SUBSTANCE ABUSE SERVICES COUNCIL

ANNUAL REPORT
2019

to the Governor and

the

General Assembly

COMMONWEALTH OF VIRGINIA

October 1, 2019

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To: The Honorable Ralph Northam
and
Members, Virginia General Assembly

In accordance with §2.2-2696 of the *Code of Virginia*, I am pleased to present the 2019 Annual Report of the Substance Abuse Services Council. The *Code* charges the council with recommending policies and goals relating to substance abuse and dependence and with coordinating efforts to control substance abuse. It also requires the council to make an annual report on its activities. The membership of the council includes representatives of state agencies, delegates, senators and representatives of provider and advocacy organizations appointed by the Governor.

On behalf of the council, I appreciate the opportunity to provide you with our annual report detailing the council's study of several critical issues. We hope it will contribute to improving the lives of the many Virginians affected by substance use disorders.

Sincerely,

Mary McMasters, MD

cc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources
Mira Signer, Acting Commissioner, Department of Behavioral Health and Developmental Services
Paula Mitchell, Chair, State Board of Behavioral Health and Developmental Services

Introduction

The Substance Abuse Services Council (SASC) is established in the *Code of Virginia* [2.2-2696] to advise the Governor, the General Assembly, and the State Board of Behavioral Health and Developmental Services on matters pertaining to substance abuse in the Commonwealth. As required, the Council met four times during 2019 (March 13, April 10, May 15, and September 25.) All meetings were conducted in the metropolitan Richmond area. Meeting notices and approved minutes are posted on the Council's web page at http://www.dbhds.virginia.gov/about-dbhds/Boards-Councils/SASC. Presentations and other information distributed at the meetings are also available at this website.

The contents of this report cover the activities of the Council in calendar year 2019. During this time period, the Council studied critical topics related to the workforce, including workforce training and development.

The following sections describe the Council's activities and presentations that informed the Council's discussion and recommendations.

Review of Definitions

Dr. Mary McMasters, Council chair and noted addiction specialist, provided an overview of addiction for Council members and guests, with a focus on terminology relative to addiction. Three major accepted sources for definitions of substance abuse disorders were cited: the Diagnostic and Statistical Manual V (DSM V), the criteria established by the American Society of Addiction Medicine (ASAM), and the International Code of Diseases (ICD). These sources also provide appropriate language for talking about substance abuse disorders, as much of the language commonly used is pejorative (e.g. "getting clean). It was stressed that physical dependence resulting in withdrawal symptoms is NOT the same thing as the disease of Addiction. Addiction is use of substances despite knowing that its use is harmful coupled with unsuccessful efforts to reduce/stop its use. Individuals with the disease of addiction lack control over the use of the substances to which they are addicted, and, as addiction is not substance-specific, the individual will seek other substances to address their craving if the substance of choice is not available. Functioning level is also negatively impacted by the disease of addiction and should be taken into consideration when assessing an individual's substance abuse. Recovery is possible, with relapse always a possibility; the disease of addiction should be managed as any other chronic disease. For example, levels of care for diabetes may mirror those for addiction, with medication used to support education and counseling. Medications for substance addiction may include methadone, buprenorphine and Naltrexone for individuals with opioid use disorder, acamprosate and naltrexone for individuals with alcohol use disorder, and varenicline and nicotine replacements for individuals addicted to nicotine. Currently, medical students and residents receive limited training, if any, about the disease of Addiction and the medications used to treat it.

Certified Peer Recovery Specialists

Mark Blackwell, Director of the Office of Recovery Services at the Department of Behavioral Health and Developmental Services (DBHDS), and Mary McQuown, MA, CPRS, Peer Recovery

Specialist, Office of Recovery Services, DBHDS, presented on Certified Peer Recovery Specialists in Virginia. Both the process of certification and the pathways to become a Certified Peer Recovery Specialist (CPRS) in Virginia were reviewed. When the process of certifying peer recovery specialists began, individuals who were already serving in the role of peer advisor were allowed to apply to be "grandfathered." This resulted in 464 individuals becoming certified for two years. Those persons who were grandfathered reached the end of their two-year certification period at the end of 2018, and approximately 100 of those individuals have not recertified; they have 12 months beyond that time to recertify without going through the certification process again. The cost for certification is $175; the cost for recertification is $75. Required training for the CPRS certification is a total of 72 hours; 60-hours in the classroom and 12-hours of homework. Peer Recovery Specialists must also be registered with the Board of Counseling for their services to be billed to Medicaid; registration fees are $30 yearly. In order to be registered with the Board of Counseling, an individual must be certified; however, once the person has been registered they do not need to be certified to renew their registration yearly. It was noted that a peer would not need to be certified if their employer was not billing for their services; this allows for continuing opportunities for naturally-occurring peer supports. It was reported that Virginia Commonwealth University is developing a report identifying barriers to becoming a CPRS and Council members expressed an interest in reviewing the report this Council year.

Medication Assisted Treatment (MAT)

Dr. Mary McMasters presented on MAT: a Synthesis of Definition. Basic definitions for Medication Assisted Addiction treatment were reviewed, including for diversion (which is primarily a law enforcement issue) and for substance misuse and addiction; substance misuse and addiction were differentiated by the element of choice (present in misuse, not in addiction.) The effects of genetic predisposition, along with exposure to a substance, on the development of addiction were discussed. The effect of substances on the brain was noted, with some substances spiking dopamine higher and faster than others; it was emphasized that misusing initially elevates dopamine above levels normally experienced. Evaluating functioning as part of treatment is important; if medication is being used to relieve pain, functioning should improve, if the medication is feeding addiction, functioning will get worse. Comparisons were made between diabetes and addiction regarding the impact of genetic predisposition. For both, medications add to the level of care, but do not dictate the level of care. The importance of dealing with cravings as well as preventing withdrawal was stressed. As for other diseases, a variety of medications are needed, as not every medication fits every individual, and as with other diseases, medication should be continued for as long as they are needed. Harm reduction was stressed.

Physicians can become "waivered" (receive permission from the US Drug Enforcement Agency) to prescribe buprenorphine to individuals with opiate use disorder (OUD) after completing eight hours of training. At this time, the need for physicians who can prescribe far exceeds availability; 1,900 Addiction Medicine Physicians are listed on the APBM website and the American Society of Addiction Medicine counts 6,200 (including 5,200 physicians), while 21 million individuals need care for addiction (according to the New Haven Register). For Virginia, estimates provided by Heather Saunders, M.S.W. of the Department of Health Behavior and Policy, Virginia Commonwealth University, indicate that the number of Medicaid enrolled waivered physicians

per 1,000 members with OUD ranges from a low of eight in the Southside area to a high of 59 in the Northern area. Virginia lags behind neighboring states of Maryland and North Carolina in numbers of physicians who were newly waivered in 2018 to provide Office-Based Opioid treatment (276 in Virginia, 661 in Maryland and 556 in North Carolina). Reasons for more physicians not prescribing buprenorphine include lack of belief in the treatment (incorrectly believing that it substitutes one opioid for another), lack of time to do the training, and poor reimbursement rates. Methadone and buprenorphine diversion was acknowledged, with reasons including self-treatment (primary reason), money, euphoria, and lack of evidence-based treatment. However, it was noted that most methadone is diverted from pain patients, not from methadone maintenance programs.

A commonality identified between physicians taking the buprenorphine waiver course and Recovery Coach certification is that many practitioners who take these courses do not go on to work as Recovery Coaches or to treat patients with the disease of Addiction. It was hypothesized that participants are attending these trainings to get more information about the disease of Addiction. This reflects a larger need within the state for Evidence Based Addiction education.

Bringing Up Opioid Literate Healthcare Providers

Dr. Barbara Allison-Bryan, Chief Deputy, Department of Health Professions, stressed the need for providers to be "opioid literate," which was described as being able to screen for a substance use disorder, provide brief intervention, and know when to refer for treatment (SBIRT). In 2017, 80% of newly-graduated family practice doctors felt unequipped to evaluate and manage addiction, which would be unacceptable for other diseases. To address this, the 2017 General Assembly mandated a workgroup to establish educational guidelines for training health care providers in the safe prescribing and appropriate use of opioids. The goal of the workgroup was to develop core competencies for both prescribers and non-prescribers which included information on the history and current situation of the opioid crisis, the science of addiction, and the treatment of pain. The competencies have been widely distributed, with a copy provided to every professional school in the Commonwealth. Educational best-practices for becoming literate in these competencies including incorporating the learning into an internship; immersion by working at a drug/alcohol treatment facility, and integrating technology, such as offering computer-assisted courses, including Competency Modules; the Modules are four one-hour modules with content designed for a broad audience.

Virginia's Healthcare Workforce: A Game of Hide and Seek?

Dr. Allison-Bryan noted that there is currently an imbalance between supply and demand in the healthcare professions, due to an aging and more diverse population, rising chronic disease rates, multiple underserved areas, and increased insurance coverage, with many practitioners approaching or entering retirement and a smaller pipeline of younger practitioners. The Governor's Commission recognized the need to examine these workforce issues with a recommendation and legislation authorizing data collection (2007 and 2009). From 2008 – 2010 over 100 stakeholders and national consultants collaborated to determine key questions and identify the "holes" in existing data sources, and from 2010 to the present Healthcare Workforce Data Center (HWDC) has employed profession-specific surveys in the online licensure renewal

system. Response to the voluntary surveys has averaged 85%, with profession-specific questions relative to specialty area, practice environment, and other policy-relevant issues. Standard methods enable direct comparison within and across professions, geographically and over time.

The Behavioral Health Workforce Advisory Group, co-chaired by Megan Healy, Chief Workforce Development Advisor, and Marvin Figueroa, Deputy Secretary, Health and Human resources, was created to align the supply of high quality mental health providers with the increasing need for behavioral health services in Virginia by identifying and drafting recommendations that can be implemented through executive, legislative or budgetary action this fall and early next year. The group will also identify larger problems and identify steps to address resolution. Membership included leaders from social workers, government agencies, health systems, recovery programs, treatment programs, VHHA, CSBs, and others, with significant input and support from Senator Barker. The three subgroups (Regulations, Resources, and Routes) will assure the current alignment of professional role definitions, titles, and scopes of practice between health agencies; incorporate the behavioral health training and on-the-job experience of Veterans to expedite entrance into the civilian behavioral health workforce; define and implement regulations that support evidence-based best practices in tele-behavioral health and tele-psychiatry; ensure urban/rural parity of access in terms of workforce and funding; increase behavioral health industry career awareness and access to potential workers; strengthen the alignment between educational institutions in Virginia and the behavioral health industry; and consider the skills, experience and competencies that are necessary to effectively provide each behavioral health service across the continuum of care with clear career pathways for advancement.

A statewide mental health access program focused on children and adolescents, Virginia Mental Health Access Program (VMAP) was launched on May 6 as a pilot in three offices. Key objectives include education for PDPs on screening, diagnosis, management and treatment; PCP telephonic/video consults with regional VMAP teams; telehealth visits with psychiatrists or psychologists; and care navigation to help identify regional mental health resources. Additional funding and resources will be needed to sustain this program.

Assessing and Strengthening Per Recovery Counseling Services in Virginia

Mary A. Moore, Ph.D., Senior Research Associate, Survey and Evaluation Research Laboratory, Center for Public Policy, at the L. Douglas Wilder School of Government and Public Affairs of Virginia Commonwealth University (VCU), spoke about The Virginia Peer Recovery Specialist project, a collaborative effort examining the current state and future directions of Virginia's Peer Recovery Specialist workforce. In partnership with Virginia DBHDS and the Virginia Department of Health (VDH), the VCU Survey and Evaluation Research Laboratory, Department of Rehabilitation Counseling and VCU Medical Library engaged in a series of evaluation inquiry to provide a holistic view of the workforce in Virginia, as well as nationally. The project consisted of several phases including a literature review, key informant interviews, focus groups, and surveys with a variety of stakeholders (e.g. supervisors, Certified Peer Recovery Specialists, Peer Recovery Specialists trained, but not yet certified, administrators, etc.). The findings from evaluation efforts will provide a historical overview of the development

of peer recovery specialists, discussion on the diversity among definitions, roles and responsibilities, as well as an in-depth examination of current issues in Virginia.

Overall, Virginia is working towards developing a high quality Peer Recovery Specialist workforce aimed at providing comprehensive and holistic support to individuals in various stages of recovery. Thematic analysis of the focus groups and individual interviews will provide a summary of the current strengths and challenges to training, supervision and overall job responsibilities. The results will be mirrored against the national literature and a series of recommendations provided to guide future work force development.

Conclusion and Recommendations:

The current "Opioid Crisis" is actually an Addiction Crisis. The large number of Virginia's citizens who suffer from the disease of Addiction is not only a threat to the health of its citizens, but also to the financial security of the state. Therefore, in regard to the healthcare workforce needed to deal with the crisis, we make the following recommendations

1. Evidence Based Addiction Medicine should be mandated in Virginia's Medical and Healthcare Professional School curriculums. This curriculum has already been developed by the 2017 General Assembly workgroup attended by Dr. Allison-Bryan and has been disseminated to healthcare professional schools throughout Virginia. Furthermore, in order to discourage wasted resources on non-Evidence Based approaches, we recommend that Addiction Medicine be taught and/or overseen by Addiction medicine physicians who are certified in addiction medicine by ABPM, ABAM, or AOA.
2. We recommend that Addiction health care workforce training should receive additional funding and resources in order to sustain and increase numbers
3. We recommend that professional pathways be streamlined to avoid wasted resources and, more importantly, to avoid discouraging qualified Addiction healthcare providers who may be turned away by expensive, convoluted and repetitive educational pathways to certification.