Virginia Opioid & Heroin Stakeholders' Meeting

Secretary William A. Hazel, Jr., MD

Secretary Brian J. Moran

June 21, 2017

Agenda

Welcome and review of Task Force Recommendations, 1:30 – 1:50 pm

Active workgroups, studies, and regulations on prescribing in Virginia, 1:50 – 2:05 pm

State Targeted Response SAHMSA Grant activities and programs, 2:05 – 2:20 pm

Medicaid ARTS and peers benefit update, 2:20 – 2:35 pm

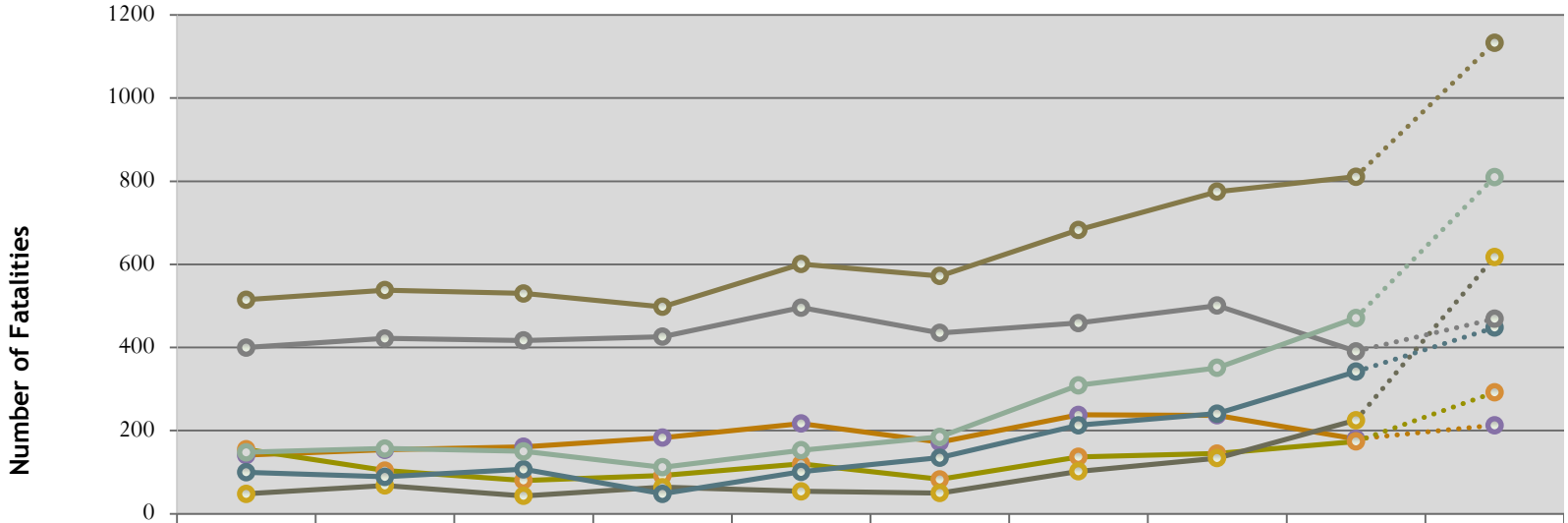
Comprehensive Harm Reduction in Virginia, 2:35 –2:55 pm

Executive Leadership Team staff updates, 2:55 – 3:05 pm

Open discussion/Secretaries close, 3:05 – 3:30 pm

ALL DRUGS

Total Number of Fatal Drug Overdoses Drug Name/Category and Year of Death, 2007-2016
(Data for 2016 is a Predicted Total for the Entire Year)



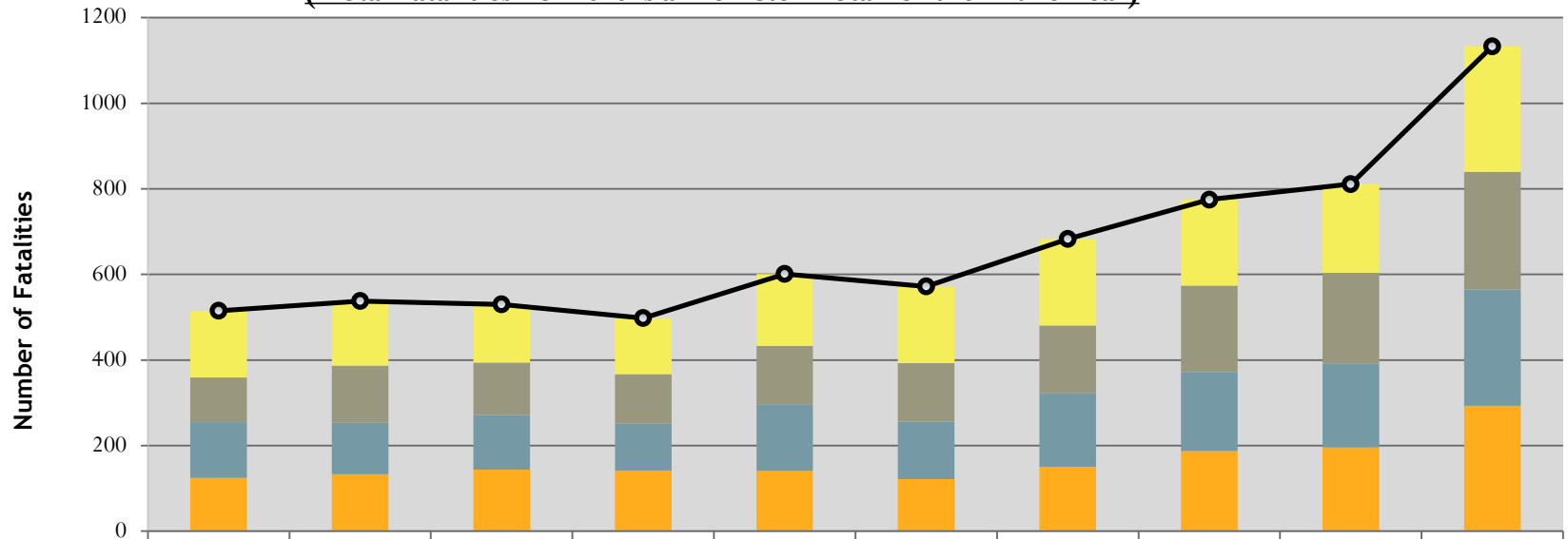
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016*
Benzodiazepines	141	154	161	183	217	172	238	237	180	213
Cocaine	155	104	80	92	120	83	137	145	174	292
Fentanyl	48	68	43	64	54	50	102	134	225	618
Heroin	100	89	107	48	101	135	213	241	342	448
Prescription Opioids (excluding Fentanyl)	400	422	417	426	496	435	459	501	391	469
All Opioids	515	538	530	498	601	572	683	775	811	1133
Heroin and/or Fentanyl	148	157	150	112	153	185	309	351	471	810

[1] Deaths may be represented in more than one category due to groupings of drug categories (e.g. heroin)
[2] 'All Opioids' include heroin, prescription opioids, and opioids unspecified
[3] 'Opioids Unspecified' are a small category of deaths in which the determination of heroin and/or one or more prescription opioids cannot be made due to specific circumstances of the death. Most commonly, these circumstances are a result of death several days after an overdose, in which the OCME cannot test for toxicology because the substances have been metabolized out of the decedent's system.
[4] Historically, fentanyl has been categorized as a prescription opioid because it is mass produced by pharmaceutical companies. However, recent law enforcement investigations and toxicology results have demonstrated that several recent fentanyl seizures have ***not*** been pharmaceutically produced, but illicitly produced. This illicit form of fentanyl is produced by international drug traffickers who import the drug into the United States and often, mix it into heroin being sold. This illicitly produced fentanyl , especially fentanyl mixed with heroin, has been the biggest contributor to the significant increase in the number of fatal opioid overdoses in Virginia.
[5] Illicit and pharmaceutically produced fatal fentanyl overdoses are represented in this analysis. This includes all different types of fentanyl analogs (acetyl fentanyl, furanyl fentanyl, etc.)
[6] Fatal opioid numbers have changed slightly from past reports due to the removal of fentanyl from the category of prescription opioids, as well as the addition of buprenorphine, levorphanol, meperidine, pentazocine, propoxyphene, and tapentadol added to the list of prescription opioids.

ALL OPIOIDS

From 2007-2015, opioids (fentanyl, heroin, and/or one or more prescription opioids) made up approximately 75% of all fatal drug overdoses annually in Virginia. However, this percentage is increasing each year due to the significant increase in fatal fentanyl and/or heroin overdoses which began in late 2013 and early 2014. Fatal opioid overdoses increased by 39.7% in 2016 when compared to 2015.

Total Number of Fatal Opioid Overdoses by Quarter and Year of Death, 2007-2016
('Total Fatalities' for 2016 is a Predicted Total for the Entire Year)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016*
Q4	156	151	136	131	168	179	202	201	207	293
Q3	104	134	122	116	136	137	158	202	213	275
Q2	130	120	128	109	156	134	173	185	195	272
Q1	125	133	144	142	141	122	150	187	196	293
Total Fatalities	515	538	530	498	601	572	683	775	811	1133

[1] 'All Opioids' include all versions of fentanyl, heroin, prescription opioids, and opioids unspecified
[2] 'Opioids Unspecified' are a small category of deaths in which the determination of heroin and/or one or more prescription opioids cannot be made due to specific circumstances of the death. Most commonly, these circumstances are a result of death several days after an overdose, in which the OCME cannot test for toxicology because the substances have been metabolized out of the decedent's system.
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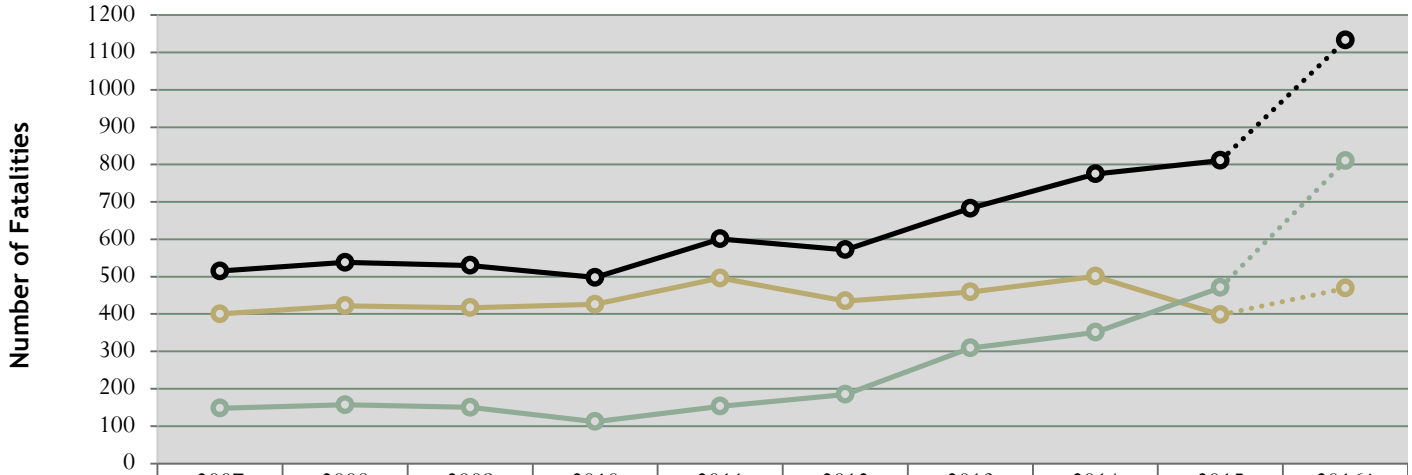
OPIOIDS- A DIFFERENT PERSPECTIVE

Prescription opioids are a group of drugs that are commercially made by pharmaceutical companies in certified laboratories that act upon the opioid receptors in the brain. Historically, fentanyl has been one of these drugs. However, in late 2013, early 2014, illicitly made fentanyl began showing up in Virginia and by 2016, most fatal fentanyl overdoses were of illicit production of the drug. Separating fentanyl from the grouping of prescription opioids for this reason demonstrates a decrease in fatal prescription opioid overdoses in 2015 and a dramatic increase in the number of fatal fentanyl and/or heroin overdoses. This has caused the significant rise in all fatal opioid overdoses in the Commonwealth since 2012.

Total Number of Prescription Opioid (excluding Fentanyl), Fentanyl and/or Heroin, and All Opioid Overdoses by Year of Death, 2007-2016
('Total Fatalities' for 2016 is a Predicted Total for the Entire Year)



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[1] 'All Opioids' include all versions of fentanyl, heroin, prescription opioids, and opioids unspecified

[2] Illicit and pharmaceutically produced fatal fentanyl overdoses are represented in this analysis. This includes all different types of fentanyl analogs (acetyl fentanyl, furanyl fentanyl, etc.)

[3] 'Prescription Opioids (excluding fentanyl)' calculates all deaths in which one or more prescription opioids caused or contributed to death, but excludes fentanyl from the **required list** of prescription opioid drugs used to calculate the numbers. However, given that some of these deaths have multiple drugs on board, some deaths may have fentanyl in addition to other prescriptions opioids, and are therefore counted in the total number. Analysis must be done this way because by excluding all deaths in which fentanyl caused or contributed to death, the calculation would also exclude other prescription opioid deaths (oxycodone, methadone, etc.) from the analysis and would thereby undercount the actual number of fatalities due to these true prescription opioids.

[4] Fatal opioid numbers have changed slightly from past reports due to the removal of fentanyl from the category of prescription opioids, as well as the addition of buprenorphine, levorphanol, meperidine, pentazocine, propoxyphene, and tapentadol added to the list of prescription opioids.

Framework

- **Harm reduction** until treatment is available and accepted
- **Treatment** for those who are addicted
- **Prevention** through reducing the supply of legal opiates
- **Prevention** through tracking and reducing the supply of illegal opiates
- **Culture changes** in 3 areas

Harm Reduction

- Expand access to naloxone by lay rescuers and law enforcement to prevent death from overdose. (p. 7; Sec III, A; p. 32; Sec V, X)
- Increase access to naloxone by allowing pharmacists to dispense naloxone under proper protocols. (p. 9; Sec III, E)

Naloxone for Law Enforcement First Responders

- Legislation in 2015 allows LEO to administer
  - REVIVE! Training by DBHDS for 84 LE agencies
- DCJS awards $35K to 11 LE agencies for naloxone purchase
- VSP issuing naloxone to 400 personnel
- Examples of lives saved
  - Virginia Beach (over 50); Franklin County (9); Spotsylvania (13)

Treatment

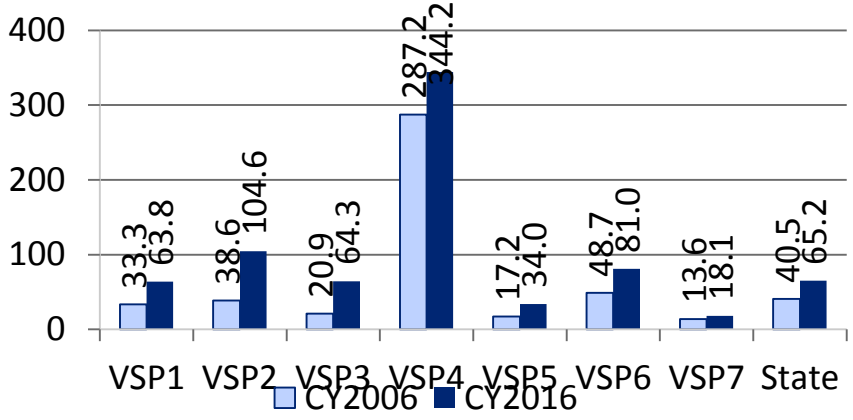
- Enhance and enforce a standard of care for treatment with office-based buprenorphine. (p. 30; Sec V, S)
- Explore ways to enhance access to MAT through CSBs, Drug Treatment Courts, and jail-based treatment. (p. 27; Sec V, N)
- Examine and enhance Medicaid reimbursement for substance abuse treatment services. (p. 17; Sec IV, H)
- Explore and expand use of appropriate peer support services, with necessary oversight. (p. 15; Sec IV, F)

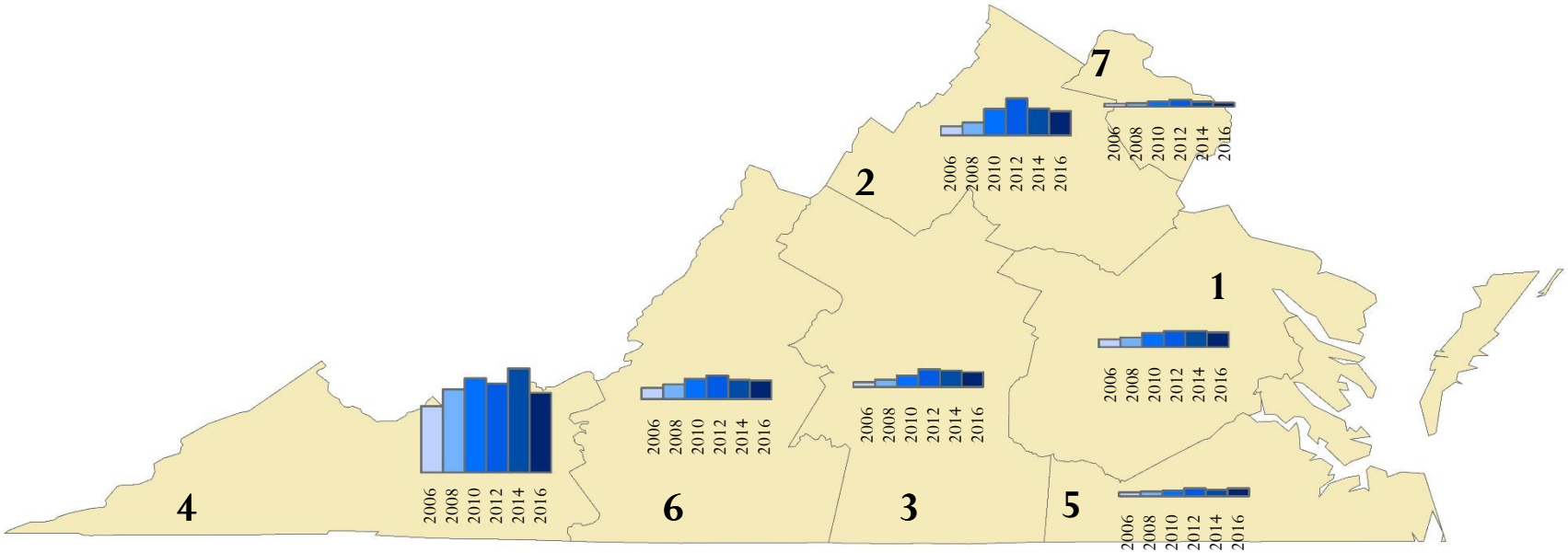
Prevention of Legal Opioid Abuse

- Encourage placement of stationary disposal containers in every locality and subsequently inform Virginians of their locations. (p. 33; Sec V, Z)
- Evaluate options for continuing medical education (CME), including incentives and consequences to encourage participation in CME of opioids to treat pain while minimizing the risk of addiction and substance abuse. (p. 19; Sec V, D)
- Increase training opportunities for health care professionals, both in training and in practice, on how to treat addiction and how to diagnose or manage chronic pain. (p. 18 & 19; Sec V; A, D)
- Grant authority to the PMP, through the Director of the Department of Health Professions (DHP), to send unsolicited reports on egregious outlier prescribing and dispensing behavior to the Enforcement Division of DHP and/or to law enforcement, based on criteria developed by the PMP Advisory Panel in consultation with applicable licensing boards. (p. 36; Sec V, GG)

Prescription Opioid* Submission Rate

Rate of submissions per 100,000 Population, calendar years 2006-2016





*Fentanyl submissions identified as being in the form of a transdermal patch are counted with other prescription opioids. All other forms of fentanyl and fentanyl derivatives are counted as "illicit" for purposes of this report.

Prescription Opioid* Summary

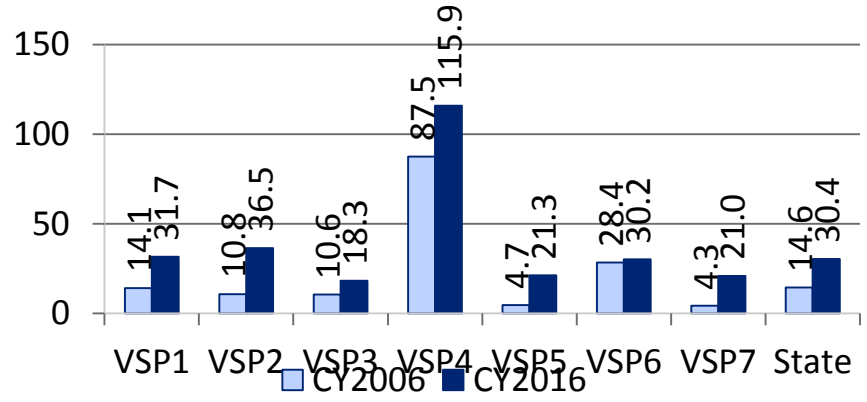
Statewide and by VSP Division

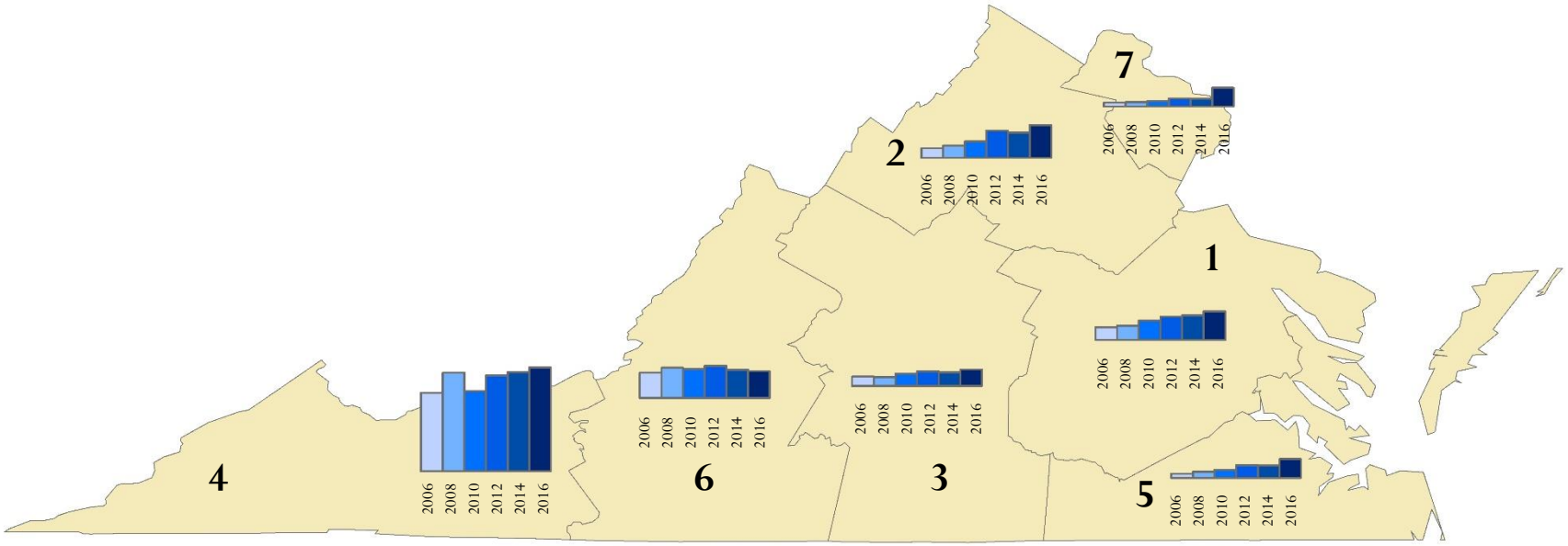
- Number of prescription opioid case submissions:
  - The number of prescription opioid cases submitted to DFS decreased 3% statewide between 2015 and 2016.
  - After peaking in 2012, the number of prescription opioid submissions dropped each year. Between 2012 and 2016, submissions dropped 18% statewide.
  - VSP Division 4 has consistently submitted the most prescription opioid cases. In 2016, 28% of the statewide prescription opioid cases were from Division 4.
- Rate of submissions, per 100,000 population
  - The rate of prescription opioid submissions from Division 4 was more than three times higher than any other Division.

*Fentanyl submissions identified as being in the form of a transdermal patch are counted with other prescription opioids. All other forms of fentanyl and fentanyl derivatives are counted as "illicit" for purposes of this report.

Benzodiazepine Submission Rate

Rate of submissions per 100,000 Population, calendar years 2006-2016



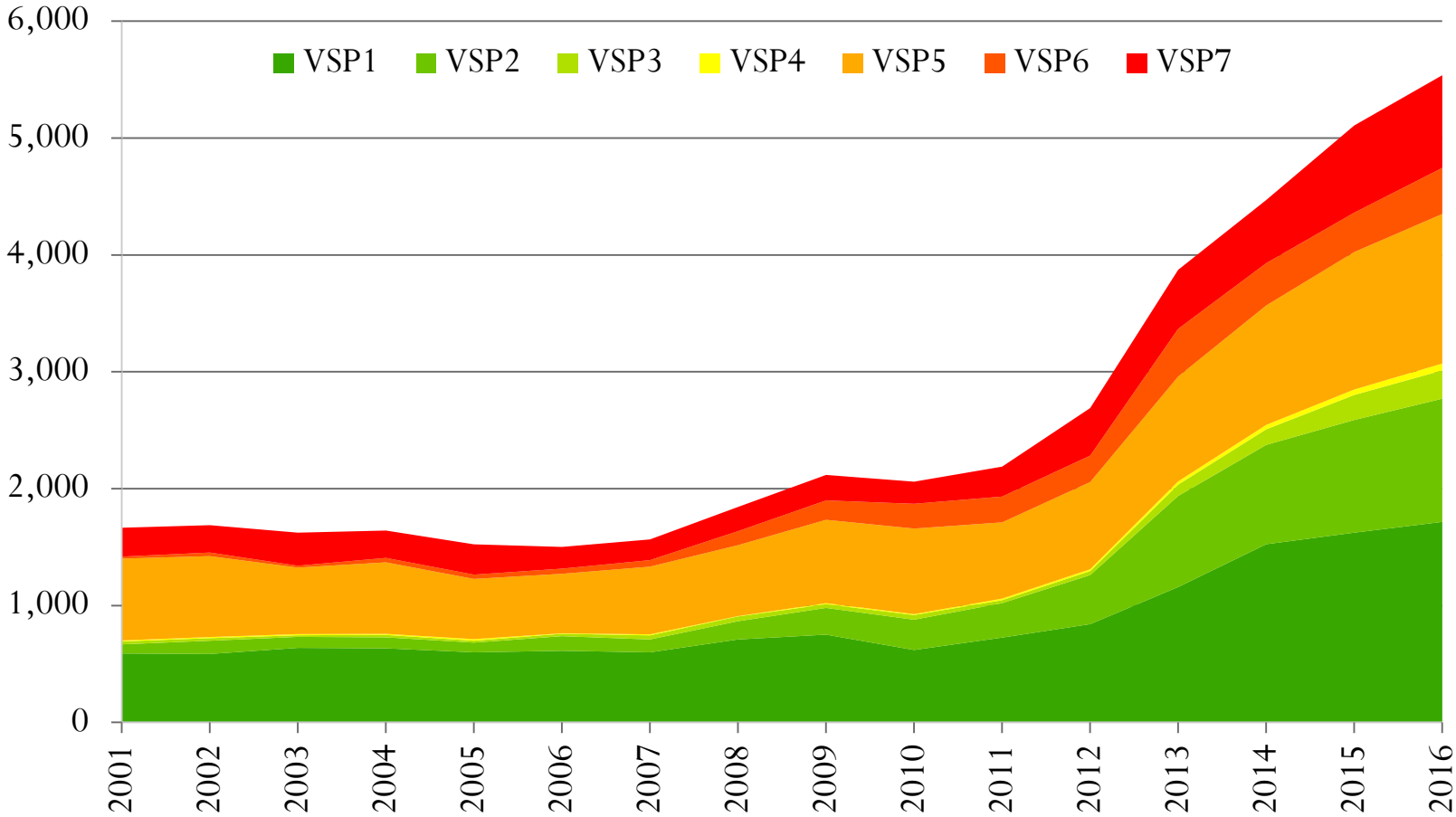


Prevention of Illegal Opioid Use

- Create a Health and Criminal Justice Data Committee, comprised of data analysts from applicable agencies within the Secretariats of Public Safety & Homeland Security and Health & Human Resources, to study data for the purpose of better understanding the ways in which criminal justice and public health issues intersect, with the goal of improving government responses to crises, as well as identifying and responding to concerns before they become crises. (p. 21; Sec V, F)

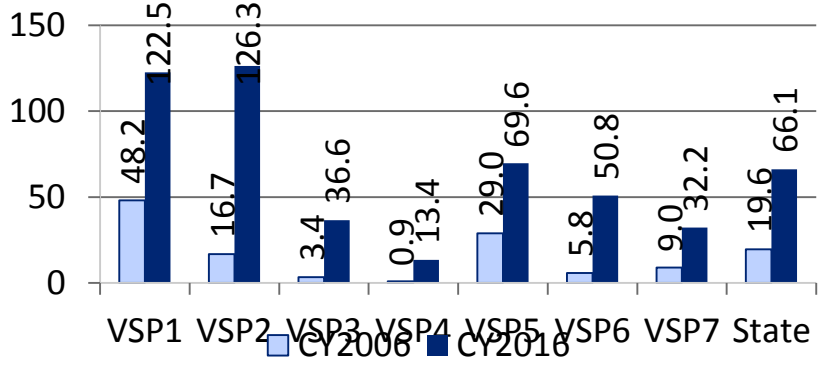
Heroin Submissions to DFS

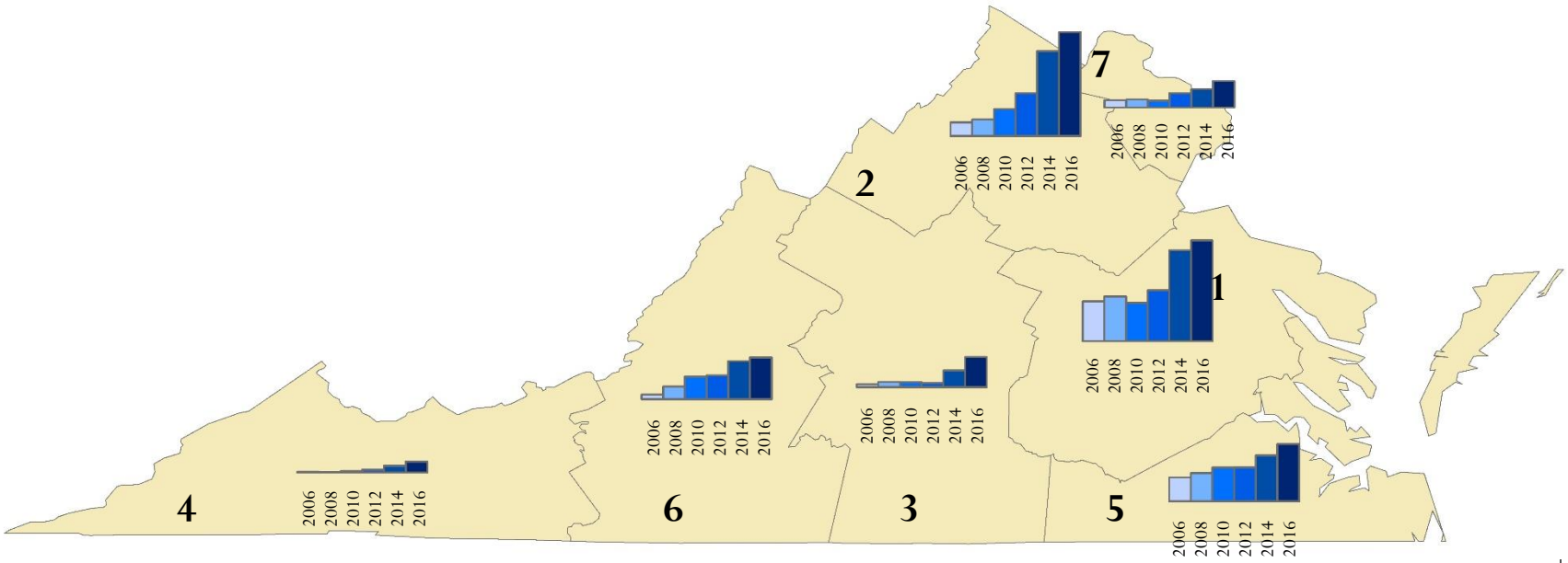
Cases submitted to DFS, calendar years 2001-2016



Heroin Submission Rate

Rate of submissions per 100,000 Population, calendar years 2006-2016





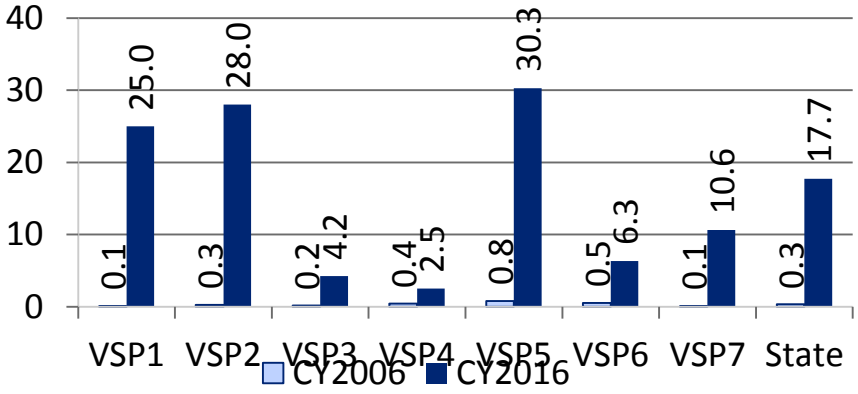
Heroin Summary

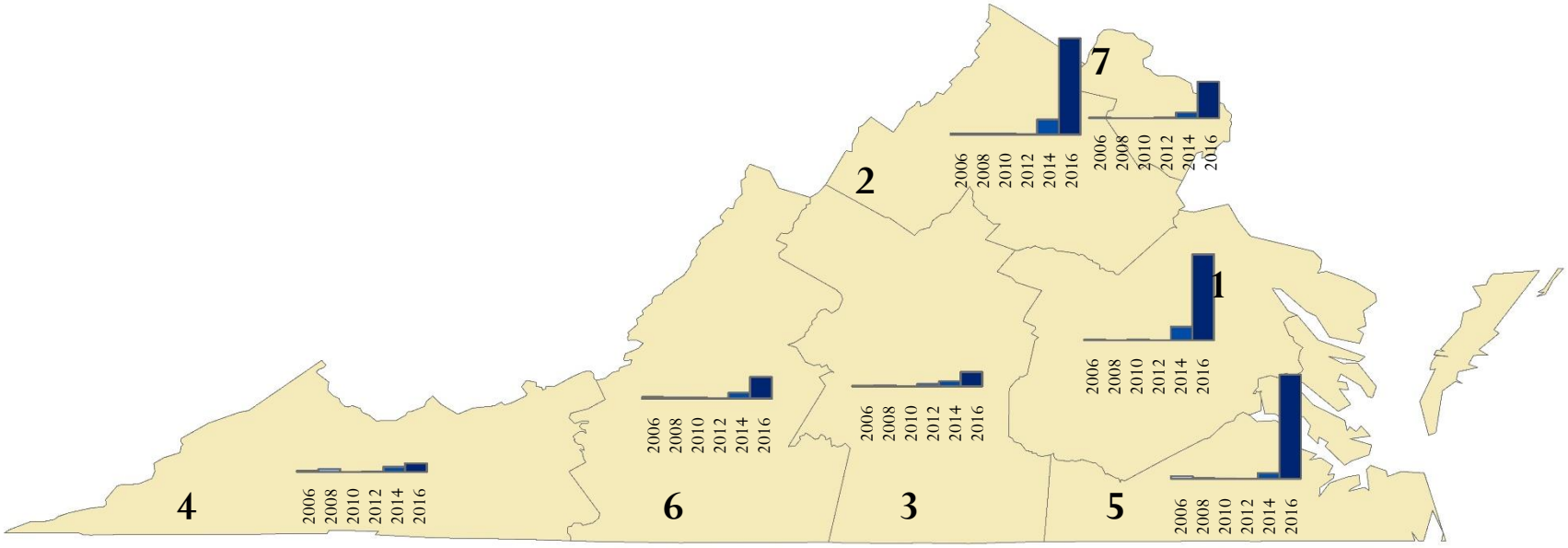
Statewide and by VSP Division

- Number of heroin case submissions:
  - Heroin cases submitted to DFS increased 8% statewide between 2015 and 2016.
  - Between 2011 and 2016, heroin submissions increased 154% statewide.
  - VSP Divisions 1 and 5 submitted the majority of the statewide total number of heroin cases in 2016 (31% and 23%, respectively).
  - Relatively few cases were submitted by Divisions 4 and 3 in 2016 (1% and 4%, respectively).
- Rate of submissions, per 100,000 population
  - The rate of heroin cases submitted from Divisions 1 and 2 were each almost twice as high as any other Division.

Illicit Fentanyl* Submission Rate

Rate of submissions per 100,000 Population, calendar years 2006-2016





*Fentanyl submissions identified as being in the form of a transdermal patch are counted with other prescription opioids. All other forms of fentanyl and fentanyl derivatives are counted as "illicit" for purposes of this report.

Illicit Fentanyl* Summary

Statewide and by VSP Division

- Number of illicit fentanyl case submissions:
  - Illicit fentanyl cases submitted to DFS increased 207% statewide between 2015 and 2016.
  - Illicit fentanyl cases began increasing rapidly in 2013. Between 2013 and 2016, cases increased 1,656%.
  - VSP Divisions 5 and 1 submitted the majority of the statewide total number of illicit fentanyl cases in 2016 (37% and 23%, respectively).
  - Relatively few cases were submitted by Divisions 4 and 3 in 2016 (1% and 2%, respectively).
- Rate of submissions, per 100,000 population
  - The rate of heroin cases submitted from Divisions 5, 2, and 1 were each more than twice as high as any other Division.

*Fentanyl submissions identified as being in the form of a transdermal patch are counted with other prescription opioids. All other forms of fentanyl and fentanyl derivatives are counted as "illicit" for purposes of this report.

Culture Change

- Collaborate with appropriate medical and healthcare school leadership to encourage them to provide curricula in health professional schools on the safe and appropriate use of opioids to treat pain while minimizing the risk of addiction and substance abuse.
- Work with schools of social work to encourage education on addiction, treatment resources, and resource coordination for students going on to work as mental health providers. (p. 18; Sec V, B)

Challenge:

What has not been done that could be?

Other questions?

Appendix: Successes to Date Cheat Sheet

2015

Legislative Initiatives

- Expanded pilot to make Naloxone and Naloxone training accessible to first responders throughout Virginia - 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)

Programmatic/Policy Initiatives

- Added morphine equivalent doses per day (MEDD) score to PMP patient reports
- Creation of Health and Criminal Justice Data Committee to share opioid-related data across agencies
- Hosted Appalachian Opioid Summit to discuss cross-border policy and practice to address overdose epidemic with neighboring states

Appendix: Successes to Date Cheat Sheet

2016

Legislative Initiatives

- Mandates Continuing Medical Education for providers regarding proper prescribing, addiction, and treatment – HB829 (Stolle)
- Reduces 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)
- Sends unsolicited reports on egregious prescribing/dispensing behavior to agency enforcement – HB657 (O'Bannon/Herring)
- Requires query of PMP for all opioid prescriptions over 14 days – SB513 (Dunnavant)/ HB293 (Herring)
- Provides certification for substance abuse peer support – HB583 (Yost)

Programmatic/Policy Initiatives

- Enhancing Medicaid Substance Use Disorder benefit in state budget
  - Expanding short-term detox to 15 days for all Medicaid members
  - Expanding short-term residential treatment up to 30 days for all members
  - Increasing reimbursement for currently covered Medicaid SA services
  - Adding coverage for peer supports
  - Adding SA care coordinators at Medicaid MCOs
  - Adding provider education, training, and recruitment for MAT
- VAaware.com website

Appendix: Successes to Date Cheat Sheet

2017

Legislative Initiatives

- Mandates e-prescribing for all opioid prescriptions by 2022; includes workgroup to develop implementation and funding plans, SB1230/HB2165 (Dunnavant/Pillion)
- Enables community organizations that train lay rescuers in Naloxone to store and dispense the drug, SB848 (Wexton)
- Requires registration of certified peer recovery specialists in order to be reimbursed under the state's Medicaid benefit, SB1020/HB2095 (Barker/Price)
- Deletes DSS exemption that removing reports of substance-exposed infants if the mothers were receiving treatment, ensuring access to treatment for mother and child if necessary, SB1086/HB1786 (Wexton/Stolle/Herring)
- Creates comprehensive harm reduction pilot programs through local health departments in localities with high rates of Hep C and HIV infection, HB2317 (O'Bannon)
- Mandates a PMP check for any initial opioid prescriptions over 7 days HB1885/SB1232 (Hugo/Dunnavant)

Programmatic/Policy Initiatives

- Boards of Medicine and Dentistry Pain Management Regulatory Changes
- Boards of Medicine and Dentistry Treatment Regulatory Changes