HEALTH

Southwest Virginia patients struggle with access to addiction medication

As Virginia's overdose numbers continue to rise, pharmacies are reluctant to dispense drugs used to treat opioid use disorder

BY: **KATE MASTERS** - APRIL 11, 2022 12:08 AM

Suboxone, a medication used to treat opioid dependence, is almost impossible to get in Southwest Virginia, despite an unprecedented need. (Photo by Spencer Platt/Getty Images)

Marcy Rosenbaum had a problem.

For years, Southwest Virginia Community Health Systems had been running successful recovery programs from its clinics in Bristol and Saltville, small communities encircled by the Appalachian Mountains. Earlier this year, the federally qualified health center announced it was expanding services to Tazewell, which – like much of Virginia's southwestern corner – had been hit hard by the opioid crisis.

The system offers what's known as office-based addiction treatment, commonly abbreviated as OBAT. Services include psychotherapy and counseling along with medication, a crucial tool that can relieve cravings and help prevent withdrawal symptoms.

But as Rosenbaum, the system's behavioral health director, was starting the new program, she stumbled into a huge barrier. Not a single pharmacy in Tazewell or the surrounding community was willing to prescribe Suboxone, a drug used to treat opioid addiction that's also known by its generic name, buprenorphine. Ashley Harrell, a senior program adviser for Virginia's Department of Medical Assistance Services, said two different OBAT providers in

the region reached out to 38 pharmacies — 18 chains and 20 independent stores — and every one refused to dispense the medication.

It's created an access problem that state and federal agencies have struggled to resolve. Southwest Virginia has some of the greatest need for recovery services, according to Rosenbaum. But the lack of willing providers has limited the reach and scope of existing programs.

"We're not advertising at all because we're afraid we're going to get people in and not be able to get them the medication they need," she said. "Tazewell County has one of the highest overdose rates in Virginia, so it's frustrating not to be able to expand those services."

Southwest Virginia Community Health Systems offers treatment for substance use disorders at three clinics in the region. The federally qualified health center has struggled to expand services in Tazewell due to a lack of pharmacists willing to dispense addiction medications. (Courtesy of SVCHS)

Experts say the issue is multifaceted, putting an easy solution out of reach. And in many ways, the roots of the problem stem to decisions made at the federal level. Steve Hylton, an independent pharmacist in Saltville, said the U.S. Drug Enforcement Administration has come down hard against buprenorphine despite publicly supporting medication-assisted treatment. He pointed to a pharmacy in West Virginia that was raided by the agency after providing the medication to customers.

Though two judges later ruled in favor of pharmacist Martin Njoku, according to reporting from NPR, the DEA's actions effectively shuttered the business. In court transcripts from the case, an assistant U.S. attorney said the agency's aggressive stance stemmed from criticism over its lack of action during the height of the opioid crisis.

As a result, some pharmacists say they've become heavily scrutinized for dispensing buprenorphine and other addiction treatment medications. Hylton began his career as a pharmacy technician in 1984 and said he's almost never encountered the DEA, except in rare instances when the agency needed records on a doctor or patient. But beginning in April of 2021, agents made individual site visits to 130 pharmacies in Southwest Virginia, a process that took nearly a year.

In a Feb. 15 email, Special Agent M. Patrick Long informed pharmacists that it was "Phase 1" of an ongoing outreach initiative, with "Phase 2" — cursory records reviews — set to begin in the coming months.

“It’s almost like a PR stunt because they dropped the ball on oxycodone,” Hylton said. The DEA did not respond to an interview request from the Mercury or a detailed list of questions about the initiative.

At a DMAS Pharmacy meeting in early December, Diversion Program Manager Justin Wood acknowledged some pharmacists viewed the initiative as “adversarial.” Still, he insisted the agency was in strong support of prescribing buprenorphine.

“There’s this unfounded rumor that DEA doesn’t support medication-assisted treatment, or support substance abuse treatment,” Wood said. “And I just want to say that is totally not true. The DEA, we absolutely support people getting the treatment they need.”

The message doesn’t always come through to pharmacists. Harrell said the state’s Department of Medication Assistance Services has been building a relationship with the DEA’s central office, but conversations don’t always translate to actions in the field. Some pharmacists in Southwest Virginia told DMAS that agents handed out booklets with information on the Controlled Substances Act during their site visits.

“They’re not necessarily saying, ‘You’re violating the law,’ but it certainly makes an impression,” Harrell said. And the uncertainty has a trickle-down effect across the system. While there’s no specific cap on dispensing controlled substances, Hylton said wholesalers — the companies that supply pharmacies with medications — are instructed to watch out for potentially suspicious orders. As a result, many are reluctant to increase shipments of the medication, making pharmacists reluctant to take on more prescriptions.

The end result is often more restrictions. Some pharmacies in Southwest Virginia have refused to dispense Suboxone without a diagnosis on the prescription, even though providers are prohibited from requiring opioid use disorder patients to disclose that information under federal regulations.

JoeMichael Fusco, the pharmacy compliance manager for DMAS, said the agency had tried to intervene in those cases. “Honestly, though, the conversation hasn’t really gone far,” he said.

It’s patients who end up shouldering the biggest burden. Harrell pointed to a man who was prescribed Suboxone by a federally qualified health center and visited 10 different pharmacies in an effort to fill it. Finally, he found a pharmacist in Roanoke — a strong advocate for substance abuse treatment — who was willing to dispense the medication, Harrell said.

“But because that individual had to travel an hour and a half to get to that pharmacy, it was flagged as a suspicious order,” she added. That can result in site visits from the DEA and placement on an agency watch list.

“That’s something that pharmacies do not want to be on,” Harrell said. “And the bottom line is that if they have any doubt whatsoever, they don’t have to fill those prescriptions.”

With little clarity on the federal level, Virginia officials are taking their own steps to increase access. In March, DMAS distributed a memo acknowledging the issue and offering guidance on how to validate prescriptions — including a list of all 193 approved OBAT sites across Virginia. Some of those clinics offer telemedicine, and prescriptions from a remote provider can often raise red flags, Harrell said. But the agency hoped the referral list would help pharmacists identify valid prescribers more easily.

Southwest Virginia Community Health Systems offers office-based addiction treatment, which pairs counseling with medication used to treat substance use disorders. (Courtesy of SVCHS)

For Hylton, though, the regulatory component is just part of the problem. Another barrier, he said, is that pharmacists typically lose money on prescriptions for Medicaid members insured through the state's six managed care organizations, who make up a significant portion of patients in Southwest Virginia.

While the state's program covers generic buprenorphine and naloxone tablets, it requires brand-name Suboxone film strips, a form of the medication that dissolves in the mouth. Rosenbaum said strips are typically preferred by providers, especially since they have a lower risk of being diverted and used illegally.

Technically, the insurance companies that cover Medicaid patients can approve generic strips, but not without prior authorization, Rosenbaum said. That means prescriptions are often written for the more expensive Suboxone. Starting in May, DMAS has ordered managed care organizations to begin distributing a $10.65 dispensing fee to pharmacists in an effort to make up for those losses. But Hylton wasn't sure the increased reimbursement would fully solve the problem.

"It's a one-time fee, but most patients get their refills every week," he said. "So if I fill four prescriptions for a patient a month, I might make a dollar and a half on the first one, but I still lose money on the next three."

It's an added strain that underscores one of the biggest challenges in expanding substance use treatment — stigma. Hylton said existing barriers, from DEA scrutiny to monetary losses, are a real discouragement to many pharmacists. But he said there are also ways around those issues. Currently, he's one of the only pharmacists willing to dispense Suboxone in Southwest Virginia and said he's had no problem getting an increased allocation from his supplier. Other pharmacies have the same option of talking to their wholesalers and taking the extra step to validate prescriptions, Hylton said, but some businesses are resistant to accepting patients in recovery.

"If you've ever been in a small town, some of these people are known in the community," he said. Many patients have had past run-ins with the legal system and often require more care, especially early in their treatment. Recovery programs are vital to helping them rebuild, but Hylton said patients often face pre-existing stigma that's difficult to overcome.

Rosenbaum said there's also existing bias against medication-assisted treatment by some providers and community members, who still believe in abstinence-only recovery models. Both she and Hylton said the current dispensing challenges are sometimes used to avoid taking on new clients.

"It's a good excuse for a pharmacy who wants to say, 'Well, we only have so many patients we can take,'" Hylton said.

DMAS officials had the same concerns. Harrell said there are valid worries about inappropriate prescriptions from unethical providers, but the agency has tried to address barriers raised by pharmacists over the past several months. Its March memo explicitly encouraged pharmacies to ask for increased allotments from wholesalers and included talking points to justify the request, including statistics on Virginia's worsening opioid epidemic.

In 2020, the first year of the pandemic, fatal overdoses increased by nearly 48 percent over the previous year. At the same time, the number of approved prescribers in Virginia jumped by 246 percent and Medicaid members diagnosed with opioid use disorder climbed by nearly 54 percent, according to data from the department.

Health experts are pushing for increased access to medication — often described as the gold standard in treating opioid addiction — to reverse those trends. But despite growing clinical acceptance and Virginia's efforts to overcome dispensing challenges, DMAS officials say they still encounter pharmacies who put up signs declaring they won't fill those prescriptions. It's getting increasingly difficult to justify, they said, given the clear encouragement coming from the state.

"We'll talk to a provider or pharmacy and they'll say, 'Well, this is the main barrier,'" Fusco said. "And we'll address that barrier, but then all of a sudden there's another issue. So it's like, 'Okay, is it really the barrier, or is it stigma?'"

"It seems like no matter what we do, it's never quite enough," he added.

KATE MASTERS

Kate grew up in Northern Virginia before moving to the Midwest, earning her degree in journalism from the University of Missouri. She spent a year covering gun violence and public health for The Trace in Boston before joining The Frederick News-Post in Frederick County, Md. Before joining the Mercury in 2020, she covered state and county politics for the Bethesda Beat in Montgomery County, Md. She was named Virginia's outstanding young journalist for 2021 by the Virginia Press Association.

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Can Patrick County save its local hospital?

As rural health systems struggle to survive, a freshman delegate is hoping to reverse the trend in his own community

BY: **KATE MASTERS** - APRIL 18, 2022 12:02 AM

Pioneer Community Hospital, a 25-bed facility in Patrick County, closed in 2017. Freshman Del. Wren Williams is hoping newly passed legislation will help the rural hospital reopen its doors. (Courtesy of Addison Merryman)

At first, Wren Williams just wanted to study if reopening the hospital was feasible.

Over the last five years, the freshman delegate from Patrick County had watched his community struggle to revive Pioneer Community Hospital, a 25-bed facility that closed suddenly in 2017 amid bankruptcy proceedings for its Mississippi-based parent company.

The news was so unexpected that medical workers had to start diverting patients from the local emergency room in Stuart. Residents later learned that a deal to sell the site had fallen through at the last minute, saddling much of the community with a 30-mile drive to the next closest hospitals in Martinsville and Mount Airy, North Carolina.

Efforts to reopen Pioneer stalled over the next few years. Williams said the bankruptcy case left a massive lien on the property that didn't expire until 2021 — a major deterrent for other investors. There were early efforts to extend the hospital's licensing, but by 2019, local officials told the Associated Press that revitalizing the site was financially unworkable.

“So, the property has just been sitting there, closed, since that day in 2017,” Williams said. At the start of his first term this year, he filed HB 1305, which initially directed the Virginia Department of Health to examine the possibility of reopening Pioneer on the original site or two other locations in Stuart. Williams wasn’t ready to give up, but said he wasn’t sure the building – vacant for the last five years – could even function as a hospital anymore.

But as the session moved forward, the bill started gaining traction. Through conversations with the Virginia Hospital and Healthcare Association and other health systems in Virginia, Williams said he learned the original location was still viable. Once that became the focus, the effort switched to making the site more attractive to investors.

After Pioneer Hospital closed, Patrick County residents faced a 30-mile drive to the nearest emergency room. (Courtesy of Addison Merryman)

VDH stepped in to help redraft the bill, crafting legislation that restored the site’s certificate of public need, a type of state licensing typically required for almost every new medical facility. Navigating Virginia’s COPN process can take thousands of dollars and multiple years to complete, but Williams’ bill – which passed the General Assembly unanimously – will allow new buyers to bypass the process as long as the hospital reopens with the same equipment and number of beds it had before. “It was the right size and it’s been the right size since it was built,” Williams said. “That was what we needed, and we didn’t want to ask for anything more.”

Since the bill passed, there’s been a flurry of new activity surrounding the hospital, including – at last – a purchase. Virginia Community Capital, an economic development nonprofit, confirmed it sold the building last week to a Chicago-based holding company legally registered in Virginia Beach.

A spokesperson for the company confirmed it was purchased by Foresight Health Investment Group, a “health care organization” with plans to convert the site to a medical facility. But the company wouldn’t confirm details of the proposal, saying in a statement that “plans and timelines will be announced at a later date.”

While the future of the site is still unclear, experts say it’s rare for a rural hospital to reopen. Pioneer is one of two facilities in Virginia to close over the last decade, and nationwide, a total of 138 rural hospitals have closed since 2010, according to data from the Sheps Center at the

University of North Carolina. Facilities have been strained by an overall population decline in rural areas coupled with a growth in outpatient services. Rural hospitals also frequently serve a higher proportion of patients on Medicaid or with no insurance at all, leading to tighter operating margins and higher rates of bad debt.

Julian Walker, vice president of communications for the Virginia Hospital and Healthcare Association, said roughly a third of the state's rural hospitals had negative operating margins in 2020, a higher share than the fifth of all hospitals across Virginia. Pioneer also struggled financially when it was still in business, state records show.

From 2014 to 2015 — the latest available data from Virginia Health Information, a state-run nonprofit that compiles health care data — the facility spent more than $1 million more on expenses than it brought in through patient revenue and other operating income and recorded more than $8.7 million in long-term debt. "It definitely was not turning a profit," said Deborah Waite, VHI's chief operating officer.

Finding a sustainable business model is just one of the challenges. Beth O'Connor, executive director of the Virginia Rural Health Association, said reopening a hospital is a lengthy process requiring both state and federal recertification, which can take multiple site visits and often renovations to bring the building up to code. Pioneer's assets were sold as part of its bankruptcy proceedings, which means new investors would also need to purchase new equipment and furnishings, according to Erik Bodin, director of the COPN division at the Virginia Department of Health.

Williams' legislation, which effectively bypasses some of Virginia's biggest regulatory hurdles, would help speed up the process. "Mostly it reduces the time required for someone to move in there, and obviously time is money," Bodin said.

But reopening the hospital would also mean recruiting new staff, sometimes a challenge in rural counties. Dr. Richard Cole, the founder of Patrick County Family Practice, said he's struggled to find someone to replace the office's only other physician, who's set to retire at the end of the month.

"It's been very difficult — doctors are in very short supply," he said. "And I'd say the new, young family practitioners coming out of training tend to land in big hospital systems." Without a new replacement, Cole would be left as the community's only doctor. His office is currently the only family medicine practice in Patrick County, which spans a 483-square mile stretch along Virginia's southern border.

'I've told my wife, if anything happens to me, put me in the truck and drive me to the ER'

It's a real-world example of how rural hospital closures can hit communities where health care options are already scarce. Cole said Pioneer was also the sole provider of specialty care including cardiology and podiatry. When the hospital closed, it left patients without a place to go for many essential health services.

"You used to be able to get mammograms here locally," he said. "And I'd say a lot of women are not getting their mammograms now because the nearest clinic is 30 miles away." Then there are more obvious repercussions, including the loss of a local emergency department, which has put a real strain on the county's first responders.

Williams said one of the biggest impacts has been a loss of participation in volunteer rescue squads. Manufacturing is Patrick County's largest industry, and with a hospital in town, it used to be easy for workers to step off the line for a 25- or 30-minute ambulance ride. Now those calls can mean a three-hour round trip, according to Chelsea Spangler, who volunteers as an emergency medical technician for Jeb Stuart Rescue Squad.

"It's not the same where you can ask your boss, 'Hey, do you mind if I run that call, I'll be right back," she said. Neighboring Henry County has two helicopter services, but Williams said

they're not always available or able to fly when weather is bad. That leaves volunteer squads handling the majority of the county's calls, which can bring wait times for ambulances up to half an hour.

Spangler said it's led to delays in care and even to tragedy. A recent patient called 911 for chest pain but died before an ambulance could reach him.

"It's sad, but I've told my wife, if anything happens to me, put me in the truck and drive me to the ER," Williams said. "Our EMS can't get here fast enough because they're always running other calls or they're out of the county with other patients."

Local leaders have spent years advocating for a new hospital in the face of those community pressures. But there's been hesitation to bring in private investors given Pioneer's rocky history. In 2018, the chairman of Patrick County's Board of Supervisors said the county should purchase the building and lease it to a third-party hospital operator so that officials could replace the tenant if the venture failed. But the initiative never took off, largely because the county couldn't afford the $5.5 million asking price for the site (Virginia Community Capital wouldn't disclose the final sale price).

Virginia Community Capital, an economic development nonprofit, announced it sold the former Pioneer Hospital building to a Chicago-based health care group in early April. (Courtesy of Addison Merryman)

Two years later, a local advisory council dismissed the idea of reopening the hospital, citing the prospective cost of renovating or replacing the aging building, according to reporting by Cardinal News. Some community members are still skeptical that a traditional hospital model would work for Patrick County.

Cole said it might be possible if the facility could regain its status as a critical access hospital, a federal designation that includes higher Medicare reimbursement rates. In 2021, Congress also introduced a new rural emergency hospital model that boosts payments even more for facilities that meet certain criteria. Even then, he said it could be an uphill battle.

"We have an elderly population and a very high percentage of our residents on Medicaid and Medicare," Cole said. "And when that's the bulk of people using your hospital, it's hard to find any place where you can make a profit."

State social services workers signed up homeless residents for Medicaid at a resource fair in Richmond in 2018. (Ned Oliver/ Virginia Mercury)

Still, there's already a precedent for success in Virginia. Medicaid expansion has been a crucial protection against closures by connecting more than half a million Virginians with health insurance, reducing uncompensated care for hospitals across the state. Only two rural facilities in Virginia have closed in the past decade, including Pioneer — a sharp contrast to non-expansion states like Texas and Tennessee where more than a dozen have shut down.

The other, in Lee County, successfully reopened in 2021, an accomplishment O'Connor described as almost unheard of. The hospital was saved in large part through community organizing, including the formation of a local hospital authority that purchased the building two years after it closed.

But another large health system also played a crucial role. In 2019, the authority sold the site to Ballad, which holds a monopoly on hospital services across Southwest Virginia and much of Northeast Tennessee. It was a success story for Lee County, but it's still not clear if other rural communities can follow the same model without buy-in from a much larger provider.

"Certainly, the people in town liked having that hospital there — hospitals are good for the community, they're good for industry, they're good for job creation," Bodin said. "But I think one of the big determining factors for Lee County was the creation and the presence of Ballad Health."

KATE MASTERS

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Virginia's program to reduce police mental health transports isn't working

State's alternative provider is only completing around 10 percent of patient transports to psychiatric hospitals

BY: **KATE MASTERS** - JULY 25, 2022 12:03 AM

A police car in Richmond, Va. Police currently provide the vast majority of transports to psychiatric hospitals across Virginia. (Ned Oliver/Virginia Mercury)

Since 2019, Virginia has spent millions of dollars rolling out an alternative transportation program intended to reduce the role of law enforcement in driving patients to state mental hospitals and other psychiatric facilities.

Under a contract with the state, the security company Allied Universal is tasked with building capacity to eventually transport 50 percent of patients committed for treatment under what's known as a temporary detention order, or TDO — issued in cases when the person is unwilling to seek care but poses a danger to themselves or others.

But over time, the number of transports provided by the company has actually decreased. Prior to the COVID-19 pandemic, Allied was consistently driving 25 to 30 percent of patients in Southwest and southern Virginia, the first region where the program was fully implemented, according to Gail Paysour, the alternative transportation coordinator for the state's Department of Behavioral Health and Developmental Services. As the program rolled out across the state, its capacity also dropped, and by 2021, Allied was only providing 10 to 12 percent of TDO transports across Virginia.

Advocates say the struggling program illustrates Virginia's continued failure to meaningfully reform its mental health services. Unlike most police transports, Allied does not restrain patients during drives, and Paysour said the service was intended as a more compassionate way to get them to needed inpatient treatment.

But the program was also intended to be a relief for law enforcement officers, who were previously responsible for transporting virtually all of the state's TDO patients. Amid a critical shortage of psychiatric beds, that often means driving hours across the state to drop patients off at the nearest hospital with an opening.

"When you have to transport someone from Abingdon to Petersburg, that's an issue," said Dana Schrad, executive director of the Virginia Association of Chiefs of Police. Currently, though, she said the program is doing little to relieve the pressure on officers.

That hasn't stopped lawmakers from trying to expand its scope. Originally, Allied only stepped in to transport patients once an inpatient bed had been found. But under new legislation that went into effect at the start of July, law enforcement officers can now transfer custody of patients immediately after a TDO is issued.

That means Allied workers would be the ones sitting with patients while they waited for a bed — something Paysour said the company is unable to do.

"Because the staff does not have an ability to restrain or anything like that, maintaining custody for long periods of someone who may become highly disregulated is not something they're prepared to do," she said. "Nor is it part of their current contract."

The struggle to boost alternative transportation services, and extend the program to patient custody, underscores broader challenges within Virginia's mental health infrastructure. Allied, like virtually all providers, is currently struggling to recruit and retain staff, limiting the availability of its services.

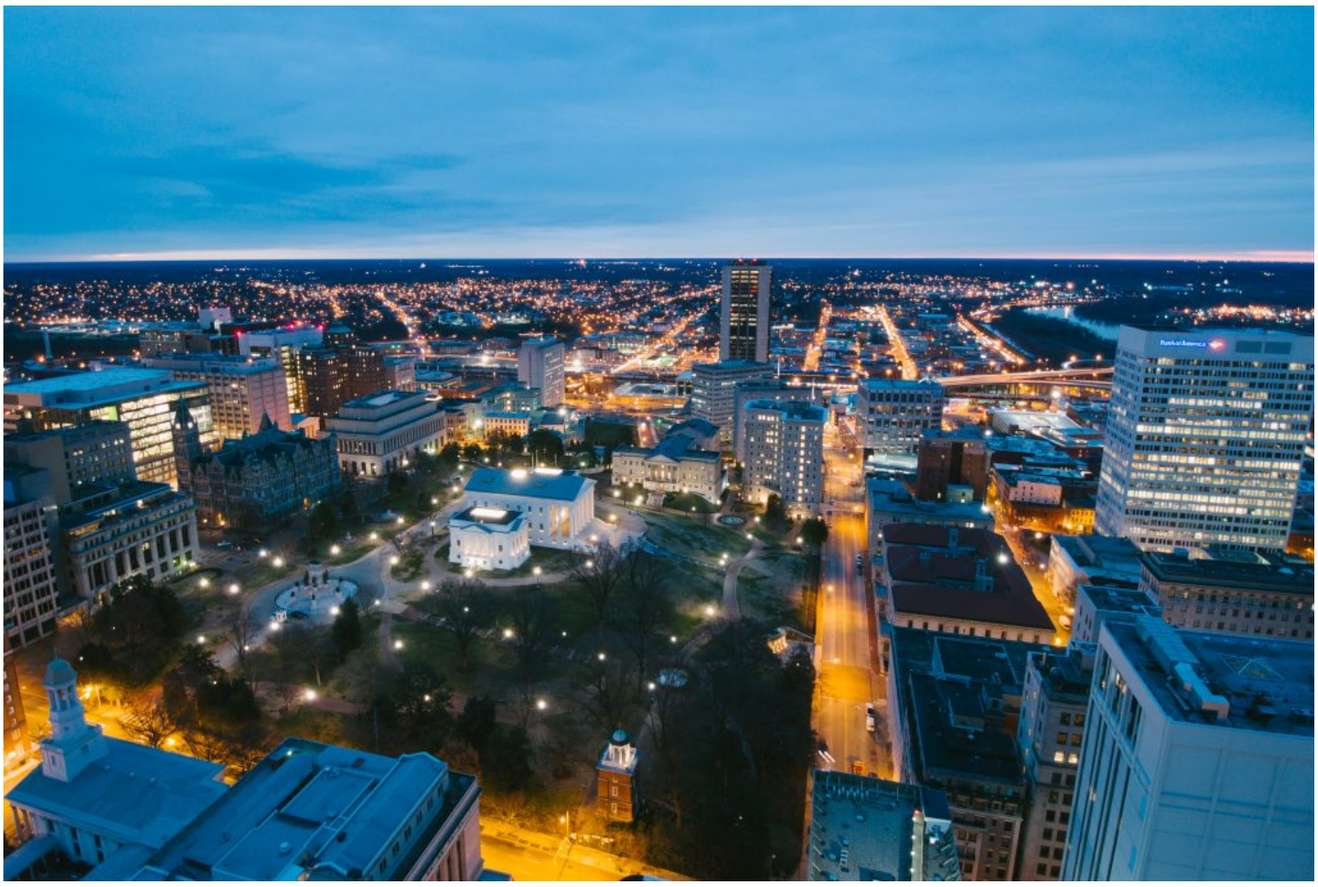
As of July 8, Paysour said there was a 20 percent vacancy rate for transport workers in Virginia, which — while an improvement over December's numbers — made it nearly impossible for the company to respond to more requests.

"It really just goes back to the difficulty of hiring someone for a job they have to cover 24/7, 365 days a year," she said. "When we began, the salaries were competitive. But as time has gone on, we've had to re-examine that."

Eligibility is another limiting factor. Because Allied drivers don't restrain clients, alternative transportation services are only approved for patients who don't show signs of aggression. But given the current bed shortage, most Virginians with a TDO are waiting at least two days (and sometimes far longer) to be admitted — time they typically spend stuck in local emergency rooms. The stress of waiting can exacerbate mental health symptoms, Paysour said, so by the time a bed is found, many patients are no longer eligible for Allied's services.

The COVID-19 pandemic also reduced already limited bed space and delayed the agency's outreach and training to law enforcement and local magistrates. Schrad said some courts still don't seem to know that alternative transportation services are now available across the state.

But funding has also been inadequate. Until recently, Virginia paid $4.5 million yearly for its contract with Allied, which — according to analysis by the state's Department of Planning and Budget — was not enough for the company to cover 50 percent of TDO transports across Virginia.



The Virginia General Assembly included $7 million in the 2019 and 2020 fiscal year budgets to implement an alternative mental health transportation model throughout the whole state for adults and children. The next year, the state provided $4.5 million for the program.

Virginia's current budget increased that funding by roughly $2 million, but DBHDS now estimates it would cost more than $16 million to extend the company's services for the full duration of patient custody.

"It makes me wonder whether we need to go back and re-evaluate the program from the ground up," said Sen. Creigh Deeds, D-Bath, the chair of the state's Behavioral Health Commission. "Maybe our expectations were not reasonable in the first place."

Paysour said the agency is also re-examining its contract with Allied, including whether it was overly ambitious to set a goal of providing half of all TDO transports across the state. The company is also considering retention bonuses, and there's been discussion of implementing restraints in order to accommodate patients with higher behavioral health needs.

But both she and Schrad said the current reliance on law enforcement traces back to deeper problems within Virginia's mental health system. Schrad said policymakers have never fully invested in the type of community programs that can truly reduce psychiatric hospitalizations – and the need for officers to drive patients to those beds. Without those services, which can include stabilization centers and mobile crisis teams, she said it's unlikely that demand for transportation will drop anytime soon.

"We need smaller programs, sprinkled across the state, so someone is not driven for hours in a police car while they're in crisis," Schrad said. "But right now, we're just scratching the surface."