Cover Sheet / Written Testimony

Hearing Title: "Combatting the Opioid Crisis: Battles in the States"

July 12, 2017

Attribute statement to: Brian Moran, Secretary of Homeland Security and Public Safety for the Commonwealth of Virginia

Submitted by:

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Executive Summary

America is in the midst a national crisis. The opioid and heroin addiction epidemic led to the deaths of nearly 310,000 individuals between 1999 and 2015. The number of deaths annually has quadrupled since 1999. More people in America died of opioid overdose in 2014 and 2015 than were killed in Viet Nam. In addition to the personal devastation this epidemic wreaks upon individuals and families across our great nation, this crisis is overwhelming current health care resources and challenging our criminal justice system to respond in a way that provides for individual and public health needs as well as the safety of our citizens and communities.

Virginia ranks 18th among the 50 states in opioid deaths; in 2016, 1,133 people died from opioid overdose in Virginia. We must work collaboratively across Federal, state and local governments, across traditionally silo-ed systems and alongside private providers, faith communities and non-profit organizations to stem the tide of this devastating disease.

The causes of the epidemic are complex – from the prevalence of cash and carry pill mills and overprescribing prescription medications which are then illicitly diverted to the sharp rise in illegally manufactured synthetic opioids such as Fentanyl and Carfentanil – lethal in even infinitesimal amounts. 2016 saw a 175% increase in fentanyl related deaths (616 of 1,133 opioid deaths in Virginia). But it is not only the deaths which must concern us: It is the increasing numbers of non-fatal overdoses, the resource and access challenges to providing evidence based treatment and recovery supports. It is also the nexus between addiction and crime – from the property crimes often committed by those trying to support their illicit habit to the lucrative drug trafficking trade aided by the advent of the "dark web.'

In Virginia our Governor convened a statewide Prescription Drug and Heroin Use Task Force, for which I served as co-chair, along with Secretary of Health and Human Resources, Dr. Bill Hazel. The Task Force membership reflected the necessary breadth of input and developed over 50 recommendations from which have been or are being implemented by the follow up Executive Leadership Team. The goal of these collaborations is to effectively align goals, share best practices, work to overcome barriers to success across Virginia's localities.

The challenges to effectively combat this epidemic are many. We must remove statutory and resource barriers to data collection, sharing and analytics; increase support for ONDCP, HIDTA and the National Guard's Counterdrug program; breaking down funding and programmatic silos is imperative; and consistent, flexible and long term funding for evidence based drug treatment programs and interdiction efforts must be undertaken in lieu of sporadic grant based funding.

Statement

Brian Moran, Secretary of Public Safety and Homeland Security for the Commonwealth of Virginia

Written Testimony Provided to the Subcommittee on Health of the House Energy and Commerce Committee

July 12, 2017

Virginia Response to the Heroin, Opioid and Addiction Epidemic

Overview

I. National Perspective

a. America is in the midst of an opioid and heroin addiction epidemic that is killing our children and loved ones, devastating families, overwhelming health care resources and challenging our criminal justice system. Between 2006 and 2015 the number of annual deaths from opioid overdoses nearly doubled from 17,545 to 33,091. It quadruples from 1999 to 2015. These numbers are unacceptable. Law enforcement officers, first responders and medical professionals are encountering untold numbers of non-fatal overdose victims on the streets of our towns, cities and counties. This epidemic does not respect social, economic, racial, religious or political divides. It is an equal opportunity killer.

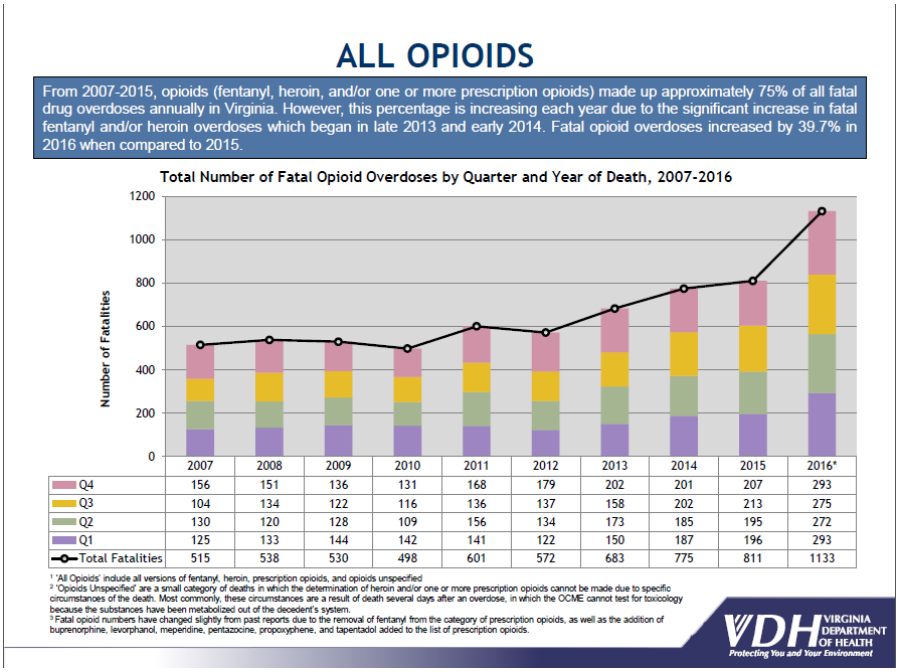
b. Addiction is a devastating disease, and its causes are many. For example, the quantity of opioids prescribed in 2015 would be enough to provide every American with around-the-clock painkillers for three weeks. In the 1960's, nearly 80% of opioid addicts, started out on heroin. By the 2000's those numbers were reversed: according to some sources, nearly 80% of those addicted started out using prescription opioids.

c. However, it isn't just prescribers, the prevalence of prescription drugs or improper storage of legal medications that are to blame. Over the last several years, the rise in illegally manufactured, highly lethal synthetic opioids such as Fentanyl and Carfentanil has contributed significantly to the impact of these drugs, both nationally and in Virginia.

II. Virginia Perspective

a. Our own Commonwealth's disheartening statistics bear this out: According to Virginia's Chief Medical Examiner (OCME), since 2014, more people are dying from drug overdose (1028) than from motor vehicle crashes (879) or gunshots (940). In 2016, 1,420 Virginians died from drug overdoses, and

1,133 of those lives (80%) were lost because of 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

	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.
[3] 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.

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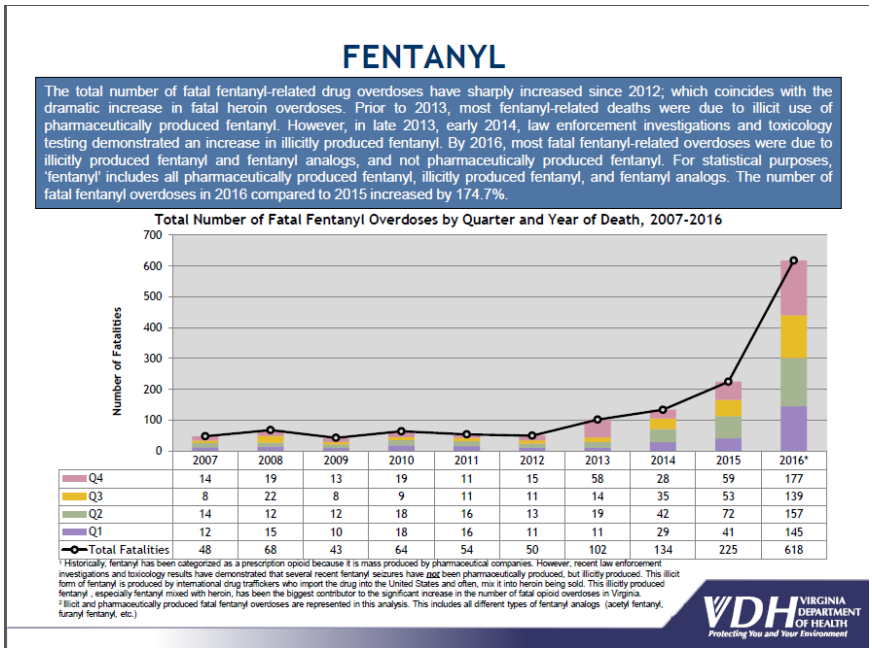
b. The problem is more acute now than ever. With the rise of illicitly produced fentanyl in Virginia, the total number of fatal fentanyl-related drug overdoses has sharply increased since 2012; which coincides with the dramatic increase in fatal heroin overdoses. Prior to 2013, most fentanyl-related deaths in Virginia were due to illicit use of pharmaceutically produced fentanyl. However, in early 2014, law enforcement investigations and toxicology testing demonstrated an increase in illicitly produced fentanyl. By 2016, most fatal fentanyl-related overdoses were due to illicitly produced fentanyl and fentanyl analogs, and not pharmaceutically produced fentanyl. The number of fatal fentanyl overdoses increased 175% from 2015 to 2016, and now accounts for 618 of 1133 opioid deaths.

c.



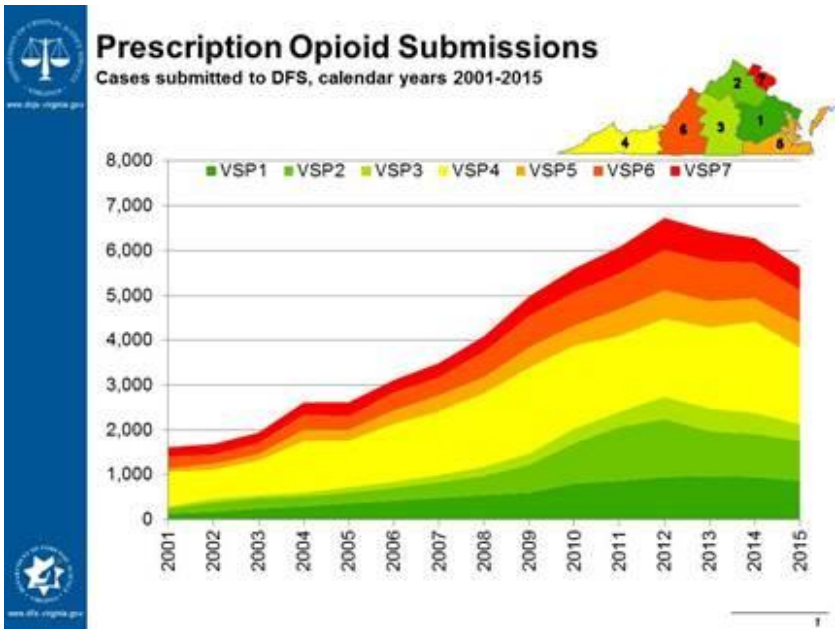
III. Regional Differences

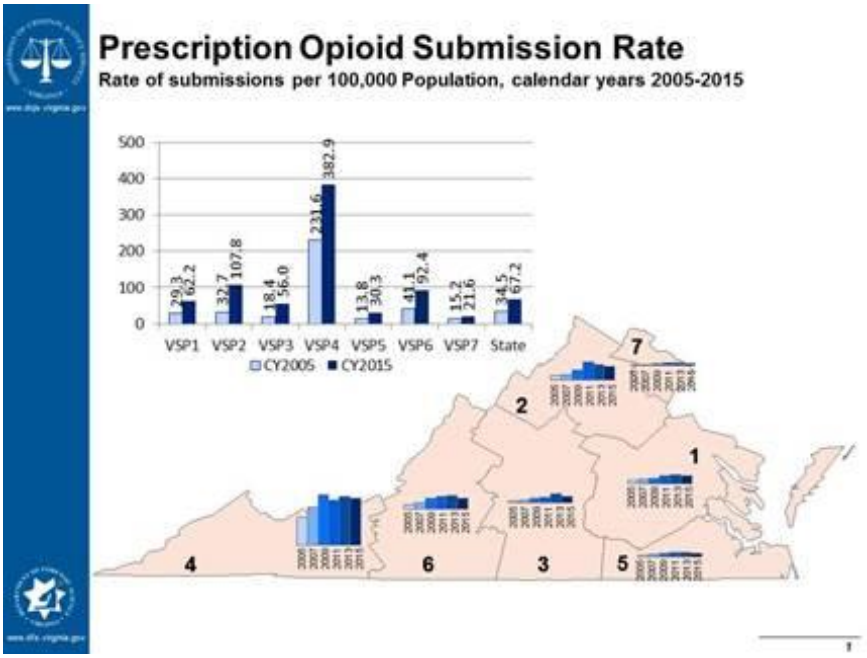
a. Virginia, like the rest of the nation, sees differences based on geography. There is a much higher prevalence of prescription opioids in the Southwest portion of the state (Virginia's Appalachian and historic coal producing region), and a much greater reliance on heroin in Northern and Eastern areas. We are dedicated to gathering and sharing data across Virginia to analyze relevant drug trends in the Commonwealth. While challenged by limited resources to provide analysis in a more timely way, we are able to coordinate data from a number of sources, including the Virginia Department of Health, the Office of the Chief Medical Examiner, the Department of Forensic Science and the Virginia State Police Fusion Center, among others. We organize and analyze data by Virginia State Police Divisions to determine how the opioid and heroin epidemic is manifested differently across the state, and seek to modify our health and public safety responses to address region-specific problems.

b. While we can create monthly, quarterly and annual reports that aid us in coping with this epidemic, we are severely limited in our capacity to share real time data. Further in this testimony are some suggestions for Federal action which might alleviate some of this backlog.

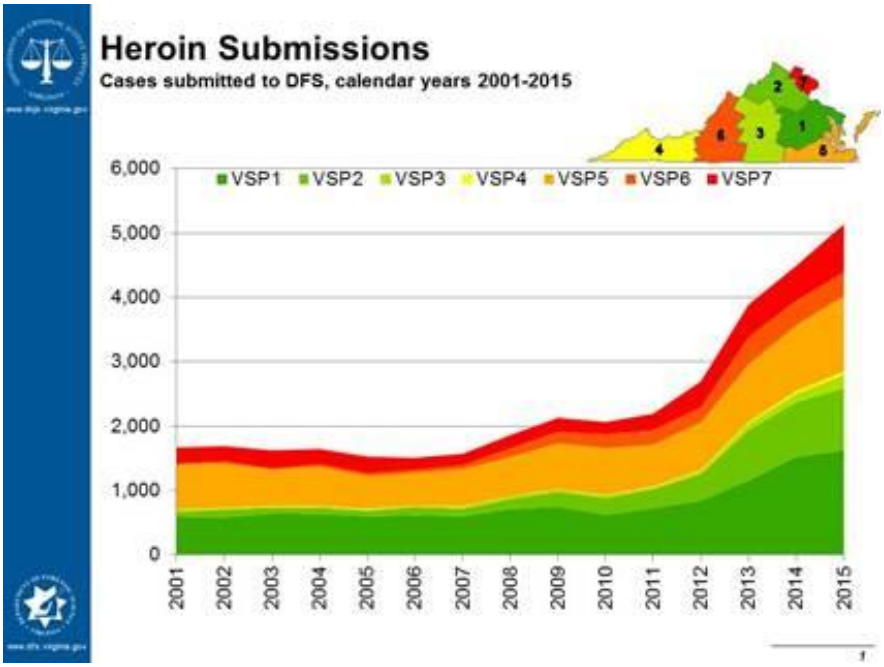
c. 

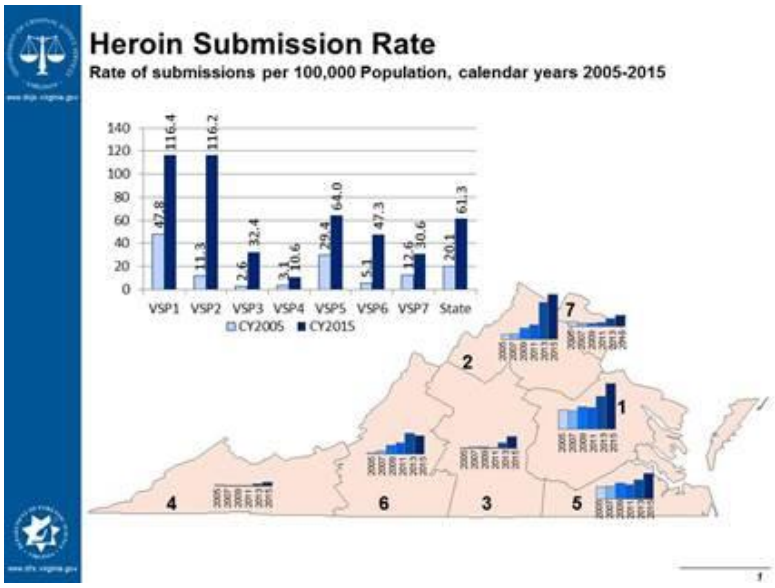
d. The rate of prescription opioid submissions from far Southwest Virginia (Division IV) is three times higher than any other part of the state.



e. 

f. In Regions II and V, which include Richmond, Northern Virginia, and Hampton Roads, the amount of heroin cases is 2x higher than any other regions.

g. 

h. 

i. A heartbreaking result of this epidemic of addiction is the number of babies who are born addicted. In 2016, 1334 babies were reported to Child Protective Services to have been exposed to substances, a 21% increase from the 1,099 babies in 2015. The prevalence of Neonatal Abstinence Syndrome (NAS) in Virginia has risen steadily over the past 10 years, and in 2015 there were 6.1 NAS discharges for every 1,000 live births. In some localities in Southwest Virginia, up to 58.8 babies for every 1,000 live births are born with NAS.

Virginia's Collaborative Approach to Treating the Epidemic

I. We cannot expect law enforcement to arrest our way out of this epidemic; we cannot expect health care providers to treat our way out of it; and we cannot expect people with serious addictions to just "get over it". This is a multifaceted problem that requires a multifaceted solution.

II. Task force

a. Understanding the necessity for cross system collaboration and the importance of a holistic response to this multifaceted crisis, Governor Terry McAuliffe issued an executive order in April, 2014, convening a Task Force on Prescription Drug and Heroin Abuse. The Governor recognized how deeply connected health and public safety are when responding to this issue, so he appointed Secretary Moran of Public Safety and Homeland Security and Secretary Hazel of Health and Human Resources to co-chair the Task Force. This group brought together parents, people in various stages of recovery from drug addiction, legislators, health professionals, educators, corrections and law enforcement to craft policy recommendations addressing the growing opioid and heroin overdose epidemic. The Task Force established five working groups comprised of subject matter experts who developed recommendations in the

following areas: Education, Treatment, Data and Monitoring, Storage and Disposal, and Enforcement.

b. The Task Force issued over 50 policy recommendations in an interim report in April of 2015, and updated that report in October of 2015 (see attached).

c. In December, 2016, the Governor issued Executive Directive No. 9, establishing an Executive Leadership Team (ELT), again led by the Secretaries of Public Safety and Homeland Security and of Health and Human Resources, to oversee continuing implementation of the Task Force recommendations and coordination of ongoing efforts to address the heroin and opioid addiction crisis in the Commonwealth.

i. The Executive Leadership Team is comprised of top management from each of the relevant state agencies with responsibilities for or interaction with individuals affected by the issue. Staffing is provided by the two secretaries' Deputy and Policy Advisor, as well as representatives of key agencies: Virginia State Police, Departments of Criminal Justice Services, Corrections, Health Professions, Health, Behavioral Health and Developmental Services, and Social Services.

ii. The ELT meets twice a year with stakeholders, holds quarterly executive leadership meetings, and the staff group meets monthly.

iii. The staff group oversees coordination of data and resources across state agencies and provides regional leadership to coordinate with regional 'grassroots' coalitions across the Commonwealth. The goal is to make sure that from the grassroots to the tree tops, Virginia's efforts to combat the epidemic are aligned, that communication is open, data and information is easily shared, needs and gaps ascertained and potential resources identified and leveraged to the greatest extent possible.

iv. Through these efforts, we are able to share information on the successes and challenges we are experiencing across the Commonwealth. Our ELT and grassroots coalitions exchange best practices across localities and develop innovative approaches to addressing the heroin and opioid addiction epidemic.

III. Law Enforcement

a. With the invaluable assistance of the Virginia State Police, Virginia's Public Safety and Homeland Security Secretariat continues to emphasize the importance of viewing addiction as a disease rather than a criminal activity, and promote a culture change in law enforcement and across the criminal justice system. With an understanding that we cannot arrest or prosecute our way

out of this problem, Virginia is emphasizing rehabilitation instead of incarceration for those individuals struggling with opioid addiction. Law enforcement can help addicted individuals access treatment, through "angel programs" and other criminal justice diversion approaches. However, we must also have the resources to limit the supply of illegal opioids into our state, target those pill mills and dealers whose actions are creating the addiction cycle, and interdict the influx of precursors and internet predators from countries such as China.

i. An example of our local law enforcement's leadership on this issue has been the Chesterfield County Sheriff's Department. Sheriff Karl Leonard and his staff started the Heroin Addiction Recovery Program (HARP) for incarcerated men in March, 2016, and a corresponding program for incarcerated women in September, 2016. HARP treats addiction as a disease rather than a crime and offers peer-to-peer counseling, group recovery sessions and family participation in the recovery process. Inmates in the HARP program hear interviews from potential participants and have the ability to remove participants who are not fully committed to the program. Additionally, individuals can continue to use HARP as a support network after they are released, and can return to the HARP unit at any time if they are tempted to relapse. This program has a success rate of over 90% for 250 participants since its inception.

ii. In 2014, the city of Winchester and Frederick and Clarke Counties formed the Northern Shenandoah Valley Substance Abuse Coalition. The Coalition brought together over 100 stakeholders, including law enforcement, health personnel, social workers and non-profit organizations, to launch a community model for responding to the opioid epidemic. The three localities initiated education programs, drug take-back and drop-box programs and encouraged participation in the Prescription Monitoring Program to reduce opioid overdoses. These localities show how constant collaboration can lead to community-based solutions.

iii. One way to address the influx of illegal opioids to Virginia is through increased availability and flexibility of funds through Virginia's two High Intensity Drug Trafficking Area designations and from Department of Justice grant programs funded through the Byrne Justice Assistance Grants and others.

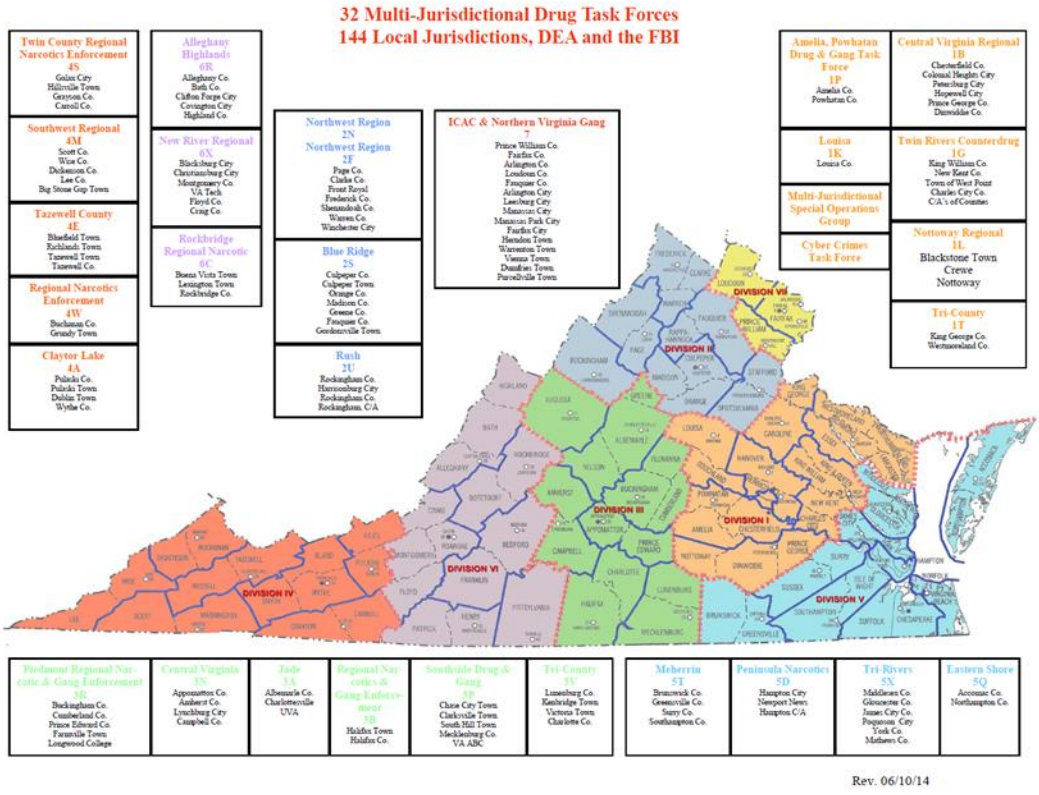
b. High Intensity Drug Trafficking Area (HIDTA)

i. HIDTA provides support for interstate and interagency collaboration, intelligence and information sharing, and specialized training for law enforcement and treatment agencies in areas

characterized by high amounts of drug trafficking. The extra support and resources HIDTA offers increases local law enforcement's capacity to limit the supply of illegal opiates within the region.

ii. Virginia participates in two HIDTA regions, the Washington-Baltimore region and Appalachia region, which includes counties in SW Virginia, Kentucky, West Virginia, and Tennessee. The mission of Appalachia HIDTA is to use a multi-disciplinary approach to deal with ongoing threats to public health and safety, particularly regarding prescription drug diversion and the emerging threat of heroin. The Appalachia region is arguably the epicenter of this crisis, and will require unprecedented multi-disciplined cooperation to effectively address the many health and public safety problems that result from this threat.

iii. Virginia has 22 counties participating in HIDTA efforts (Washington-Baltimore and Appalachia). Our state police are involved in 32 multi-jurisdictional drug task forces, encompassing 144 local jurisdictions, the DEA, and FBI. We appreciate our federal partners at HIDTA for providing resources to Frederick, Pulaski, and Wythe counties; this expansion increases Virginians' ability to share data and collaborate across localities.



c. Interstate collaboration

i. As HIDTA demonstrates, the epidemic of opioid addiction does not recognize borders, so interstate collaboration is a necessary piece in addressing this crisis. In October 2016, Governor McAuliffe, Governor Hogan of Maryland, and Mayor Muriel Bowser of D.C. signed the National Capital Region Compact to Combat Opioid Addiction. On May 9th, 2017, Maryland, the District of Columbia, and Virginia came together at the Regional Opioid and Substance Abuse Summit for a day-long conference focused on curtailing this ongoing public health and safety crisis. We hope to continue exchanging best practices and engaging in initiatives with surrounding states, knowing that another state's progress is progress for all of us.

ii. We have also had the opportunity to collaborate with other states through NGA's learning labs on opioids. Virginia has participated in two NGA learning labs regarding the opioid epidemic. From October, 2016 to February, 2017, Virginia was part of a learning lab that addressed the unique problem of fentanyl. In June, 2017, Virginia began another learning lab on expanding opioid treatment options for offenders.

Successful Implementation: Task Force Recommendations

I. Based on the recommendations of the Task Force, the Governor's office advocated for and passed 14 pieces of bipartisan legislation addressing the opioid epidemic. These bills were passed in the legislative sessions of 2015 through 2017. Some bills adapted existing regulations in response to the opioid crisis and others created new initiatives (see Appendix A for a complete list of bills).

II. Three significant pieces of legislation include:

a. Reducing dispensing reporting time to the Prescription Monitoring Program from 7 days to 24 hours when physicians and healthcare providers prescribe opiates (SB287, 2016).

b. Making Naloxone and Naloxone training available to first responders throughout Virginia (HB1458, 2015).

c. Allowing for the registration of peer recovery specialists to assist addicts in recovering from addiction (SB1020, 2017).

III. The Prescription Monitoring Program (PMP)

a. The Prescription Monitoring Program has been an essential tool in tracking opiate distribution and holding prescribers accountable. Currently, over 64,000 prescribers and 14,500 physicians in Virginia are registered to use the PMP, and the program is interoperable with 21 states. As of January 1, 2016, all newly licensed physicians are automatically registered to participate in this

program. The PMP allows us to see in real time exactly where and how often doctors are prescribing opiates as pain management.

b. At the task force's recommendation, Governor McAuliffe made the PMP a more robust and responsive program. Dispensers formerly were required to submit opioid prescriptions to the PMP within 7 days, but now must do so within 24 hours. Virginia also put procedures in place for reporting egregious prescribing to agency enforcement and for prescribers to request patient information when prescribing a course of opiates longer than 14 days (previously 90 days). These adaptations have already increased awareness of and control over opiate prescriptions.

c. In 2016, Virginia passed a law mandating Continuing Medical Education for medical care providers regarding proper prescription, addiction and treatment. By 2020, all prescriptions containing opiates will be registered electronically. Both of these measures will ensure that our agencies can monitor opioid prescriptions and be poised to respond to future outbreaks.

IV. Addiction and Recovery Treatment Services (ARTS) Program

a. The Department of Medical Assistance Services administers Medicaid in Virginia. In 2016, Virginia passed the Addiction and Recovery Treatment Services (ARTS) program. The ARTS program went live in April, 2017, and offers evidence-based addiction treatment to Medicaid users in Virginia. The continuum of treatment includes every level of treatment from inpatient detox to intensive outpatient treatment to office based opioid treatment. Though the ARTS benefit is limited without comprehensive Medicaid expansion, it does expand the menu of options available to those seeking treatment. The ARTS benefit created new treatment types and expanded services in every existing treatment category to provide a more comprehensive response to opioid and heroin addiction. For example, before the ARTS benefit only four providers offered Residential Treatment programs; after the ARTS benefit, 65 did. No providers offered Office-Based (remote) Opioid Treatment before the ARTS benefit; after, 24 did.

V. Medically Assisted Treatment (MAT)

a. Additionally, we have expanded Medically Assisted Treatment for those struggling with addiction. MAT is a combined medication and counseling treatment that is successful for 40 to 60% of its users. With MAT, healthcare providers have flexible options to treat the addicted population that uses Medicaid. Providers now can bill all Medicaid plans for substance abuse care and can bill for Certified Peer Recovery specialists under MAT.

b. While MAT is an important component of treating addiction, medication must be combined with peer support services and other wraparound services in order to be effective. Under the MAT model, assessing individuals'

psychosocial needs, linking them to family or peer support networks and referring them to community-based services are as important as providing monitored medication for addicts.

VI. Peer Support Services

a. A critical component of treatment is the Peer Support Services program, effective July 1, 2017. Individuals can be trained and registered as Peer Recovery Specialists to offer support and assistance to those in the recovery process. Peer Recovery Specialists allow individuals to undergo treatment within their communities rather than in a hospital or other intensive care option.

VII. Through the Public Health Emergency declaration in 2014, the Commissioner of the Virginia Department of Health was able to create a standing order that allowed any person to go to a pharmacy and obtain a prescription for Naloxone (commercial name Narcan).

a. In 2015, Virginia expanded Naloxone use and training to first responders in Virginia. EMS and law enforcement personnel are being trained to use Naloxone to respond to overdoses at the scene.

i. In June, 2017, non-profit EMS agencies began applying for Rescue Squad Assistance Fund grants to obtain Naloxone free of charge.

ii. Local law enforcement agencies have been administering Naloxone with great success. In 2016, Fauquier county sheriff's deputies and Warrenton police officers administered Naloxone 22 times. In Virginia Beach, officers began carrying Naloxone in the spring of 2016 and were saving lives at the pace of one per week.

iii. We hope to continue to expand EMS, physician and law enforcement use of Naloxone so that the medication is accessible statewide.

VIII. The passing of HB2317 in the 2017 General Assembly Session initiated Virginia's Comprehensive Harm Reduction with Syringe Services program. In response to this legislation, the Virginia Department of Health drafted standards and protocols which will be used by authorized Comprehensive Harm Reduction (CHR) programs including but not be limited to the Syringe Services Program (SSP). Localities must demonstrate both a need for the CHR and SSP programs, as well as a readiness for implementation, to ensure all stakeholders are invested in the programs' success. Additionally, localities must demonstrate an ability to sustain the program in the long term and a plan for engaging the communities they serve.

Opportunities for Federal Partnership

I. Data sharing – Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2

a. HIPAA regulations particularly protect privacy in substance abuse cases pursuant to federal law (42 U.S.C. § 290dd-2) and regulations (42 CFR Part 2). These restrictions limit law enforcement, health professionals and community stakeholders' data sharing ability.

b. Because of the epidemic proportions of the current heroin and opioid addiction crisis, it may be time to reexamine states abilities to access and share information – whether the data is 'de-identified' or individually identifiable – lives can be saved through creation of issue specific strategies for sharing information pertaining to opioid use.

c. Improved data sharing between state and local agencies will better aim the efforts in treatment and prevention that could be measured in several areas, such as the analysis of narcotic related arrests, property crimes and overdoses and types of drugs involved. Treatment and prevention partners can thus better target community needs and adjust law enforcement strategies accordingly.

d. While these regulations protect the privacy of individuals' medical information, they also cause an inability to have real-time data on the number of overdoses, concentration of prescriptions, how drugs are being distributed at the local level, and other key data. Specific relaxation of certain aspects of HIPAA and associated regulations would lead to easier data sharing and better informed efforts in combatting this epidemic.

e. One initiative that could be immediately implemented as a reasonable response to the opioid epidemic is nationwide mandatory reporting of heroin and opioid overdoses. Mandatory reporting would allow hospitals, labs and law enforcement to pinpoint the source of the problem. Additionally, having accurate statistical information on drug overdoses is crucial for federal and state grant applications.

II. II. Medicaid expansion

a. Virginia's Medicaid program spent $26 million on opioid use and misuse in 2013, with $10 million of this spending occurring in Southwest Virginia. More broadly, at least 40,000 adults in Virginia's Medicaid program have a substance abuse disorder, and over 50% of Medicaid members with serious mental illness also have a substance use disorder. The Joint Legislative Audit and Review Commission estimates that untreated substance abuse costs Virginia state and local governments $613 million per year in public safety and health care services alone.

b. In order to address this epidemic, treatment must be available through Medicaid for Virginia's underserved population. Any reduction to

Medicaid funding or services would severely harm our ability to combat this ongoing public health crisis. Expanding opportunities for treatment is one of the most fundamental ways to address this epidemic.

III. The Importance of Drug Courts

a. The success of drug courts is indisputable, but Virginia state legislators have been reluctant to support widespread use of this option.

b. The most rigorous and conservative scientific "meta-analyses" have all concluded that Drug Courts significantly reduce crime as much as 45% more than other sentencing options. Nationwide, 75% of Drug Court graduates remain arrest-free at least two years after leaving the program. For every $1.00 invested in Drug Court, federal taxpayers save as much as $3.36 in avoided criminal justice costs alone. Drug Courts produce cost savings ranging from $3,000 to $13,000 per client. These cost savings reflect reduced prison costs, reduced revolving-door arrests and trials, and reduced victimization.

c. It is essential that public servants in Congress adopt a supportive attitude towards the drug court system and communicate the importance of implementing this system to local legislators.

IV. Supporting local coalitions through grant funding and data expansion

a. In the mid – late 90's the Department of Justice offered several grants to state/local agencies to slow the distribution and manufacturing of Methamphetamine in this country. These dollars ultimately resulted in the decrease of sales and manufacturing of Methamphetamine. Today, heroin and opioids require a similar response. Using federal Byrne Justice Assistance Grant funds, the Department of Criminal Justice Services (DCJS) in Virginia are providing grants to local law enforcement agencies to purchase naloxone. In Virginia, DCJS developed a program to train law enforcement officers in the delivery of Naloxone as a treatment to overdose cases. Enhanced federal support for the expansion of this program would equip first responders to save lives of more Virginians.

b. Increased federal support for the HIDTA Program would be critical at the state, federal, and local level to allow coordination at all levels designed to stop the flow of drug production and trafficking.

Appendix A: Opioid Legislation in Virginia, 2015-2017

Opioid Task Force Recommendations: Passed Legislation		
Year	Bill Number	Description
2017	SB1230	Mandates e-prescribing for prescriptions containing opiates beginning July, 2020
	SB848	Allows authorized persons to train emergency services and law enforcement personnel to administer Naloxone in the case of an opioid overdose
	SB1020	Authorizes the registration of peer recovery specialists by the Board of Counseling
	SB1086	Directs department of social services to collect information on in utero exposures to controlled substances
	HB2317	Authorizes pilot programs for the provision of sterile and the disposal of used hypodermic syringes and needles
	HB1885	Extends requirement for PMP prescribers to request patient information when prescribing opiates for longer than 14 consecutive days to 2022 (see SB513)
2016	HB829	Mandates Continuing Medical Education for opiate providers regarding proper prescribing, addiction and treatment
	SB827	Reduces opiate dispenser reporting time from 7 days to 24 hours
	HB657	Authorizes the Director of the Department of Health Professions to send reports on unusual prescribing/dispensing behavior to agency enforcement
	SB513	Requires PMP prescribers to request patient information when prescribing opiates for longer than 14 consecutive days
	HB583	Provides certification for substance abuse peer support
2015	HB1458	Allows trained first responders to administer Naloxone; allows pharmacists to dispense Naloxone under proper protocols
	HB1841	Requires every licensed opiate dispenser to register with the Prescription Monitoring Program
	HB1738	Requires hospices to notify pharmacies of the death of a patient

Source: Virginia's Legislative Information System

Appendix B: Relevant Links

Drug Cases Submitted to the Virginia Department of Forensic Science, CY 2015
http://www.dfs.virginia.gov/wp-content/uploads/2016/09/CY15DfsDataReportSlides.pdf
**Note: updated report for 2016 to be released soon

Executive Directive 9, Establishing the Governor's Executive Leadership Team on Opioids, 2016:
http://governor.virginia.gov/media/8166/ed-09-establishing-the-governor-s-executive-leadership-team-on-opioid-abuse-and-addiction.pdf

Executive Order 29, Establishing the Governor's Task Force on Prescription Drugs and Heroin Abuse, September, 2014:
https://governor.virginia.gov/media/3342/eo-29-establishing-the-governors-task-force-on-prescription-drug-and-heroin-abuseada.pdf

OCME Fatal Drug Overdose Report, April, 2017:
http://www.vdh.virginia.gov/content/uploads/sites/18/2016/04/Fatal-Drug-Overdose-Quarterly-Report-1.pdf

Overview of ARTS benefit
http://www.dmas.virginia.gov/content_atchs/bh/Medicaid%20Addiction%20Recovery%20and%20Treatment%20Services%20Update%20-%20April%205%202017....pdf

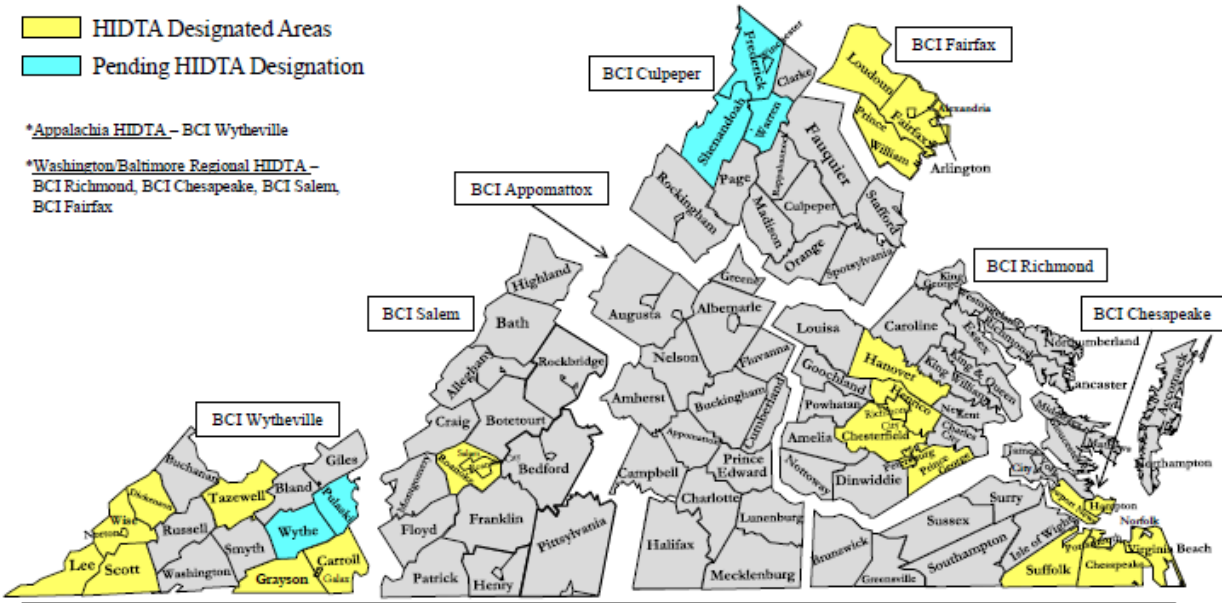
Prescription Drug Spending Report
http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD5632016/$file/RD563.pdf

Task Force Recommendation Report: Implementation Plan (June 2015)
https://www.dhp.virginia.gov/taskforce/minutes/20150630/TaskForceImplementationPlan.pdf

Task Force Recommendation Report: Implementation Plan Update (October 2015)
https://www.dhp.virginia.gov/taskforce/minutes/20150630/TaskForceImplementationPlan.pdf

Appendix C: HIDTA Map

HIDTA Task Force Areas



BCI - Richmond	BCI - Wytheville		BCI – Chesapeake	BCI – Salem	BCI - Fairfax
Chesterfield P.D.	Lee County S.O.	Tazewell County S.O.	Hampton P.D.	Roanoke City P.D.	Arlington County S.O.
Hanover S.O.	Scott County S.O.	Town of Tazewell P.D.	Newport News P.D.	Roanoke County P.D.	Alexandria City P.D.
Henrico P.D.	Wise County S.O.	Richlands P.D.	Virginia Beach P.D.	Salem City P.D.	Fairfax County S.O.
Hopewell P.D.	Dickenson County S.O.	Cedar Bluff P.D.	Norfolk P.D.		Loudoun County S.O.
Petersburg P.D.	Town of Big Stone Gap P.D.	Bluefield P.D.	Portsmouth P.D.		Prince William County S.O.
Richmond City P.D.	City of Norton P.D.		Chesapeake P.D.		
Prince George P.D.			Suffolk P.D.		