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Craig Hudson for POLITICO Magazine

LETTER FROM WEST VIRGINIA

The Immigrant Doctor Who's Solving West Virginia's Opioids Crisis

A data-driven health commissioner figured out a way to slow overdose deaths. But treating addiction is a much harder problem.

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CHARLESTON, W.Va.—Last fall, after watching the death toll from opioids climb unchecked for years, Dr. Rahul Gupta, the man in charge of combating one of the worst health crises in America, decided to do something no one had ever tried. He ordered his staff to do an in-depth analysis of every person in his state who had died of a drug overdose over the preceding year—all 887 of them.

Since 2014, West Virginia has held the grim distinction of having the highest overdose death rate in the country, according to Centers for Disease Control figures. In 2016, West Virginia's death rate, according to the most recent federal data, was 52 per 100,000 people—nearly three times the national average. The next highest state, neighboring Ohio, had 39 deaths per 100,000. What West Virginia lacked, though, were the hard numbers that might point officials to a way out of a disaster that showed no signs of abating.

"We wanted to know who each person was and what we could have done to help them," Gupta, West Virginia's public health commissioner, told me when I interviewed him in his Charleston office recently. Doctors, he said, know the risk factors for heart disease and use them to screen patients and prescribe treatment. "We didn't have something like that for opioids. We're all sort of trying to address a problem without a lot of data to know how to approach it from a prevention aspect. So we wanted to develop those risk factors."

Over the next 10 weeks, Gupta's staff combed through public databases, Medicaid rolls, medical examiner reports, birth certificates, death certificates and criminal records. They wanted to find out who was at highest risk of an overdose in West Virginia so they could produce a report for the state legislature before its session began in January. The idea was to give policymakers a data-driven road map of how to get the death rate down, who to focus resources on, and what programs and policies might help them achieve it.

The findings ultimately would show a depressing pattern of vulnerability: Men were twice as likely as women to die of an overdose. And those with jobs in blue-collar industries like construction had a higher risk of overdosing than the general population, likely because they take prescription opioids or illicit substances to deal with chronic pain from injuries. "If you're a male between the ages of 35 to 54, with less than a high school education, you're single and you've worked in a blue-collar industry," Gupta said, "you pretty much are at a very, very high risk of overdosing."

The report included recommendations ranging from limiting initial prescriptions for acute pain to seven days to expanding access to medication-assisted therapies by exempting doctors from federal licensing to administer the treatment. Those recommendations were absorbed into legislation that was signed into law by

Governor Jim Justice in March.

But there was another finding, one so obvious and urgent Gupta felt his agency had to act on it immediately. In November, Gupta's team realized that about 71 percent of people who had fatally overdosed had received emergency medical treatment sometime before they died. But only about half of that group had been administered naloxone, a medicine that when injected can reverse the effects of opioids within minutes.

"We saw this was clearly a missed opportunity where we could have saved people … so it's critical that whenever these individuals do come into contact with one of the health systems, we take advantage of that opportunity and we do not let that slide."

Over the past three months, the state has also engaged in a full-court press to get naloxone into the hands of as many people as possible. That includes a recent mandate passed by the state legislature (price tag: $1 million) requiring all first responders to carry the overdose antidote and encouraging libraries and public schools—elementary through high school—to stock up on the lifesaving drug. In January, Gupta issued a standing order for naloxone so that individuals don't have to pay out of pocket for the drug, which can cost around $40 per dose. In Cabell County, which surrounds Huntington, the city considered to be the epicenter of the West Virginia epidemic, the number of EMS overdose responses declined 36 percent between the first quarter of 2017 and the first quarter of 2018, according to county figures.

The emergency distribution of naloxone may finally be having an effect on the seemingly unstoppable death toll in West Virginia. Although overdose fatalities in 2017 increased 2 percent to 909 from the year before, deaths slowed by about 25 percent in the second half of the year. Officials caution that number could change as there is often a lag in data. Death reports from 2016 are still trickling in. But federal data also shows a slowdown of overdoses in West Virginia. A CDC snapshot of 2017 hospital data showed that hospitalizations for drug overdoses were slightly down in West Virginia, even at a time when most other states across the country saw a dramatic increase.

"We are expecting improvements in overdose deaths this year with all of these things

we're putting into place," Gupta told POLITICO Magazine. "We're thrilled about it, but we still feel that we have a long way to go."

West Virginia's work to get a handle on the drug abuse epidemic comes as Congress and the Trump administration continue to debate the best ways to tackle the crisis nationwide. Congress recently appropriated an additional $4 billion to help address drug abuse, including for programs to help states expand access to treatment and prevention programs as well as law enforcement activities. Surgeon General Jerome Adams recently issued a rare public advisory encouraging more people across the country to carry naloxone.

But as Gupta and most public health experts warn, naloxone isn't going to end the opioid crisis. It's a temporary bandage that saves people but does not treat them. Often many of the same patients who get revived from an overdose end up overdosing again. "We're doing a good job of saving lives," said Jack Luikart, the director of correctional substance abuse control under West Virginia's Military Affairs and Public Safety Department, "but treating addiction, that's where we need to step up our game."

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Gupta, the son of an Indian diplomat, was born in India but grew up in a Maryland suburb of Washington. He came to West Virginia in 2009 to lead the Kanawha-Charleston Health Department after doing stints as a local health official in Tennessee and Alabama. He was appointed state public health commissioner by former Democratic Governor Earl Ray Tomblin in December 2014, following his work overseeing the response to the massive chemical spill near Charleston in January 2014.

While leading the local health department, Gupta, 47, watched the opioid crisis develop and then explode. He lobbied the state legislature to require special opioid prescribing training for physicians and pushed measures to crack down on "pill dumping," in which opioid manufacturers send mass quantities of pills to one area, far outpacing demand. Most of the focus then was on limiting prescription opioids, but by the time he took over as state public health commissioner, the opioid crisis had evolved from prescription drug abuse to illicit drug use like heroin and the powerful

synthetic opioid fentanyl.

In his first two years as state public health commissioner, the state approved guidelines for opioid prescribers and passed Good Samaritan laws, but, Gupta said, the overdose death data revealed that their work wasn't saving lives. Despite those efforts, the overdose death rate continued to climb. In 2015, 735 West Virginians died of an overdose, according to state figures. The next year that number climbed to 887.

"For me, it was the second year in a row that I was seeing the numbers continue to incline," he said. "That's when I said we have to do something different."

The state in 2017 applied for, and received, a number of federal grants that officials used to buy naloxone kits to distribute to communities. The federal government also approved a waiver for West Virginia last fall to allow Medicaid to pay for inpatient substance abuse treatment at certain facilities as part of a push to expand access to care.

But Gupta wanted a more immediate way to get a handle on the deaths, and that's where his overdose analysis project came in. "We were in a rush for time because if there was an opportunity to have legislation passed this year, this was it," he said. His team turned the report around in three months, partnering with Johns Hopkins University, West Virginia University and Marshall University to come up with a set of 12 policy recommendations. "We didn't want it to sit on the shelf. We wanted to present practical steps that we could put into place immediately," Gupta said.

"We often don't get data-driven policy making in times of an epidemic or a crisis," Gupta said. "We were using this social autopsy of West Virginians who had died to create policy … and that's very hard to push back against."

Roughly 91 percent of all overdose victims had a documented history within the state's prescription drug monitoring program, meaning they had previously filled a prescription for an opioid. About half of all female victims had filled an opioid prescription within 30 days of their death. From this finding, lawmakers crafted, and approved, legislation that limited initial opioid prescribing and cracked down on providers found to be inappropriately prescribing opioids to patients.

"The problem is there is so much of it in circulation," Gupta said of prescription

opioids.

West Virginia, in the past few years, has taken action to prevent pill dumping, after mass quantities of prescription painkillers flooded into small towns far surpassing necessary amounts. According to a congressional probe by the House Energy and Commerce Committee, over the past 10 years, drug manufacturers have shipped 20 million prescription painkillers to two pharmacies in Williamson, Virginia, a town of about 3,000 people. The Drug Enforcement Administration last month released a proposed rule that would limit how many opioids drug makers can manufacture in an effort to prevent pill dumping.

Gupta said the state is trying to be cautious not to restrict opioids so much that people who actually need them can't access them. "It's very important that we don't forget about those people with legitimate pain. We want minimum disruptors for them," he said, adding that "there's still a role for opioids to play."

Four out of five West Virginians who died from an overdose in 2016 had come into contact with the health system, whether it was during a visit to the emergency room from a prior overdose, or a visit to a clinic for a routine checkup. About 71 percent had or were eligible for Medicaid coverage.

More than half of West Virginians who died of an overdose in 2016 had been incarcerated at some point. That told policy makers that there needed to be more policies built around the incarcerated population.

After that finding, Gupta partnered with the Department of Corrections to develop a number of programs aimed at helping prison and jail inmates who are struggling with addiction. One pilot program, which will be expanded statewide in the summer, gives assisted treatment to inmates with an opioid medication upon their release and then helps connect them to longer term care in the community.

"First, we were like, why do we want to get involved in treatment? That's not our thing … but when we took a look at this, one of the reasons we have contraband in our facilities is because of inmates with addiction," said Luikart, of West Virginia's Military Affairs and Public Safety Department. "So, if we can provide treatment in our prisons and jails, there will be less demand for contraband." He added that by treating addiction, they also hope to cut recidivism, which is high among people with

addiction. “That will help with prison overcrowding.”

Gupta is data-driven, but he also knows the value of gathering anecdotal evidence. Once a month, Gupta works on the front lines of the epidemic, treating patients with drug addiction at West Virginia Health Right, a charity clinic in Charleston that is also one of the city’s two needle exchanges. He treats patients with chronic pain, who became hooked on prescription painkillers and are now self-medicating with illicit drugs that are cheap and easy to find. He tries to direct them into longer-term treatment. “These are mainstream individuals that got entangled into the grips of addiction, and the data shows us that,” Gupta said.

He sees patients who have overdosed a half dozen times and who are still not given any kind of follow through or long-term help. On a recent visit to the clinic, he spoke with a woman who had been resuscitated nine times by paramedics.

Michelle Spencer, 37, has been in and out of treatment for several years. After she was rescued from her latest overdose, she was told by paramedics that they wouldn’t use the antidote on her again. “They narcanned me so much that they said they aren’t willing to do it anymore,” Spencer told Gupta during one of his volunteer shifts at West Virginia Health Right. She came to the clinic with her teenage daughter, who is encouraging her to get into, and stick with, treatment. “It’s so easy to go and do more,” she says.

Spencer’s addiction started like many, with prescription drugs, which she stole or bought from friends. Then she switched to methamphetamine, which was easier to find. She says she has bipolar disorder and has been self-medicating for at least a decade. She went to prison for drug possession and was released about three years ago. That’s when she started using heroin. Like meth, it was cheap and easy to find. She says she uses several times a day.

The treatment program Gupta has recommended for Spencer, who is on Medicaid, takes several days to get into. Because she was suffering extreme withdrawal symptoms, she begged him to get her into more immediate treatment, fearful that she might use again if she didn’t get help immediately.

Spencer was in a common predicament. Out of the more than 2.1 million Americans with opioid use disorder, just 20 percent receive specialty addiction treatment,

according to the Substance Abuse and Mental Health Services Administration. It can be particularly challenging to find medication-assisted treatment, which has a proven track record of treating addiction, in rural areas. One of the challenges West Virginia and many other states across the country are facing is how to expand access to that treatment, which is not widely available across the country for a variety of reasons.

Doctors who administer medication-assisted treatment like buprenorphine are required to have federal licensing and waivers that some say are burdensome and deter doctors from getting them. West Virginia recently passed a measure that allows primary care doctors with smaller practices to administer medication-assisted treatment without having to be licensed federally.

West Virginia state Sen. Ron Stollings, who is also a primary care doctor in Madison, West Virginia, said the waiver allows physicians like him, who don't specialize in substance use treatment but come across many patients struggling with addiction.

"You need to realize that if you don't treat them right away, they're more likely to become a statistic—dead from overdose," Stollings said. "The idea is to get someone on medication-assisted treatment early on." He added that he isn't sure how many fellow primary care providers will want to take part in the program, but "it's a tool in the toolbox."

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On a recent Tuesday, Chris Rauhecker, a recovering heroin addict who now counsels people with drug addiction, and Lindsey Harmon, a Cabell County paramedic, jumped into an old, unmarked police car and drove into downtown Huntington on a mission to find a homeless man who had overdosed in the public library the day before.

They knew nothing more about him than his name and the county paramedic's report that detailed the overdose incident. He was discovered unconscious on the library's second floor and was revived by paramedics with naloxone. When he woke up, he walked out of the library and back onto the streets.

The scenario is all too common in Huntington, the rural, Appalachian community that's become the epicenter for the opioid abuse epidemic: A person overdoses,

paramedics rush to the scene to revive him, and once he's awake, he's free to walk away with an untreated drug addiction and a high chance of overdosing again, with the next time even more likely to be fatal.

Rauhecker and Harmon are part of a small but persistent team that is working to break that cycle. With federal funding and assistance from Gupta's office, Cabell County's Quick Response Team was launched last December to be the link to care for people who suffer from drug overdoses.

The team follows up with drug overdose victims within 72 hours of the incident and helps connect them to long-term treatment. If a patient has a home address, they'll make house visits. If not, they'll check the local shelters and drive around town until they find them. Gupta said Charleston is in the stages of developing its own "QRT" and thinks Huntington's program could serve as a model for other communities nationally that are looking to get a handle on drug overdose deaths.

Rauhecker and Harmon eventually located the man about five blocks from the library near a Sheetz convenience store—known as a local hangout for drug users and dealers. They approached him, introduced themselves as the Cabell County's Quick Response Team and assured him they were there to help, not implicate him. After some convincing, he agreed to go to an inpatient detox facility. They called a local treatment center, secured a bed for him and drove him there.

"By the end of the week, hopefully, if he's still receptive, we'll try to get him into long-term care," Rauhecker says, cautioning that not everyone the team encounters is ready to be helped, and they know there is a process to gaining a patient's trust. Word is catching on about the Quick Response Team. He said more and more often people are expecting them to show up, "sometimes they're even relieved."

Since December 4, the Huntington QRT has connected with 179 patients who had previously suffered a drug overdose. Of that group, 61 people are now in a form of long-term treatment including medication-assisted therapies, residential treatment centers and sober living homes. That's about a 34 percent success rate, which county officials are pleased with since the program is only four months old.

The key to QRT, Larrecsa Cox, a paramedic on the team, explained, is that they treat each patient they meet differently, based on their needs. They spend time talking to

the individuals to learn what kind of treatment, if any, they are interested in pursuing. This often means either medication-assisted treatment or an abstinence-based program like a recovery home.

People aren't always receptive. "I wouldn't say they're always glad to see us. Some people don't want us there," Cox said. That doesn't deter the team, which often makes multiple trips a week to a patient's home to follow up and make sure he's sticking to his appointments. QRT members also stay in touch with patients by texting and talking on the phone.

"If they aren't interested, we come back later," Cox said.

Harmon, another paramedic, said she once knocked on the door of a patient's home every day for a month before finally the woman agreed to hear her out. Her persistence paid off: The woman is now in an inpatient facility in another town, and Harmon still texts her to check in.

"Some of these people, you deal with them so much, you kind of get attached to them," Harmon said. She added that many of the people they visit don't have family support systems to help them cope. "In some cases, we become their friends and their family," she said.

"I wish there would have been someone that would have done this for me," said Rauhecker, who has been clean from heroin for 26 months and now works as a recovery coach at Recovery Point, a sober living home in Huntington. He said he is certain he would have gotten help earlier if a team of people had knocked on his door and dedicated their time to getting him treatment.

Rauhecker rides along with the group and uses his own experiences recovering from heroin addiction to relate to patients and help them get connected to longer term care. The QRT also employs someone from a clinic that provides medication-assisted treatment to represent that option.

"What works for one person isn't always going to work for someone else," he said, adding that sometimes patients want to go to a sober living home, while others prefer medication-assisted treatment. Either way, "the biggest thing is that they have to be ready and want to get help; otherwise it's not going to work."