



NC Department of Health and Human Services

NC Opioid and Prescription Drug Abuse Advisory Committee (OPDAAC)

March 7, 2019

Welcome and Introductions of Attendees

Alan Dellapenna, Head, Injury and Violence Prevention Branch, Chronic Disease and Injury Section, Division of Public Health

Dr. Carrie Brown, Medical Director, Division of Mental Health, Developmental Disabilities & Substance Abuse Services

- *Take breaks as needed*

More Powerful Campaign

Laura Brewer

More Powerful NC

MORE POWERFUL

Creative

MORE POWERFUL

MORE POWERFUL

Anthem Video

Toolkits

MORE POWERFUL

Get the Facts

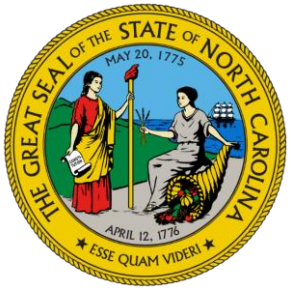
Get Involved

Get Help

MORE POWERFUL

Leadership and Funding Coalition

MORE POWERFUL



Public Schools of North Carolina
State Board of Education
Department of Public Instruction

operation medicine drop

GOVERNOR'S INSTITUTE

Atrium Health

www.MorePowerfulNC.org

MORE POWERFUL

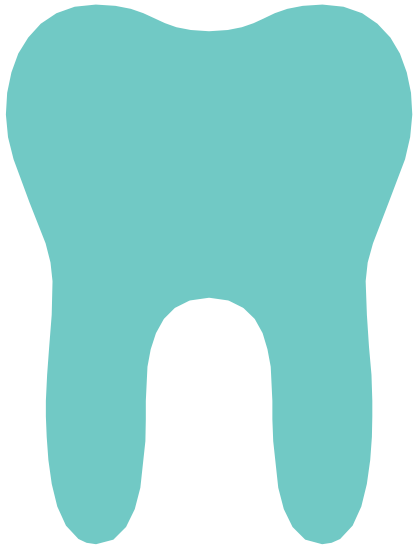
Spotlight: The Role of Dentists in the Opioid Epidemic

Overview of NC's Dental Action Plan

Anna Stein

NC DENTAL OPIOID ACTION PLAN

2018-2021



ADA Statements on Opioids (2016, 2018)

The American Dental Association (ADA) recommends that dentists:

- Follow CDC guidelines for opioid prescribing
- Use nonsteroidal anti-inflammatory analgesics as first-line therapy for acute pain
- Check the state prescription drug monitoring program when prescribing opioids
- Discuss opioid safety, storage and disposal with patients
- Participate in continuing education on opioid prescribing

Many dental health organizations in NC are working to address the opioid overdose epidemic….

North Carolina Caring Dental Professionals
When You Need Someone to Care…

NORTH CAROLINA DENTAL SOCIETY

East Carolina University
SCHOOL OF DENTAL MEDICINE

North Carolina Society of Oral and Maxillofacial Surgeons

NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

OLD NORTH STATE DENTAL SOCIETY

NORTH CAROLINA ORAL HEALTH

UNC DENTISTRY

north carolina ncapd academy of pediatric dentistry

adha North Carolina Dental Hygienists' Association

NCDAA

NC Opioid Action Plan Focus Areas

The NC Dental Opioid Action Plan aligns with the NC Opioid Action Plan to implement complementary strategies in the following focus areas:

1. Create a coordinated infrastructure
2. Reduce oversupply of prescription opioids
3. Reduce diversion of prescription drugs and flow of illicit drugs
4. Increase community awareness and prevention
5. Expand treatment and recovery oriented systems of care
6. Measure our impact and revise strategies based on results

1. Coordinated Infrastructure

Strategy	Action	Leads
Leadership	Convene stakeholders to lead implementation of the NC Dental Opioid Action Plan	OPDAAC Dental Workgroup, DPH Oral Health Section, DPH IVP Branch

2. Reduce oversupply of prescription drugs

Strategy	Action	Leads
Safe prescribing policies	Create and maintain continuing education opportunities and resources for practicing dentists with an emphasis on safer pain management and preventing drug overdoses, substance use disorders, and diversion	NCBDE, NCDS, NCSOMS, NCDHA, UNC, ECU
	Offer training in all dental, dental hygiene, and dental assistant schools on safer pain management and preventing drug overdoses, substance use disorders, and diversion	ECU, UNC, NCDHA, NCDAA
CSRS utilization	Register 100% of eligible dental prescribers in NC CSRS	NCBDE, DHHS
	Report CSRS data to NC dental board so it can investigate aberrant prescribing behaviors and lack of compliance with the STOP Act [pursuant to NCGS 90-113.74(b1)(1a)&(2)]	NCBDE, DHHS
Medicaid and commercial payer policies	Support coverage of non-opioid modalities for management of acute postoperative pain (e.g., Exparel)	NSOMS, DHHS, UNC
Special population: Youth	Reduce the number of opioid prescriptions for youth (e.g., codeine to children, opioids for third molar extraction)	NCSOMS, NCAPD, UNC

3. Reduce Diversion and Flow of Illicit drugs

Strategy	Action	Leads
Electronic prescribing	Establish technology frameworks to facilitate electronic prescribing for all controlled substances by 2020	NCBDE, NCDS, UNC
Dental personnel diversion prevention	Implement model diversion prevention protocols within dental school clinics and dental practices	UNC, NCDS
Drug takeback, disposal, and safe storage	Educate patients on safe storage and disposal of opioids	DHHS, NCDS, NCDHA, UNC

4. Increase Community Awareness and Prevention

Strategy	Action	Leads
Patient education campaign	Launch or promote an education campaign about safe pain management, the efficacy of non-opioid pain modalities, and safe storage and disposal of opioids. Consider coordinating with DHHS statewide messaging campaigns (e.g. CDC R_x Awareness or SAMHSA's Lock Your Meds campaigns)	DHHS, NCBDE, NCDS, NCDHA, UNC, ECU

5. Expand Treatment Access and Recovery Supports

Strategy	Action	Leads
Care linkages	Encourage coordination with pain specialists when prescribing opioids for management of chronic orofacial pain	NCDS, NCSOMS, UNC
	Link patients screened at risk for SUD to services	ECU, UNC
Employee protection	Train dental practice employees in recognizing the signs and symptoms of drug addiction and how to intervene or assist members of the dental profession	NCCDP, NCDS, ONSDS, NCDHA, UNC, ECU
Support recovery	Utilize best practices in pain management options to prevent exacerbation of or relapse of opioid use disorders among people with OUD or in recovery for OUD	UNC

6. Measure Impact

Strategy	Action	Leads
Metrics/Data	Create a data dashboard of key metrics	DPH IVP, UNC
Research/ Evaluation	Establish an opioid research agenda among NC dental schools and academic research institutions to inform future and evaluate existing work	UNC

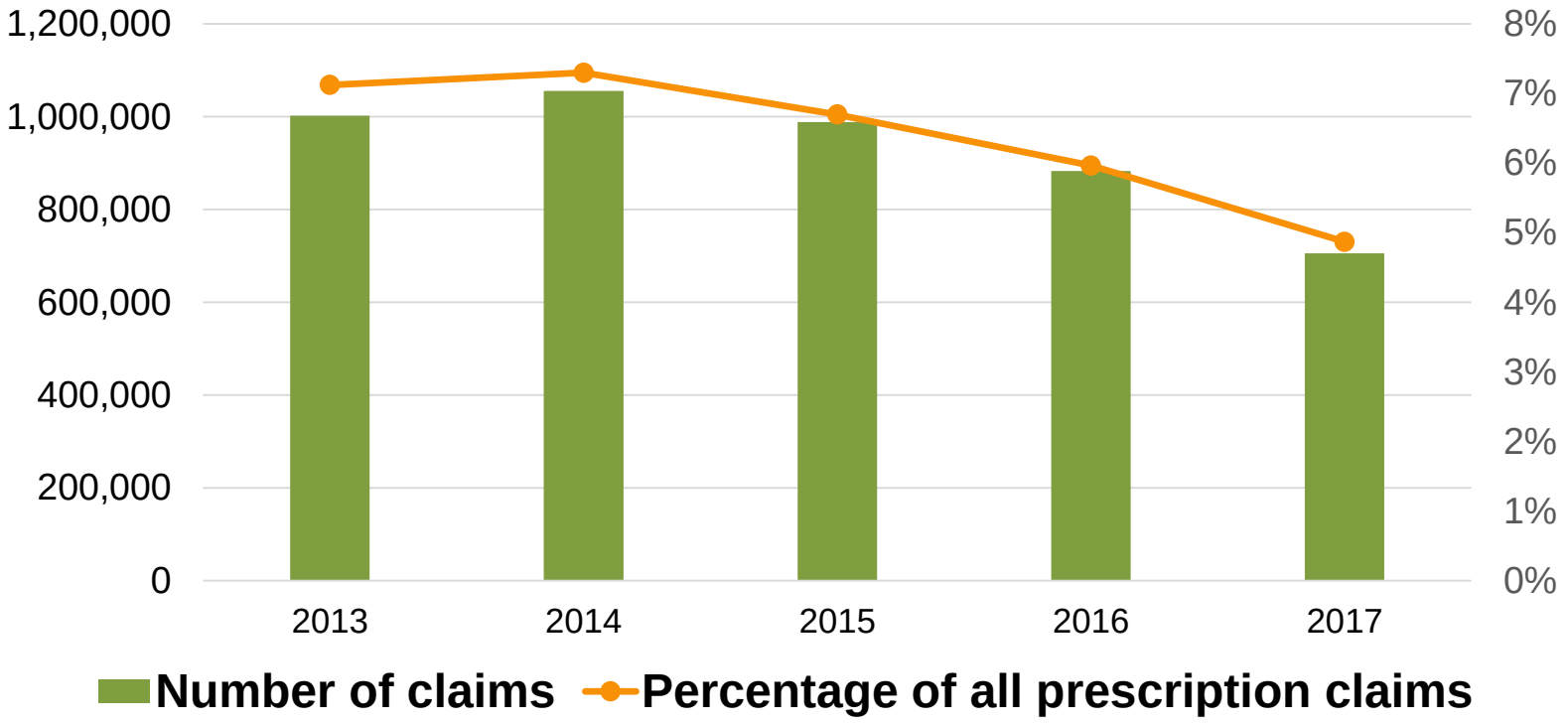
Acronyms

- **CDC**: Centers for Disease Control and Prevention
- **CSRS**: Controlled Substances Reporting System
- **DHHS**: Department of Health and Human Services
- **DPH**: Division of Public Health
- **ECU**: East Carolina University School of Dental Medicine
- **IVP**: Injury and Violence Prevention Branch
- **NC**: North Carolina
- **NCAPD**: NC Academy of Pediatric Dentistry
- **NCBDE**: NC Board of Dental Examiners
- **NCCDP**: NC Caring Dental Professionals
- **NCDAA**: NC Dental Assistants Association
- **NCDHA**: NC Dental Hygienists' Association
- **NCDS**: NC Dental Society
- **NCSOMS**: NC Society of Oral and Maxillofacial Surgeons
- **ONSDS**: Old North State Dental Society
- **OPDAAC**: Opioid and Prescription Drug Abuse Advisory Committee
- **SUD**: Substance Use Disorder
- **UNC**: University of North Carolina at Chapel Hill School of Dentistry

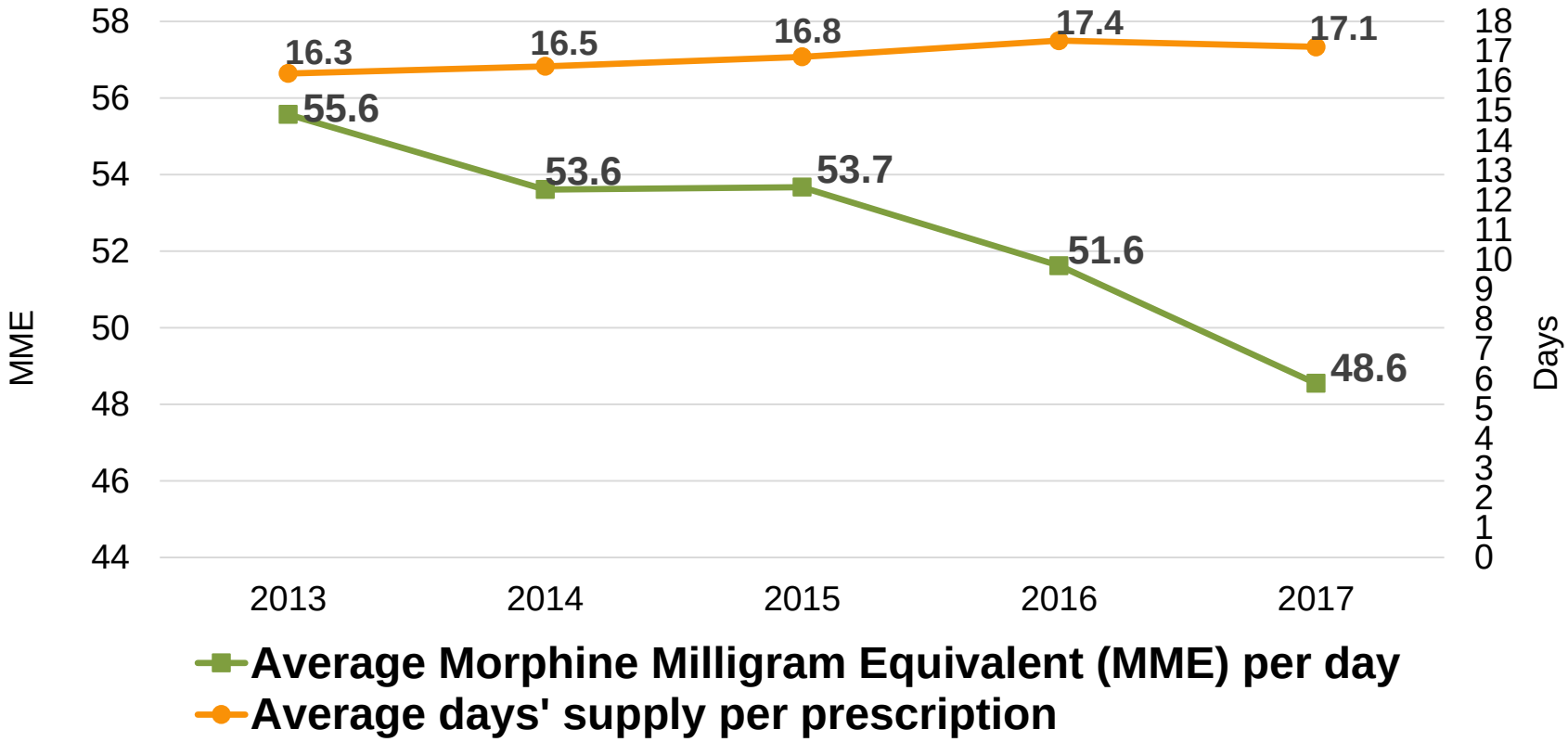
Opioid Prescribing and Utilization in NC Medicaid

Aaron McKethan

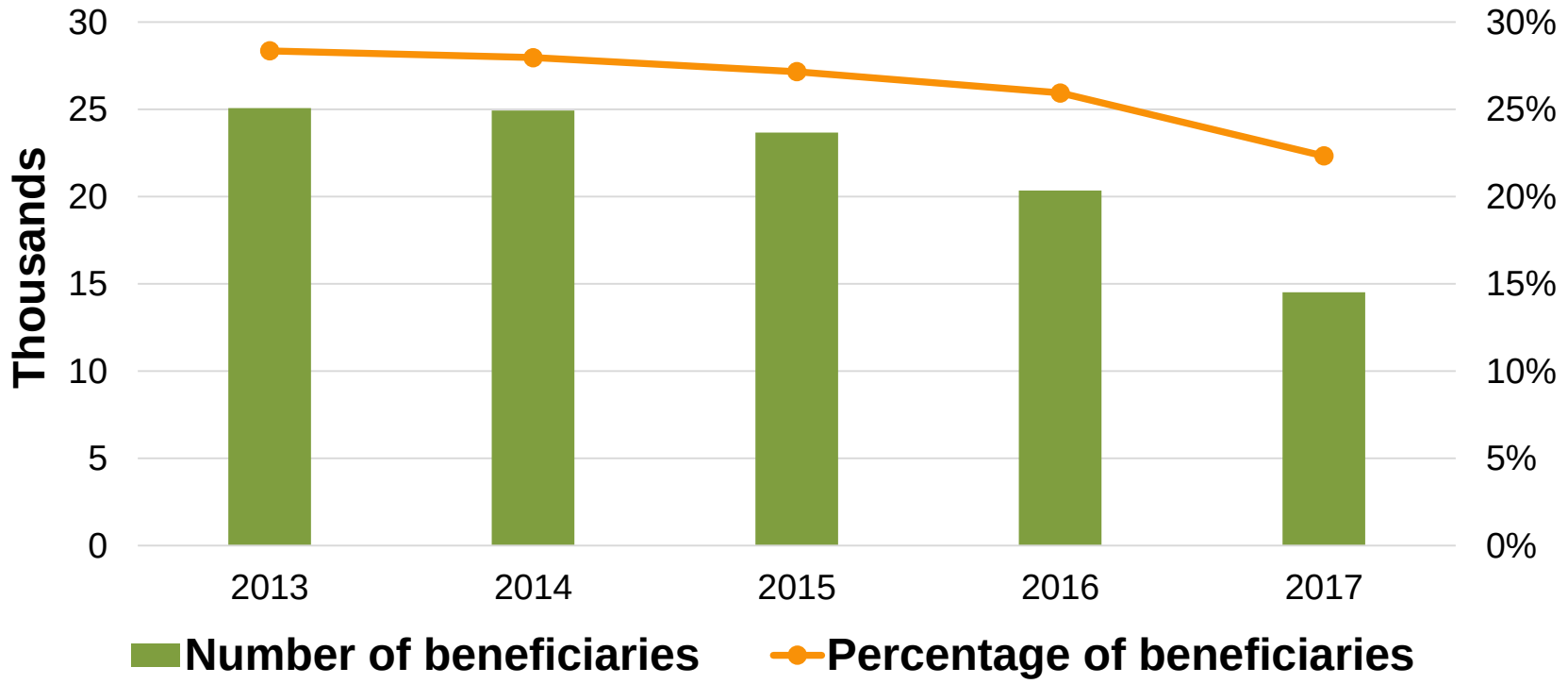
Number of opioid prescription claims and percentage of all NC Medicaid prescription claims that are opioids (2013-2017)



Average morphine milligram equivalents (MME) per day and average days supply per prescription in NC Medicaid (2013-2017)



Number and percentage of NC Medicaid beneficiaries 18 to 64 years old with concurrent use of prescription opioids and benzodiazepines, 2013-2017



Measuring the quality of "new opioid starts" in NC Medicaid (1 of 2)

Opioid prescriptions:

- Time period: filled between 2013 and 2017
- Eligibility: Medicaid beneficiaries who were continuously enrolled in Medicaid for one year prior to their first opioid prescription
- Exclusions: beneficiaries > 65 and beneficiaries with cancer or hospice claims
- Outcomes: *next slide*

HEALTH AFFAIRS BLOG

RELATED TOPICS:
QUALITY OF CARE | MEDICAID | MEDICARE SAVINGS PROGRAMS | QUALITY ASSESSMENT | BENEFICIARIES | PERFORMANCE MEASURES | QUALITY MEASUREMENT | EMERGENCY DEPARTMENTS | CLAIMS DATA | CANCER

Measuring The Quality Of New Opioid Prescriptions: New Performance Measures Are Needed

Aaron McKethan, Hilary Campbell, Scott Proescholdbell, Lu Xu, Azalea Kim, Lawrence Greenblatt

NOVEMBER 26, 2018 10.1377/hblog20181116.776800

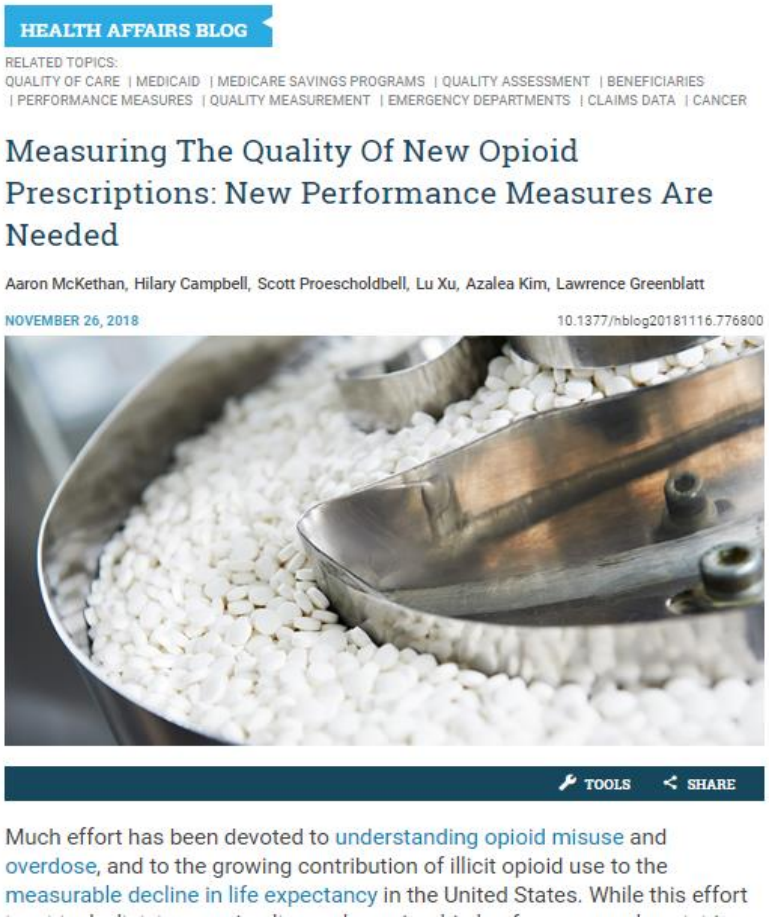
TOOLS SHARE

Much effort has been devoted to understanding opioid misuse and overdose, and to the growing contribution of illicit opioid use to the measurable decline in life expectancy in the United States. While this effort

Measuring the quality of “new opioid starts” in NC Medicaid (2 of 2)

Outcomes:

- Was an immediate-release, short-acting (not extended-release or long-acting) formulation.
- Did not overlap with a benzodiazepine dispensed within the 30 days preceding the new opioid claim.
- Began with a low dosage defined as:
  - Less than 50 MME per day or
  - Less than 25 MME per day.
- Started with a brief duration defined as:
  - Less than or equal to seven days’ supply or
  - Less than or equal to three days’ supply.



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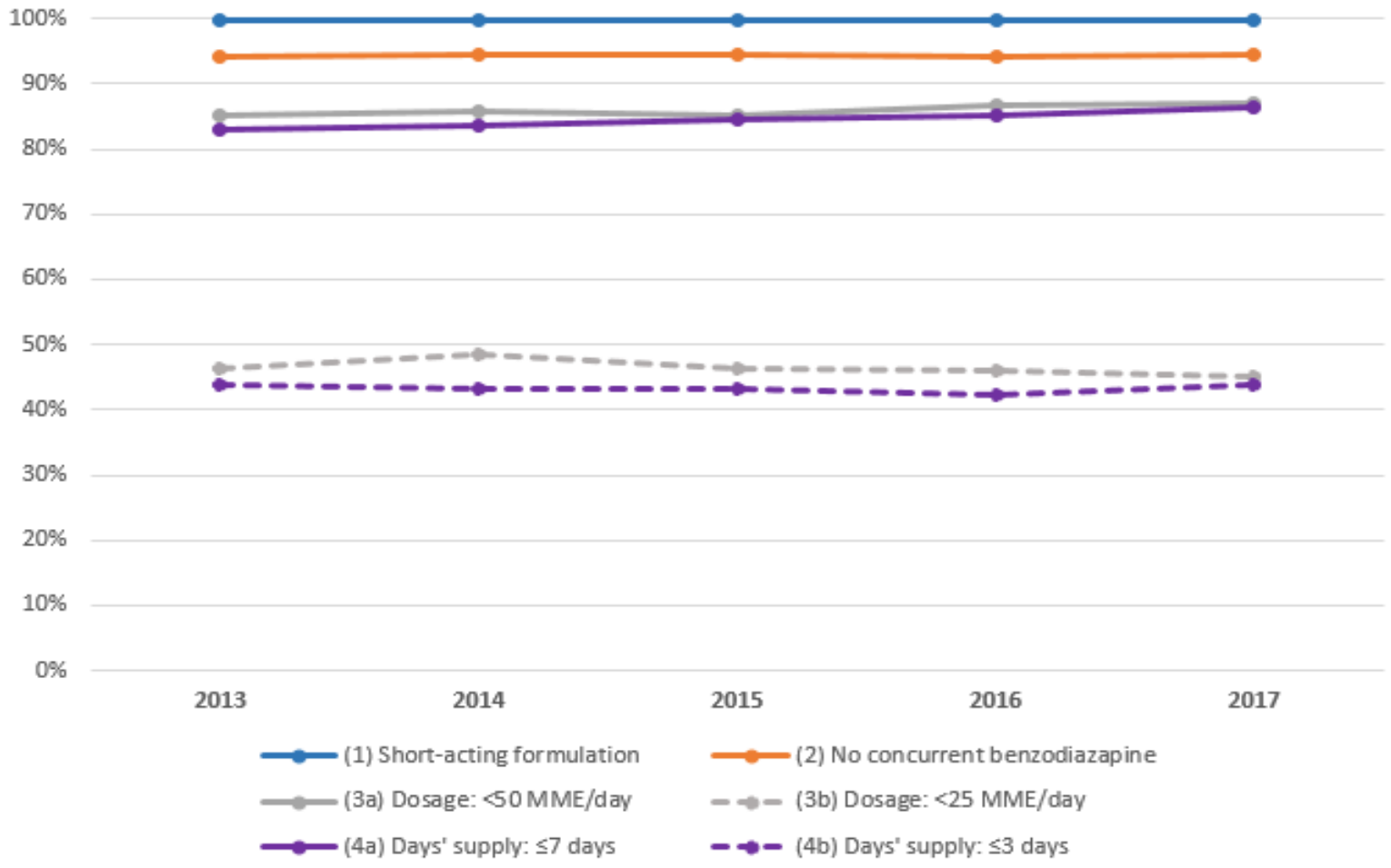
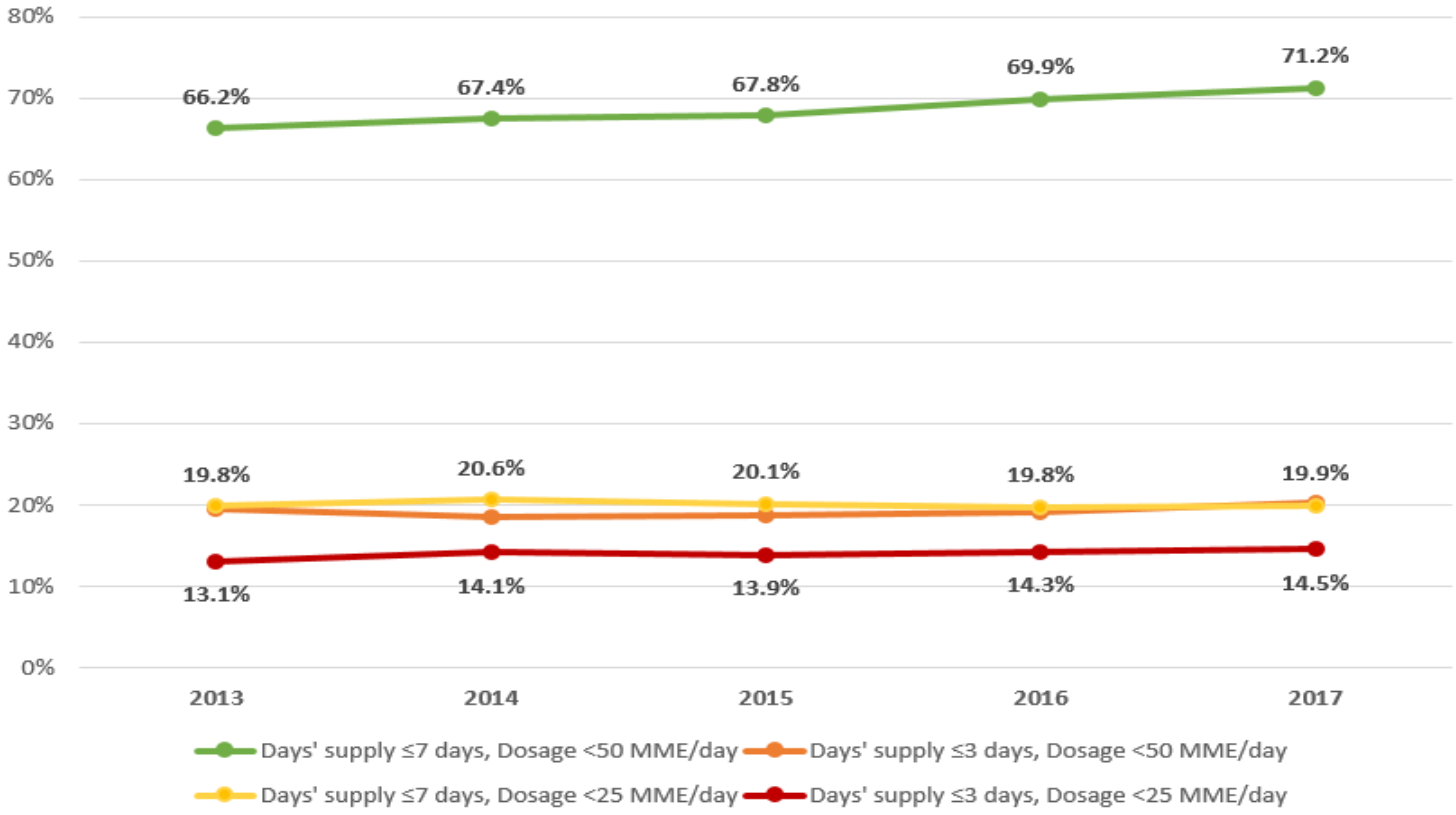
Percentage Of New Opioid Prescriptions in NC Medicaid Meeting Each Prescribing Criterion (2013–17)



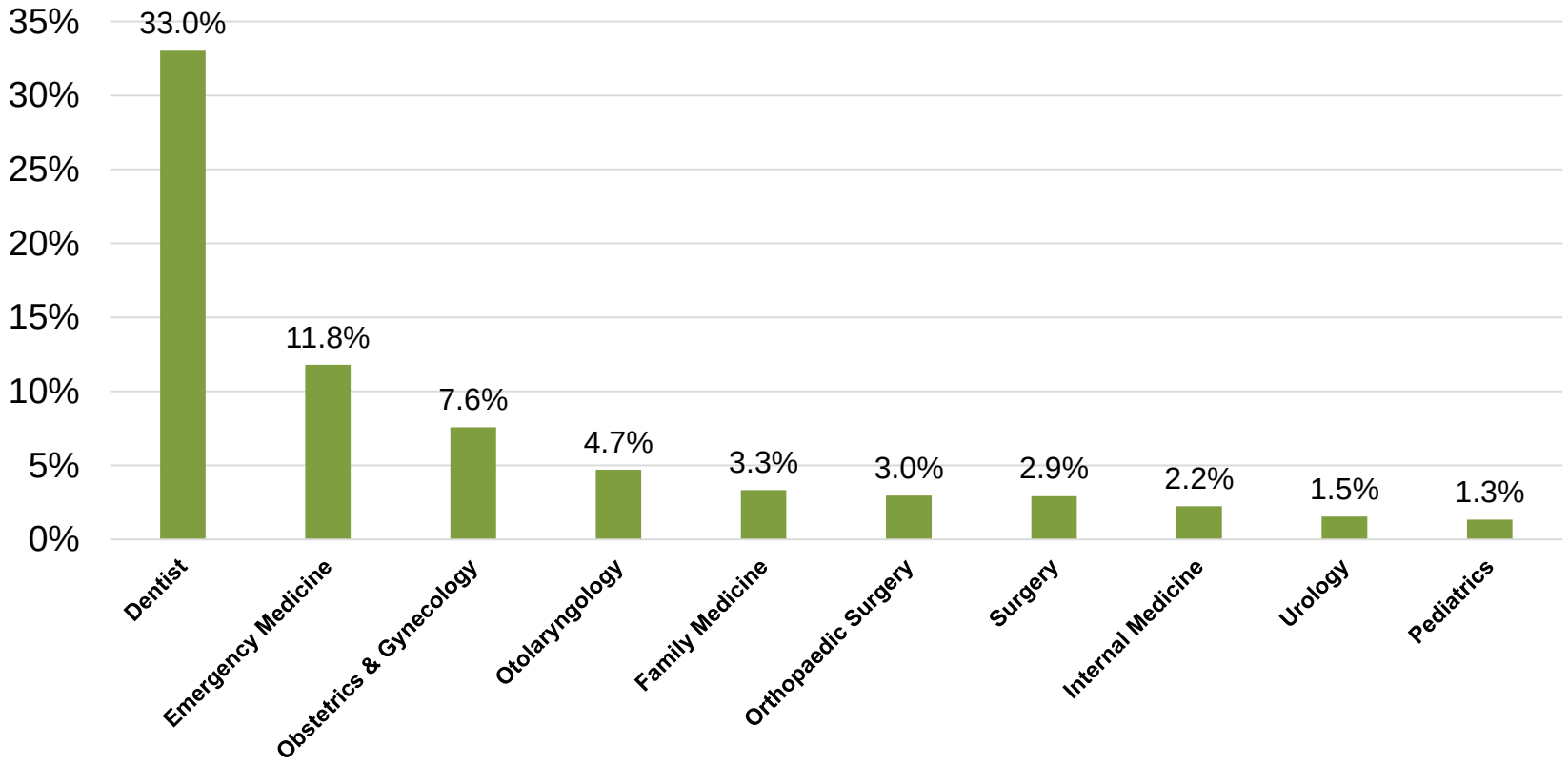
Percentage Of New Opioid Prescriptions Meeting Composite Measures Of All Four Prescribing Criteria, With Combinations For Different Days' Supply And Dosage Limits (2013–17)



"The main finding was that while 71.2% of new opioid prescriptions in 2017 were aligned with a composite of all four criteria...., just 14.5% of new opioid prescriptions conformed to the stricter composite of dosage less than 25 MME/day and duration <= 3 days' supply.

Hence, the quality of new opioid prescriptions appears to be either good or in need of improvement, depending on the thresholds used to measure dosage and days' supply."

Percentage of Total Index Opioid Prescriptions in NC Medicaid Study Population by Physician Specialty, 2017

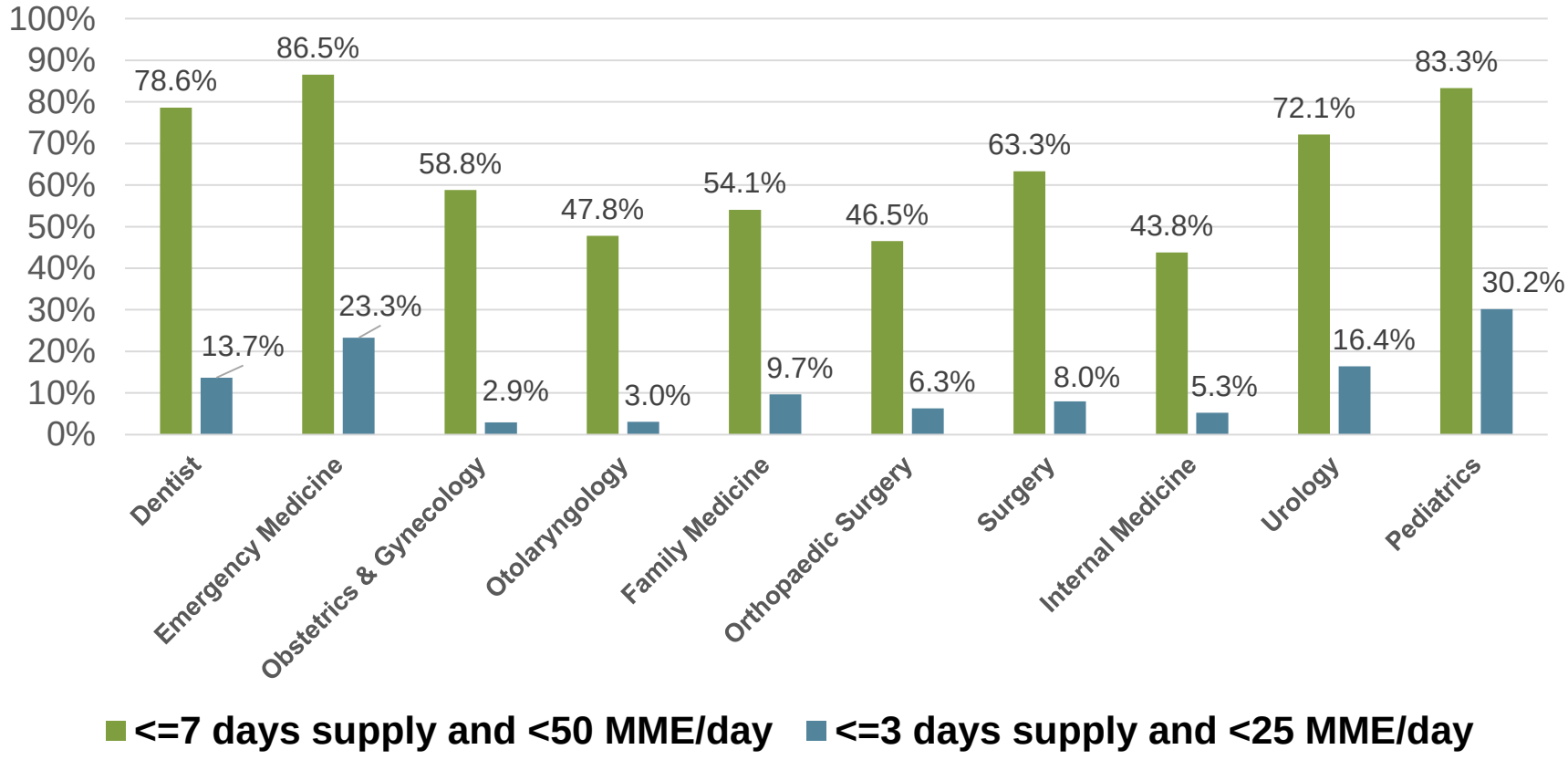


NC Medicaid New Start Analysis: Overview

Top ten prescriber specialties			
	Days' supply		
Dosage	≤3 days	3-7 days	>7 days
<25 MME/day	13.3%	21.1%	8.4%
≥25-50 MME/day	21.1%	19.1%	2.8%
≥50 MME/day	8.2%	5.5%	0.5%

Dental			
	Days' supply		
Dosage	≤3 days	3-7 days	>7 days
<25 MME/day	14.2%	22.2%	2.2%
≥25-50 MME/day	24.0%	21.6%	1.1%
≥50 MME/day	8.9%	5.7%	0.0%

Percentage of index opioid claims meeting composite measure of all four criteria (with two combinations for days supply and dosage)



New Project on Dental Prescribing in NC Medicaid (1 of 2)

Objectives

- Describe statewide opioid dispensing associated with common dental procedures
- Describe the variation in opioid dispensing among dental providers
- Identify the range of opioid prescribing associated with specific dental procedures

New Project on Dental Prescribing in NC Medicaid: Overview (2 of 2)

- Identify enrollees prescribed opioids by dentists in 2016-2017.
- Describe the distributions of average dose, days supplied, type of opioid prescribed.
- Identify the dental procedure (CDT) codes associated with those prescriptions.
- Describe the distribution of CDT codes most frequently associated with opioid claims, opioid prescribing patterns, and the relationships between opioid dose and procedure.
- Assess definitions of high-opioid prescribing dentists.

THE DUKE ENDOWMENT

Discussion

- **What steps could be taken to educate dentists on opioid prescribing practices?**

  Ex: NSAIDs as first line

  Ex: Low days' supply ("three days or less will often be sufficient" per CDC)

- **What interventions are most appropriate to address outlier prescribing?**

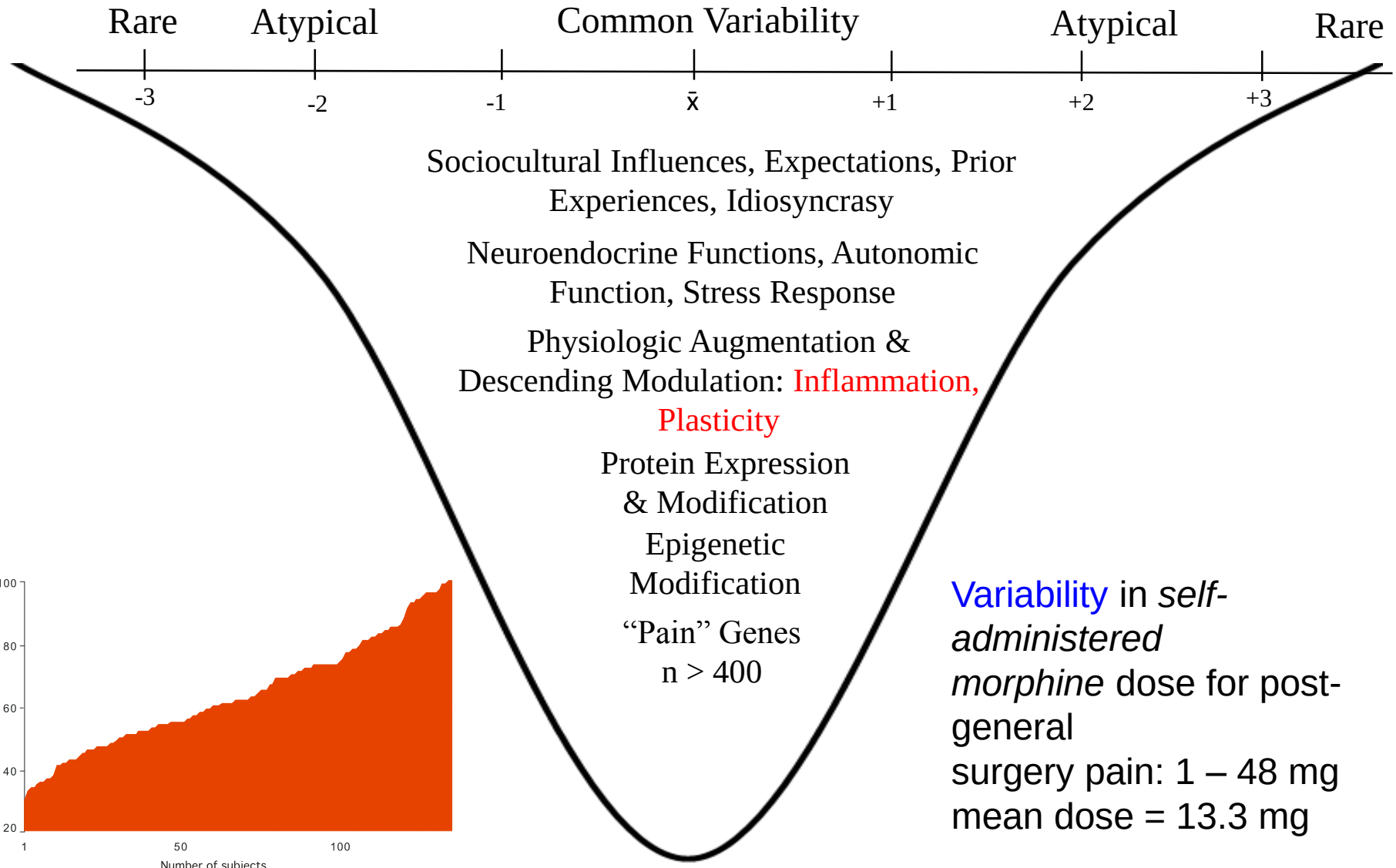
Opioids: Bad Medicine for Dental Pain, Patients and Society

Ray Dionne

- Rationale for targeting the inflammatory etiology of acute dental pain to minimize opioid prescribing
- Dental profession leadership in fighting substance abuse:
  - Opioid stewardship – avoid use of irrational analgesic combinations
  - Recognizing inherent vulnerability for substance abuse
  - Early prevention through patient education in the dental office
- Beware the potential consequences of inappropriate opioid prescribing

Conflict of Interest Statement: The speaker is on the faculty of the ECU School of Dental Medicine and the University of Connecticut School of Medicine, serves on the scientific advisory board of Charleston Laboratories and the GSK Global Pain Advisory Board and has consulted for the pharmaceutical industry in the past. He is also on the editorial board of the Compendium, Applied Clinical Pharmacology and Toxicology, and Clinical Pharmacology and Translational Medicine.

Risk Factors Related to Opioid Prescribing: Wide Variability in Pain and Analgesia



Variability in *self-administered morphine* dose for post-general surgery pain: 1 – 48 mg
mean dose = 13.3 mg

Aubrun et al. Anesthesiology 2003; 98:1415

Clinical Pain (3rd Molar Extraction)

A Milligram of Prevention is Better than a Pound of Rehabilitation

Inflammatory Pain

Blocked by NSAIDs

Minimize

Results in Much Less

Little or No

'Slight' Pain after LA offset, instead of

P = **Prevention**

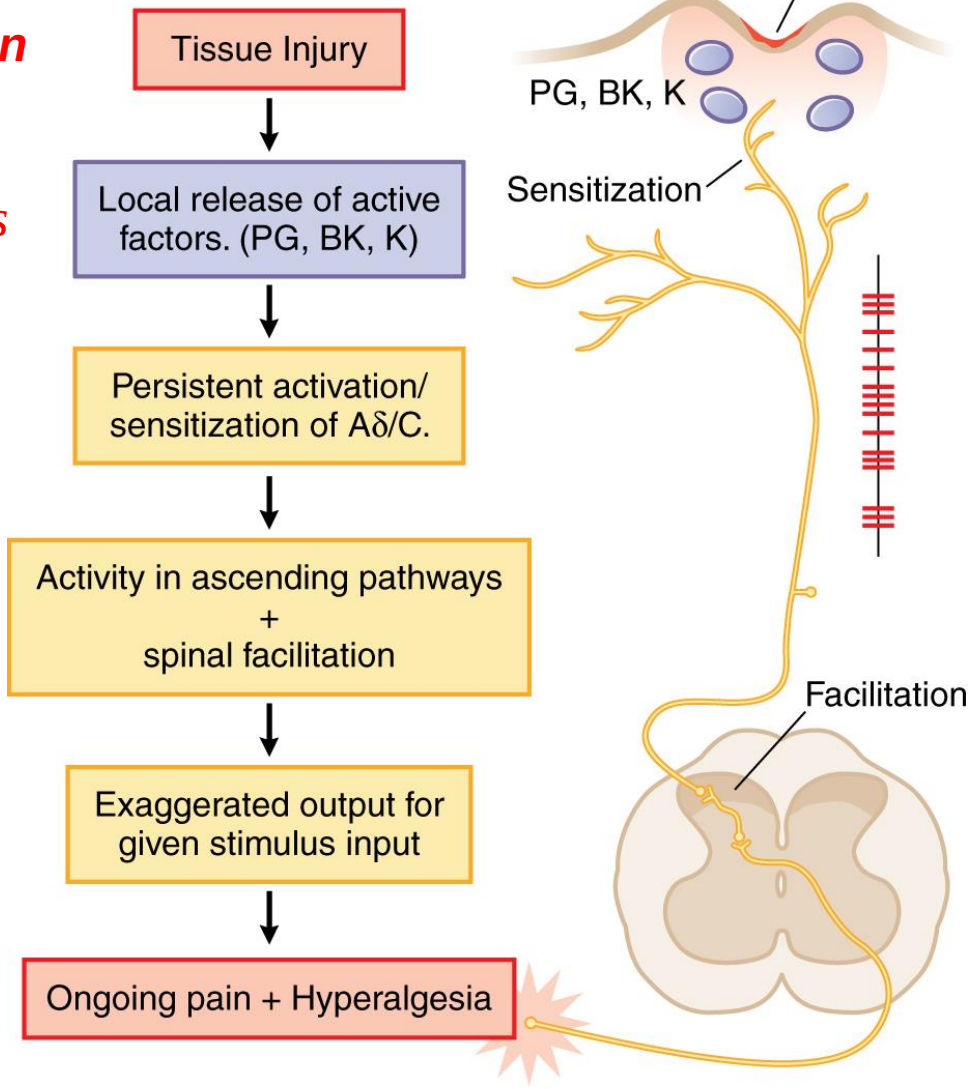
A = **Anti-inflammatory**

Acetaminophen

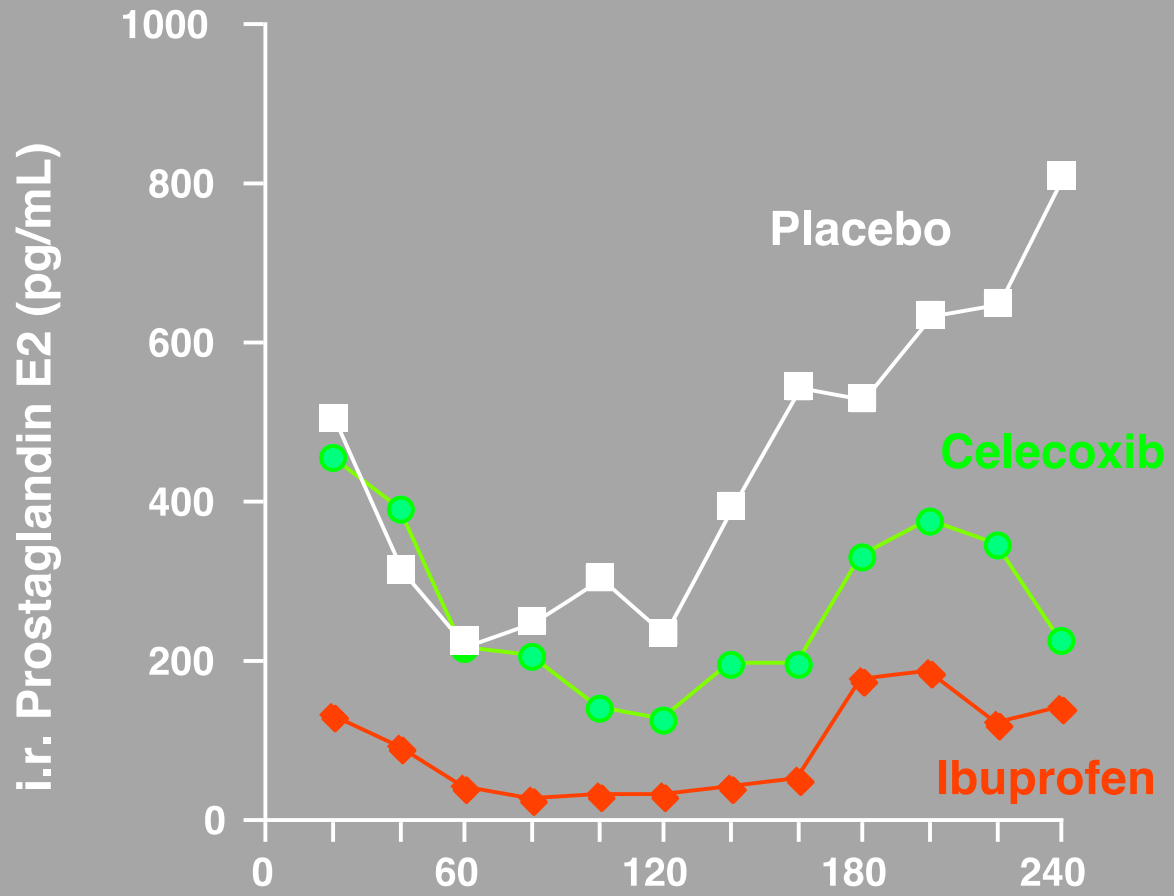
Anesthetics

I = **Individualize**

N = **Narcotics (opioids)**

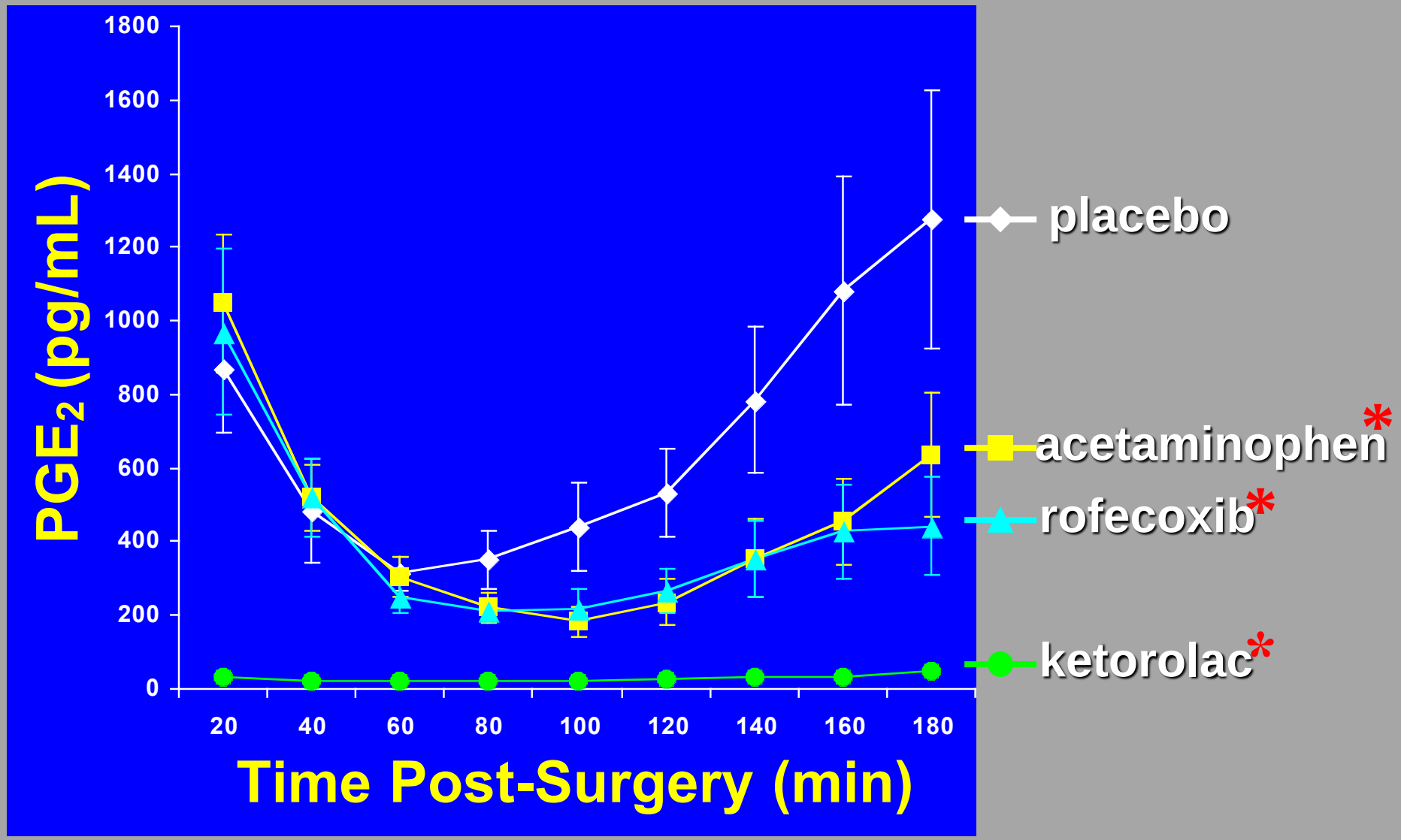


1. NSAID Suppression of COX

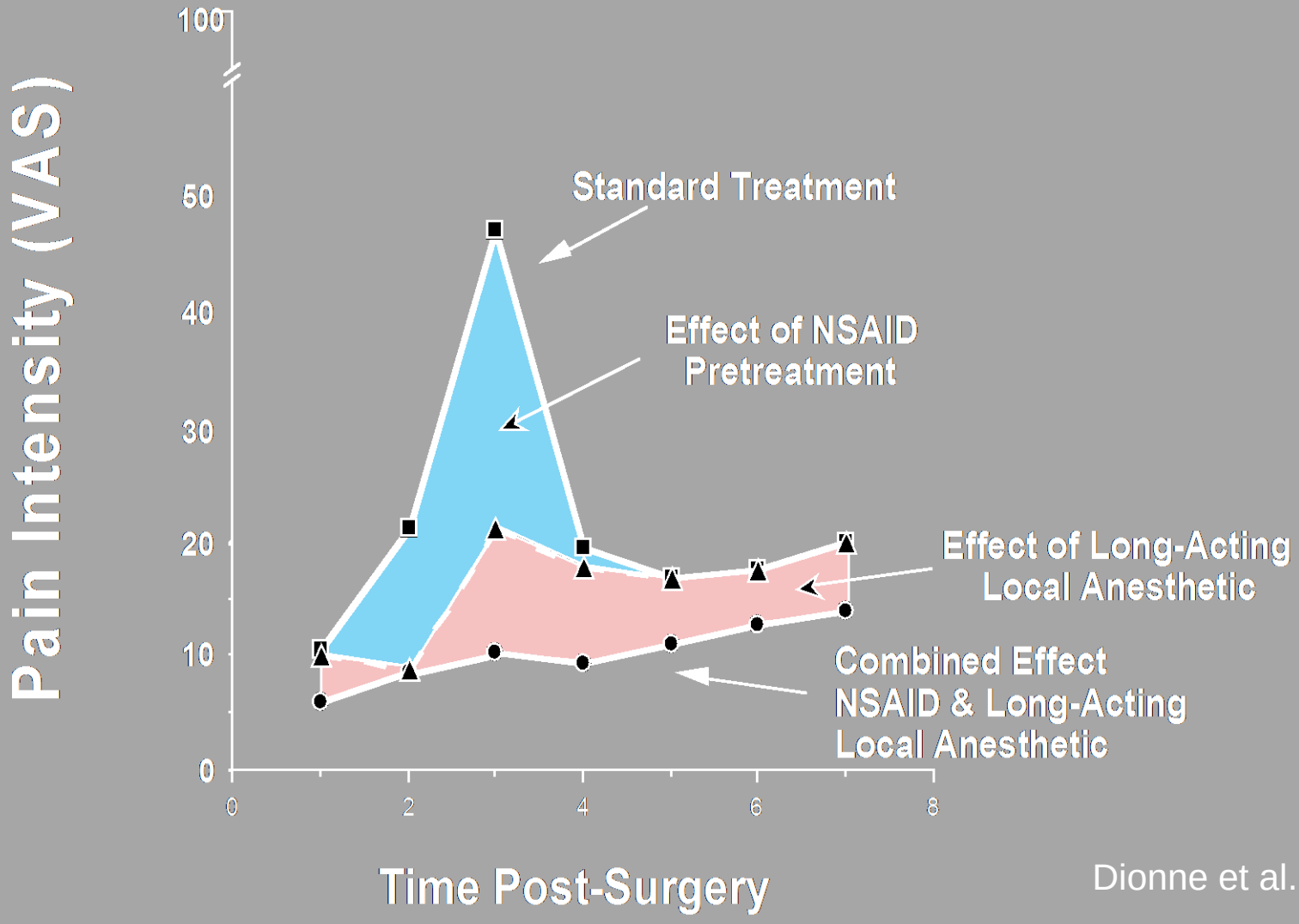


Khan AA et al.
Clin Pharmacol Ther. 2002

2. Use Acetaminophen for Additive Analgesia

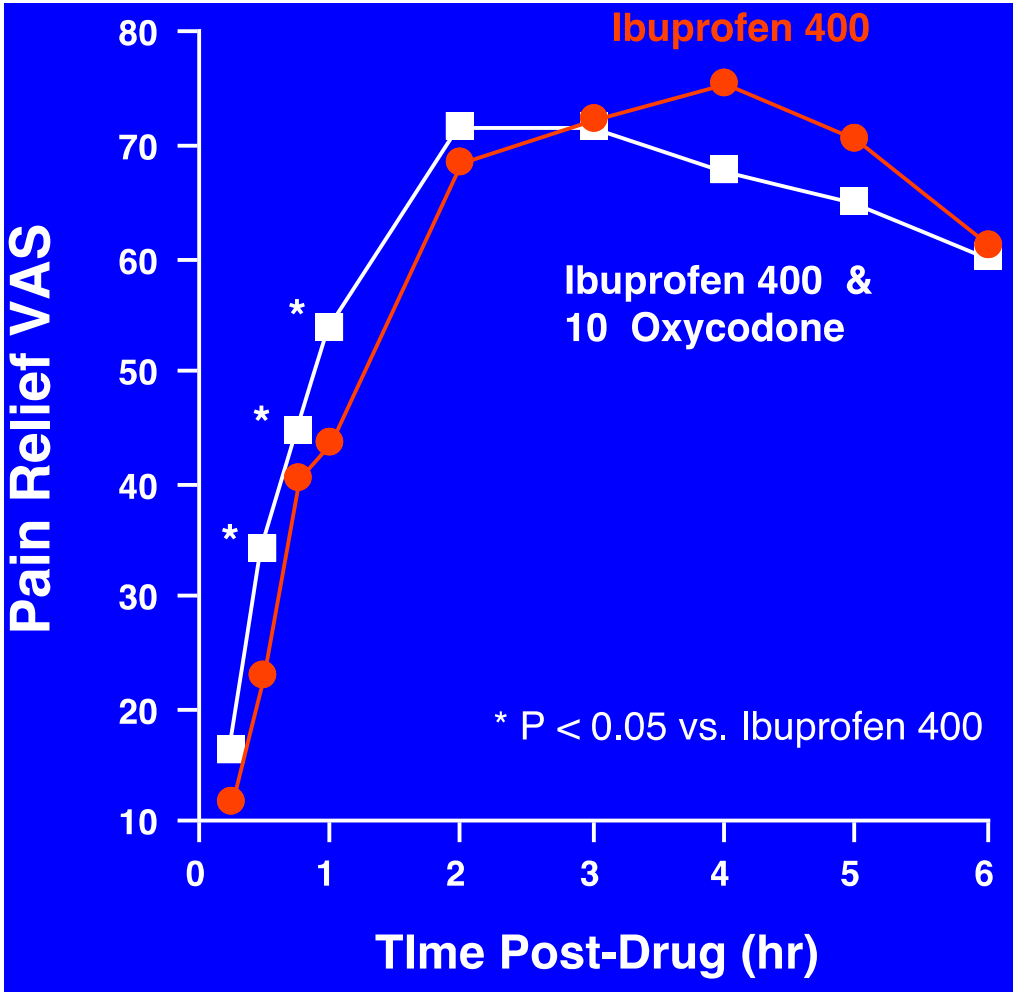


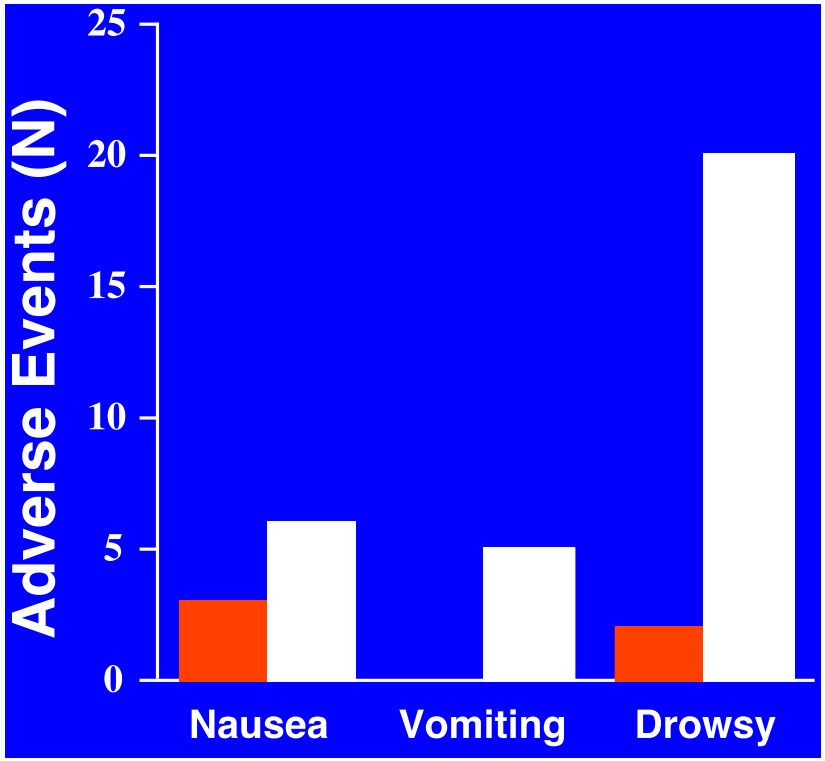
3. Additive Preemptive Analgesia for NSAID and Long-Acting Local Anesthetic



Dionne et al. 1984

Little additive analgesic effect in combination with an NSAID





< Half of opioids prescribed for pain after oral surgery were used, only 5 patients used all of the prescribed pills (N=28). Maughan BC et al. Drug and Alcohol Dependence 2016

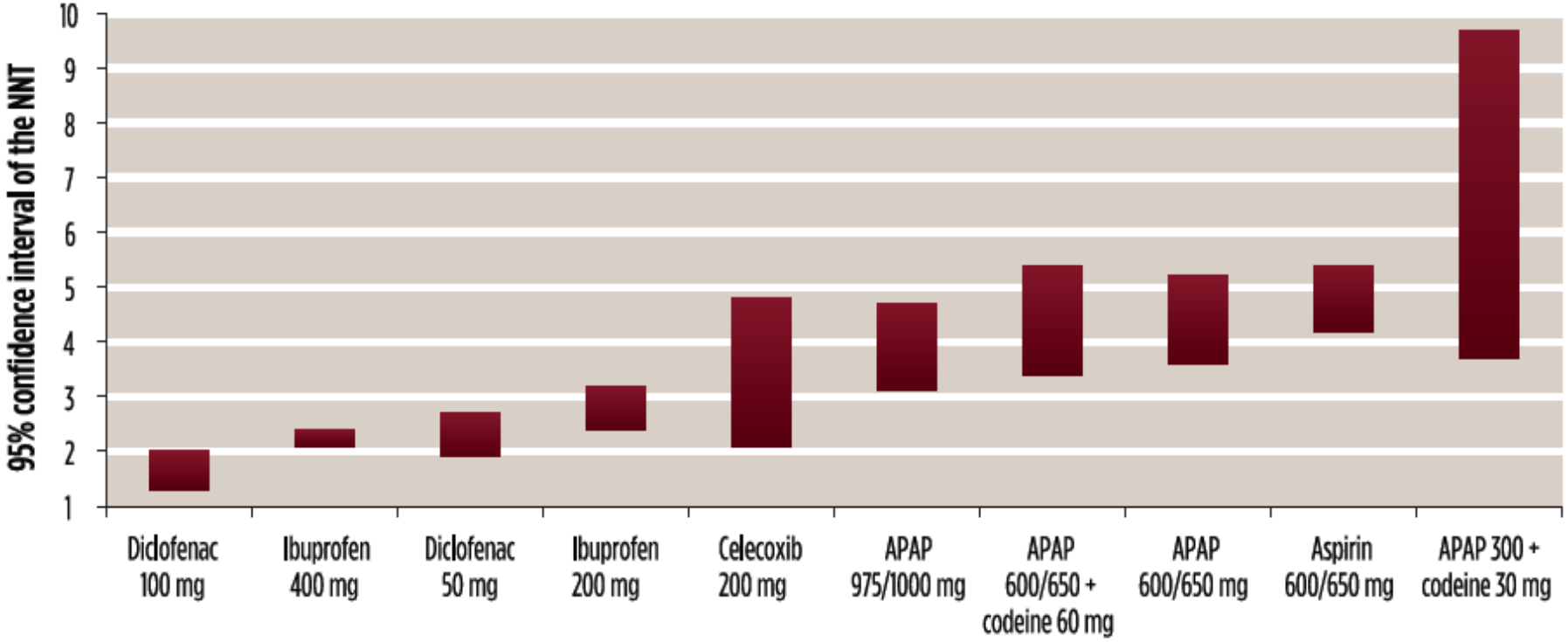
Extrapolates into millions of pills available for diversion after dental procedures

4. Consider Atypical Centrally-Acting Analgesics if an Opioid in Indicated

- Tramadol (Ultram®)
  - Moderate-strong analgesic
  - Agonist at mu receptors and blocks uptake of NE and 5-HT so spinal pain processing is less efficient
  - Minimal potential for dependence or abuse
  - Minimal potential for respiratory depression
  - Effects partially blocked by naloxone
  - Metabolized by CYPs (CYP2D6 and others) to 5 different metabolites
    - Desmethyltramadol is 200 times more potent
    - Depending on genetics analgesic effects can either increase or decrease

FDA states that tramadol is contraindicated < 12 years of age for pain
Can be prescribed over the phone or electronically per CVS
Not listed in STOP Act provisions to limit opioids misuse

5. Prescribe Analgesics Based on Scientific Evidence not Tradition



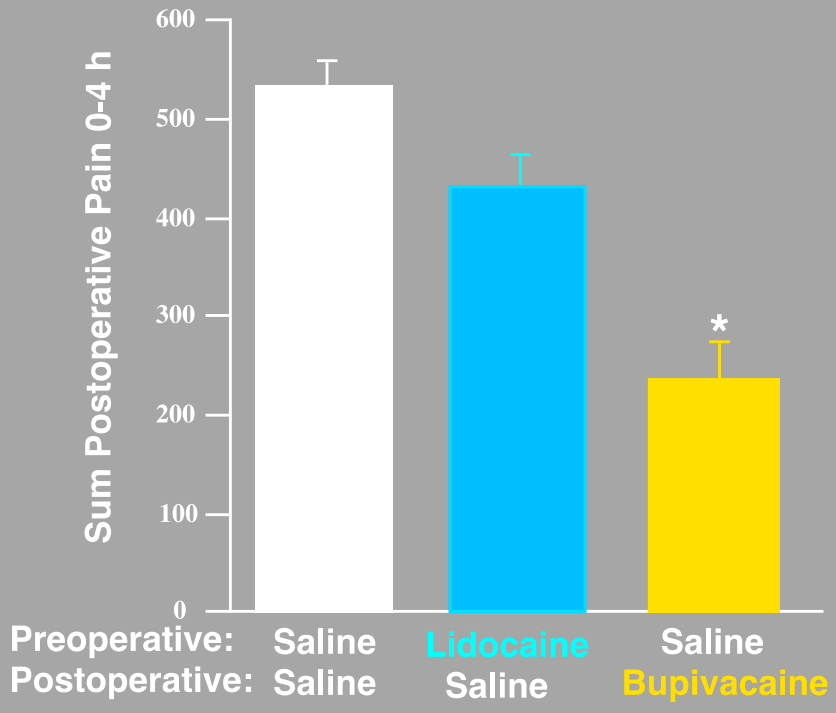
Adapted from:

J. Barden,[1] J. E. Edwards,[2] H. J. McQuay,[3] P. J. Wiffen[4] and R. A. Moore[5]

© British Dental Journal 2004; 197: 407–411

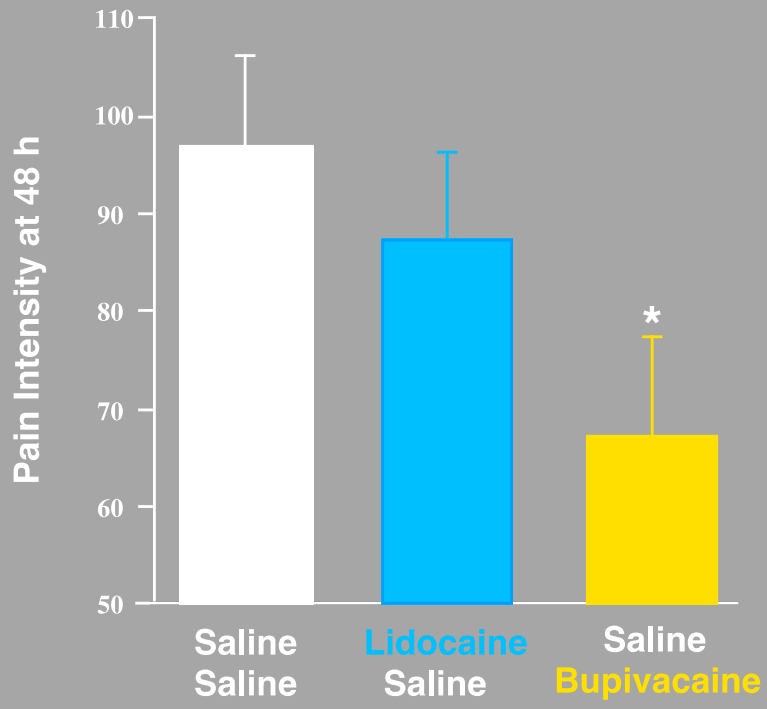
Preventive Effects of Postop Pain Control

Immediate Postop. Pain



* P < 0.001 Bupivacaine drug effect, 2-ANOVA

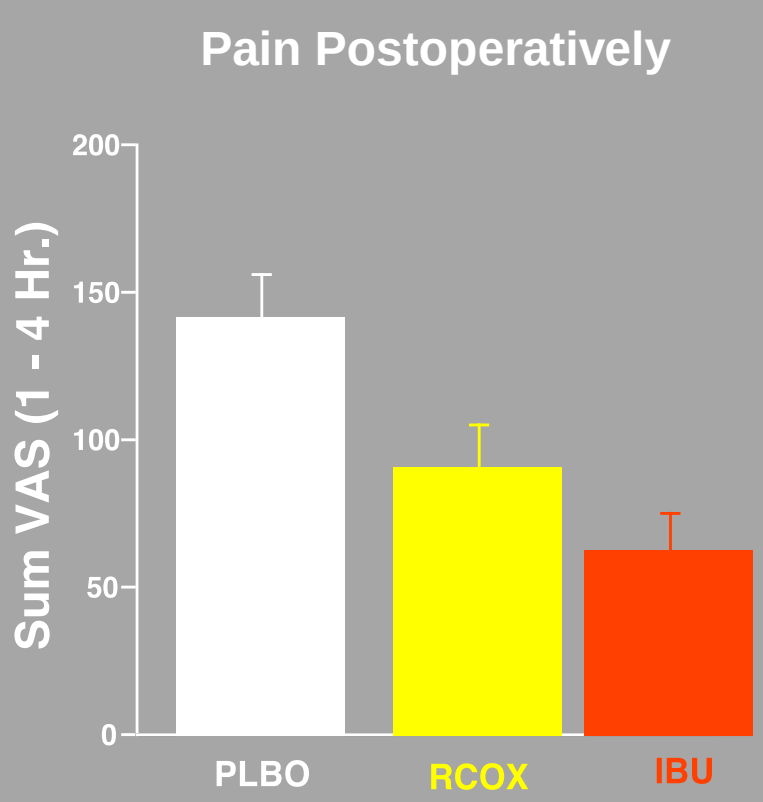
Pain at 48 Hours

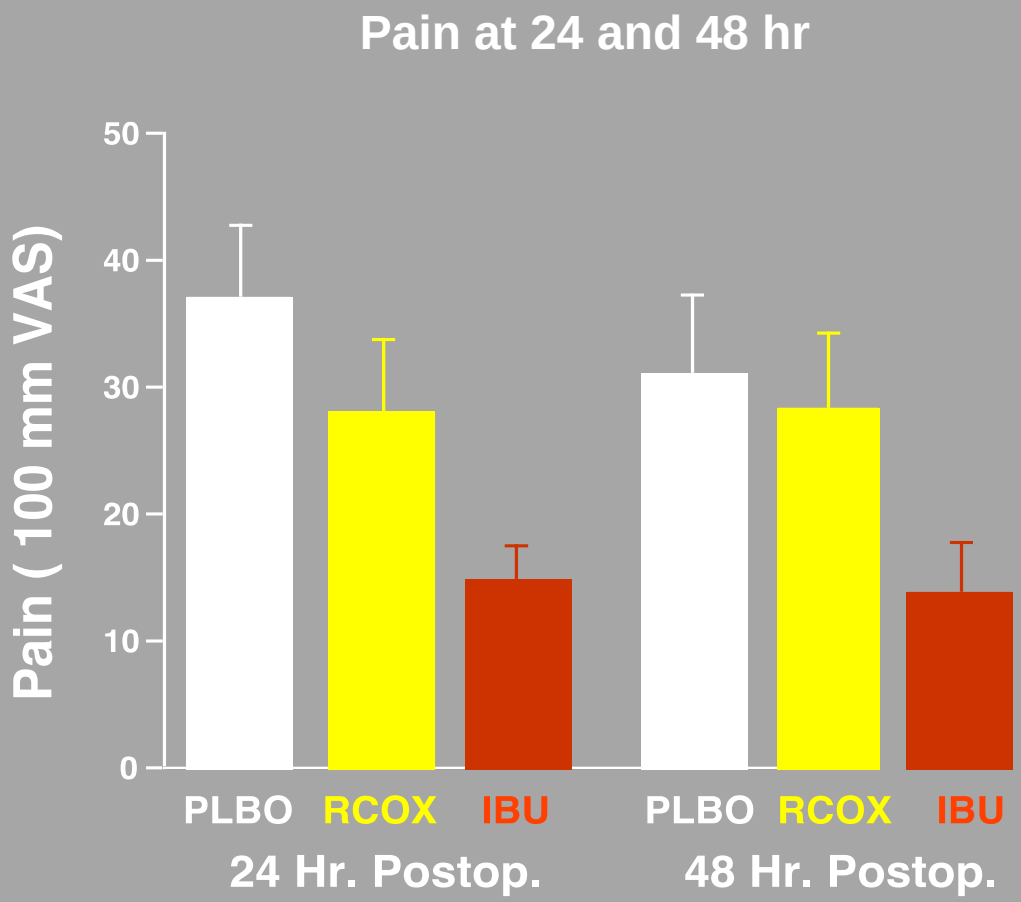


* P < 0.05 Bupivacaine drug effect, 2-ANOVA

Gordon SM et al. 2002

Dual COX-1/COX-2 Suppression Prevents Central Sensitization





Comparison of Conventional Approach to Targeted Strategies

	Opioid Combinations	Preventive/Additive/Adaptive
Analgesia	++	+++
Adverse Effects	+++	+
Abuse Potential	+++	0 (without opioid) + (with tramadol) ++ (with oxycodone or hydrocodone)
Overdose Risk	++	0 (without opioid) + (with tramadol) ++ (with oxycodone or hydrocodone)

Relative effects based on well-established pharmacology of drug classes and specific agents in Table 1

Dionne, Gordon, Moore: Compendium 2016; 37:372-378

Original Contributions

Cover Story

Opioid prescribing practices from 2010 through 2015 among dentists in the United States

What do claims data tell us?

Niodita Gupta, MD, MPH, PhD; Marko Vujicic, PhD; Andrew Blatz, MS

Check for updates

ADA CE Program

Supplemental material is available online.

ABSTRACT

Background. Dentists wrote 6.4% of all opioid prescriptions in the United States in 2012. The purpose of this study was to examine opioid prescription rates, dosage of opioids prescribed, type of opioid drug prescribed, and type of dental visit at which dentists prescribe opioids.

Methods. The authors used the 2010 through 2015 Truven Health Marketscan Research databases and the Prescription Drug Monitoring Program (PDMP) Training and Technical Assistance Center conversion data set. The authors conducted descriptive analyses for days' supply, quantity prescribed, and daily morphine milligram equivalent dose.

Results. The opioid prescription rate per 1,000 dental patients increased from 130.58 in 2010 to 147.44 in 2015. Approximately 68.41% of all opioids prescribed were during surgical dental visits and approximately 31.10% during nonsurgical dental visits. During nonsurgical dental visits at which dentists prescribed an opioid, most of the procedures were restorative.

Conclusions. Among a population of dental patients with private insurance, opioid prescribing rates in the United States increased slightly from 2010 to 2015. The largest increase was among 11- through 18-year-olds. Almost one-third of opioid prescriptions written by dentists were associated with nonsurgical dental visits.

Practical Implications. Use of PDMP resources and use of nonopioid analgesics could help reduce the number of opioid prescriptions in dentistry.

Key Words. Opioids; prescriptions; dentists.

JADA 2018:149(4):237-245
https://doi.org/10.1016/j.adaj.2018.01.005

The United States is facing a severe opioid addiction epidemic. In 2015, approximately 12.5 million people misused prescription opioids.[1] Approximately 2.1 million people misused prescription opioids for the first time, and an estimated 2 million had a prescription opioid use disorder.[1] Opioid overdoses caused 33,091 deaths in 2015 alone.[1] The amount of opioids prescribed in 2010 was 782 morphine milligram equivalents (MMEs) per capita, which decreased to 640 MME per capita in 2015.[2] Investigators estimated the economic burden of opioid overdose, abuse, and dependence in 2013 to be $78.5 billion from a societal perspective.[3]

In 1998, dentists were the top specialty prescribers of immediate-release opioids, accounting for 15.5% of all immediate-release opioid prescriptions.[4] However, by 2009, the amount of opioid prescriptions written by dentists decreased to 8% of all opioid prescriptions in the United States,[5] and by 2012, this amount further decreased to 6.4%.[6] More recent and detailed data are available in some states. For example, in South Carolina during 2012 and 2013, dentists accounted for only 8.9% of all opioid prescribers but prescribed 44.9% of the initial opioids dispensed to patients.[7] Patients younger than 21 years received 11.2% of the total amount of opioids that dentists prescribed.[7] Investigators conducted a study in Indiana and used 2011 data, and their results showed that access to dentists and pharmacists increased the availability of prescription opioids and that this

This article has an accompanying online continuing education activity available at: http://jada.ada.org/ce/home.

‘Approximately 31% of the opioids prescribed for all age groups were associated with nonsurgical dental visits… suggests there might be opportunities to reduce opioid prescribing by targeting nonsurgical dental visit prescribing practices.’

Example of Successful Intervention Effort to Minimize Problematic Clinical Practice

Medication-Assisted Treatment Training of Medical Students and Residents

Sara McEwen & Blake Fagan

We have no disclosures

Agonist Therapy for OUD prior to 2000

Methadone plus counseling, drug testing, medical care, recovery supports/ services

- Only available in Opioid Treatment Program: a regulated and restrictive setting that is not appropriate for nor acceptable to many patients with OUD
- Safety profile
- Capacity

DATA 2000 Act

- Increase access
- Assure quality treatment
- Assure proper privacy and confidentiality

DATA 2000

- DATA 2000 enables qualifying physicians to receive a waiver from the special registration requirements in the Narcotic Addict Treatment Act (NATA) of 1974 for the provision of OUD treatment.
- This waiver allows qualifying physicians to prescribe or dispense Schedule III, IV, and V “narcotic” medications for the treatment of OUD in the office and other clinical settings if (and only if) those medications have been approved by the FDA for use in addiction treatment.
- NATA makes it illegal for narcotics to be used “off label” to treat opioid addiction. This prohibition extends even to other forms of buprenorphine (e.g., Buprenex®) that have not been specifically approved for OUD.

OBOT Challenges

- Stigma
- Historically, physicians only/patient limits (30/100/275)
- Lack of SUD/OUD education and practical training
- Specific training required (live/online/half and half)
- NPs and PAs only recently able to prescribe
- Implementation challenges (e.g. work flow)
- Misconceptions

Buprenorphine Misconceptions

- Trading one addiction for another
- Treatment pessimism
- Needs addiction medicine expert and onsite BH
- Diversion a huge problem
- Endpoint: abstinence only

Increasing Access: Focus on Practicing Providers

- Initially psychiatrists and family physicians
- Branching out to Internal med, ED, OB/GYN
- Waiver training necessary but not sufficient
- Some success but not nearly enough

Providers Clinical Support System (PCSS)

- PCSS is project of SAMHSA; lead organization is American Academy of Addiction Psychiatry (AAAP)
- Coalition of 20 leading national organizations representing healthcare providers and other stakeholders
- Goals & Objectives of PCSS
  - Expand MAT training for MDs, DOs, PAs, APNs
  - Facilitate clinical mentoring
  - Provide electronic repository

Increasing Access: Focus on Provider Pipeline

- Medical Schools
- Physician Assistant Schools
- Nurse Practitioner Schools
- Residency Programs

SAMHSA PCSS Universities Grant

- SAMHSA funded
- 3 years: October 2018 to September 2021
- Eligibility
- NC schools involved (UNC, ECU, WF, Campbell)
  - Medical students; will share with PA and NP schools

PCSS U Project Goals

1. Increased supply of physicians educated in NC eligible to provide MAT for patients with OUD
2. Increased capacity of NC medical schools to train workforce prepared to prevent, ID, and treat OUD and other SUDs
3. Increased supply of providers with the DATA 2000 waiver who actively prescribe once eligible
4. Develop/build on existing infrastructure to ensure sustainability

Policy Steering Committee: Plan

- Online training tailored for students (8 hrs) integrated into the standard curriculum by the 2019-2020 Academic year
- Followed by 3-4 hours in person training/case discussion
- Expanded opportunities for clinical exposure
  - Faculty capacity at each school
  - UNC ECHO
  - Dr. Fagan's Residency Project
  - PCSS mentors statewide

Residency, NP and PA School Pilot Project

- The funding is from North Carolina Department of Health and Human Services through the Centers for Disease Control and Prevention (CDC) Cooperative Agreement Number 6NU90TP921993.

- “Increasing Workforce Capacity for Medication-Assisted Treatment Through Residency Programs”

Goal

- Offer/train 10 medical residencies, NP and PA schools in MAT/Suboxone, and ultimately identify a “champion” at each residency/school who will train the next class of learners into the future

- Started Nov 1, 2018
- Ends August 31, 2019

To align with current best practice and national residency training & curriculum trends this project offers:

- The “MAT/Addiction 101” CME presentation- This program is an overview and allows discussion about MAT, evidence based treatment for OUD and Office Based Opioid Treatment (OBOT)
- A technical assistance package- After the MAT 101 program residencies may receive a MAT toolkit and can participate in bimonthly technical assistance calls to learn more about OBOT and MAT services
- A buprenorphine waiver CME training- Required for all physicians to become waivered and can count towards the 24 hours required for Advanced Practice Providers
- “Recovery within Reach” team based care for OBOT- This is a companion to the waiver training, with nursing and behavioral health credits, to help teams prepare for OBOT
- Case consultation- NP, PA schools, and Residencies completing the waiver training may participate in Project ECHO for MAT and/or set up chart reviews to help launch OBOT
- Train the trainer mentorship- to prepare your Provider Champion to teach NP and PA students and residents about MAT and to become approved to teach the waiver training in the future
- A program evaluation report- highlighting accomplishments and next steps for each school or residency
- Reimbursement – up to $5000 per school or residency for training expenses

Medical Residency Trainings

- 11 Family Medicine Residency Programs have signed up for the buprenorphine waiver course
- 4 MAHEC residencies are training their residents yearly
- 1 OB residency at New Hanover Regional in Wilmington
- 1 Psychiatry residency at Wake Forest

NP and PA Schools

- UNC CH PA program has signed up for the 1 hour Intro to MAT

- In discussions with Duke PA, Wingate PA, and Western Carolina University NP schools for trainings

Programs Agreeing to Incorporate MAT Education Ongoing (as of 2/22/2019)

New Hanover Regional- FMR	Agree to Continue MAT
UNC-Chapel Hill - FMR	Agree to Continue MAT
Duke - FMR	Agree to Continue MAT
East Carolina University - FMR	Agree to Continue MAT
Novant - FMR	Agree to Continue MAT
Wake Forest - FMR	Agree to Continue MAT
Cone Health - FMR	Agree to Continue MAT
SR-AHEC – Fayetteville – FMR	Agree to Continue MAT

Programs Already Incorporating
MAT Education into their residencies

MAHEC Family Medicine Asheville
and Hendersonville
MAHEC OB/GYN
MAHEC Psychiatry

Questions?

Panel: Highlights of Opioid Work at the Local Level

Locally Funded Initiatives – Overview

- **Emergency Department Peer Support Pilot Programs**
  - RFA via North Carolina Healthcare Association (NCHA)
- **Opioid Action Plan Implementation Initiative**
  - RFA via Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS)
- **Emergency Overdose: Local Mitigation to the Opioid Crisis for Local Health Departments (LHDs)**
  - RFA via Division of Public Health (DPH)
- **Post-Overdose Response Team Development**
  - RFA via NC Office of Emergency Medical Services (OEMS) / DPH

Locally Funded Initiatives (part 1)

- **Emergency Department Peer Support Pilot Programs**
  - RFA via NCHA
  - 6 grantees (hospital emergency departments)
  - Peer Support Specialists connect patients that present to the emergency department with an opioid overdose to support services such as treatment and harm reduction
- **Opioid Action Plan Implementation Initiative**
  - RFA via DMH
  - 13 grantees (variety of organization types)
  - 8 strategies to choose from, but must include one from priority list
    - Certified peer support specialists
    - Connect justice-involved persons to harm reduction, treatment, and recovery services, including arrest diversion programs
    - Post-overdose response team development
    - + additional optional activities (Syringe Exchange Programs [SEPs], naloxone trainings, prescriber education, Medication-Assisted Treatment [MAT] training)

Locally Funded Initiatives (part 2)

- **Emergency Overdose: Local Mitigation to the Opioid Crisis for LHDs**
  - RFA via DPH
  - Funded 22 local health departments/districts
  - 3 strategies from Opioid Action Plan
    1) Establish or expand syringe exchange programs (SEPs)
    2) Connect justice-involved persons to harm reduction, treatment, and recovery services
    3) Establish post-overdose response teams
- **Post-Overdose Response Team Development**
  - RFA via NC OEMS / DPH
  - Funded 8 local EMS systems
  - Post-overdose response teams to be led by EMS to prevent overdose and connect to harm reduction, care, treatment, and recovery supports. Follow-up visits within 72 hours of reversal.

Panel Questions

- How the funding has helped you?
- What activities are you currently working on?
- Where you are in the implementation process?
- Problems and successes encountered

Opioid Misuse and Overdose Prevention Summit and Opioid Action Plan v2

Elyse Powell

Opioid Misuse & Overdose PREVENTION SUMMIT

June 11-12, 2019

Raleigh NC

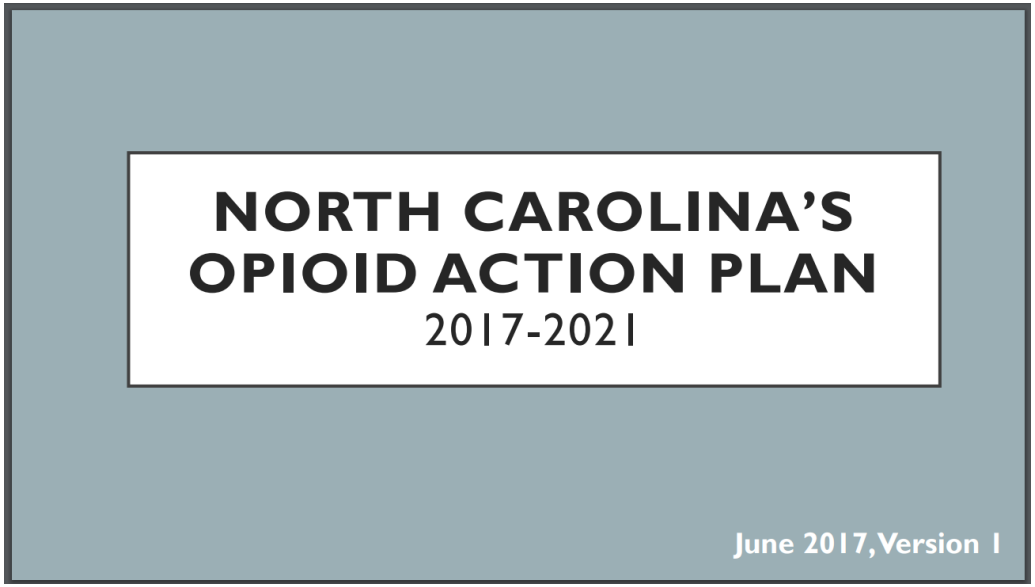
OpioidPreventionSummit.org

Register

Apply to be an exhibitor

Submit posters

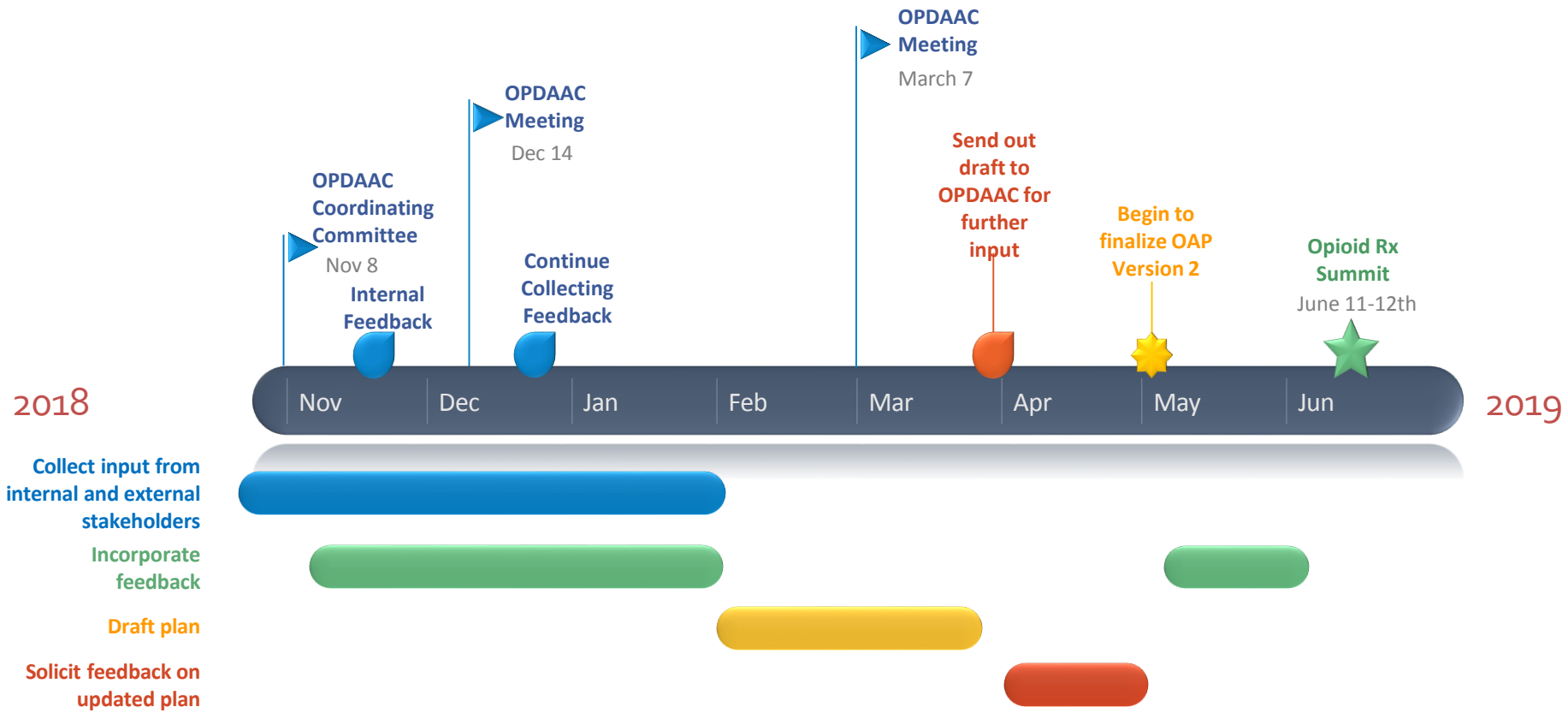
Opioid Action Plan *Version 2.0*



Opportunity to identify strategies that are:

- Ongoing priorities
- New priorities
- No longer priorities

Drafting OAP 2.0 involves the input of many stakeholders



December 14th OPDAAC Breakout groups

Break out groups

1. Community Prevention
2. Harm Reduction
3. Justice Involved persons and Law Enforcement
4. Providers and Health Systems

Menu of Local Actions

- Menu of strategies for counties, local coalitions and stakeholders to implement
- Strategies that were **impactful** and **implementable** at the local level
- The menu will become part of the Opioid Action Plan Version 2.0

Menu of local actions

- Improve naloxone access
- Build and support syringe exchange programs
- Develop a post-overdose response team
- Establish pre-arrest diversion, pre-release education, and post-release naloxone and connections to care
- Support connecting families to treatment and support services
- Map resources and improve linkages to them
- Train housing providers on housing first principles, and having naloxone available
- Work with local employers to implement supportive policies
- Promote public awareness and stigma reduction
- Implement evidence based youth prevention

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Wrap up and THANK YOU!

Alan Dellapenna, Branch Head, Injury and Violence Prevention Branch, Division of Public Health

THANK YOU!

(Please travel safely!)

See you on June 11-12 for the Opioid Misuse and Overdose Prevention Summit!

Opioid Misuse & Overdose PREVENTION SUMMIT