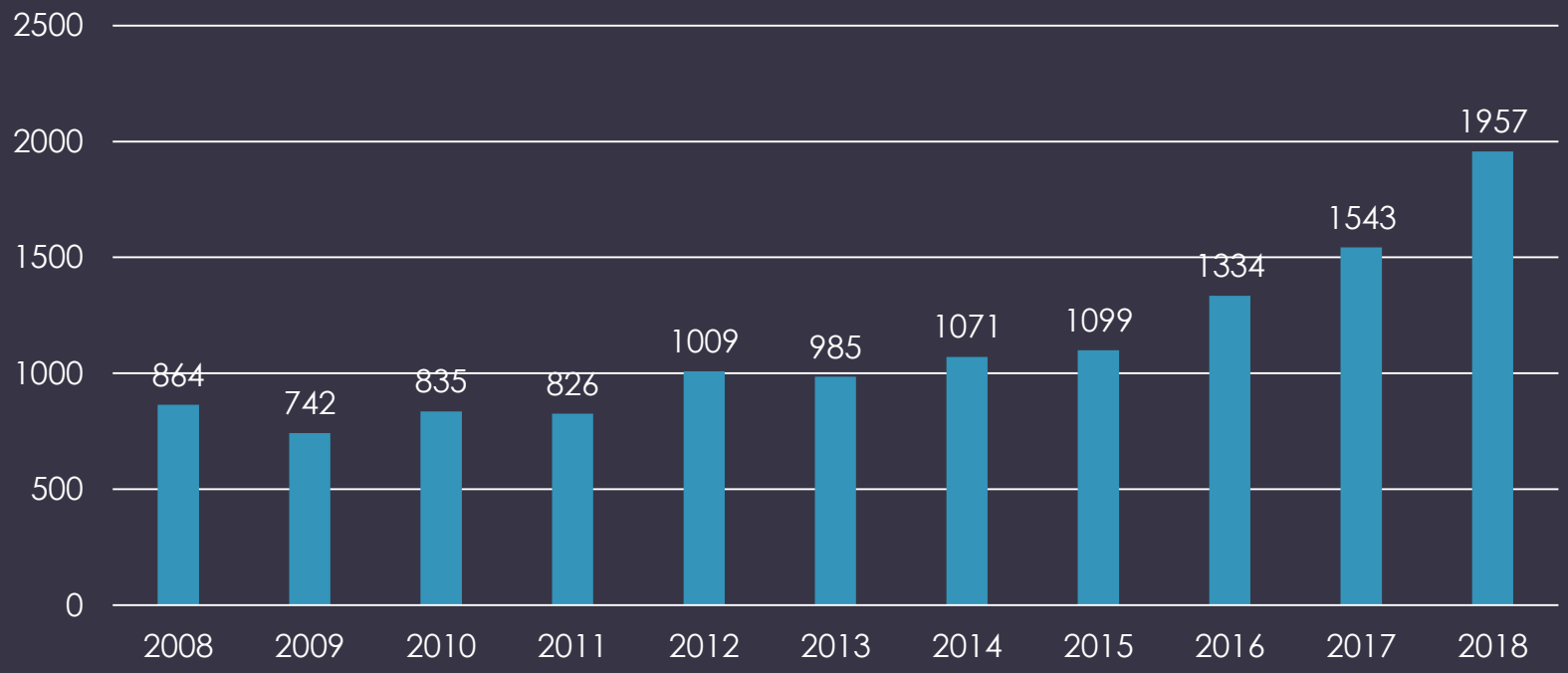
Supporting Medically Assisted Treatment (MAT)

- Biopsychosocial disorders require biopsychosocial interventions
  - Not all substances have biological interventions available
  - Interventions must be simultaneous and ongoing (sometimes for a lifetime)
- Medically Assisted Treatment options for opioids
  - Naltrexone (implant, oral, or injectable therapy, low abuse potential)
  - Buprenorphine (oral or injectabl, usually + naloxone, abuse potential but not deadly)
  - Methadone (replacement therapy, highly regulated, abuse potential)
- Replacement therapy is just that. ***It IS replacing one drug for another.***
  - Stigmatized in both recovery and professional settings
  - Defining behaviors of SUD
  - Biologically necessary
  - Recovery rates of 40-60% (5-20% in abstinence-only models)

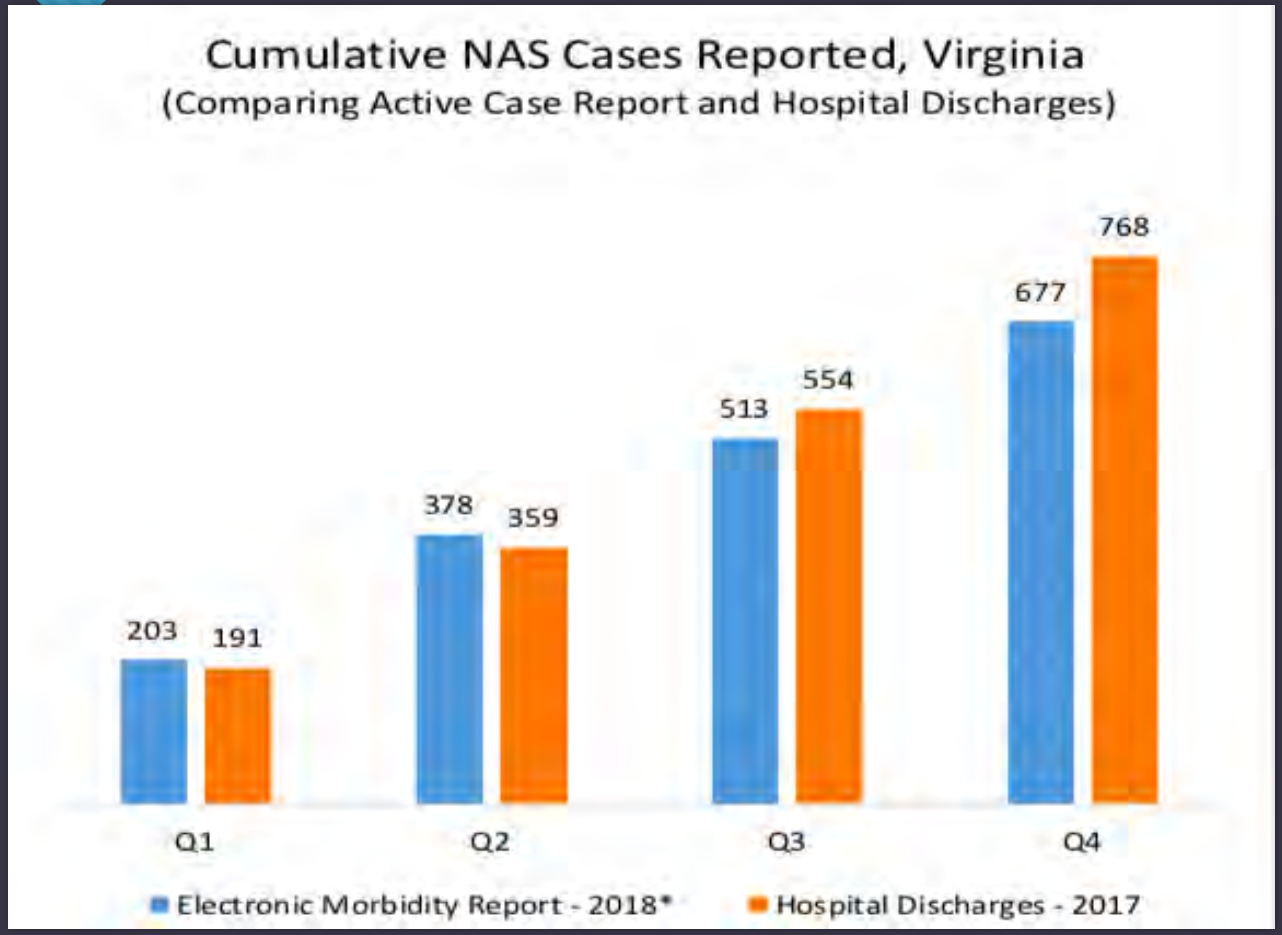
Treatment: Priority Populations

- Priority populations:
  - Pregnant and parenting women
  - Individuals who are incarcerated
  - People with chronic pain
  - Children exposed to substance use disorder
    - Substance-exposed infants
    - Children experiencing active addiction in a caretaker

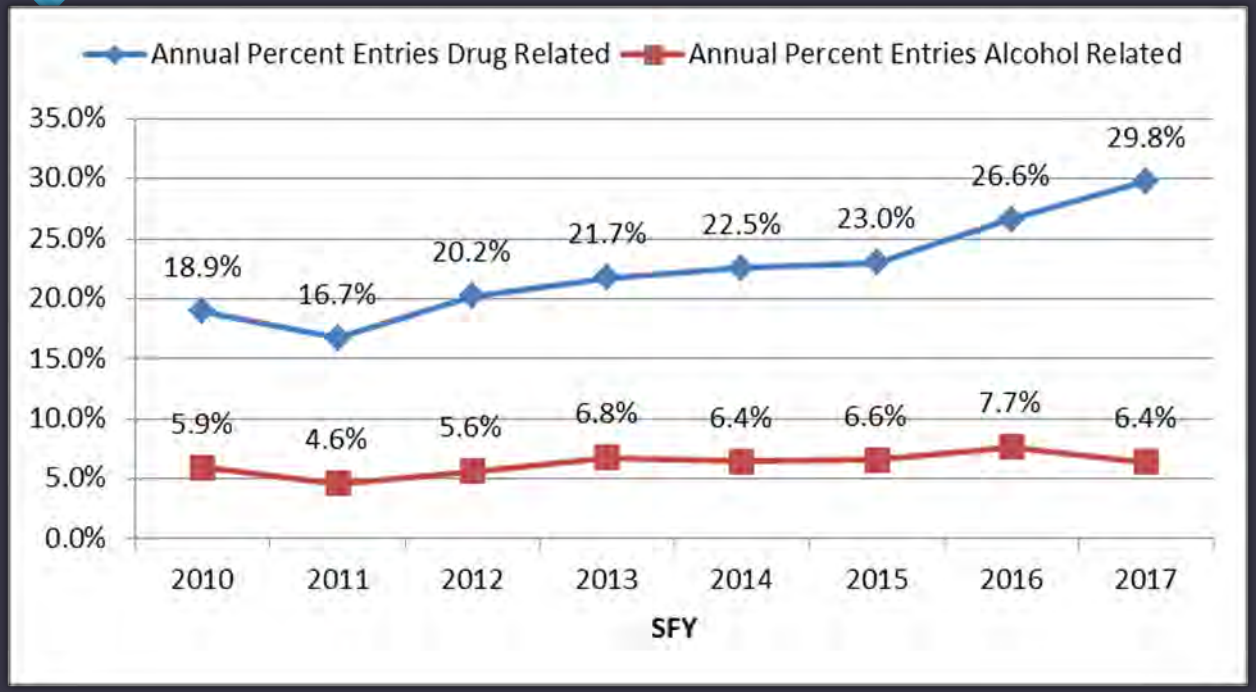
Substance-Exposed Infants in Virginia



Reported Neonatal Abstinence Syndrome, 2018



Foster Care Entries Related to Parental Drug/Alcohol Abuse



DSS experienced a substantial (93%) increase in the number of foster care entries related to parental drug abuse. Foster care entries related to parent drug abuse climbed from a low of 40 children (16.7% percent of all entries in SFY 2011) to 787 children (29.8% of all entries in SFY 2017).

Plans of Safe Care

Medical

- Family Physicians
- OB-GYN Physicians
- Neonatologists
- Pediatricians
- Psychiatrist

Behavioral Health

- Community Service Boards
- Home Visitation Programs
- Medication Assisted Treatment Providers
- Early Intervention
- OTP

Child Welfare

- Prevention
- Child Protective Services

Plans of Safe Care

- Similar to Individualized Service Plans
  - Guided by preference for keeping moms, babies and families together.
  - Include available family and social support.
  - Include follow up plans that support the family. Focuses on the long(er)-term well-being of the infant, mother and family.

Justice – Involved Interventions

- Led by Department of Corrections
- Develop model protocols for Medically Assisted Treatment (MAT) for individuals that are being released from correctional settings that local/regional jails and CSBs can use to implement.
  - Naltrexone Pilot: Voluntary participants returning to 3 areas of Virginia with high incidence of opioid overdose + CSB with OUD services + strong drug court

- Additional objectives
  - Include Buprenorphine MAT availability
  - Increase Medicaid enrollment

Justice-Involved Interventions

- DOC Vivitrol pilot with 3 CSBs (SWVA, Norfolk, Richmond)
- DOC Community Corrections Alternative Program introducing MAT in developing programs
- Four SOR-funded CSB-jail Vivitrol pilots (DBHDS considering proposals currently)
- One RSAT-funded regional jail pilot (2 more in development)

Harm Reduction

- Led by Virginia Department of Health
- Establish operational comprehensive harm reduction (CHR) programs
  - CHR includes HIV/HCV testing, referrals to treatment, referrals to SUD treatment, and exchange of used syringes
  - 0 to 3 existing sites in 2018 (Wise, RVA, Smyth Counties – Roanoke very close)
  - Early stats (Smyth County)
    - ✓ 25 participants
    - ✓ 95% syringe return rate
    - ✓ 32% HCV positive, 100% referral for tx
    - ✓ 69% report injecting suboxone
  - Ability to develop programs sunsets in 2020

Harm Reduction

- Additional objectives
  - Increase Naloxone availability
  - Decreasing Neonatal Abstinence Syndrome
  - Increasing treatment capacity for Hep C
  - Increasing treatment connections for addiction
  - Education on potential dangers of fentanyl contamination in drug supply

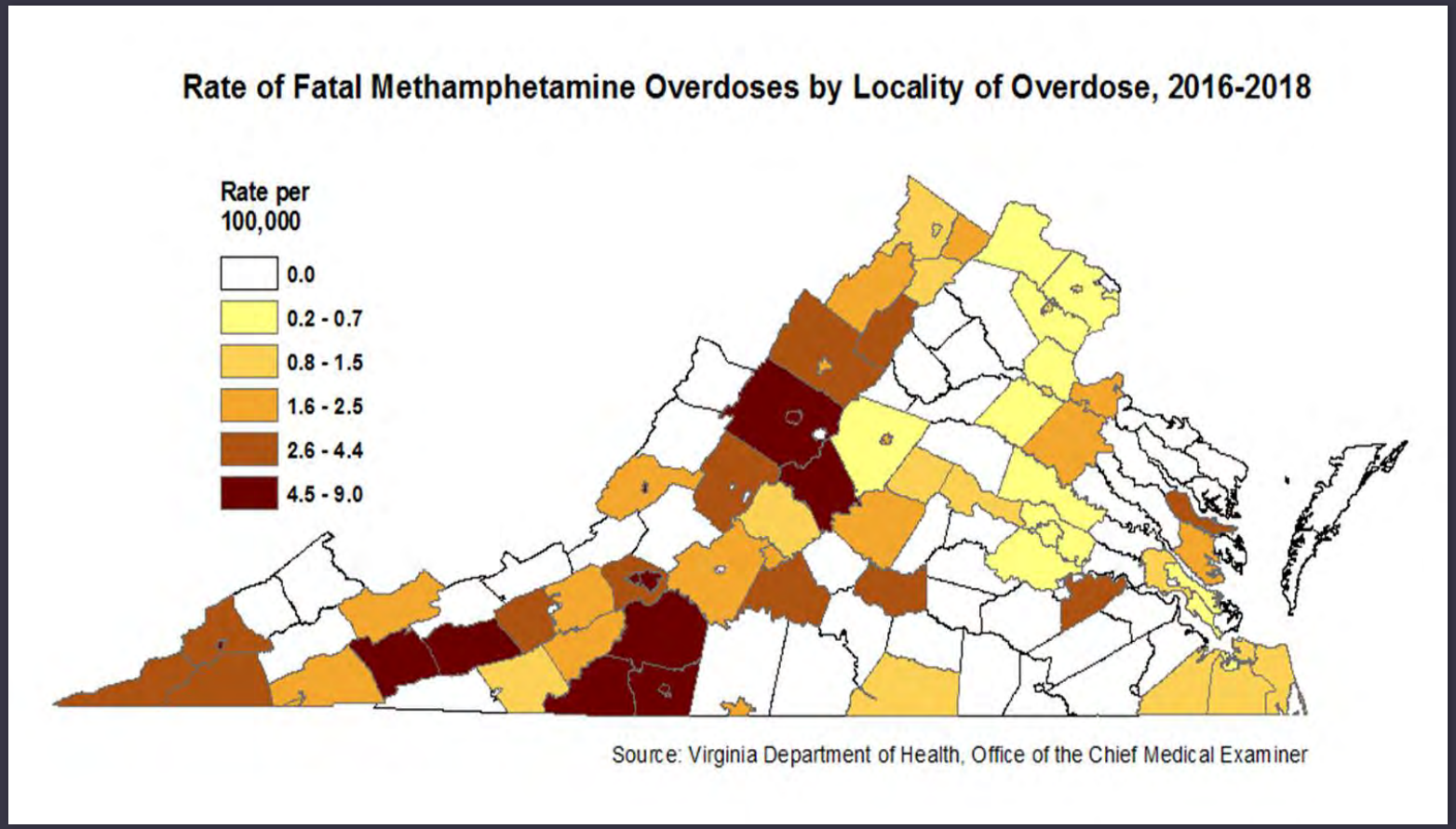
Importance of Data Sharing

- Population of people with SUD tends to touch disparate systems
- Understanding an individual experience through those systems illuminates gaps and opportunities
- Sharing barriers are real!
  - Software and systems
  - Legal perceptions
  - De-identification and security are essential
- Opioids are the use case, potential is much greater

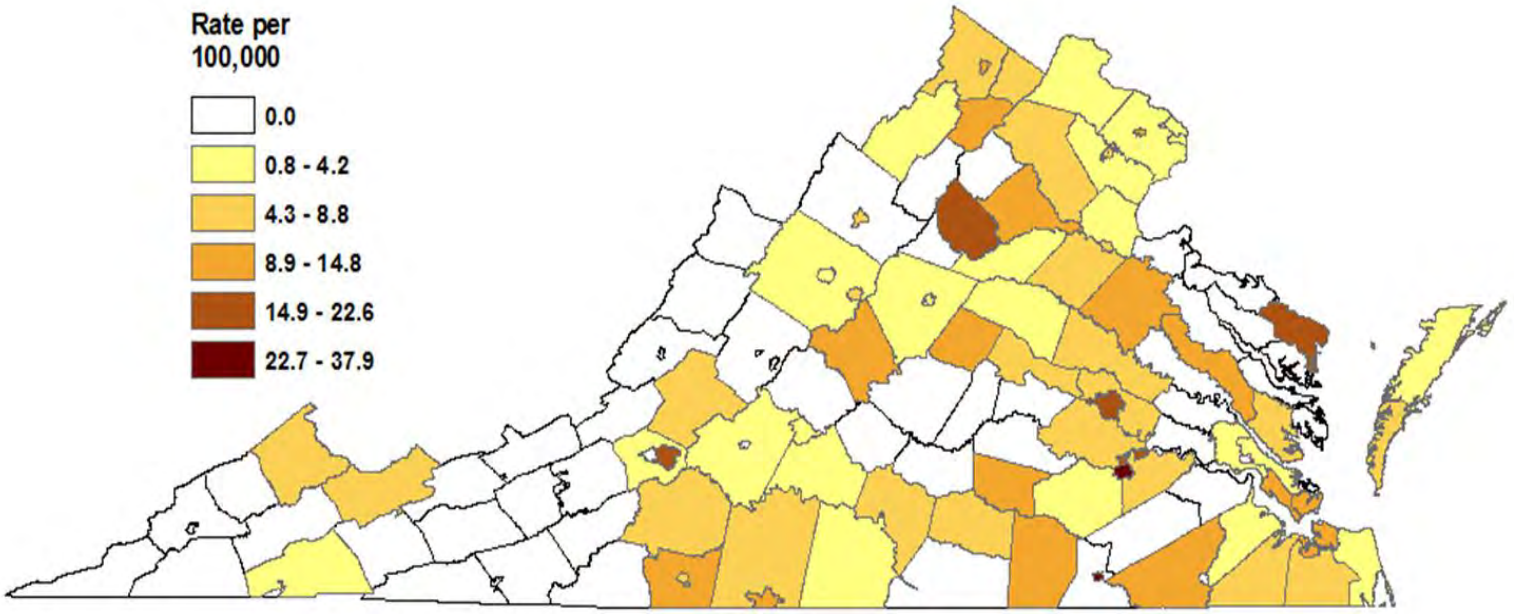
Data Sharing Pilot Successes

- Moving the coalition's focus from opioids to substance use/addiction; reactive to proactive
- Understanding age of first use helps drive attention to youth to do evidence based curriculum for these identified age groups to stem early use.
- Data related to Marijuana (age of first use and drug of choice) provides some caution in legalization conversation
- Coalition "Peers" now located in hospitals to help those with substance use find and engage treatment options
- Crimes attributable to addiction - violent crime rise and monitoring along with where it is happening to understand potential drug hot spots
- Demographics of opioid versus stimulant dependency is different
- Eligibility for drug courts requires non-violent offenses; this conflicts with stimulant users experience, indicating a potential need to amend the law to fulfill the need and truly help that population of users.

Methamphetamine-related Overdose Deaths, 2018



Cocaine Overdose Deaths, 2018



Questions and Contact Info

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- 804 663-7447

Sources

- https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/preventing-drug-misuse-addiction-best-strategy
- https://acestoohigh.com/2017/05/02/addiction-doc-says-stop-chasing-the-drug-focus-on-aces-people-can-recover/
- https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf

Appendix: Allocating SAMHSA funds

- **State Targeted Response (STR) Grant**, 2017-18, $9 M
  - Nearly entirely allocated to CSBs for prevention, treatment, and recovery services
- **State Opioid Response (SOR) Grant**, 2018-19, $16 M yearly
  - Significant allocations to CSBs for prevention, treatment, and recovery services
  - Other major projects supported (not exhaustive):
    - University research-led evaluation
    - Peer supports (professional development and peer placement)
    - Naloxone purchasing
    - Harm reduction supports
    - University recovery program development
    - Media awareness campaign
    - Supports for Tx at FQHCs

Appendix: 2015 Legislative Changes

- Expanded pilot to make Naloxone and training available for first responders statewide, HB1458 (O'Bannon)
- Allowed pharmacists to dispense naloxone under proper protocols, HB1458 (O'Bannon)
- Expanded mandatory PMP registration and amended use of PMP data, HB1841 (Herring)
- Required hospices to notify pharmacies about the death of a patient HB, 1738 (Hodges)

Appendix: 2016 Legislative Changes

- Mandated Continuing Medical Education for providers regarding proper prescribing, addiction, and treatment, HB829 (Stolle)
- Reduced dispenser reporting time from 7 days to 24 hours, allows clinical consultation with pharmacists regarding patient history, and place copy of PMP report in patients' medical history, SB287 (Wexton)
- Allowed unsolicited reports on egregious prescribing/dispensing behavior to agency enforcement, HB657 (O'Bannon/Herring)
- Required query of PMP for all opioid prescriptions over 14 days, SB513 (Dunnavant)/ HB293 (Herring)
- Provided certification for substance abuse peer support, HB583 (Yost)

Appendix: 2017 Legislative Changes

- Mandated e-prescribing, SB1230/HB2165 (Dunnavant/Pillion)
- Naloxone dispensing, SB848 (Wexton)
- Peer recovery registration, SB1020/HB2095 (Barker/Price)
- Substance exposed infants, SB1086/HB1786 (Wexton/Stolle/Herring)
- Harm reduction pilot programs, HB2317 (O'Bannon)
- PMP initial opioid Rx reduction, HB1885/SB1232 (Hugo/Dunnavant)

Appendix: 2018 Legislative Changes

- Added Schedule V drugs and naloxone to PMP, HB1556 (Pillion) SB832 (Carrico)
- Removed 14 day surgical exemption to 7-day initial opioid prescription law, HB1173 (Pillion) SB632 (Dunnavant)
- Required veterinarians to register with PMP and requires check for Rx above 7 days on owner and animal, SB226 (Stanley)
- Added Department of Corrections to those carrying and trained on Naloxone, HB322 (Bourne)
- Removed burglary as barrier crime for SUD and MH providers, SB555 (Mason)

Appendix: 2019 Legislative Changes

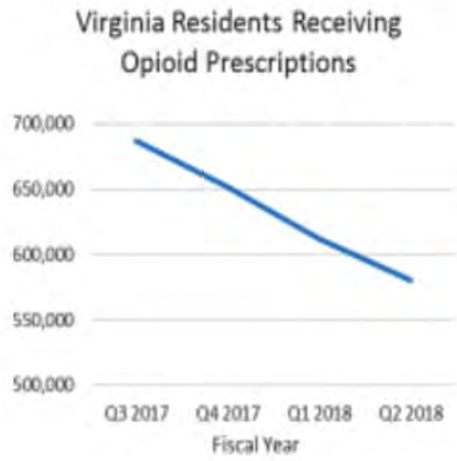
- Directed the Department of Behavioral Health and Developmental Services to promulgate regulations to certify recovery residences, HB2045 (Hurst)
- Added employees of regional jails to the list of individuals who may possess and administer naloxone, HB1878 (Garrett)
- Expanded list of individuals who may dispense naloxone to include providers in EDs and EMS personnel, also established syringe-based naloxone dispensing requirements and allowed that community organizations may charge to dispense naloxone, though the fee can't exceed the cost of naloxone itself, HB2158 (Plum)
- Allowed possession and administration of naloxone by school nurses and local health department employees who provide service sin schools, HB2318 (McGuire)
- Prohibits providers from requesting or requiring cash payment from Medicaid members for MAT services, HB2558 (Pillion)/SB1167(Chafin)
- Eliminated the requirement for individuals to substantially cooperate with law enforcement in order to qualify for affirmative defense when reporting an overdose, SB1349 (McDougal)
- Established felony homicide for sales and distribution of Schedule I or II drugs that result in the death of an individual, HB2528 (Hugo)

Appendix: 2017 Regulatory Changes: Boards of Medicine and Dentistry Regulations – Pain Management

- Initial acute pain opioid prescriptions not to exceed 7 days
- Document reasons to exceed 50 MME/day, refer to pain specialist over 120 and co-prescribe naloxone
- Limit co-prescribing of benzos, sedative hypnotics, carisoprodol, and tramadol
- Buprenorphine primarily indicated for addiction
- Requirement of patient history and risk prior to Rx
- Consider non-opioid treatment first
- Document rationale to continue opioids every 3 mos
- Regular opioid use disorder screens and referral to Tx

Appendix: Prescribing Regulation Impact

Health Professions

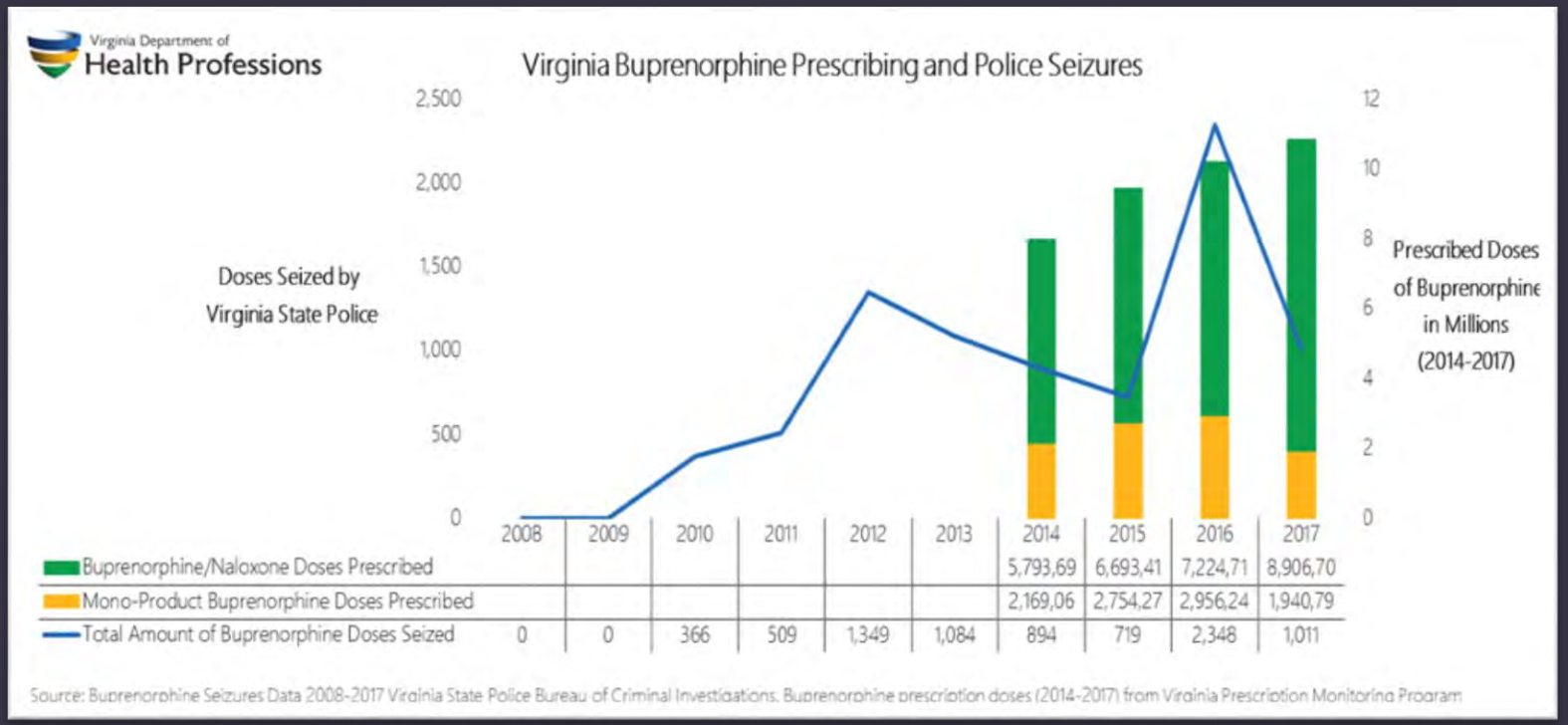


The Virginia Prescription Monitoring Program recorded 580,256 Virginia Residents received an opioid prescription in Q2 2018. This is a decline from the previous quarter and is part of a general downward trend in the number of Virginia residents who receive opioid prescriptions.

Appendix: 2017 Regulatory Changes: Board of Medicine Regulations – Addiction Treatment

- Requires MAT be prescribed alongside counseling
- Requires use of less-abusable/divertable suboxone as opposed to subutex
- Requires that Subutex (monoproduct) is to be prescribed only for pregnant women and people with documented allergies

Appendix: Treatment Regulation Impact



Appendix: Budgetary Changes

2016

- Medicaid Addiction, Recovery, and Treatment Services Benefit
  - Implemented April 1, 2017
  - Increased treatment rates by 50%
  - Increased number of members receiving pharmacotherapy for Opioid Use Disorder by 30%
  - Number of practitioners providing outpatient psychotherapy or counseling to Medicaid members more than doubled

2018

- Medicaid expansion to 138% FPL approved
  - To be implemented via Managed Care January 1, 2018
  - Will include all services under ARTS benefit

2019

- ~$1M to support Department of Corrections (DOC) Community Corrections Alternative Program (CCAP)
- $3.3 M to fund Department of Forensic Science's opioid crisis emergency response plan, funding positions and outsourcing costs to address controlled substances backlogs.
- $5 M GF for treatment at CSBS