Report to Clinicians 2017

Alexandria Health Department

Our Vision

Healthy People, Healthier Communities

Our Mission

Protecting and Promoting Health and Well-Being in Our Communities

Our Values

Working Together, Improving Continuously, Making a Difference

Preface

Dear Colleague,

As a practicing clinician in the City of Alexandria, you serve an essential role in ensuring the health of our community. The work that you do not only maintains and improves health on an individual level, but the impact you make benefits the entire community.

We at Alexandria Health Department (AHD) are committed to working with all community partners who contribute to building and improving the landscape of health in the City. In this spirit, AHD is proud to present this Communicable Disease Report to Clinicians and hope you find it informative and helpful as a resource in your daily work. Borne of public health science and epidemiology, this report enhances your ability to provide quality care to your patients. As partners in health, we can work together to ensure not only that individuals – but also populations – are healthy, thriving, and protected from the burdens associated with illness.

We encourage you to incorporate public health ideals into your work and collaborate with us on future projects. Our qualified staff – whether epidemiologists, planners, communication specialists, environmental health specialists, biologists, or public health nurses – are eager to collaborate with our healthcare providers to maximize the benefit that public health and clinical medicine can provide for our population.

We welcome your feedback, comments, suggestions, and ideas for how we can improve the health of our residents and make a difference in your practice patterns. We look forward to collaborating with you in the future to serve as a model for community partnership and an example of what it means to be healthy.

Thank you,

Stephen A. Haering, MD, MPH, FACPM

Health Director

Alexandria Health Department

Report to Clinicians 2017

Introduction and Overview

This Alexandria Health Department (AHD) Report to Clinicians provides a summary of reportable disease investigations by AHD. This report includes data from 2016 and 2017 and a summary of reports from calendar years 2012-2017. For this report, AHD presents sexually transmitted infections (STI) and tuberculosis (TB) separately from other reportable diseases. We also offer several timely and important public health updates on conditions of concern. These updates increase awareness of each topic area and provide clinicians with credible resources for additional information. This report is best read electronically, as it includes hyperlinked URLs to online resources.

Case Definitions

Public health case definitions are published by the Centers for Disease Control and Prevention (CDC) to standardize reporting of diseases across the country (CDC Case Definitions). These case definitions ensure that disease-specific morbidity is comparable between different states and jurisdictions. Public health case definitions are not intended for clinical diagnosis. Periodic changes to case definitions, as well as changes in diagnostic methods (e.g. culture independent diagnostic tests), may limit comparisons of case counts across years.

Disease Surveillance

The case counts presented in this report do not represent the true incidence of disease within the community, because not all ill persons seek medical care and not all cases are reported to the Health Department. AHD relies on providers and laboratories to report cases - or suspected cases - of reportable illnesses to improve our estimates of disease burden and our administration of essential public health services, including disease prevention and control. For more information about how and what to report to us, see page 22.

Limitations

Rates should be interpreted with caution because of the effect of population size on rates. For communities like Alexandria with a small population and low disease incidence, a small increase in the number of cases of an illness can make the rate for that illness high in that year while the absolute numbers have not increased substantially. This can make comparisons over time or with larger communities difficult.

Data Source

Unless otherwise noted, data represents Virginia Department of Health (VDH) primary surveillance data available in the Virginia Electronic Disease Surveillance System (VEDSS) as of April 4, 2018.

Acknowledgements

We would like to thank all of our community partners - including healthcare providers, infection control practitioners, laboratorians, and public safety personnel, who report cases to AHD. We also wish to acknowledge the hard work and dedication of the AHD employees who investigate and control communicable diseases, including STIs, HIV, and TB in Alexandria.

AHD Epidemiologists Christina Chommanard, Melissa Arons, Agathe Hoffer-Schaefer, and AHD Medical Director Dr. Kim Luk prepared this report. Johns Hopkins Preventive Medicine Resident Dr. Natalia Golub provided substantial editing and proofreading. This report was approved by AHD Health Director Stephen A. Haering, MD, MPH, FACPM. Any errors are solely the responsibility of AHD. Feedback is welcome and may be sent to alex_epi@vdh.virginia.gov.

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Summary of Selected Reportable Diseases

Program Highlights

In 2017, AHD's Communicable Disease (CD) Division completed 605 disease investigations for conditions reportable by state law, and six outbreak investigations (Norovirus; Hand, Foot, and Mouth Disease (2); Fifths Disease; Influenza; and Scabies). By comparison, in 2016, AHD's CD Division completed 503 disease investigations for conditions reportable by state law, and six outbreak investigations (Norovirus (2); drug resistant *Acinetobacter*; Hand, Foot, and Mouth Disease; Influenza; and Respiratory Syncytial Virus). This report provides a summary of all reported cases[1] from 2012-2017 (Table 1).

Table 1: Total Number of Reportable Conditions in Alexandria, VA (2012-2017) [1]

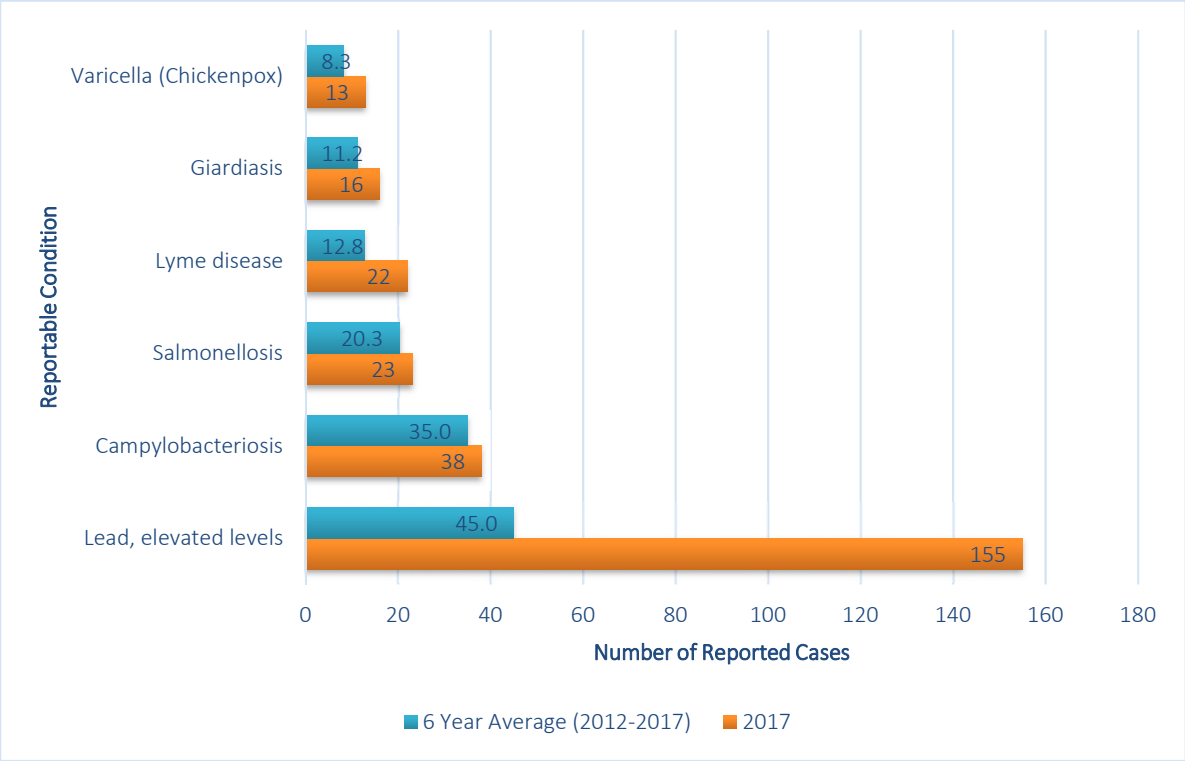
CONDITION	2012	2013	2014	2015	2016	2017	6 year average 2012-2017
Amebiasis	0	3	3	2	1	3	2.0
Arsenic	2	1	3	0	4	2	2.0
Botulism, infant	0	0	0	0	0	0	0.0
Campylobacteriosis	16	21	23	50	62	38	35.0
Chagas disease	0	1	0	0	0	0	0.2
Chikungunya neuroinvasive disease	0	0	3	0	0	0	0.5
Cryptosporidiosis	15	11	9	10	12	11	11.2
Cyclosporiasis	0	0	1	1	1	0	0.5
Dengue	0	0	0	1	1	0	0.3
Dengue fever	1	1	0	0	0	0	0.3
E. coli infection, shiga toxin-producing	1	2	2	2	2	5	2.3
Ehrlichia chaffeensis infection	0	2	0	2	0	0	0.7
Encephalitis, CA serogroup virus, neuroinvasive	0	0	1	0	0	0	0.2
Giardiasis	15	11	8	4	13	16	11.2
Haemophilus influenzae, invasive	3	0	1	1	3	1	1.5
Hepatitis A, acute	2	0	1	1	0	4	1.3
Hepatitis B, acute	1	0	0	0	2	1	0.7
Hepatitis B, chronic	39	48	53	72	68	111	64.3
Hepatitis C, chronic	44	65	58	106	137	159	93.2
Lead, elevated levels	1	3	8	18	82	158	45.0
Legionellosis	1	1	0	1	2	2	1.2
Listeriosis	0	0	0	0	0	0	0.0
Lyme disease	3	14	19	13	7	22	12.8
Malaria	7	9	6	4	9	10	7.5

[1] Total number of reported cases excludes sexually transmitted infections (STI); information on these conditions is presented separately.

CONDITION	2012	2013	2014	2015	2016	2017	6 year average 2012-2017
Meningococcal disease (Neisseria meningitidis)	0	0	1	0	1	0	0.3
Mercury, elevated levels	0	0	0	2	0	1	0.5
Mumps	0	0	1	1	1	4	1.2
Pertussis	5	4	9	7	3	0	4.7
Q fever, acute	0	0	1	0	0	0	0.2
Salmonellosis	13	15	16	28	28	23	20.3
Shigellosis	10	2	21	6	10	5	9.0
Spotted Fever Rickettsiosis (including RMSF)	2	1	1	2	0	0	1.0
Staph aureus, methicillin resistant (MRSA)	23	14	15	18	12	0	13.7
Streptococcus pneumoniae, invasive (age < 5)	1	1	0	1	1	0	0.7
Streptococcus, Group A, invasive	2	3	2	6	5	2	3.3
Toxic-shock syndrome, streptococcal	0	0	0	0	0	2	0.3
Tuberculosis	6	15	15	16	19	10	13.5
Typhoid fever (Salmonella typhi)	1	0	0	0	0	0	0.2
Unusual occurrence of public health concern - TOX	0	2	3	2	0	0	1.2
Varicella (Chickenpox)	4	5	8	6	15	13	8.3
Vibriosis, non-cholera	0	3	1	0	0	1	0.8
West Nile infection, neuroinvasive	0	1	1	1	1	0	0.7
West Nile infection, non-neuroinvasive	1	0	0	1	0	0	0.3
Yersiniosis	0	0	0	0	1	1	0.3
Total Number of Reported Cases	**219**	**259**	**294**	**385**	**503**	**605**	**375.8**

Figure 1 displays the top six reportable conditions[2] in Alexandria in 2017 and the 6-year average. Elevated blood lead levels were the most frequently reported, with 158 cases in 2017, followed by Campylobacteriosis (38 cases), Salmonellosis (23 cases), Giardiasis (16 cases), and Varicella (13 cases).

Figure 1: Top Six Reportable Conditions in Alexandria, VA (2017)[3]



Public Health Concerns in Alexandria

- **Elevated blood lead levels**: In 2015-2017, there was a 21.5-fold increase in the number of individuals who had elevated blood lead levels compared to 2012-2014 (average of 4.0 cases per year in 2012-2014; average of 86 cases per year in 2015-2017). These increases may be due to changes in case definition and reporting procedures.
- **Sexually transmitted infections**: AHD, similar to state and national trends, has experienced increased rates of STIs in the last 6 years. From 2012 to 2017, the rate of chlamydia increased from 322.6 to 476.9 per 100,000 people, and the rate of gonorrhea increased from 67 to 143.5 per 100,000. Between 2014-2016, the syphilis rate increased from 10 to 23.5 per 100,000 people, and the HIV rate increased from 19.3 to 27.4 per 100,000. Rates of syphilis and HIV decreased in 2017.
- **Chronic Hepatitis B and C**: In 2015-2017, there was a 1.8 fold increase in number of chronic Hepatitis B diagnoses compared to 2012-2014 (average of 46.7 cases per year from 2012-2014; average of 83.7 cases per year from 2015-2017). In addition, in 2015-2017, there was a 2.4-fold increase in the number of chronic Hepatitis C diagnoses compared to 2012-2014 (average of 55.7 cases per year from 2012-2014; average of 134 cases per year from 2015-2017). Some of these increases are likely due to changes in the case definition and broader screening recommendations from the US Preventive Services Task Force.

[2] Figure 1 does not include chronic hepatitis, STI, or TB cases

[3] Number of Reported Cases indicates cases that were reported to Virginia's Electronic Disease Surveillance System (VEDSS) and met case definition

Reportable Blood Lead Levels

According to the Centers for Disease Control and Prevention (CDC), childhood lead poisoning is the leading environmental health threat to young children. While lead can adversely impact almost every organ and system in the body, the main target for lead toxicity is the nervous system. Any detected blood lead level indicates an exposure to lead has occurred and no level is considered safe (CDC, 2018). **As of October 20, 2016, any detectable level of lead in a child in Virginia is required to be reported to the local health department** (Levine, 2016).

Although environmental exposure to lead has decreased substantially in the US, lead continues to be a major hazard in many developing countries where exposure to lead is still widespread. Additionally, the ongoing use of products purchased outside the US (like cosmetics, spices, and medicines) can prolong lead exposure even after moving to the US.

Virginia State Law (12VAC5-90-215) requires that every high risk child be screened for elevated blood lead level at 12 and 24 months of age. Children 25 to 72 months of age should also be screened if they haven't previously been tested or have had a change of exposure. Venous blood samples are required to confirm elevated lead levels. AHD relies on healthcare providers to take the necessary actions to retest and/or educate the parents/guardians of children whose blood lead levels are below 10 µg/dL. AHD is available to assist healthcare providers with this. AHD performs environmental home inspections for every child whose venous blood lead is ≥20 µg/dL to ensure the environmental causes of exposure are identified for remediation.

To learn more about the risks of lead exposure in new immigrants to the United States:

- CDC Lead Poisoning Prevention in Newly Arrived Refugee Children: Toolkit

- Please visit our website or contact us for educational materials that may be help your conversation with your patients!

High Risk for Lead Exposure

1. Receives benefits or is eligible for WIC or Medicaid
2. Living in or frequently visiting a building built before 1960
3. Living in or frequently visiting a building built before 1978 with peeling paint or recent renovations
4. Having siblings, housemates, or playmates with evidence of lead exposure
5. Living with an adult who participates in a lead-related occupation or hobby
6. Living near active lead smelters, battery recycling plants, or other industries likely to emit lead
7. Parent or guardian requests a test due to a suspected exposure
8. A recent refugee, immigrant, or is adopted from outside the US

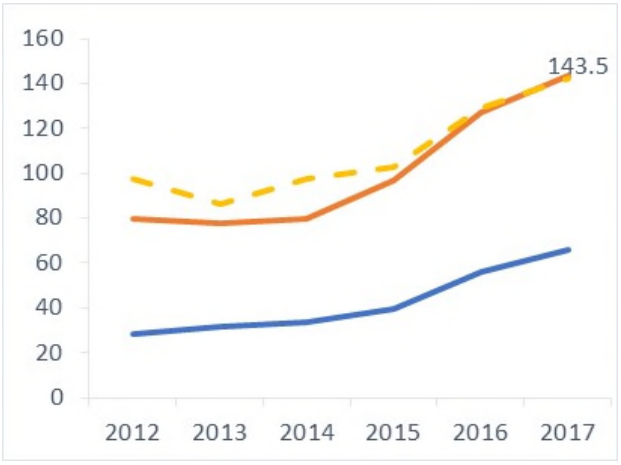
Sexually Transmitted Infections (STIs)

Significant increases in rates of gonorrhea and syphilis have been reported since 2014, consistent with state and national increases in rates. Early syphilis diagnoses have doubled between 2010 and 2016. Gonorrhea infections in 2016 surpassed the previous high set in 2008, and chlamydia diagnoses have risen by 55 percent from 2012 to 2017.

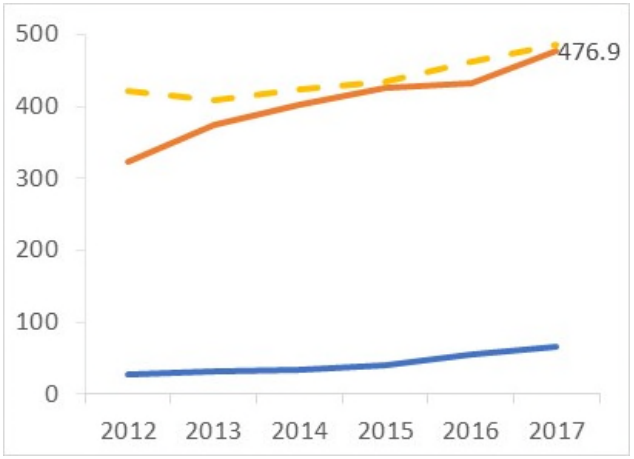
Figure 2 shows Alexandria, Northern Virginia, and the Commonwealth of Virginia rates per 100,000 people for gonorrhea, chlamydia, syphilis, and HIV from 2012 to 2017.

Figure 2 a-d. Rates per 100,000 for Gonorrhea, Chlamydia, Syphilis, and HIV in Alexandria, Northern Virginia (NOVA), and Virginia 2012-2017

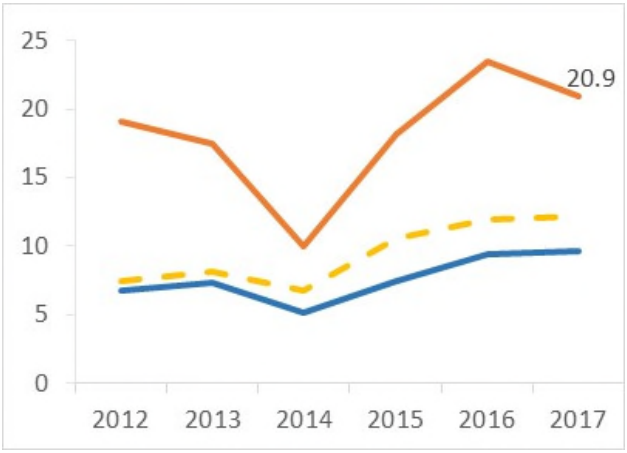
a. Gonorrhea



b. Chlamydia



c. Syphilis



d. HIV

Alexandria — Virginia — NOVA

For more comprehensive STI data, please consult VDH Division of Disease Prevention's (DDP) annual reports on STIs (which summarize demographic and risk factor data). These reports can be accessed online (DDP Reports). CDC also offers updated STI resources (which include training, treatment information, and fact sheets).

Getting to Zero Alexandria

In December 2017, AHD was awarded a $540,000 grant from VDH to combat HIV. AHD's City-wide HIV initiative will work on "Getting to Zero" with the aim of Zero new HIV infections, Zero HIV deaths, and Zero stigma. This campaign emphasizes universal HIV testing for all patients regardless of their risk behaviors, promotes PrEP to prevent new infections and enhances linkage to care for those who test positive.

Call to Action: Increase STI Screening and Treatment, Provide Pre-Exposure Prophylaxis

Increase STI Screening and Treatment

STIs are a major public health problem, are often asymptomatic and, if left untreated, may lead to complications including pelvic inflammatory disease, infertility, and adverse pregnancy outcomes. Syphilis can lead to long term neurologic and cardiac sequelae. In 2015, the CDC and the US Preventive Services Task Force made additional STI screening recommendations to improve early detection of STIs to decrease STI transmission and the complications associated with delayed or absent treatment.

A comprehensive overview of the CDC STI Screening recommendations are in the Appendix.

Provide Pre-Exposure Prophylaxis (PrEP)

Pre-exposure prophylaxis (PrEP) is a safe, effective, daily HIV medication (*emtrictabine/tenofovir*) suggested for individuals at substantial risk for contracting HIV. PrEP reduces the risk of contracting HIV through sex by more than 90% and reduces the risk of getting HIV through sharing needles by more than 70%. Help Alexandria in "Getting to Zero" by talking to your patients about PrEP. Table 2 describes the types of high-risk groups who should consider taking PrEP (CDC, 2014; Giliead, n.d.).

Table 2: High-Risk Groups – Consider PrEP

Men who have Sex with Men (MSM)	Transgender Individuals
• More than 1 HIV-negative, monogamous partner • Partner with HIV • History of rectal STIs or syphilis • Inconsistent condom use with partners of unknown HIV status, or multiple sexual partners • Commercial sex workers	• Sex with MSM • Partner with HIV • History of rectal/vaginal STIs or syphilis • Inconsistent condom use with multiple or unknown partners • Commercial sex workers
Heterosexual Women and Men	**Injection Drug Users (IDUs)**
• Sex with MSM • Partner with HIV • History of vaginal or rectal STIs, or syphilis • Inconsistent condom use with partners of unknown HIV status, or multiple sexual partners • Commercial sex workers	• HIV-positive injecting partner • Sharing injection equipment • Recent drug treatment • Risk of sexual acquisition (see above)

Talking to Patients about PrEP

- PrEP is highly effective for preventing Human Immunodeficiency Virus (HIV) infection when taken daily.
- It is estimated to take approximately 7 days for PrEP to reach levels of protection for rectal sex and 20 days for vaginal sex.
- Potential medication side effects: 1 in 10 people may have GI symptoms (these usually resolve within 1 month), 1 in 200 may have renal dysfunction (typically reversible if PrEP is discontinued).
- Contraindications include:
    - Reduced kidney function (eGFR < 60)
    - HIV positive
    - HIV exposure within 72 hours (first consider PEP then PrEP)
- Patients should have an initial HIV, Hepatitis B and Hepatitis C screen before starting PrEP; consider Hepatitis A, Hepatitis B, and Human Papilloma Virus (HPV) vaccines
- Within 1 week, providers should confirm adherence by checking if the prescription was filled
- Within 1 month, providers should check HIV antigen/antibody (4th generation) as well as adherence to regimen
- Providers should counsel their patients and remind them that PrEP does not prevent STIs and patients should be screened for STIs every 3 months (San Francisco Department of Health, 2015)

HAVE YOU ORDERED YOUR FREE CONDOMS? BE A CONDOM DISTRIBUTION PARTNER.

VDH has over 100 condom distribution partners and invites more to join. Organizations may order up to 100,000 per year. If you would like to participate, please contact **Beth Marschak** at Elizabeth.Marschak@vdh.virginia.gov

Additional PrEP and HIV Resources for Clinicians and Patients

US Public Health Service PrEP guidance: Guidance provides details on prescribing PrEP to patients. 2014 Clinical Practice Guidelines for Pre-exposure Prophylaxis for the Prevention of HIV in the United States

ADAP - AIDS Drug Assistance Program: Income-eligible people living with HIV can obtain designated drugs at no cost. Learn more at www.vdh.virginia.gov/ADAP or call the Medication Assistance Hotline at 1.855.362.0658.

Primary Medical Care/Case Management/ Dental Care for Persons Living with HIV: Neighborhood Health Services, Inc. offers comprehensive services for persons with HIV/AIDS, including medical care, health guidance, and dental services. Learn more at 703.535.5568 (ext. 3015) or email rwinfo@neighborhoodhealthva.org. You can also visit www.neighborhoodhealthva.org/

For more resources for persons living with HIV/AIDS in the Northern Virginia community, please visit the NOVA Regional Commission HIV Services website.

STI Resources for Providers and for Patients

When a patient tests positive for an STI, AHD asks all providers to consult the Disease Surveillance Investigators in our STI department. This is particularly important if your patient tests positive for syphilis or HIV. AHD Disease Surveillance Investigators can assist you with treatment and diagnosis decisions, clarify previous lab results for your patients, and inform contacts at risk of contracting the disease to get them into rapid treatment. Treatment for contacts is free (and confidential) at AHD. Providers can contact AHD's STI Division directly at 703.746.4976 to access this service.

Do you want expert advice about syphilis or other STIs? Do you need more information to make your clinical decision?

The STD clinical consultation network is a free service that provides clinicians with expert advice about STIs. Clinicians can submit a clinical picture to the network, which disperses the inquiry to infectious disease physicians throughout the country. Providers should receive a response within 2 days.

The Alexandria Health Department offers multiple Reproductive Health Clinic services to prevent and treat sexually transmitted infections (and includes family planning). Reproductive Health Clinic services are available at AHD's Main Office (4480 King Street, Alexandria VA) and Teen Wellness Center (3330 King Street, Alexandria VA).

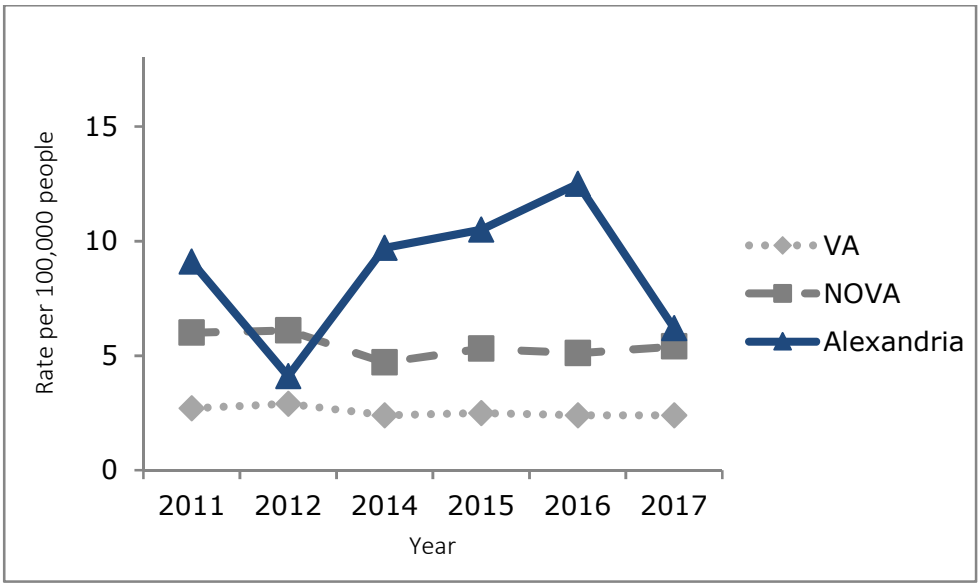
HIV Counseling and Testing: 703.746.4976 **Wednesday:** 1 to 3 p.m. **Thursday:** 5 to 6:30 p.m. AHD offers free, confidential HIV rapid testing. Appointments are not required and anyone is eligible for this service.	**Sexually Transmitted Infections (STI) Clinic: 703.746.4846** **Wednesday:** 3:30 to 6 p.m. STI Clinic provides confidential STI testing and treatment, HIV testing, Hepatitis B and HPV immunizations. You do not have to live in Virginia to qualify for this service.
Rainbow Tuesdays Clinic: 703.746.4986 or text 571.214.9617 **Tuesday**: 4:30 to 6:30 p.m. This clinic is a welcoming and safe environment for gay, bisexual, and same gender loving men as well as persons of trans experience. Services include free HIV rapid testing, confidential STI testing and treatment, Hepatitis B, and HPV immunizations.	**Teen Wellness Center: 703.746.4776** **Monday - Friday**: 9:00 a.m. to 5:00 p.m. **Thursday**: 12:00 to 5:00 p.m. The Teen Wellness Center provides accessible, confidential reproductive health services to any teen between 12 and 19 living in the City of Alexandria.

Tuberculosis (TB)

Alexandria has one of the highest rates of active tuberculosis (TB) disease among Virginia's 35 health districts. Alexandria had a decrease in active TB cases from 19 (rate: 12.5/100,000) in 2016 to 10 (rate: 6.2/100,000) in 2017. Even with that decline, Alexandria's rate is still higher than the rest of northern Virginia.

Figure 3 compares rates of diagnosed active TB in Alexandria City, Northern Virginia and the Commonwealth of Virginia from 2011 to 2017. Case counts were obtained from the VDH Division of Surveillance and Investigation (http://www.vdh.virginia.gov/tuberculosis-and-newcomer-health/tuberculosis/tb-surveillance-reports/).

Figure 3: Rate of Tuberculosis in Alexandria, Northern Virginia (NOVA), and Virginia (2011-2017)



VDH's Division of Tuberculosis and Newcomer Health publishes annual reports on Tuberculosis that summarize demographic and risk factor data (www.vdh.virginia.gov/tuberculosis-and-newcomer-health/tuberculosis/tb-surveillance-reports/).

Frequently Asked Questions about TB in Alexandria

Q. Who is at risk for being infected with TB?

Individuals who have been exposed to the bacteria causing TB are at risk of either latent TB infection (asymptomatic and non-infectious) or active TB disease. Those at high risk of exposure to TB include:

- Individuals who have immigrated from countries where TB is common. Between 2011-2015, the majority of AHD's TB cases were in individuals who immigrated from Ethiopia, El Salvador, Sierra Leone, Eritrea, and Afghanistan (Source: Virginia Electronic Disease Surveillance System-Tuberculosis Control and Prevention)
- Individuals who reside in or work in correctional facilities, homeless shelters, hospitals, and nursing homes
- Individuals who inject drugs

Q. Who is at risk for developing active TB infection?

- 5-10% of individuals with latent TB will go on to develop active TB at some point during their life.
- Individuals with any of the following comorbidities that result in immunocompromise: cancer, diabetes, end stage renal disease, HIV/AIDS.

- Individuals on long-term immunosuppressant therapy such as prednisone, Humira® (adalimumab), or Remicaid® (infliximab).
- Close contacts of an individual with active untreated TB
- Individuals with an abnormal chest X-ray consistent with prior TB disease

Q. How does active TB disease present in patients?

A prolonged cough lasting greater than three weeks could be the first sign of TB. Other symptoms may include chest pain, hemoptysis, unintentional weight loss, fatigue, fever, night sweats, and chills. Children under six years may exhibit cough, weight loss, fever, night sweats, decreased activity, playfulness or energy, lymph node swelling, and/or personality changes. Please note that IGRA and TST cannot be used to exclude a diagnosis of TB. Individuals with suspected active TB based on clinical symptoms should undergo complete evaluation, including a chest X-ray and sputum cultures.

Q. My patients born outside the U.S. received the Bacillus Calmette-Guerin (BCG) vaccine. Are they protected from TB?

No. An adult who received the BCG vaccine as a child is not protected from pulmonary TB. The protection conferred by the BCG vaccine does not last into adulthood.

Q. What test should I use to screen my patient for TB if they had the BCG vaccine as a child?

CDC guidelines state that the Interferon Gamma Release Assay (IGRA test) is preferred for TB screening in patients who have previously received the BCG vaccine (CDC, 2016). American Academy of Pediatrics released updated guidelines in June 2018 stating that children two years of age and older can be screened with the IGRA test (AAP, 2018). A TST is an acceptable alternative, especially in situations where an IGRA is not available or too burdensome.

Q. What should I do if my patient has a positive TB skin test (TST) and they had the BCG vaccine as a child?

Among those with low risk of TB infection who present with a prior positive TST, confirmatory testing with IGRA should be performed. If the patient is at high risk of TB infection and has a positive TST with a history of BCG vaccination, chest X-ray and sputum cultures should be performed.

Q. What should I do if my patient has a positive IGRA or positive TST in absence of BCG vaccine?

Send patient for a chest radiograph to rule out active TB. If the chest radiograph shows no signs of active TB, begin the patient on treatment for LTBI. If the chest radiograph shows signs of active TB, notify the Alexandria Health Department immediately and begin treatment for active TB. Please call 703-746-4960 to consult with AHD.

Q. How much do patients have to pay for TB treatment?

AHD conducts evaluation and treatment of patients with latent TB, suspected TB and active TB. Services are free for City of Alexandria Residents.

Opioid Crisis

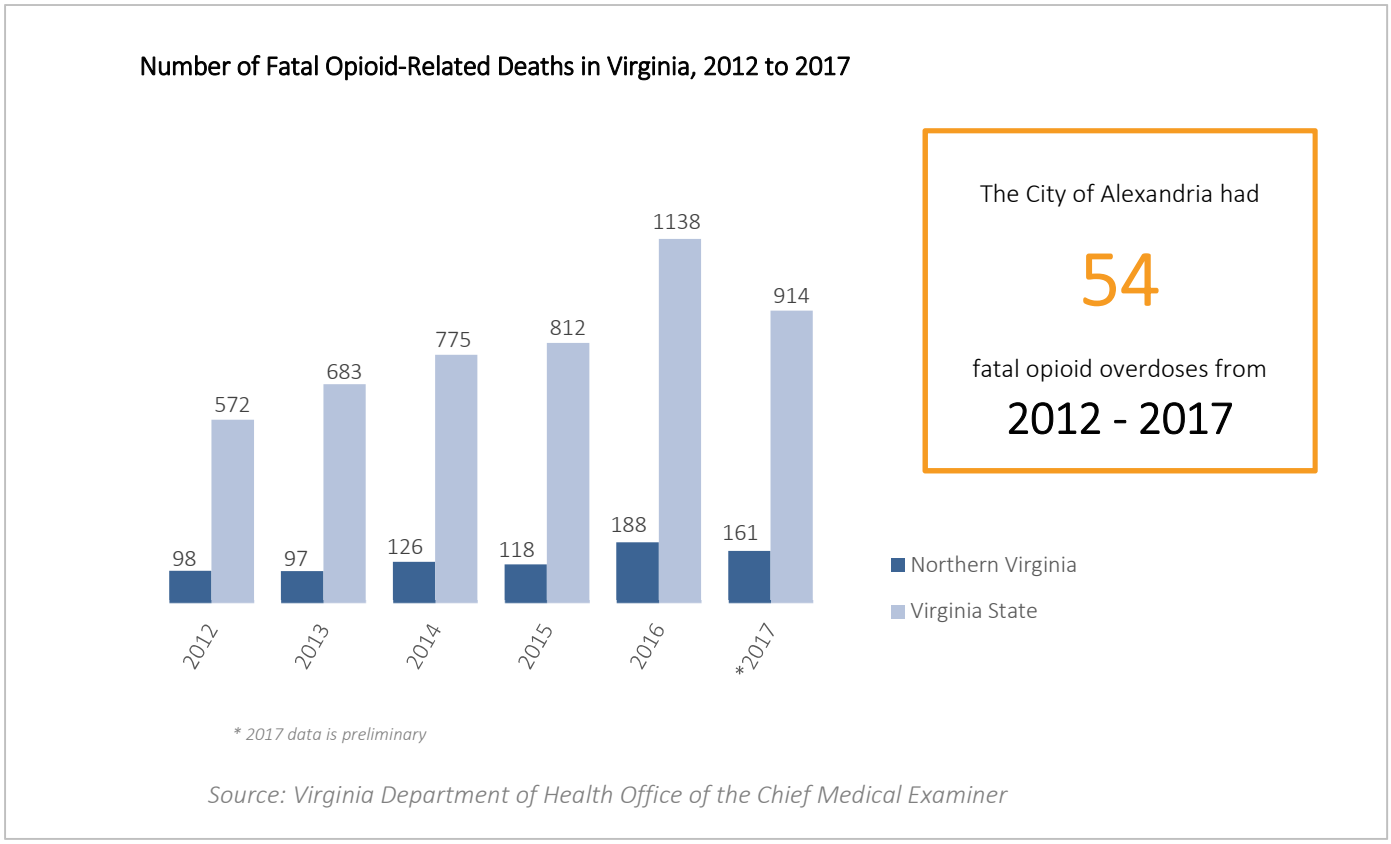
Opioid use has resulted in a four-fold increase in deaths nationwide since 1999. In November 21, 2016, the State Health Commissioner of Virginia declared the opioid addiction crisis a public health emergency across the state and issued a standing order allowing all Virginians to obtain Narcan (naloxone) – an opioid antagonist that can temporarily reverse the effects of opioids and prevent deaths from overdoses. The standing order authorizes pharmacists to dispense injectable or intranasal Naloxone in accordance with the Virginia Drug Control Act, §54.1-3408.

On April 5, 2018, the US Surgeon General issued an advisory recommending that all Americans carry Narcan. Opioid overdose death rates were reduced by half in communities providing access to Narcan. 94% of insured persons in the U.S. have coverage for Narcan, and most insurances require a nominal co-pay ($10) for a prescription. Patients can obtain Narcan at their local pharmacy. Additionally, **Alexandria Health Department is also providing free Narcan** and Narcan counseling to those at risk. We invite you to refer your patients to the Health Department for Narcan, and to help us increase awareness about the risks associated with opioid use through counseling and reducing opioid prescriptions (see next page for more information about this).

Local Data

From 2012 through 2017, the City of Alexandria experienced a total of 54 opioid-related deaths. In contrast to regional and national rates of opioids-related deaths, Alexandria has not experienced a consitant or significant increase in deaths related to opioids (OCME, 2016). However, in 2017, Alexandria experienced an increase in people presenting to the Emergency Department related to heroin overdose and other opioid overdoses.

Figure 4: Rate of Fatal Opioid Overdoses by Locality of Injury and Year of Death (2012-2017), Office of the Medical Examiner Data



Alexandria Health Department's Response

Alexandria Health Department is responding to the opioid crisis.

- AHD is supporting the City's Opioid Workgroup (see below)
- Alexandria Health Department is offering free Narcan and Narcan counseling to ANY interested member of the public.
    - Call 703.746.4888 to make an appointment. Alternatively, patients can walk-in to any of our clinics during regular clinic hours: Mon, Tues, Wed, and Fri 8 am– 4:30 pm and Thurs 12:45–4:30 pm.
- AHD Medical Director, Dr. Kim Luk, has visited Alexandria medical practices to discuss best practices for harm reduction, prevention, and treatment. If you would like Dr. Luk to visit your practice, please contact her directly at 703.746.4935 or email her at Kim.Luk@vdh.virginia.gov.

AHD also provides free medication disposal kits – which enable a safe and environmentally responsible way to dispose of unwanted medications – to individuals, organizations and healthcare providers upon request: please email AHD's Medical Director, Dr. Kim Luk, at kim.luk@vdh.virginia.gov.

City of Alexandria's Response

The Opioid Workgroup was convened in Alexandria City in 2015 to develop a coordinated, collaborative, local response to the epidemic. The Opioid Workgroup has members from the Department of Community Health Services (DCHS), Alexandria Health Department (AHD), Alexandria Police Department (APD), Alexandria Fire Department, Sheriff's Office, the Substance Abuse Prevention Coalition of Alexandria, Alexandria City Public Schools, Virginia Department of Corrections, Commonwealth Attorney's Office, and Inova Alexandria Hospital. The Workgroup is focusing on five priorities: opioid addiction prevention and education, overdose response and recovery, addiction treatment, diversion of people with addiction into treatment, and supply reduction and law enforcement strategies.

Photo: City of Alexandria Opioid Working Group 2017

Seated, left to right: Jennifer Miller (DCHS), Dr. Stephen Haering (AHD), Melissa Arons (AHD), Noraine Buttar (DCHS), Lisa Stapleton (Alexandria Probation and Parole). **Standing, left to right:** Dr. Martin Brown (Inova), Jon Teumer (DCHS), Susan Tatum (DCHS), Len Fouch (APD), Liz Wixson (DCHS), Allen Lomax (Substance Abuse Prevention Coalition of Alexandria), Kate Garvey (DCHS), Rawle Kelly (Alexandria Sherriff's Office), Joe Pankey (Alexandria Sheriff's Office), Gregg Ladislaw (APD).

Workgroup accomplishments:

- Developed online and print educational material for physicians and community members about the opioid epidemic nationally and locally, and local resources for prevention and treatment
- Increased local availability of Narcan – coordinated 18 REVIVE! Trainings and became the first Virginia Health District to make Narcan available for free, by appointment or walk-in basis, during all clinic hours
- Hosted two community events, and received two $50,000 grants to fund local opioid response.

- Became the first location in Virginia to participate in ODMAP to track suspected overdoses and deaths in real time using a mobile device application. The City also developed communication tools to notify the community and healthcare providers of spikes in a timely manner.
- Increased Department of Community and Human Services (DCHS) staff to improve capacity for treatment and detox. Please see the Local Addiction Recovery Resources below.
- Increased efforts by Alexandria Police to divert people with opioid addiction into treatment by training APD staff, responding along with EMS to every opioid overdose, and adopting policies aimed to help opioid users receive treatment as opposed to being charged
- Installed a permanent medication drop box at Del Ray Neighborhood Pharmacy
- For more information on the Alexandria City Opioid work group activities, including upcoming activities and ways that you and others can get involved, please visit: alexandriava.gov/Opioids

Call to Action: Minimize Risk of Opioid Abuse

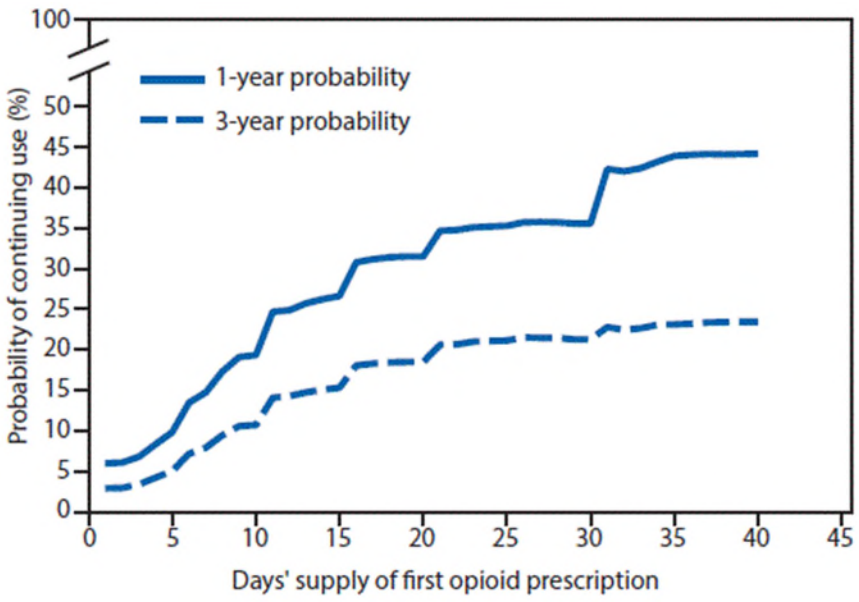
- When prescribing opioid medication, provide the lowest effective dose and only the quantity needed for the expected duration of pain
- Know the risk of opioid addiction by number of days of opioid prescription supply (Figure 5, next page)
- Use the Virginia Prescription Monitoring Program (PMP), a secure online system that provides licensed healthcare practitioners with 24/7 access to Schedule II through IV prescription history of patients receiving controlled substances. Use of the PMP helps to fight prescription drug abuse, insurance fraud, and the rising costs of healthcare.
- Know the Virginia Board of Medicine Prescribing Regulations (See Appendix)
- Reduce stigma around substance use disorder. Take a training to learn how to reduce stigma.

Talk with your patients

- Summarize the risks of taking opioids, including addiction, overdose, and death
- Discuss alternative pain treatment options, such as over the counter pain relievers, movement therapy, pain management specialists, and alternative modalities

The graph below, published in the CDC's March 2017 MMWR, presents the probability of continued opioid use based on the size of the patients first opioid prescription.

Figure 5: 1- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of days' supply of the first opioid prescription—United States, 2006-2015.



Did You Know...

Between 2007-2016

76%

of all fatal opioid overdoses in the City of Alexandria were due to prescription opioids*?

*excluding Fentanyl

Source: Virginia Department of Health, Office of the Chief Medical Examiner

Resources on Opioids for Providers and Patients

- ☐ Opioid and Pain Management CMEs/CEs (NIH)
- ☐ Clinical Resources (NIH)
- ☐ Use, Abuse, Misuse and Disposal of Prescription Pain Medication: Clinical Reference (ACPM)
- ☐ Opioid Overdose Toolkit: Information for Prescribers (SAMHSA)
- ☐ Recommendations for Physicians to help to End the Epidemic (AMA Opioid Task Force)
- ☐ List of Free Continuing Education Credit Courses for Opioid Education (Medical Society of Virginia)
- ☐ CDC Vital Signs-Opioid Prescribing
- ☐ VDH Opioid Addition in Virginia

Local Addiction Recovery Resources

Local Addiction Recovery Resources: Alexandria Community Services Board
2355A Mill Road, Alexandria, VA 22314

Treatment Services for Opioid and Other Substance Use Disorders	
• Methadone Treatment	703.746.3610
• Detoxification	703.746.3636
• Short-Term Residential	703.746.3636
• Outpatient Services	703.746.3600

Public Recovery Groups & Classes 703.746.3600
• SMART Recovery
• Understanding Recovery
• Alcohol Anonymous
• Cocaine Anonymous
• Marijuana Anonymous
• Narcotics Anonymous

Please visit www.vaaware.com for more information on state and local resources

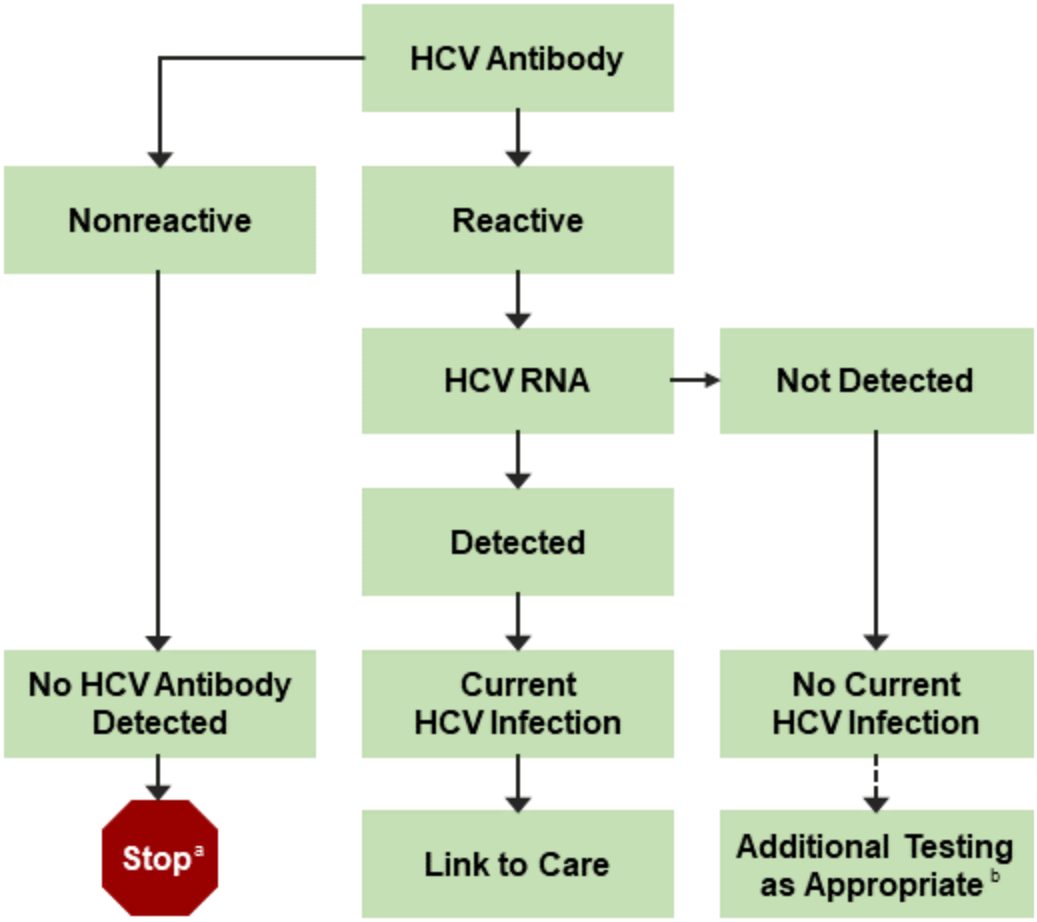
Hepatitis C

Consistent with national and Virginia trends, Alexandria experienced an increase in reported laboratory evidence of Hepatitis C (HCV) infection the past two years. Frequently, AHD receives HCV antibody screening results directly from laboratories without supplementary clinical information, but it is not possible to distinguish between acute and chronic HCV infection based on antibody results alone. Clinical information and follow-up laboratory results are essential to identify acute HCV infections. As HCV outbreaks often precede HIV outbreaks within high-risk populations, early detection of HCV is a crucial component of preventing future outbreaks.

We are asking providers to help us identify acute HCV cases that may be missed without additional reporting. Please:

- Perform additional laboratory testing according to the CDC testing guidelines (see Figure 6) and evaluation guidelines that can be found at www.hcvguidelines.org/.

Figure 6: Recommended Testing Sequence for Identifying Current HCV Infection



[a] For persons who might have been exposed to HCV within the past 6 months, testing for HCV RNA or follow-up testing for HCV antibody should be performed. For persons who are immunocompromised, testing for HCV RNA should be performed.
[b] To differentiate past, resolved HCV infection from biologic false positivity for HCV antibody, testing with another HCV-antibody assay may be considered. Repeat HCV-RNA testing if the person tested is suspected to have had HCV exposure within the past 6 months, has clinical evidence of HCV disease, or if there is concern regarding the handling or storage of the test specimen.
Adapted from Centers for Disease Control and Prevention (CDC), 2013 (CDC, 2013)

- Notify the health department of newly diagnosed cases of HCV by filling out an online morbidity report with clinical information (and testing rationale if no recent clinically compatible symptoms were present).

- Report abnormal Liver Function Testing results to AHD for patients with a newly positive antibody or other HCV laboratory result.
- Refer patients with HCV infection to a hepatitis specialist or link patients to treatment.

VDH provider resources for hepatitis, including a referral guide to local hepatitis specialists can be found at www.vdh.virginia.gov/disease-prevention/disease-prevention/viral-hepatitis/providers/.

Treatment of Patients with Confirmed HCV Infection

HCV-positive patients should have a liver function assessment, be evaluated for HCV treatment, and be offered hepatitis A and B vaccination if needed. More information on recommendations for testing, management, and treating HCV are available at www.hcvguidelines.org.

Treatment for HCV has advanced since the introduction of protease inhibitor therapy in 2011. Currently available therapies are able to produce a sustained virologic response (SVR) with no detectable virus after 12 weeks of treatment. Over 90% of HCV-infected persons can be cured of HCV infection within 8-12 weeks regardless of HCV genotype. For a complete list of FDA-approved therapies to treat Hepatitis C, prescribing information, and resource library for clinicians, please visit www.hepatitisc.uw.edu/page/treatment/drugs.

Rabies Exposures and Post-Exposure Prophylaxis (PEP)

Rabies is endemic in Alexandria. Anyone who has potentially been exposed to rabies is at risk of developing the fatal disease. In 2017, a Virginia resident died from rabies due to an international exposure. From 2013 – 2017, we have seen an increase in the number of residents reporting potential exposure to rabies and requiring prophylaxis in Alexandria (Table 3).

Table 3: Rabies Related Reports in Alexandria 2013-2017

Year	Reports to AHD of people potentially exposed to rabies	No. of people recommended PEP by AHD	No. of laboratory confirmed cases of animal rabies
2013	112	13	0
2014	143	24	0
2015	177	14	3
2016	222	24	0
2017	243	37	1

Alexandria Rabies Control in Action:

Alexandria Health Department works closely with the Animal Welfare League and Alexandria Animal Control. In fall 2017, residents reported a fox exhibiting strange behavior near an elementary school. Animal Control quickly caught the fox. Alexandria Health Department facilitated rabies testing, which found the fox tested positive for rabies. A big thank you to Animal Control for keeping the city safe!

Frequently Asked Questions about Rabies

What animals can get rabies?
Only mammals (including humans) get rabies. Birds, fish, reptiles, and amphibians cannot contract the disease. Wild animals frequently diagnosed with rabies include raccoons, skunks, and foxes. In specimens submitted to the Virginia Division of Consolidated Laboratories, rabies was detected most often in raccoons, skunks, and foxes.

How is rabies transmitted?
Rabies virus is found in the saliva and brain/nervous system tissue of a rabid animal. Rabies can be transmitted through a bite, or by getting saliva, or brain tissue in one's eyes, nose, mouth, or in an open wound.

What is considered an "exposure" to rabies?
A **bite exposure** occurs any time the skin is penetrated by the teeth of an animal. A **non-bite exposure** includes the contamination of open wounds, abrasions, mucous membranes, or scratches with saliva or brain tissue from an infected animal. Other contact - with blood, urine, feces, or skin/fur of a rabid animal - does not constitute an exposure.

Where can I refer a patient who needs rabies PEP?
Rabies PEP is available at all local hospital emergency departments.

What if I have questions about whether or not a person should receive rabies PEP or if they have had an exposure?
Please call AHD CD Division at 571.259.8549 for consultation if you have ANY questions about potential exposure to rabies or questions about rabies PEP.

Who is required to report animal bites in Alexandria?
City of Alexandria Code states that, "it shall be the duty of *every physician and medical practitioner* in the City and of every hospital in the City to report to an animal control officer or the health department the name and address of any person treated for bites or wounds inflicted by animals, together with all available information necessary for rabies control." Code of Alexandria Sec. 5-7-40.

Reportable Disease List: Information for Healthcare Providers

Mandatory Disease Reporting

Clinicians practicing in Virginia are required by law to report the following conditions to their local health department. Timely reporting ensures prompt and appropriate public health action. If you have any questions about mandated reporting, please contact us. (Please consider printing this page and posting at your work stations).

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment
www.vdh.virginia.gov

VIRGINIA REPORTABLE DISEASE LIST

For Healthcare Providers

Reporting of the following diseases is required by state law (Sections 32.1-36 and 32.1-37 of the *Code of Virginia* and 12 VAC 5-90-80 and 12 VAC 5-90-90 of the Board of Health *Regulations for Disease Reporting and Control.)* Reports may be by computer-generated printout, Epi-1 form, CDC or VDH surveillance form, or upon agreement with VDH, by means of secure electronic transmission.

Report all conditions **when suspected or confirmed** to Alexandria Health Department Communicable Disease Division

Healthcare providers call 571-259-8549 for diseases listed "Report Immediately" below

REPORT IMMEDIATELY

Anthrax [a]
Botulism [a]
Brucellosis [a]
Cholera [a]
Coronavirus infection, severe (e.g., SARS-CoV, MERS-CoV) [a]
Diphtheria [a]
Disease caused by an agent that may have been used as a weapon
Haemophilus influenzae infection, invasive [a]
Hepatitis A [a]
Influenza-associated deaths <18 years of age
Influenza A, novel virus [a]
Measles (Rubeola) [a]
Meningococcal disease [a]
Outbreaks, all (including but not limited to foodborne, healthcare-associated, occupational, toxic substance-related, and waterborne)
Pertussis [a]
Plague [a]
Poliovirus infection, including poliomyelitis [a]
Psittacosis [a]
Q fever [a]
Rabies, human and animal [a]
Rubella [a], including congenital rubella syndrome [a]
Smallpox (Variola) [a]
Syphilis, primary and secondary [a]
Tuberculosis (TB), active disease [a,b]
Tularemia [a]
Typhoid/Paratyphoid fever [a]
Unusual occurrence of disease of public health concern
Vaccinia, disease or adverse event [a]
Vibrio infection [a]
Viral hemorrhagic fever [a]
Yellow fever [a]

LEGEND

[a] Reportable by directors of laboratories. These and all other conditions listed must be reported by physicians and directors of medical care facilities.
[b] Laboratories report AFB, mycobacterial identification, and drug susceptibility for *M. tuberculosis*
[c] Laboratories that use EIA without a positive culture should forward positive stool specimens or enrichment broth to DCLS
[d] Physicians and directors of medical care facilities report influenza by number of cases only (report total number per week and by type of influenza, if known); however, individual cases of influenza A novel virus or influenza-related deaths in persons <18 must be reported immediately

REPORT WITHIN 3 DAYS

Acquired immunodeficiency syndrome (AIDS)
Amebiasis [a]
Arboviral infections (e.g., CHIK, dengue, EEE, LAC, SLE, WNV, Zika) [a]
Babesiosis [a]
Campylobacteriosis [a]
Chancroid [a]
Chickenpox (Varicella) [a]
Chlamydia trachomatis infection [a]
Creutzfeldt-Jakob disease <55 years of age [a]
Cryptosporidiosis [a]
Cyclosporiasis [a]
Ehrlichiosis/Anaplasmosis [a]
Escherichia coli infection, Shiga toxin-producing [a,c]
Giardiasis [a]
Gonorrhea [a]
Granuloma inguinale
Hantavirus pulmonary syndrome [a]
Hemolytic uremic syndrome (HUS)
Hepatitis B (acute and chronic) [a]
Hepatitis C (acute and chronic) [a]
Hepatitis, other acute viral [a]
Human immunodeficiency virus (HIV) infection [a]
Influenza [a,d]
Lead, reportable levels [a]
Legionellosis [a]
Leprosy (Hansen's disease)
Leptospirosis [a]
Listeriosis [a]
Lyme disease [a]
Lymphogranuloma venereum
Malaria [a]
Mumps [a]
Ophthalmia neonatorum
Rabies treatment, post-exposure
Salmonellosis [a]
Shigellosis [a]
Spotted fever rickettsiosis [a]
Staphylococcus aureus infection, vancomycin-intermediate or vancomycin-resistant [a]
Streptococcal disease, Group A, invasive or toxic shock [a]
Streptococcus pneumoniae infection, invasive, <5 years of age [a]
Syphilis, other than primary and secondary
Tetanus
Toxic substance-related illness [a]
Trichinosis (Trichinellosis) [a]
Tuberculosis (TB) infection <4 years of age
Yersiniosis [a]

Effective October 20, 2016

Alexandria Health Department Communicable Disease Division
Report Immediately: 571-259-8549
General Inquiries: 703-746-4951
Fax: 703-746-4953

Revised by Alexandria Health Department October, 2016

Reporting to Alexandria Health Department

Notable changes to Reporting Processes and the Reportable Disease List for 2017

Online Reporting Option

Historically, providers were required to submit notification of reportable conditions via completing and faxing a morbidity report form (Epi-1 form). **VDH now provides the option to submit a confidential morbidity report through an online portal.**

Reporting Neonatal Abstinence Syndrome

The 2017 Virginia General Assembly passed House Bill 1467, which requires the State Board of Health to add Neonatal Abstinence Syndrome (NAS) to the list of conditions that must be reported to local health departments. As of November 27, 2017, Virginia physicians and medical care facility directors must report all newborns diagnosed with NAS, a condition characterized by clinical signs of withdrawal from exposure to prescribed or illicit drugs. Reports should be submitted within one month of diagnosis via VDH's online confidential morbidity report form.

Reporting of NAS to the health department is for public health surveillance purposes only and will not lead to a referral for services. Providers are still also required to report all cases of NAS to the Virginia Department of Social Services (DSS) per §63.2-1509 of the Code of Virginia.

Contact Information for Disease Reporting

For diseases listed Report Immediately	For diseases listed Report Within 3 Days
Timeframe: Report immediately by the most rapid means available **Report Method:** Phone *Monday – Friday (8 a.m. – 5 p.m.)* Office phone: 703.746.4951 *Evenings and Weekends (24/7):* Cell phone: 571.259.8549	**Timeframe:** Submit form within 3 days of suspected or confirmed diagnosis **Electronic Report Form:** Epi-1 form **Report Method:** Phone, fax, or mail *Monday – Friday (8 a.m. – 5 p.m.)* Office phone: 703.746.4951 Fax: 703.746.4953 Mail: Alexandria Health Department Attn: Communicable Disease 4480 King Street Alexandria, VA 22302

Reporting and Lab Testing – Common Questions

Q. Do I need to report cases of chickenpox that I see in my practice?

A: Yes. Providers must report both clinically diagnosed and laboratory confirmed cases of chickenpox. Reporting helps CDC track chickenpox incidence and vaccine breakthrough.

Q: If I suspect mumps, should I order a lab test?

A: Yes. Many viruses can cause parotitis, therefore, it is important to either confirm or rule out mumps by lab testing. Alexandria Health Department can provide testing kits and facilitate testing at our state public health laboratory if patients meet the clinical criteria for mumps. Please contact us at 703.746.4951 if mumps is suspected.

Q: What are the best lab tests for mumps?

A: The recommended lab tests for mumps are molecular testing (PCR[4]) of a buccal swab collected within 72 hours of onset of parotitis and serology. After 72 hours, only serology is recommended.

Q: What testing should I do if I suspect my patient has whooping cough?

A: Physicians should only test patients with signs and symptoms consistent with pertussis. The gold standard for diagnosing pertussis remains isolation of *B. pertussis* by bacterial culture. PCR testing is also useful for diagnosis as well as commercial serologic tests (especially later in the illness). Specimens for culture and PCR testing should be obtained from the posterior nasopharynx by aspiration or swabbing. Throat swabs and anterior nasal swabs are not recommended since they have unacceptably low rates of recovery. All swab tips should be polyester; options may include Dacron®, rayon, or nylon-flocked. You should never use cotton-tipped or calcium alginate swabs. For more information, please consult the APHL brochure about Pertussis Diagnostics.

Contact the Health Department if you ***suspect*** a reportable disease such as mumps, measles, B. *pertussis*, an outbreak, or unusual occurrence of public health concern by calling 571-259-8549. Healthcare providers are the foundation of disease surveillance in our community.
NOTE*: This phone is **only** for healthcare providers and government officials.*

How to Report

Reports should be directed to the patient's local health department based on patient's home address and should include:

- ☐ Patient's name
- ☐ Home address
- ☐ Phone number
- ☐ Date of birth
- ☐ Date of Diagnosis
- ☐ Date of symptom onset
- ☐ Reports can be made by phone at 703.746.4951 or by filling out an online confidential morbidity report.
- ☐ Physicians are required to call 571-259-8549 to report all rapidly reportable conditions within 24 hours.

We encourage you to report suspected cases to the Health Department immediately so we can:

1) Provide guidance on lab testing

2) Offer infection control recommendations

3) Start a public health investigation right away

4) Facilitate sending specimens to the state public health laboratory for specialized testing, if necessary

[4] PCR-polymerase chain reaction

Additional Resources for Healthcare Professionals

Public Health Services

Alexandria Health Department provides many services to the community. An overview of our services - including program descriptions, locations, phone numbers, and hours of operation - is available in our *Guide to Services and Programs* (English and En Español).

Information about AHD clinical and public health nursing services is also available online.

Free Training Opportunities

AHD epidemiologists provide disease-specific infection control and prevention training. If you are interested in training or an in-service for your staff in these areas, please contact us at 703.746.4951 or alex_epi@vdh.virginia.gov.

Urgent updates from the State Health Commissioner, training opportunities and best practices: vdh.state.va.us/clinicians/

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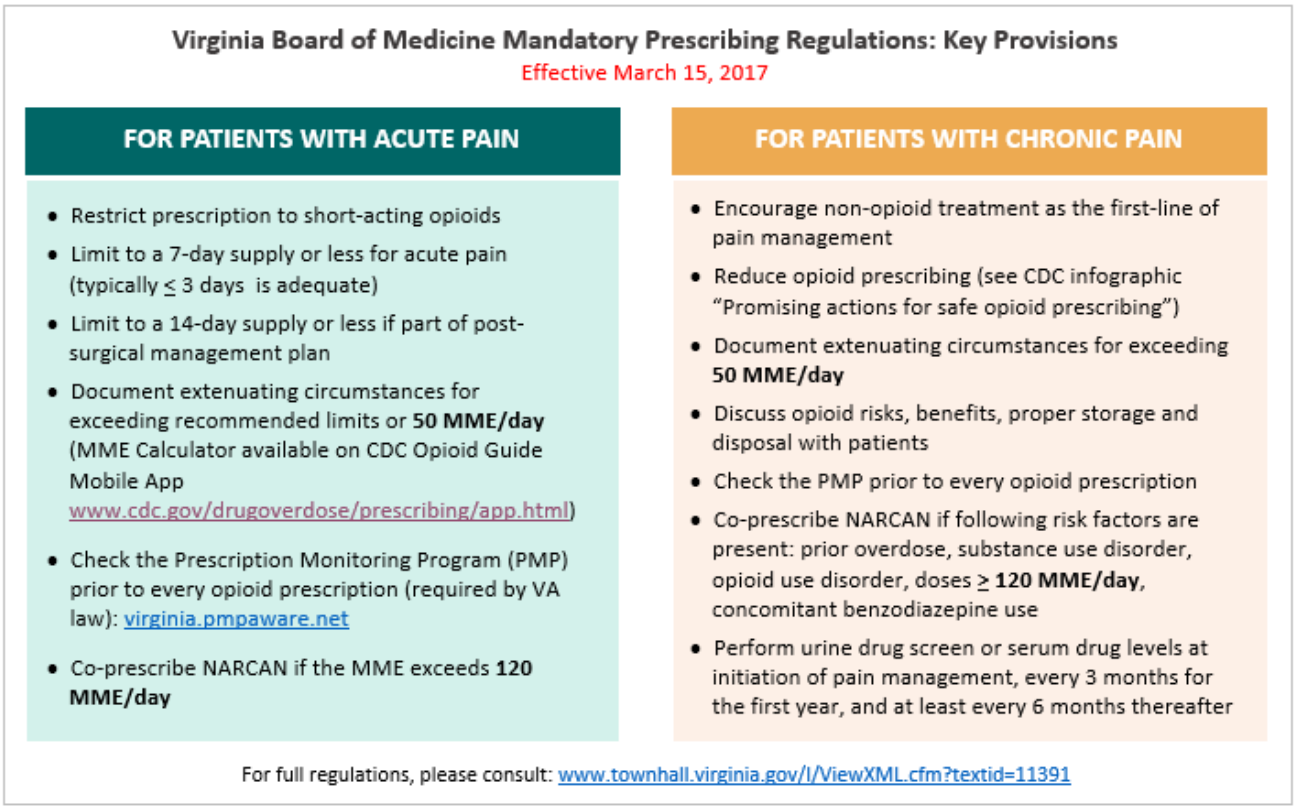
Appendix

CDC 2015 STD Screening and Treatment Guidelines

Screening Recommendations and Considerations Referenced in the 2015 STD Treatment Guidelines and Original Sources

	Women	Pregnant Women	Men	Men Who Have Sex With Men (MSM)	Persons with HIV
CHLAMYDIA	Sexually active women under 25 years of age *USPSTF*[1] Sexually active women aged25 years and older if at increased risk[2] *USPSTF*[1] Retest approximately 3 months after treatment *CDC*[3]	All pregnant women under 25 years of age *USPSTF*[1] Pregnant women, aged 25 years and older if at increased risk[2] *USPSTF*[1] Retest during the 3rd trimester for women under 25 years of age or at risk[4] *CDC*[3] Pregnant women with chlamydial infection should have a test-of-cure 3-4 weeks after treatment and be retested within 3 months *USPSTF*[1]	*Consider screening young men in high prevalence clinical settings[5] or in populations with high burden of infection (e.g. *CDC*[6]	At least annually for sexually active MSM at sites of contact (urethra, rectum) regardless of condom use *CDC*[6] Every 3 to 6 months if at increased risk[7] *CDC*[7]	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter *CDC*[8] More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology *CDC*[8]
GONORRHEA	Sexually active women under 25 years of age *USPSTF*[1] Sexually active women age 25 years and older if at increased risk[9] *USPSTF*[1] Retest 3 months after treatment *CDC*[10]	All pregnant women under 25 years of age and older women if at increased risk[11] *USPSTF*[1] Retest 3 months after treatment *CDC*[10]		At least annually for sexually active MSM at sites of contact (urethra, rectum, pharynx) regardless of condom use *CDC*[10] Every 3 to 6 months if at increased risk[7] *CDC*[7]	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter *CDC*[10] More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology *CDC*[10]
SYPHILIS		All pregnant women at the first prenatal visit *USPSTF*[11] Retest early in the third trimester and at delivery if		At least annually for sexually active MSM *CDC*[13] Every 3 to 6 months if at increased risk[7]	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter *CDC, HRSA, IDSA, NIH*[14,15,16]

Virginia Board of Medicine Prescribing Guidelines



Virginia Board of Medicine Mandatory Prescribing Regulations: Key Provisions

Effective March 15, 2017

FOR PATIENTS WITH ACUTE PAIN

- Restrict prescription to short-acting opioids
- Limit to a 7-day supply or less for acute pain (typically ≤ 3 days is adequate)
- Limit to a 14-day supply or less if part of post-surgical management plan
- Document extenuating circumstances for exceeding recommended limits or **50 MME/day** (MME Calculator available on CDC Opioid Guide Mobile App www.cdc.gov/drugoverdose/prescribing/app.html)
- Check the Prescription Monitoring Program (PMP) prior to every opioid prescription (required by VA law): virginia.pmpaware.net
- Co-prescribe NARCAN if the MME exceeds **120 MME/day**

FOR PATIENTS WITH CHRONIC PAIN

- Encourage non-opioid treatment as the first-line of pain management
- Reduce opioid prescribing (see CDC infographic "Promising actions for safe opioid prescribing")
- Document extenuating circumstances for exceeding **50 MME/day**
- Discuss opioid risks, benefits, proper storage and disposal with patients
- Check the PMP prior to every opioid prescription
- Co-prescribe NARCAN if following risk factors are present: prior overdose, substance use disorder, opioid use disorder, doses ≥ **120 MME/day**, concomitant benzodiazepine use
- Perform urine drug screen or serum drug levels at initiation of pain management, every 3 months for the first year, and at least every 6 months thereafter

For full regulations, please consult: www.townhall.virginia.gov/l/ViewXML.cfm?textid=11391

Additional Resources

1. Centers for Disease Control Case Definitions: wwwn.cdc.gov/nndss/case-definitions.html
2. VDH Division of Disease Prevention's (DDP) annual reports: www.vdh.virginia.gov/disease-prevention/disease-prevention/hiv-aids-sexually-transmitted-disease-std-hepatitis-reports/
3. Centers for Disease Control STI Resources: www.cdc.gov/std/default.htm
4. Centers for Disease Control STI recommendations: www.cdc.gov/std/treatment/
5. Online Portal for Disease Reporting: redcap.vdh.virginia.gov/redcap/surveys/?s=4HRC9Y484A
6. US Public Health Service PrEP guidance: www.cdc.gov/hiv/pdf/guidelines/PrEPProviderSupplement2014.pdf
7. ADAP - AIDS Drug Assistance Program: www.vdh.virginia.gov/ADAP
8. Neighborhood Health Services: www.neighborhoodhealthva.org/
9. NOVA Regional Commission HIV Services: www.novaregion.org/377/HIV-Resources-Project
10. ODMAP: www.hidta.org/odmap/
11. Description of Virginia's Prescription Drug Monitoring Program: www.dhp.virginia.gov/dhp_programs/pmp/docs/PMPBrochure.pdf
12. Opioid and Pain Management Continuing Medical Education: www.drugabuse.gov/opioid-pain-management-cmesces
13. Opioid Clinician Resources from the National Institutes of Health: www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/other-opioid-prescribing-resources
14. American College of Preventive Medicine Clinical Reference for the Use, Abuse, Misuse, and Disposal of Prescription Pain Medication: www.acpm.org/?UseAbuseRxClinRef

15. Substance Abuse and Mental Health Services Administration-Opioid Overdose Toolkit: Information for Prescribers: store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2016/All-New-Products/SMA16-4742
16. American Medical Association Opioid Task Force. Recommendations for Physicians to help end the Epidemic: www.end-opioid-epidemic.org/
17. Medical Society of Virginia. List of Free Continuing Education Credit Courses for Opioid Education: www.msv.org/sites/default/files/opioid_ce_list.final_.pdf
18. CDC Vital Signs - Opioid Prescribing: www.cdc.gov/vitalsigns/opioids/index.html
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