NC Department of Health and Human Services

Opioid and Prescription Drug Abuse Advisory Committee

September 29, 2017

Welcome and Introductions of Attendees

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

Please share with us…

- Your name
- Your organization/affiliation

+ VIDEO: 2017 Opioid Misuse and Overdose Prevention Summit

DeDe Severino, Division of Mental Health/DD/SAS

Update: Division of MH/DD/SAS – Opioid STR (Cures Act)

Opioid STR/Cures Grant Update

Project to Date

As of 9/15/2017

- North Carolina was awarded a total of $15,586,724 for Year 1 (May 1, 2017 through April 30, 2018)

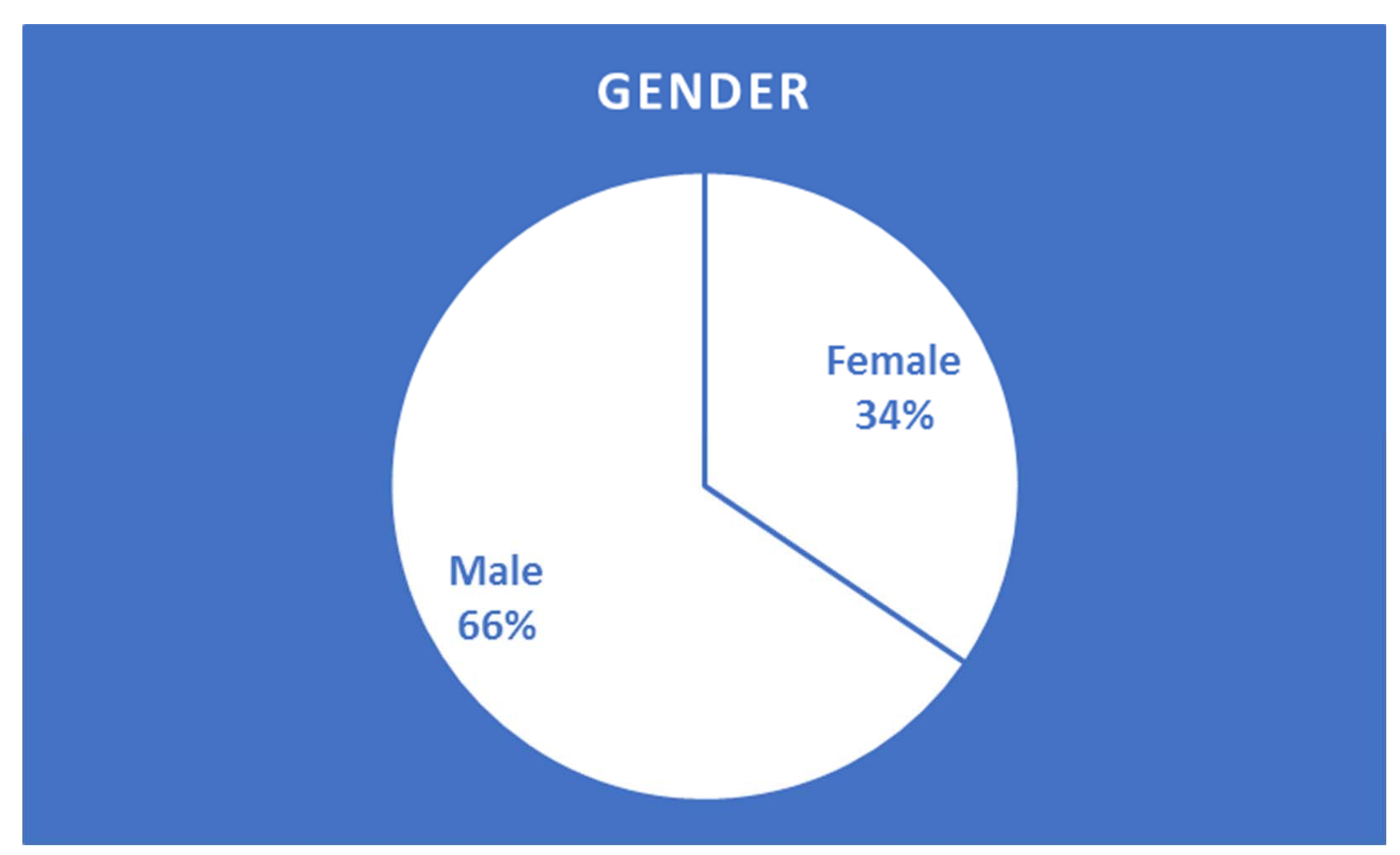
- $8,336,423 was set aside for formal clinical treatment services

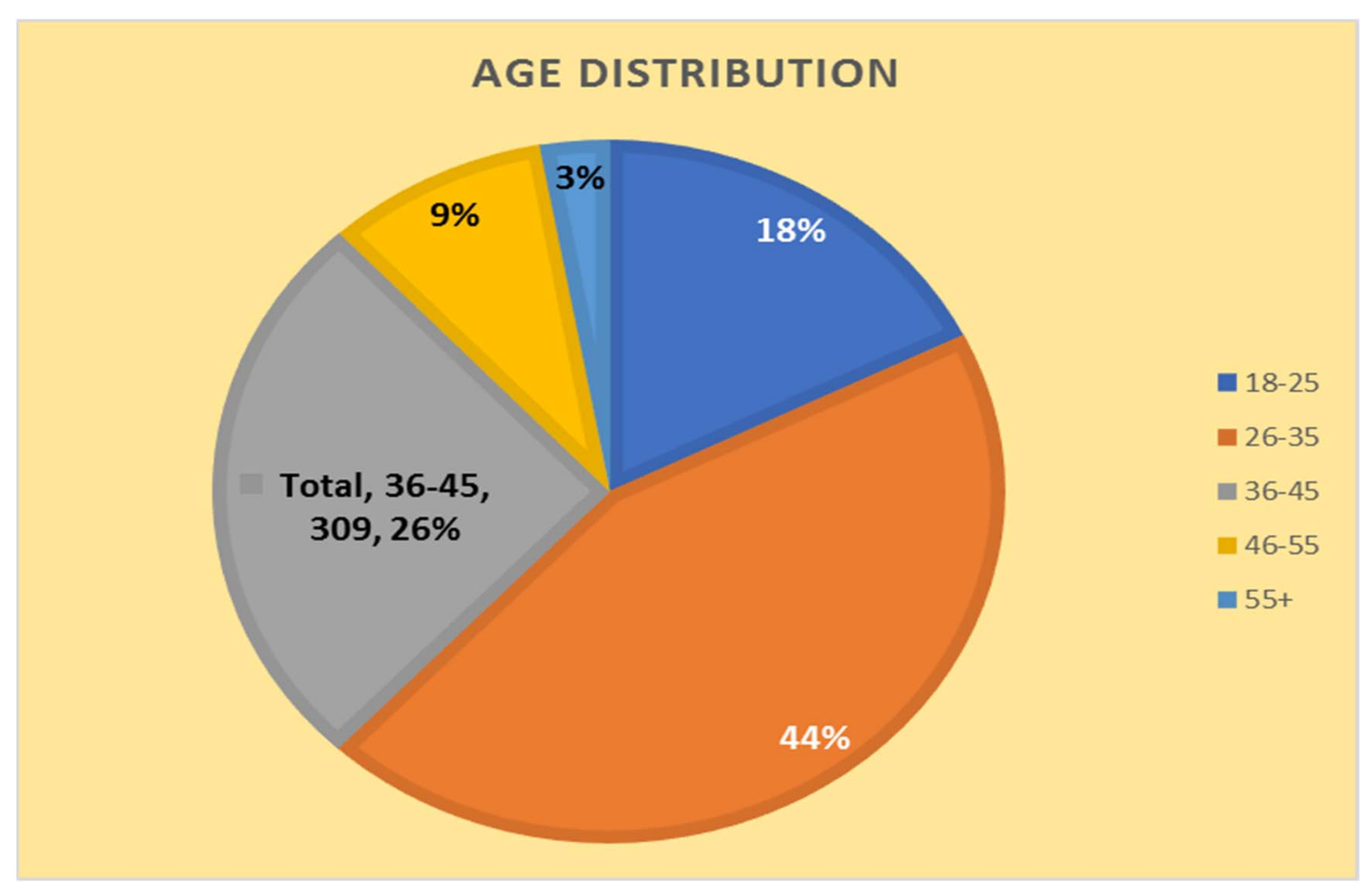
- This amount has been allocated to the seven LME/MCOs

- Funds were allocated to each LME/MCO based on the population of their service areas, number of naloxone administrations by EMS during 2015, number of opioid-related ED visits and number of opioid overdose deaths

Opioid STR/Cures Fund Expenditures, Project-to-Date

LME-MCO	Allocation Amount	# Persons Served	Service Expenditures To Date
ALLIANCE	$1,369,488	6	$1,776
CARDINAL	$2,465,970	345	$412,118
EASTPOINTE	$596,531	12	$4,785
TRILLIUM	$1,224,849	337	$431,063
PARTNERS	$854,675	372	$472,253
SANDHILLS	$926,042	52	$57,833
VAYA	$898,867	64	$38,230
Total	**$ 8,336,423**	**1,188**	**$1,418,058**


GENDER
Female
34%
Male
66%


AGE DISTRIBUTION
3%
9%
18%
Total, 36-45, 309, 26%
44%
18-25
26-35
36-45
46-55
55+

Other Components:

- A brief RFI is being developed to distribute/award the $1.5m set aside in North Carolina's proposal for outreach, engagement and recovery support services

- Contract is underway with The Change Companies (with assistance from the AHECs) for the training components of our proposal, which will target clinicians and physicians and cover areas such as ASAM levels of care, MAT essentials, etc.

- Contract with UNC-Chapel Hill for implementation of the ECHO for MAT component is underway. ECHO for MAT (hub and spoke model) will focus on OBOT physicians in an effort to expand treatment availability in under-served areas of the state.

- The NC DHHS has determined not to pursue implementation of a statewide helpline (screening, triage and referral) for individuals and family members seeking information or assistance with an opioid use disorder. These funds ($1m) will be designated for clinical treatment services.

- Upgrade underway with the current Drug Regulatory Management System to enable electronic OTP application, registration, inspections and surveillance processes.

- Statewide media campaign in development, purchase of lockboxes for counties is planned.

- Education, TA, EBP/curriculum training re non-medical use of prescriptions, TA to high need counties for coalition-building, town hall meetings, etc.

Meghan Shanahan, UNC Injury Prevention Research Center

Spotlight: Overdose Risk among Justice Involved Persons

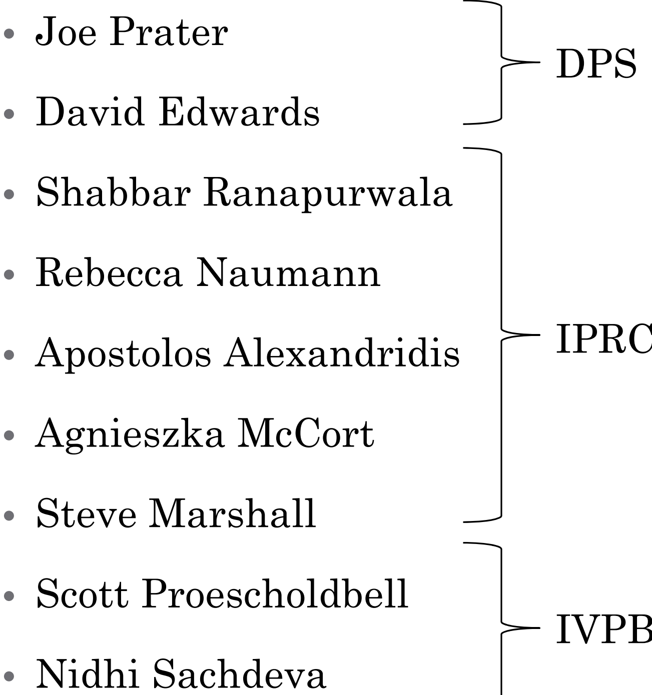
Overdose risk among justice involved individuals

Meghan Shanahan, PhD

NC DHHS Opioid and Prescription Drug Advisory Committee

September 29, 2017

Acknowledgements



Opioid Overdose Deaths Among Former Inmates in North Carolina, 2000-2015

- The ongoing opioid epidemic is adversely affecting all Americans. Most vulnerable among us, and likely the most overlooked, are the former inmates. Prior studies suggest that opioid overdose mortality is ten times higher among former inmates than the general population. In this study, we examine the rates of opioid overdose death (ODD) among former North Carolina (NC) inmates from 2000 to 2015, compare them to the general population, and identify predictors of post-release overdose death. We linked 2000-2015 prisoner release data from the NC Department of Public Safety to 2000-2015 NC death records using soundex codes for names, birth date, and sex. Opioid overdoses were identified using ICD-10CM codes. We calculated 1-year post-release ODD rates among former inmates to compare with annual NC rates, and calculated weekly and monthly rates to identify predictors of overdose death among former inmates.

Opioid Overdose Deaths Among Former Inmates in North Carolina, 2000-2015

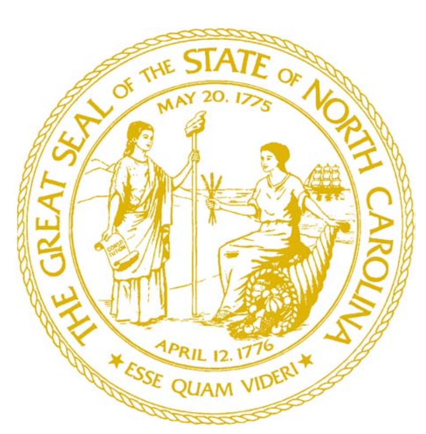
From 2000-2015:

- 237,455 prisoners were released and 12,237 died post-release, of whom 1,104 died of an opioid overdose-related death.
- Opioid overdose mortality rate among former inmates increased from 53 per 100,000 person-years in 2000 to 216 per 100,000 person-years in 2014, compared to 3.3 to 9.2 per 100,000 person-years, respectively, in the general NC population.
- Opioid overdose mortality rates were highest during the first two weeks after release, and among former inmates who were 26-50 years of age, men, White, had three or more prior prison terms, and received long term substance abuse and mental health treatment while incarcerated.
- Former inmates are highly vulnerable population and need urgent prevention measures.

UNC
INJURY PREVENTION
RESEARCH CENTER

Lillie Armstrong, Division of Public Health, Injury and Violence Prevention

Spotlight: Safer Syringe Exchange Initiative



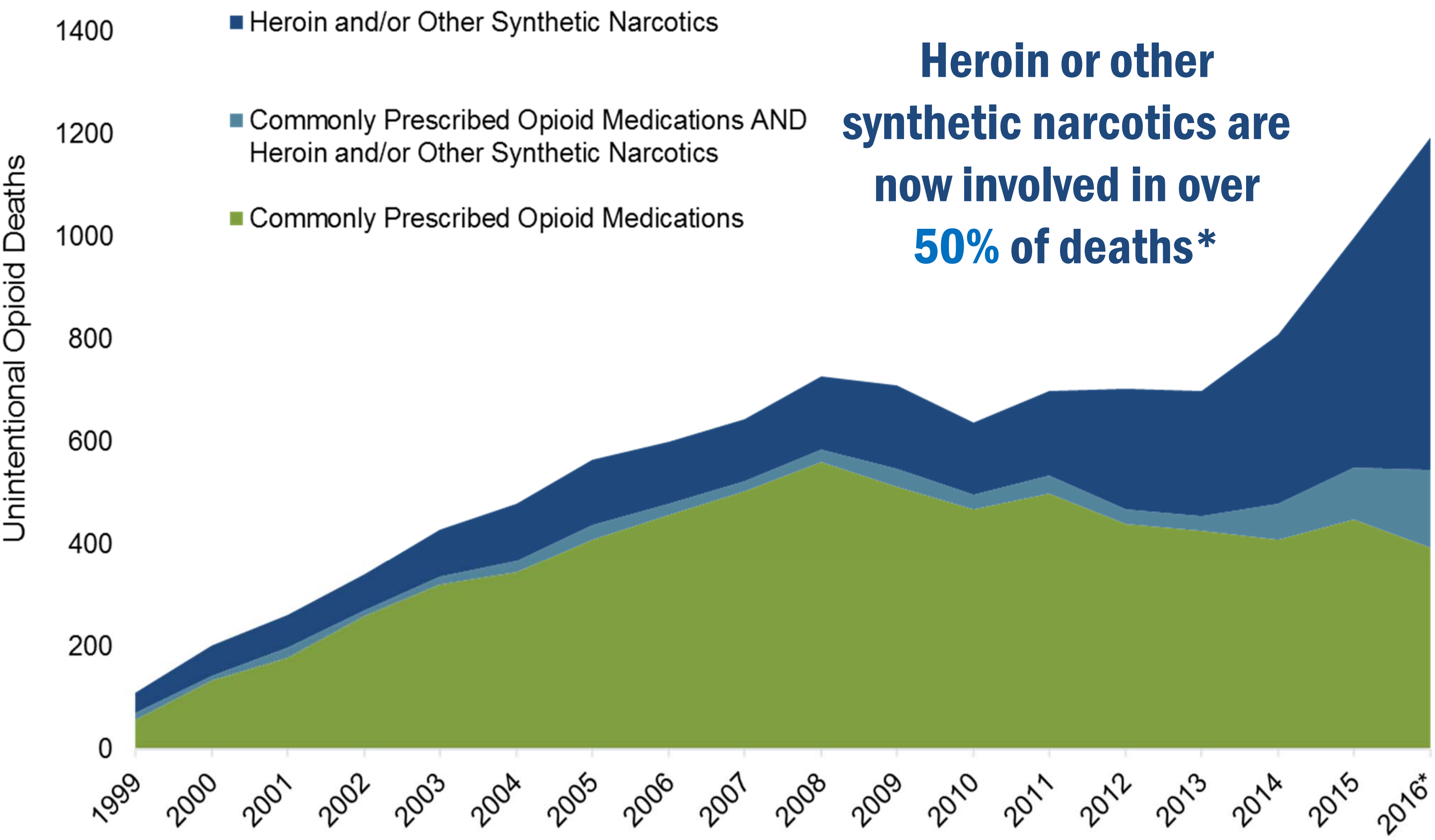
Update: North Carolina Safer Syringe Initiative

Division of Public Health
Injury and Violence Prevention Branch

Lillie Armstrong

OPDAAC
September 29, 2017

Unintentional opioid deaths have increased more than 10 fold*



*2016 data are provisional
Source: N.C. State Center for Health Statistics, Vital Statistics-Deaths, 1999-2016
Unintentional medication/drug (X40-X44) with specific T-codes by drug type.
Commonly Prescribed Opioid Medications=T40.2 or T40.3; Heroin and/or Other Synthetic Narcotics=T40.1 or T40.4.
Numbers of deaths from other synthetic narcotics may represent both prescription synthetic opioid deaths and non-pharmaceutical synthetic opioids because synthetic opioids produced illicitly (e.g., non-pharmaceutical fentanyl) are not identified separately from prescription ('pharmaceutical') synthetic opioids in ICD-10 codes.
Analysis by Injury Epidemiology and Surveillance Unit

Increase in Acute Hepatitis C Cases

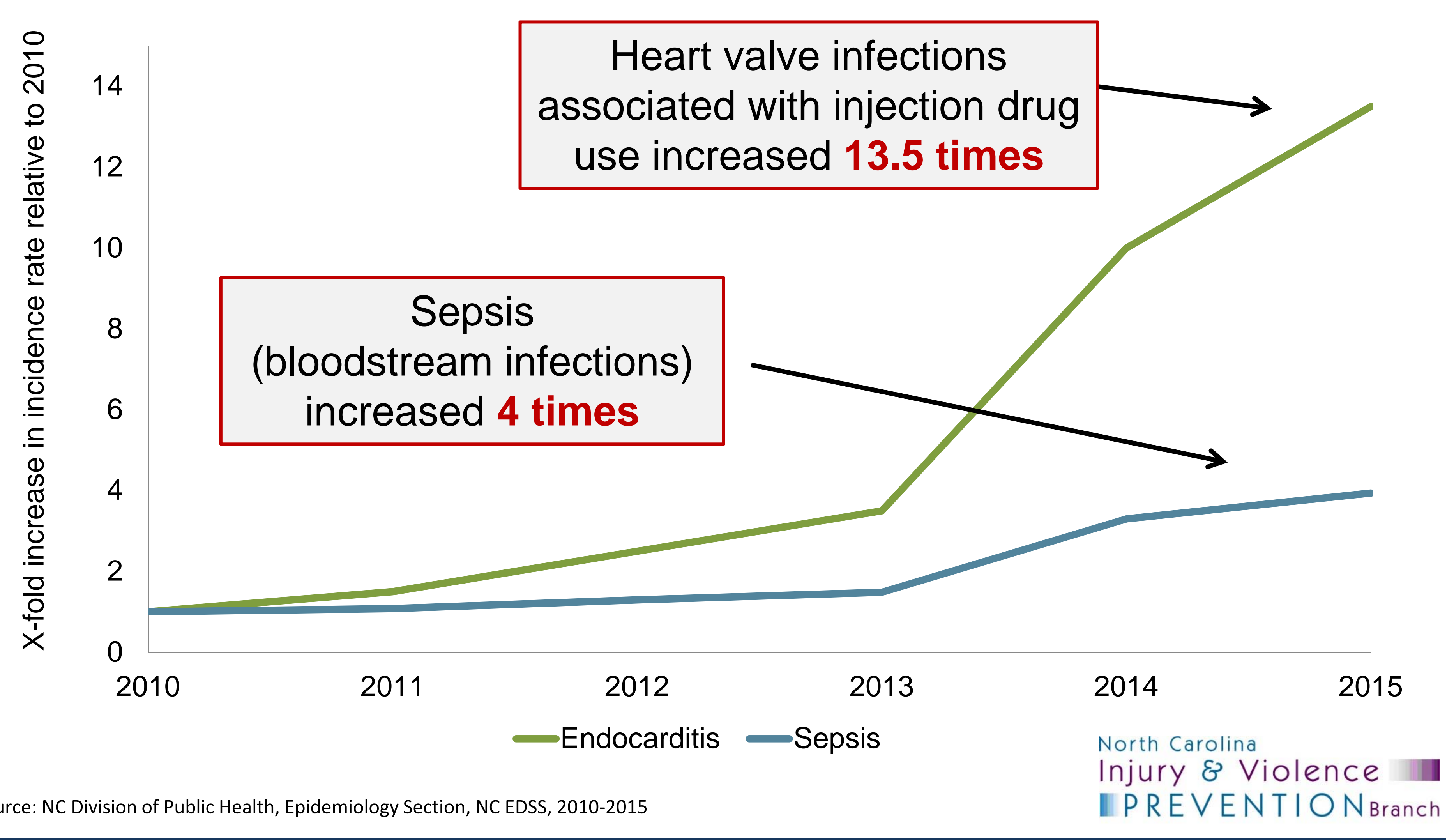
North Carolina, 2000–2016*

Note: Case definition for acute Hepatitis C changed in 2016.

*Data from 2016 are preliminary and subject to change

^ Estimated true number 10–15x higher than number of reported cases.

Endocarditis & Sepsis Among Likely Drug Users, North Carolina, 2010–2015

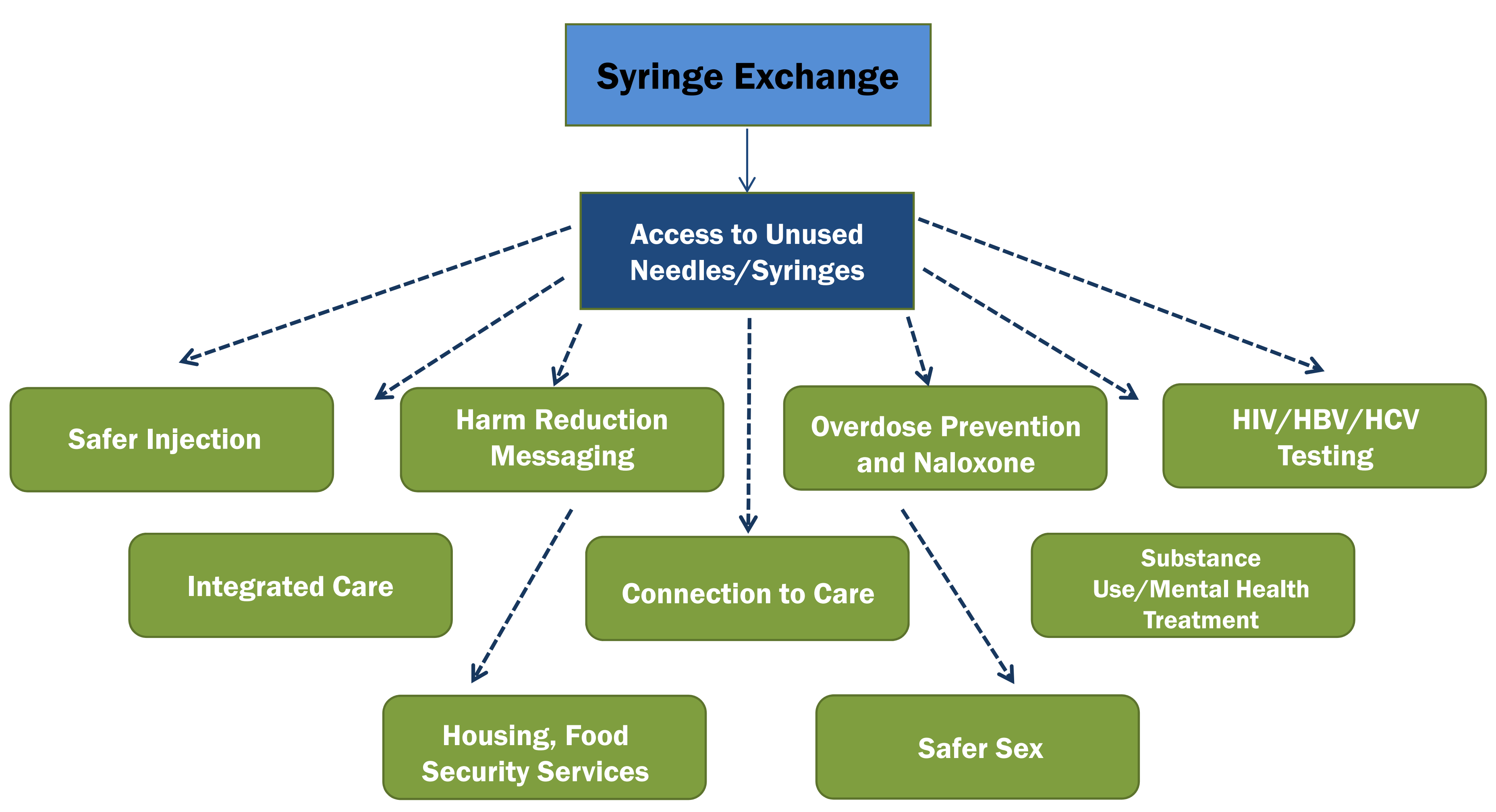


Source: NC Division of Public Health, Epidemiology Section, NC EDSS, 2010-2015

Syringe Exchange Programs

- Legalized in NC **July 11, 2016**
- Any governmental or nongovernmental organization ***"that promotes scientifically proven ways of mitigating health risks associated with drug use and other high risk behaviors"*** can start a syringe exchange program **(S.L. 2016-88)**
- Legal Protections
- Safer Syringe Initiative

Syringe Exchange Starts a Conversation



Counties served by Syringe Exchange Programs (SEPs) as of September 2017

Target county served by SEP

Additional counties reached*

22 active SEPs covering **29** counties, with individuals commuting from additional counties, EBCI reservation, and surrounding states.

*Residents from these counties without SEP coverage traveled to receive services in a SEP target county

Source: North Carolina Division of Public Health, September 2017
Analysis: Injury Epidemiology and Surveillance Unit

Annual Reporting: First Year

3983 participants, **14,997** total contacts

1,154,420 syringes distributed

490,489 syringes collected

5,682 naloxone kits distributed, **1311** referrals made

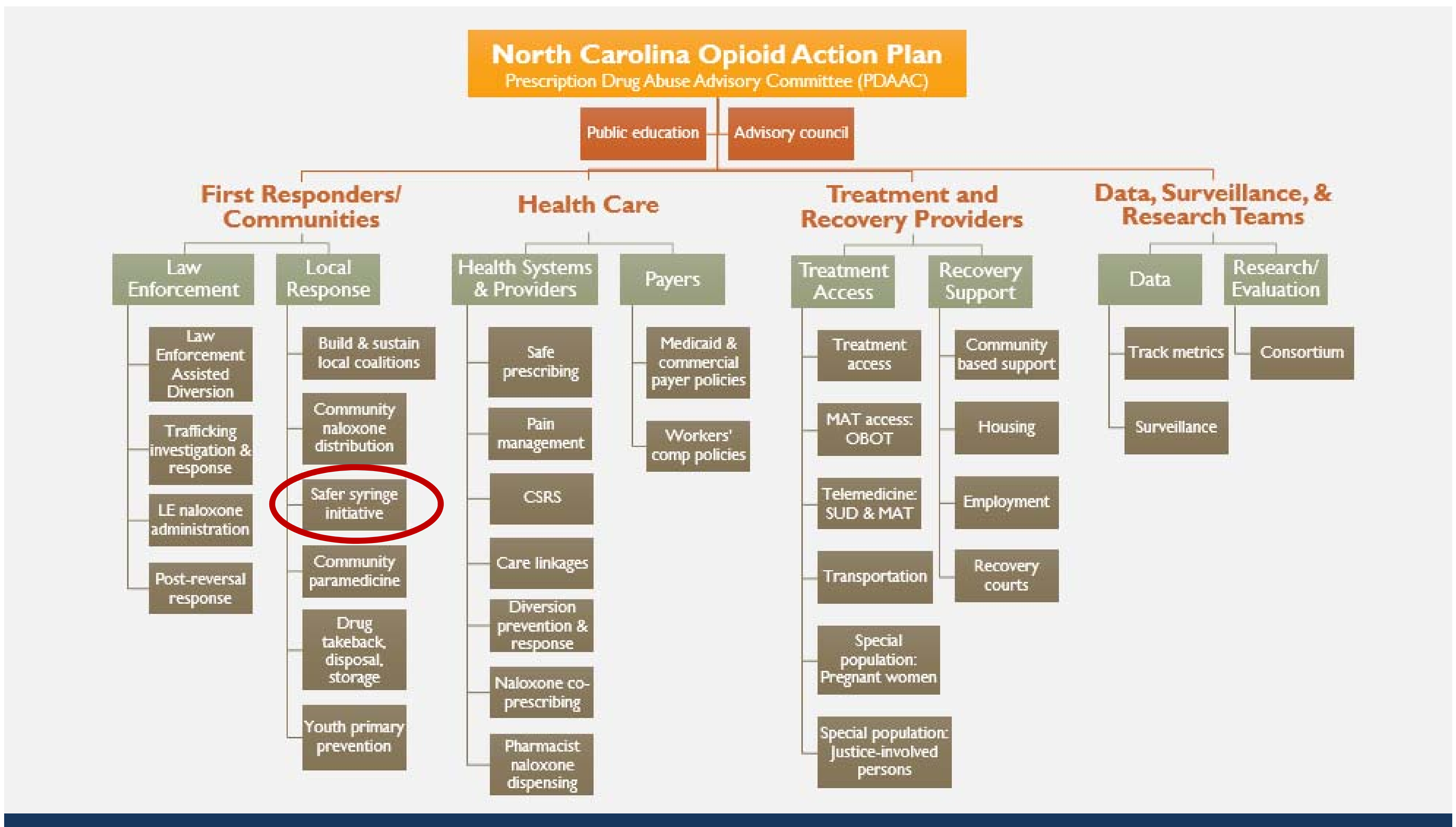
More than **2,187** reversals reported through SEPs

More than **3,766** referrals to mental health and SUD treatment

2,599 people tested for HIV

690 people tested for HCV

Building SEP Capacity



DPH Role in Syringe Exchange

- Program sign-up
- Annual reporting
- Program monitoring
- Technical assistance
- Encouraging partnerships
- Resource development

North Carolina Safer Syringe Initiative

Welcome to the North Carolina Safer Syringe Initiative. Here you will be able to find information about existing syringe exchange programs in the state, resources for healthcare providers and law enforcement agencies, testing and treatment programs, details about the limited immunity provided under the syringe exchange law, and information for health departments, community-based organizations, and other agencies interested in starting their own exchanges. Please find an updating list of active programs and contact information here.

North Carolina Safer Syringe Initiative Assistance

As of July 11, 2016, North Carolina (S.L. 2016-88) allows for the legal establishment of hypodermic syringe and needle exchange programs. Any governmental or nongovernmental organization "that promotes scientifically proven ways of mitigating health risks associated with drug use and other high risk behaviors" can start a syringe exchange program (SEP). The Division of Public Health and the Department of Health and Human Services do not operate syringe exchanges in North Carolina.

Included in the law is a provision that protects SEP employees, volunteers, and participants from being charged with possession of syringes or other injection supplies, including those with residual amounts of controlled substances present, if obtained or returned to a SEP. SEP

Public Health

Child Service Coordination

North Carolina Safer Syringe Initiative

Syringe Exchange Programs in North Carolina

Syringe Exchange FAQs

Quick Answers for Law Enforcement Personnel

Participant Cards and Limited Immunity

Resources for Providers

Preventing Transmission of Infections

HIV and Hepatitis C Prevention and Treatment Resources

Projects and Collaborations

- NCSSI workgroup
- Faithful Families program
- OPDAAC Advisory Group
- EMS-based programs
- Injury Free NC PDO Academy

Injury Free NC Academy

- Working with 8+ teams from around the state
- Local health department and law enforcement investment
- Harm reduction focus
- Technical assistance
- **Goal: 8+ new syringe exchange and/or naloxone distribution programs by the end of summer 2018**

Building Interest and Capacity

- Public funds use and the STOP Act
- Emergency funds access
- Expanding in-house services
- Integrating programs
- Engaging with SEPs and harm reduction-based programs

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SyringeExchangeNC@dhhs.nc.gov

https://www.ncdhhs.gov/divisions/public-health/north-carolina-safer-syringe-initiative

www.injuryfreenc.ncdhhs.gov

Kelly Kimple, Division of Public Health, Women's and Children's Health
Hendrée Jones, UNC Horizons Program
Starleen Scott-Robbins, Division of Mental Health/DD/SAS

Spotlight: Prenatal/Pregnant Women and OUD

Improving Outcomes in Women with Opioid Use Disorder during Pregnancy: A Multidisciplinary Approach

Hendrée E. Jones, PhD

Executive Director, UNC Horizons

Professor, Department of Obstetrics and Gynecology

School of Medicine

University of North Carolina at Chapel Hill

Disclosures

- **Methadone and buprenorphine have historically been labeled by the US Food and Drug Administration (FDA) as Category C for use in pregnancy for the treatment of maternal opioid dependence: “Animal reproduction studies have shown an adverse effect on the fetus and there are no adequate and well-controlled studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks”**
- **As of May 2016, the FDA requires methadone and buprenorphine safety labeling to include information regarding the risk of neonatal opioid withdrawal syndrome (NOWS)**
- **Pregnant women with opioid uses disorders (OUDs) can be effectively treated with methadone or buprenorphine. However, labeling states it should be used only if the potential benefit justifies the potential risk to the fetus**
- **Pregnant women with opioid use disorders can be effectively treated with methadone or buprenorphine. Both these medications should not be considered “off-label” use in the treatment of pregnant patients with opioid use disorder (Jones et al., *Am J Obstet Gynecol,* 2014).**

Acknowledgements

- **Study patients and infants**
- **National Institute on Drug Abuse**
  - **R01 DAs: 015764, 015738, 017513, 015778, 018410, 018417, 015741, 15832**
- **Maternal Opioid Treatment: Human Experimental Research (MOTHER) Site PIs and investigative teams**
- **Investigative teams in Chapel Hill and Michigan**

Historical Context of Opioid Use and Women

Main Eras of Opioid Use in the USA

1800s: 66–75% of opioid users were women
The southern United States had a larger per capita number of opioid users

1940-50s: New York saw large increase in teenage opioid use

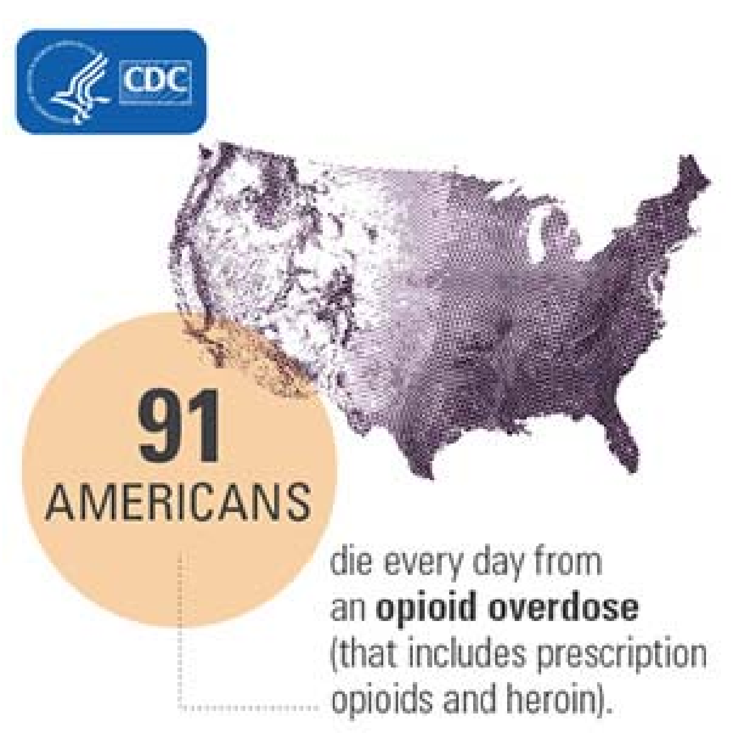
1969-70's: Opioid use by Vietnam veterans

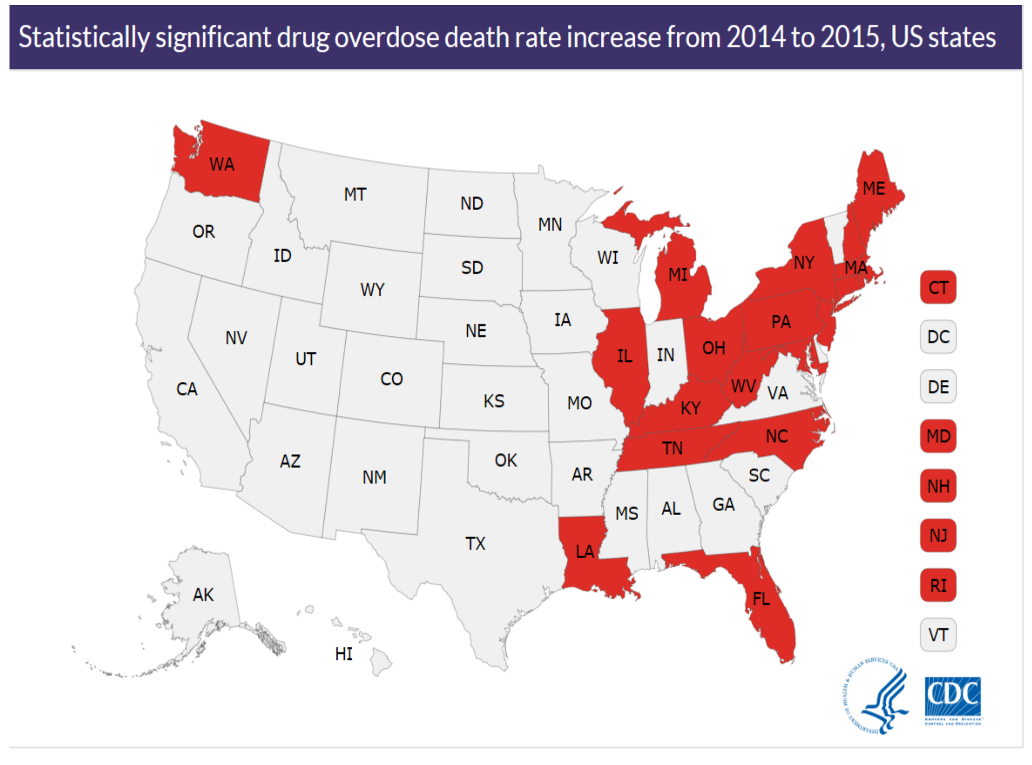
1996-now: Pain as the 5th vital sign and pain medication access

2009-2015 Drug overdose surpass motor vehicles as the leading cause of injury death

http://usslave.blogspot.com.br/2012/02/opiate-addiction-and-cocaine-use-in.html Courtwright D. *J Southern History* 1983; Kandall S *Substance and shadow*, 1996. Earle, *Medical Standards*, 1888
The Incidental Economist 2014

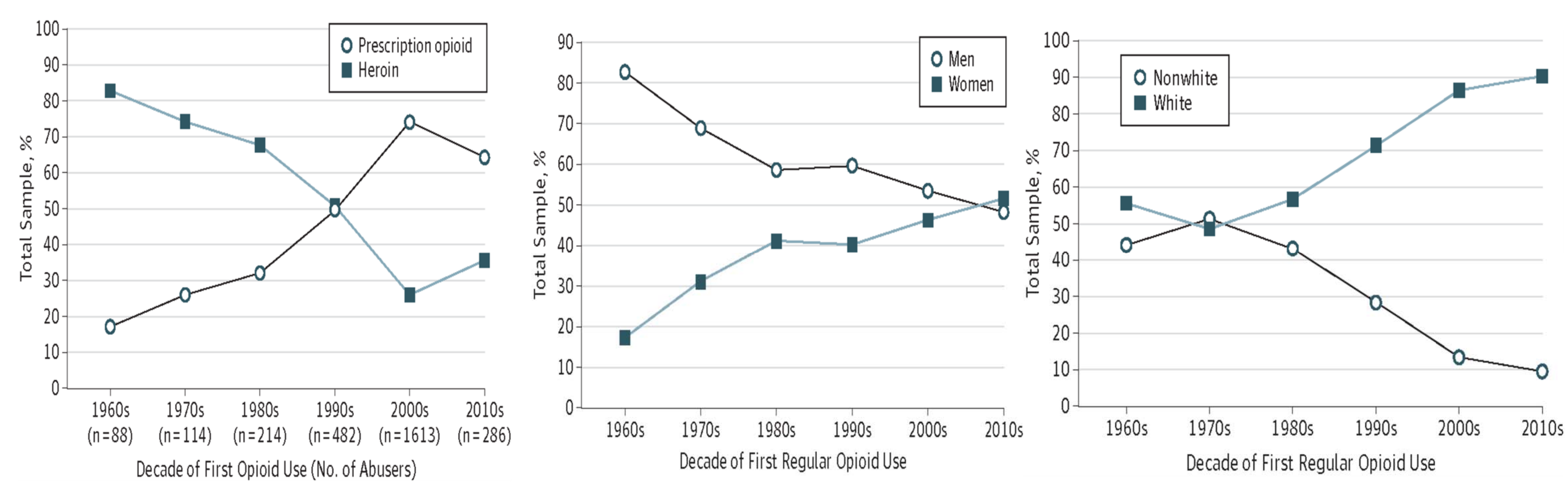
Current Context of Opioid Overdoses in the USA





https://www.cdc.gov/drugoverdose/epidemic/index.html 9/2017

Current Context: The Changing Face of Those Taking Opioids



Cicero TJ et al., JAMA Psychiatry. 2014;71(7):821-826 Copyright © 2014 American Medical Association. All rights reserved.

Current Context: USA Opioid Use and Women

Compared to men, women are more likely to:

- **report chronic pain**
- **be prescribed prescription pain relievers**
- **be given higher doses**
- **use them for longer time periods than men**

- **have a shorted duration between opioid use initiation and seeking help for an opioid use disorder**

- **Less likely to receive naloxone for an overdose**

Specific risks for the misuse of prescription opioid medication among women include: experience of violence and trauma, being a native minority, adolescent, young, older, pregnant, a sexual minority, and being a transwoman

Sumner SA et al., Prehosp Emerg Care. 2016;20(2):220-5.

http://www.cdc.gov/vitalsigns/prescriptionpainkilleroverdoses/

Hemsing N, et al. Pain Res Manag. 2016

Current Context of Opioid Misuse in the USA for Women

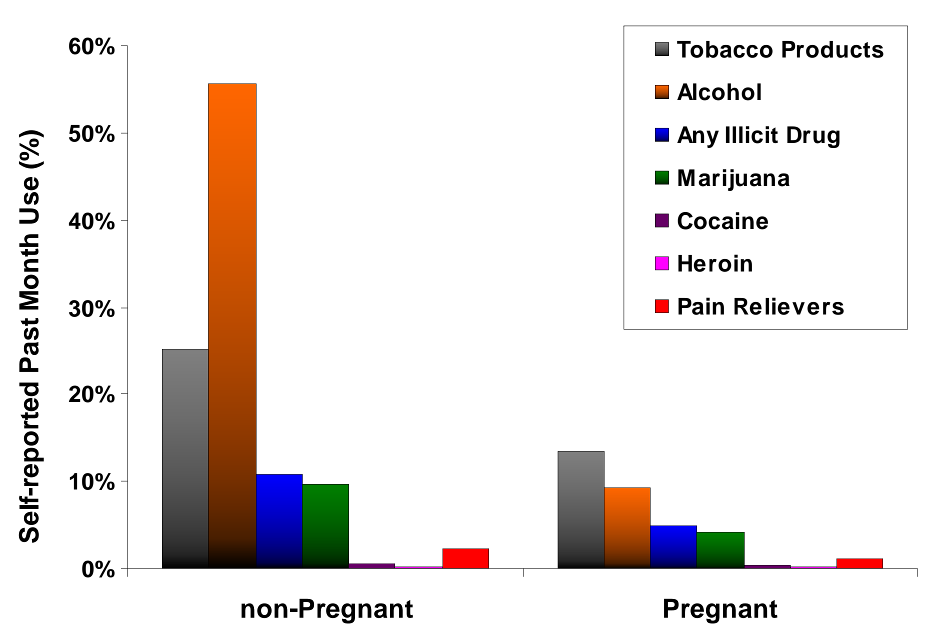
Prescription Painkiller Overdoses
A growing epidemic, especially among women
July, 2013

Nearly 48,000 women died of prescription painkiller* overdoses between 1999 and 2010.

Deaths from prescription painkiller overdoses among women have increased more than 400% since 1999, compared to 265% among men.

For every woman who dies of a prescription painkiller overdose, 30 go to the emergency department for painkiller misuse or abuse.

Current Context of Substance Use during Pregnancy



- ♦ **The two most common drugs used by non-pregnant women have been alcohol and tobacco**
- ♦ **This same statement is true for pregnant women**

➥ ***Among pregnant women, approximately .2% used heroin, and 1.1% used pain relievers non-medically in the past month***

Pregnancy: A Unique Treatment Opportunity

- Mothers with substance use disorders have a mortality rate 8.4 times that of US women of similar age
- Pregnant women who use illicit substances may delay prenatal care and miss more healthcare visits than women who do not use substances
- Prenatal care may help to reduce the negative impact of illicit drug use on birth outcomes
- Lower prenatal care utilization may be due to a diverse set of barriers to seeking and obtaining care, including fear of child custody issues
- After childbirth, ongoing substance use disorders by caregivers and the dysfunctional home environment may create detrimental effects on children's psychological growth and development
- Maternal well-being has been recognized as a key determinant of the health of the next generation

Hser, Kagihara, Huang, Evans, & Messina, 2012; Funai et al., 2003 Staton et al., 2003 and Wagner et al., 1998; El-Mohandes et al., 2003; Roberts and Pies, 2011 and Schempf and Strobino, 2009; Chatterji and Markowitz, 2001, Clark et al., 2004, Conners et al., 2004 Hanson et al., 2006 and Linares et al., 2006

Defining NAS

Neonatal Abstinence Syndrome (NAS) often results when a pregnant woman uses opioids (e.g., heroin, oxycodone) during pregnancy

NAS defined by alterations in the:

- ***Central nervous system***
  - **high-pitched crying, irritability**
  - **exaggerated reflexes, tremors and tight muscles**
  - **sleep disturbances**
- ***Autonomic nervous system***
  - **sweating, fever, yawning, and sneezing**
- ***Gastrointestinal distress***
  - **poor feeding, vomiting and loose stools**
- ***Signs of respiratory distress***
  - **nasal stuffiness and rapid breathing**

- **NAS is *not* Fetal Alcohol Syndrome (FAS)**
- **NAS is treatable**
- **NAS and treatment are not known to have long-term effects; interactions between the caregiver and child can impact resiliency/risk with potential long-term effects in some cases.**

Finnegan et al., *Addict Dis,* 1975; Desmond & Wilson, *Addict Dis,* 1975; Jones & Fielder, *Preventive Medicine,* 2015.

NAS is Not Addiction

- Newborns can't be "born addicted"
- NAS is withdrawal – due to physical dependence
- Physical dependence is not addiction
- Addiction is brain illness whose visible signs are behaviors
- Newborn do not have the life duration or experience to meet the addiction definition
- Addiction is chronic disease – chronic illness can't be present at birth

Jones & Fielder, *Preventive Medicine,* 2015.

Issues of Neonatal Withdrawal Diagnosis

Neonatal withdrawal symptoms from maternal use of drugs of addiction

- A constellation of signs and symptoms observable in a neonate that are consistent with maternal substance abuse or withdrawal while pregnant
- Fetal and neonatal addiction and withdrawal as a result of the mother's dependence on drugs during pregnancy. Withdrawal or abstinence symptoms develop shortly after birth. Symptoms exhibited are loud, high-pitched crying, sweating, yawning and gastrointestinal disturbances

Applicable To

- Drug withdrawal syndrome in infant of dependent mother
- Neonatal abstinence syndrome

Approximate Synonyms

- Neonatal drug withdrawal syndrome, maternal drug abuse
- Neonatal drug withdrawal syndrome, maternal drugs of abuse

http://www.icd10data.com/ICD10CM/Codes/P00-P96/P90-P96/P96-/P96.1

NAS: Various Substances

STATE-OF-THE-ART REVIEW ARTICLE

Neonatal Abstinence Syndrome

AUTHOR: Prabhakar Kocherlakota, MD
Pediatrics 2014;134:e547–e561

TABLE 1 Onset, Duration, and Frequency of NAS Caused by Various Substances

Drug	Onset, h	Frequency, %	Duration, d
Opioids			
Heroin	24–48	40–80[27]	8–10
Methadone	48–72	13–94[37]	Up to 30 or more
Buprenorphine	36–60	22–67[46,48]	Up to 28 or more
Prescription opioid medications	36–72	5–20[56,60]	10–30
Nonopioids			
SSRIs	24–48	20–30[64]	2–6
TCAs	24–48	20–50[64]	2–6
Methamphetamines	24	2–49[101]	7–10
Inhalants	24–48	48[70]	2–7

Medication Assisted Treatment *v*. Medication-Assisted Withdrawal

- WHO 2014 Guidelines: "Pregnant women dependent on opioids should be encouraged to use opioid maintenance treatment whenever available rather than to attempt opioid detoxification. Opioid maintenance treatment in this context refers to either methadone maintenance treatment or buprenorphine maintenance treatment."
- Guidance regarding maintenance versus medication-assisted withdrawal has traditionally been based largely on good clinical judgment
- Medication followed by no medication treatment has frequently been found to be unsuccessful, with relatively high attrition and a rapid return to illicit opioid use
- Maintenance medication facilitates retention of patients and reduces substance use compared to no medication
- Biggest concern with opioid agonist medication during pregnancy is the potential for occurrence of neonatal abstinence syndrome (NAS) – a treatable condition

Medically Assisted Withdrawal (Detoxification): Considering the Mother-Infant Dyad

- Early reports associated withdrawal with maternal relapse and fetal demise
- Recent case series data do not support this association
- Relapse remains a significant clinical concern - rates ranging from 17% to 96% (average 48%)
- Current data do not support a reduction in NAS with medically assisted withdrawal relative to opioid agonist pharmacotherapy
- Medically assisted withdrawal increases the risk of maternal relapse and poor treatment engagement and does not improve newborn health
- Treatment of chronic maternal disease, including opioid agonist disorder, should be directed toward optimal long-term outcome

Jones HE, Terplan M, Meyer M. *J Addict Med.* 2017

Why Use Opioid Medications?

With opioid medications we are not replacing one addiction for another. Opioid medications are long-acting medication that help with:

✓CRAVING

An individual's cravings are controlled

✓COMPULSION

Individual is no longer compulsively using opioids

✓CONTROL

Medication-assisted treatment gives back control to the individual

✓CONSEQUENCES

Medication assisted treatment helps the individual focus on rebuilding her life

➥***An individual receiving opioid pharmacotherapy must be monitored by a medical team that evaluates adequacy of medication dosage and general health and well-being of the individual.***

Opioid Agonist Medication Saves Lives

- Opioid use disorder is associated with higher rates of HIV and hepatitis C infection, overdose, and trauma.
- Opioid use disorder with medication assisted treatment can reduce these risks.
- Without treatment, women with opioid use disorder who become pregnant face increased risks of preterm delivery and low birth weight

Tsui JI et al., 2014; Lepère B et al., 2001; Soyka M et al., 2012; Degenhardt L et al., 2009; Binder and Vavrinková, 2008

Role of Medication in Recovery

A review of 38 studies, involving some 12,400 participants, found that opioid agonist treatment with either methadone or buprenorphine is associated with reductions in:

- **illicit opioid use**
- **injecting use**
- **sharing of injecting equipment**
- **number of multiple sex partners**
- **exchanges of sex for drugs or money**
- ***but* has little effect on condom use**

➥ ***Review also suggests that the reductions in risk behaviors related to substance use do translate into reductions in cases of HIV infection***

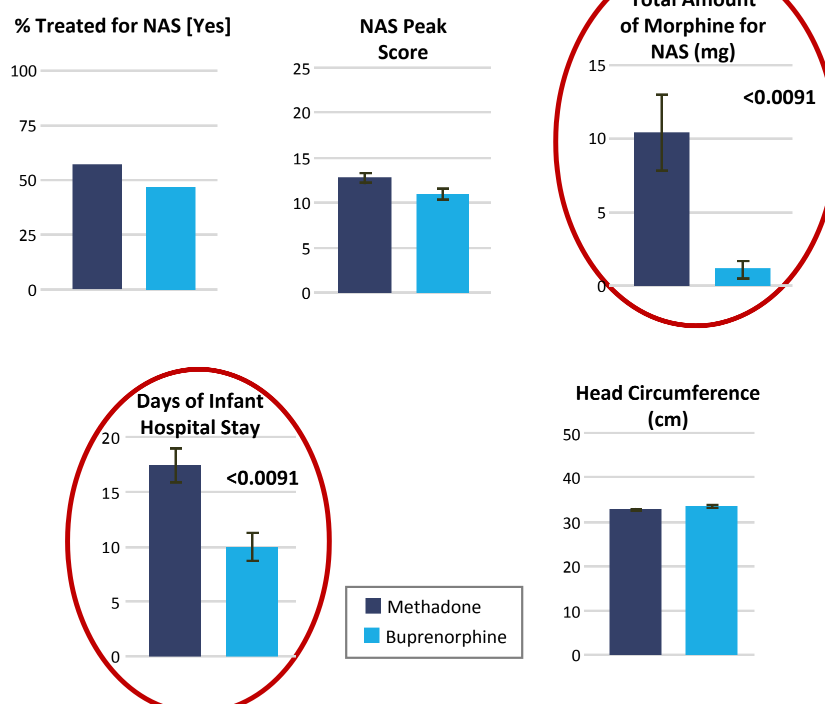
Gowing et al., 2011

Medication Options

- **Methadone**
- **Buprenorphine (alone or with naloxone)**
- ***Naltrexone***

MOTHER: Buprenorphine *v.* Methadone

Primary Outcomes

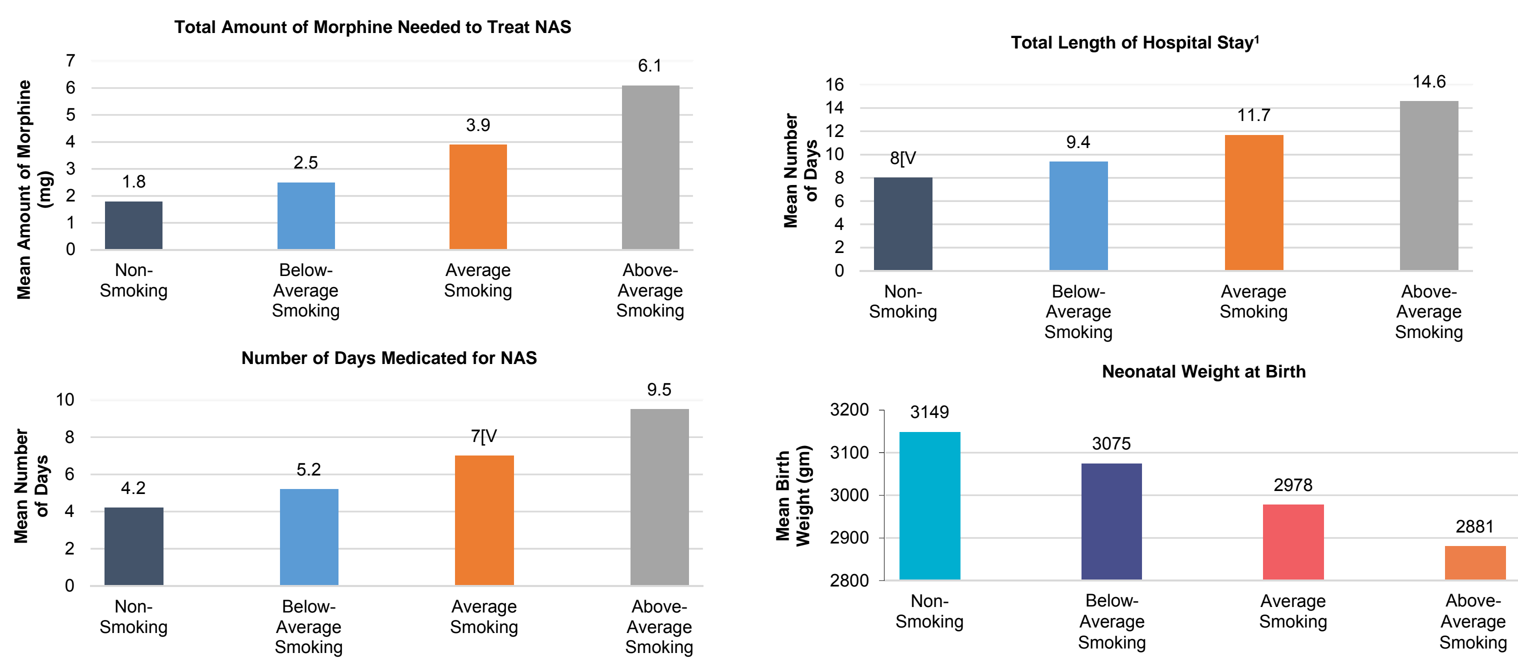


Notes: **Significant results are encircled. Site was a blocking factor in all analyses. The O'Brien-Fleming α spending function resulted in α=0.0091 for the inferential tests of the Medication Condition effect for the 5 primary outcome measures at the conclusion of the trial.**

- **Compared with methadone-exposed neonates, buprenorphine-exposed neonates**
  - **Required 89% less morphine to treat NAS**
  - **Spent 43% less time in the hospital**
  - **Spent 58% less time in the hospital being medicated for NAS**
- **Both medications in the context of comprehensive care produced similar maternal treatment and delivery outcomes**

Jones HE, Kaltenbach K, Heil SH, et al. *N Engl J Med.* 2010;363(24):2320-2331.

MOTHER: Smoking and NAS



Ordinary least squares and Poisson regression analyses were used to test average daily number of cigarettes smoked in the past 30 days at α=0.05, adjusting for both Medication Condition and Site.
Below-average cigarette smoking was defined as 6 cigarettes/day (-1 *SD*), average cigarette smoking as 14 cigarettes/day (Mean), and above-average cigarette smoking as 21 cigarettes/day (+1 *SD*).

MOTHER Child Outcomes up to 36 months

N=96 children

- No pattern of differences in physical or behavioral development to support medication superiority
- No pattern of differences for infants treated for NAS v. infants who did not receive treatment for NAS
- Results indicate children born in the MOTHER study are following a path of normal development in terms of growth, cognitive and psychological development

Kaltenbach, K. The MOTHER study: what about the children? *Presented AAAP* 2015 (manuscript under review)

Pain Management

- Medications that are full agonist opioids can effectively treat pain in patients stabilized on either methadone or buprenorphine.
- These results are consistent with data from non-pregnant surgery patients.
- The importance of uninterrupted methadone or buprenorphine treatment in these patients is critical.
- Each patient needs a pain management plan before delivery.

Jones et al., Am J Addict 2006

Breastfeeding

- Both methadone and buprenorphine are compatible with breastfeeding
- Concentration of either medication in breast milk is low
- Most recent guidelines: “the amounts of buprenorphine in human milk are small and unlikely to have negative effects on the developing infant”
- “The advantages of breast feeding prevail despite the risks of an infant opiate intoxication caused by methadone or buprenorphine.”

Image Credit: “Mother Is Breast Feeding For Her Baby” by Jomphong

Akinson et al., 1990; Marquet et al., 1997; Johnson, et al., 2001; Grimm et al., 2005; Lindemalm et al., 2009; Jansson et al., 2009; Müller et al., 2011; Reece-Stremtan, Marinelli and The Academy of Breastfeeding Medicine. Breastfeeding Medicine, 2015.

NAS: Factors

Other factors that contribute to severity of NAS in neonates exposed to opioid agonists in utero:

- **Genetics**
- **Other Substances**
  Tobacco use   Benzodiazepines   SSRIs
- **Birth weight**
- **Hospital Protocols**
  - NICU setting
  - The NAS assessment choice
  - NAS medication choice
  - Initiation and weaning protocols
  - Not breastfeeding
  - Separating mother and baby

MOTHER NAS Predictors

Receipt of NAS treatment for infants was predicted by:

- infant birthweight
- greater maternal nicotine use

Total medication dose needed to treat NAS was predicted by:

- Maternal use of SSRIs
- higher nicotine use
- fewer days of study medication received also predicted

Jansson and Velez, *Curr Opin Pediatrics*, 2012

Kaltenbach et al., *Addiction*, 2012

Summary: MOTHER Contributions

- MOTHER provided the first large RCT to examine and confirm methadone's efficacy for use in pregnant women with opioid use disorders
- Site effects were expected and controlled
- NAS protocol highly rigorous
- Maternal outcomes were similar between medications
- In terms of NAS severity, buprenorphine can be a front-line medication option for managing opioid-dependence for pregnant women who are new to treatment or maintained on buprenorphine pre-pregnancy
- NAS, its treatment and elucidating factors that exacerbate and minimize it, remains a significant clinical issue for prenatally opioid-exposed neonates

UNC Horizons: Model of Care for Women and Children

Medication Assisted Treatment

Trauma and SUD Treatment

Residential and/or Outpatient Care

Childcare and Transportation

Medical Care OB/GYN Psychiatry

Vocational Rehabilitation Housing Legal aid

Parenting Education and Early Intervention

2016-2017 Treated 266 women

- **62% Primary OUD**
- **24% reported TBI**
- **Age of first substance use started at 5 years old (mean 15 years old)**
- **Babies born at term and normal birth weight**
- **77% employed at completion**
- **100% CPS outcomes were positive at completion**

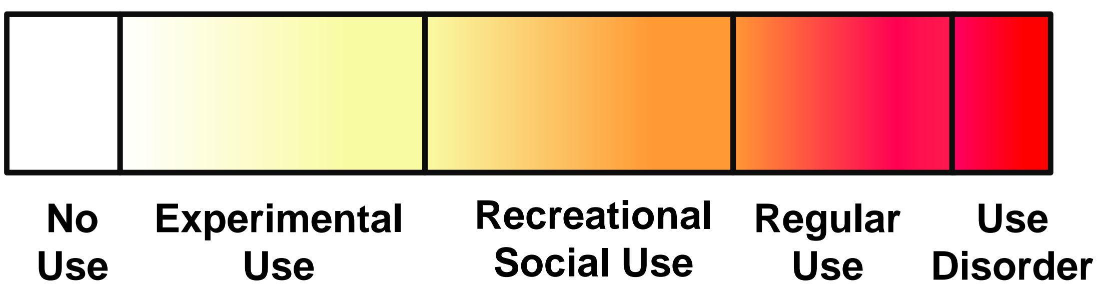
Unified Philosophy Informed by Social Learning, Relationship and Empowerment Theories

A Urine Drug Test is Not …

- It is not a parenting test
- Toxicology tests for drugs are not sufficient for a diagnosis of a substance use disorder
- Having a substance use disorder is only one of many other factors in determining child safety

http://www.ezkeycup.com/iCup-Drug-Screen-8-p/i-dud-187-013.htm

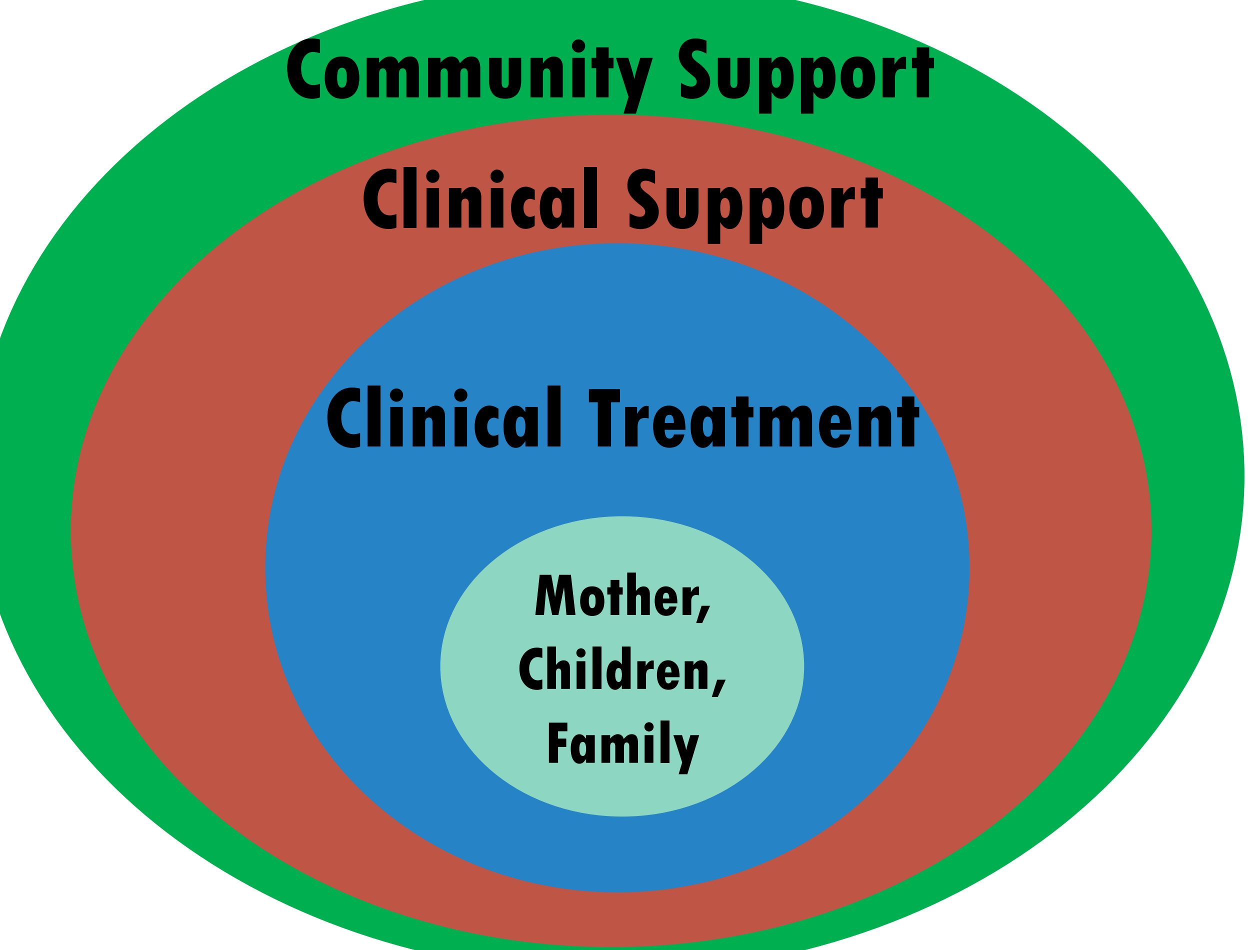
Treatment Response Needs to Match the Severity of the Problems



American Society of Addiction Medicine Placement Criteria

LEVEL 0.5	**Early Intervention**
LEVEL I	**Outpatient Treatment**
LEVEL II	**Intensive Outpatient/ Partial Hospitalization**
LEVEL III	**Residential/ Inpatient Treatment**
LEVEL IV	**Medically Managed Intensive Hospital/ Inpatient Treatment**

Recovery Oriented System of Care for Families



Summary

- Opioid use disorder is a concerning medical illness that has radiating effects on the life of the person and those around the person
- Those who have this illness deserve the most appropriate medical care – medication in only one part of a complete treatment approach
- Patients are best served by having choices in medication treatment options
- Structured, evidence-based behavioral treatment is needed to help support the mother, child and family
- Women who have opioid use disorders and their prenatally opioid exposed children are best served with a strength-based perspective

UNC Horizons

Contact:

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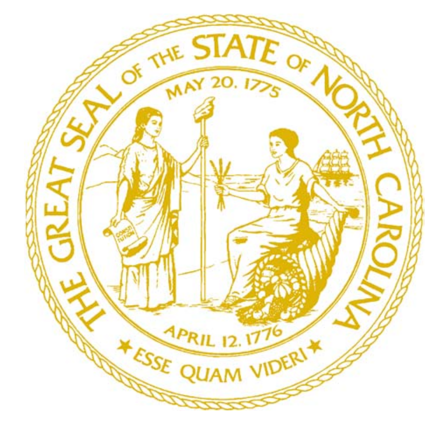
Susan Kansagra, DHHS Opioid Lead

Learn, Explore, and Clarify:
NC Opioid Action Plan

September 29, 2017

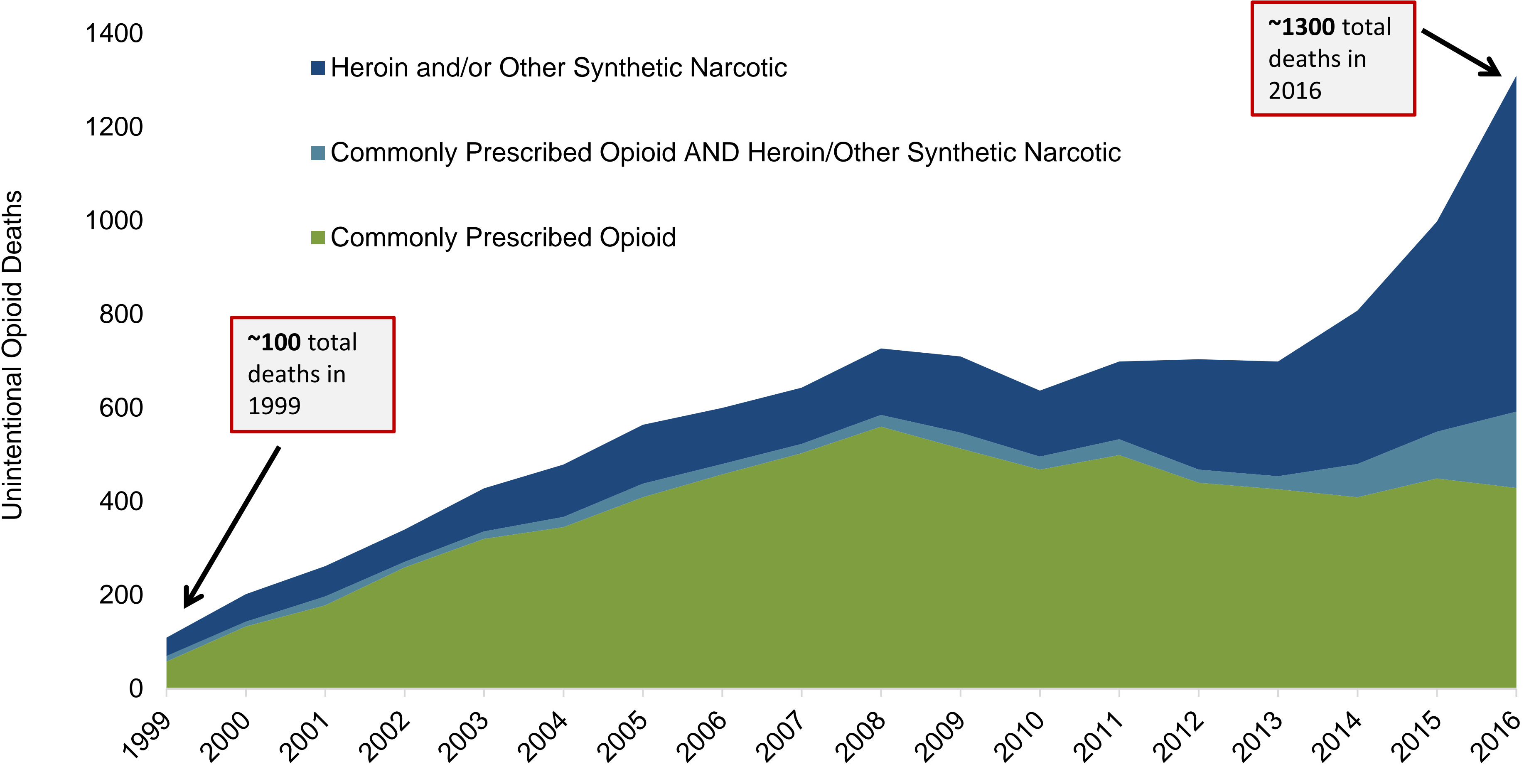
NC Opioid Action Plan



Opioid and Prescription Drug Abuse Advisory Council

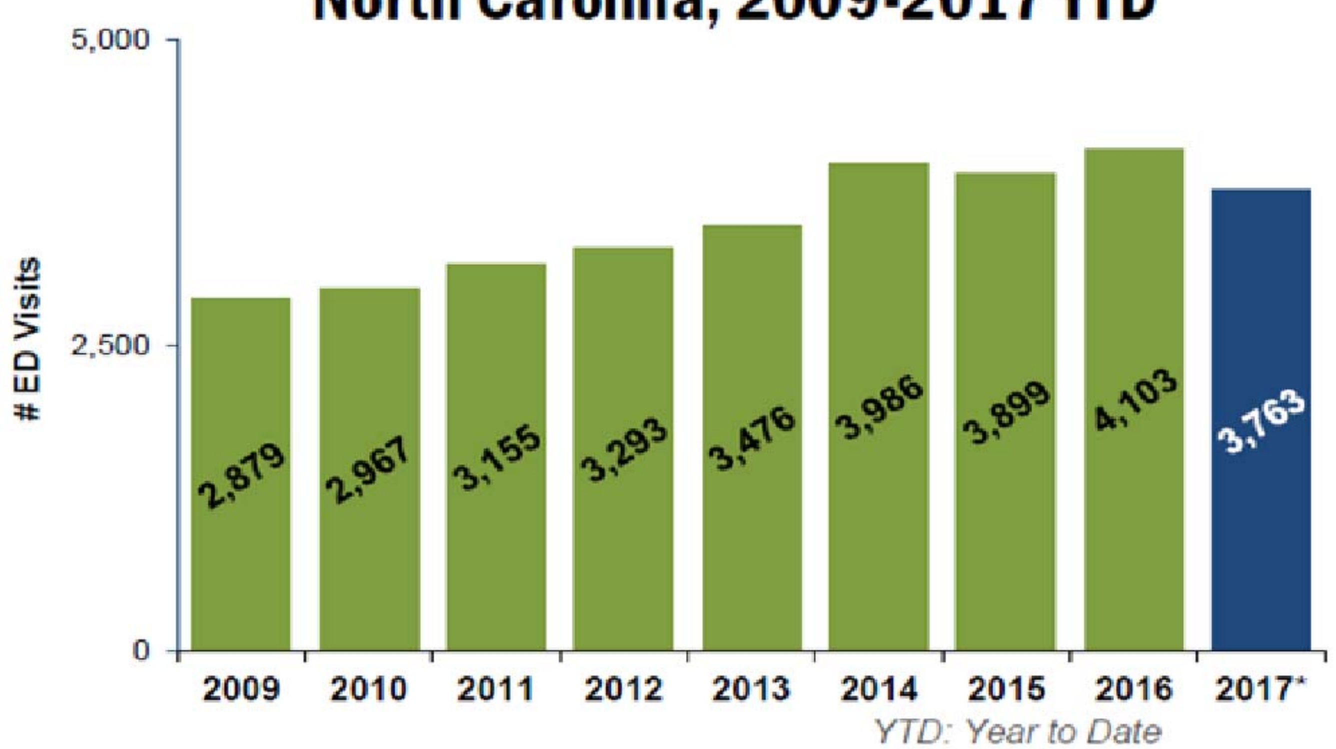
Susan Kansagra, MD, MBA
Opioids Response Lead, DHHS
Section Chief, Chronic Disease and Injury, DPH

Unintentional opioid deaths have increased more than 10 fold
Heroin or other synthetic narcotics are now involved in over 50% of deaths

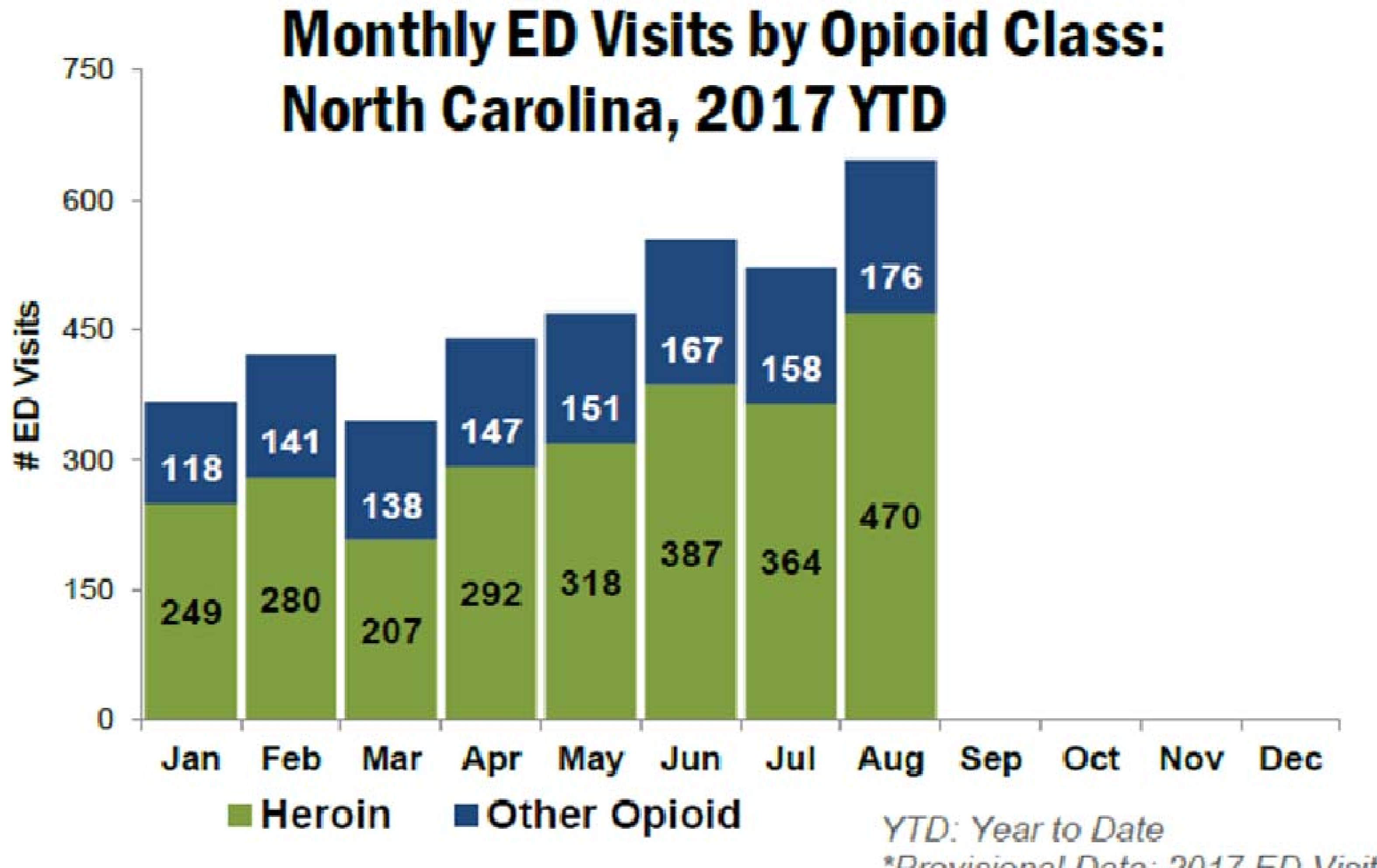


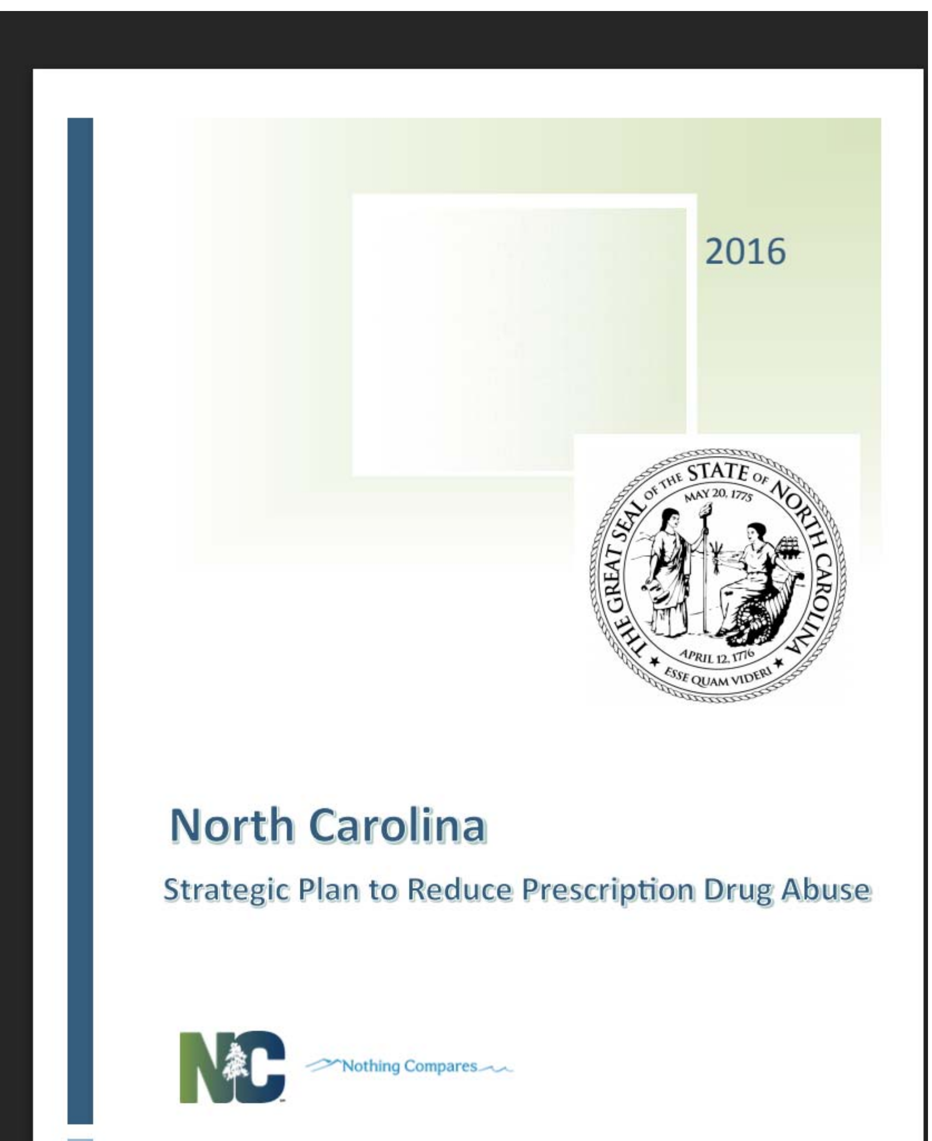
Source: N.C. State Center for Health Statistics, Vital Statistics-Deaths, 1999-2015
Unintentional medication/drug (X40-X44) with specific T-codes by drug type, Commonly Prescribed Opioid Medications=T40.2 or T40.3; Heroin and/or Other Synthetic Narcotics=T40.1 or T40.4.
Analysis by Injury Epidemiology and Surveillance Unit

North Carolina Injury & Violence PREVENTION Branch



Opioid Overdose ED Visits by Year:
North Carolina, 2009-2017 YTD
5,000
2,500
0
ED Visits
2,879
2,967
3,155
3,293
3,476
3,986
3,899
4,103
3,763
2009
2010
2011
2012
2013
2014
2015
2016
2017*
YTD: Year to Date
*Provisional Data: 2017 ED Visits
North Carolina
Injury & Violence
PREVENTION Branch
NC DETECT


Monthly ED Visits by Opioid Class:
North Carolina, 2017 YTD
ED Visits
750
600
450
300
150
0
118
141
138
147
151
167
158
176
249
280
207
292
318
387
364
470
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Heroin
Other Opioid
YTD: Year to Date
*Provisional Data: 2017 ED Visits


2016
THE GREAT SEAL OF THE STATE OF NORTH CAROLINA
MAY 20, 1775
APRIL 12, 1776
ESSE QUAM VIDERI
North Carolina
Strategic Plan to Reduce Prescription Drug Abuse
NC
Nothing Compares

NORTH CAROLINA'S OPIOID ACTION PLAN

2017-2021

June 2017, Version 1

NC Opioid Action Plan: FOCUS AREAS

- Have a coordinated infrastructure
- Reduce oversupply of prescription opioids
- Reduce diversion of prescription drugs and flow of illicit drugs
- Increase community awareness and youth prevention
- Make naloxone widely available and link overdose survivors to care
- Expand treatment and recovery oriented systems of care
- Measure our impact and revise strategies based on results

https://www.ncdhhs.gov/opioids

2. REDUCE OVERSUPPLY OF PRESCRIPTION DRUGS

Strategy	Action	Leads
Safe prescribing policies	Develop and adopt model health system policies on safe prescribing (e.g. ED and surgical prescribing policies, co-prescribing of naloxone, checking the CSRS)	NCHA, DMA, Licensing boards and professional societies
	Create and maintain continuing education opportunities and resources for prescribers to manage chronic pain	GI, AHEC, CCNC, DMA, Licensing boards and professional societies
CSRS utilization	Register 100% of eligible prescribers and dispensers in CSRS	DMH, Licensing boards and professional societies
	Provide better visualization of the data (easy to read charts and graphs) to enable providers to make informed decisions at the point of care	DMH, IPRC, CHS, GDAC, DIT
	Develop connections that would enable providers to make CSRS queries from the electronic health record	DMH, GDAC, NCHA, DIT
	Report data to all NC professional boards so they can investigate aberrant prescribing or dispensing behaviors	Licensing boards and professional societies
Medicaid and commercial payer policies	Convene a Payers Council to identify and implement policies that reduce oversupply of prescription opioids (e.g. lock-in programs) and improve access to SUD treatment and recovery supports	DHHS, DMA, BCBSNC, SHP and other payers, CCNC, LME/MCOs
Workers' compensation policies	Identify and implement policies to promote safer prescribing of opioids to workers' compensation claimants	Industrial Commission, workers' compensation carriers

3. REDUCE DIVERSION AND FLOW OF ILLICIT DRUGS

Strategy	Action	Leads
Trafficking investigation and response	Establish a trafficking investigation and enforcement workgroup to identify actions required to curb the flow of diverted prescription drugs (e.g. CSRS access for case investigation) and illicit drugs like heroin, fentanyl, and fentanyl analogues	AG, HIDTA, SBI, DEA, Local law enforcement
Diversion prevention and response	Develop model healthcare worker diversion prevention protocols and work with health systems, long-term care facilities, nursing homes, and hospice providers to adopt them	NCHA, AG, DMH, Licensing boards and professional societies
Drug takeback, disposal, and safe storage	Increase the number of drug disposal drop boxes in NC – including in pharmacies, secure funding for incineration, and promote safe storage	DOI Safe Kids NC, SBI, Local law enforcement, AG, NCAP, NCRMA, CCNC, LHDs
Law enforcement and public employee protection	Train law enforcement and public sector employees in recognizing presence of opioids, opioid processing operations, and personal protection against exposure to opioids	DPH, Local law enforcement

4. INCREASE COMMUNITY AWARENESS AND PREVENTION

Strategy	Action	Leads
Public education campaign	Identify funding to launch a large-scale public education campaign to be developed by content experts using evidence-based messaging and communication strategies Potential messages could include: ▪ Naloxone access and use ▪ Patient education regarding expectations around pain management/opioid alternatives ▪ Patient education to be safe users of controlled substances ▪ Linkage to care, how to navigate treatment ▪ Safe drug disposal and storage ▪ Stigma reduction ▪ Addiction as a disease: recovery is possible	DHHS, Advisory Council, PDAAC, Partners
Youth primary prevention	Build on community-based prevention activities to prevent youth and young adult initiation of drug use (e.g. primary prevention education in schools, colleges, and universities)	DMH, LME/MCOs, Local coalitions

5. INCREASE NALOXONE AVAILABILITY

Strategy	Action	Leads
Law enforcement naloxone administration	Increase the number of law enforcement agencies that carry naloxone to reverse overdose among the public	NCHRC, DPS, OEMS, Local law enforcement, AG
Community naloxone distribution	Increase the number of naloxone overdose rescue kits distributed through communities to lay people	NCHRC, DPH, LHDs, LME/MCOs, OTPs, CCNC
Naloxone co-prescribing	Create and adopt strategies to increase naloxone co-prescribing within health systems, PCPs	NCHA, NCAP, CCNC, Licensing boards and professional societies
Pharmacist naloxone dispensing	Train pharmacists to provide overdose prevention education to patients receiving opioids and increase pharmacist dispensing of naloxone under the statewide standing order	NCAP, NCBP, CCNC
Safer Syringe Initiative	Increase the number of SEP programs and distribute naloxone through them	NCHRC, DPH, LHDs

6. EXPAND TREATMENT ACCESS

Strategy	Action	Leads
Care linkages	Work with health systems to develop and adopt model overdose discharge plans to promote recovery services and link to treatment care	NCHA, LME/MCOs
	Link patients receiving office-based opioid treatment to counseling services for SUD using case management or peer support specialists	DMH, RCOs, APNC, CCNC, LME/MCOs, NCATOD
Treatment access	Increase state and federal funding to serve greater numbers of North Carolinians who need treatment	All
MAT access: Office-based opioid treatment	Offer DATA waiver training in all primary care residency programs and NP/PA training programs in NC	DHHS, NCHA, AHEC, NCAFP, Medical Schools
	Increase providers' ability to prescribe MAT through ECHO spokes and other training opportunities	DMH, UNC, ORH, AHEC, FQHCs
	Increase opportunities for pharmacists to collaborate with PCPs and specialty SUD providers to coordinate MAT	NCAP, NCBP, AHEC, UNC
Integrated care	Increase access to integrated physical and behavioral healthcare for people with opioid use disorder	DHHS, Health systems, LHDs

6. EXPAND TREATMENT ACCESS, Cont'd

Strategy	Action	Leads
Transportation	Explore options to provide transportation assistance to individuals seeking treatment	DMH, LME/MCOs, DSS, Local government
Law Enforcement Assisted Diversion	Implement additional Law Enforcement Assisted Diversion (LEAD) programs to divert low level offenders to community-based programs and services	NCHRC, AG, DAs, DMH
Special Populations: Pregnant women	Increase number of OB/GYN and prenatal prescribers with DATA waivers to prescribe MAT	NCOGS, Professional societies
	Support pregnant women with opioid addiction in receiving prenatal care, SUD treatment, and promoting healthy birth outcomes	DMA, CCNC, DPH, DMH, LME/MCOs, DSS
Special populations: Justice-involved persons	Provide education on opioid use disorders and overdose risk and response at reentry facilities, local community corrections, and TASC offices	DPS, DMH, NCHRC
	Expand in-prison/jail and post-release MAT and on-release naloxone for justice involved persons with opioid use disorder	DPS, DMH, Local government

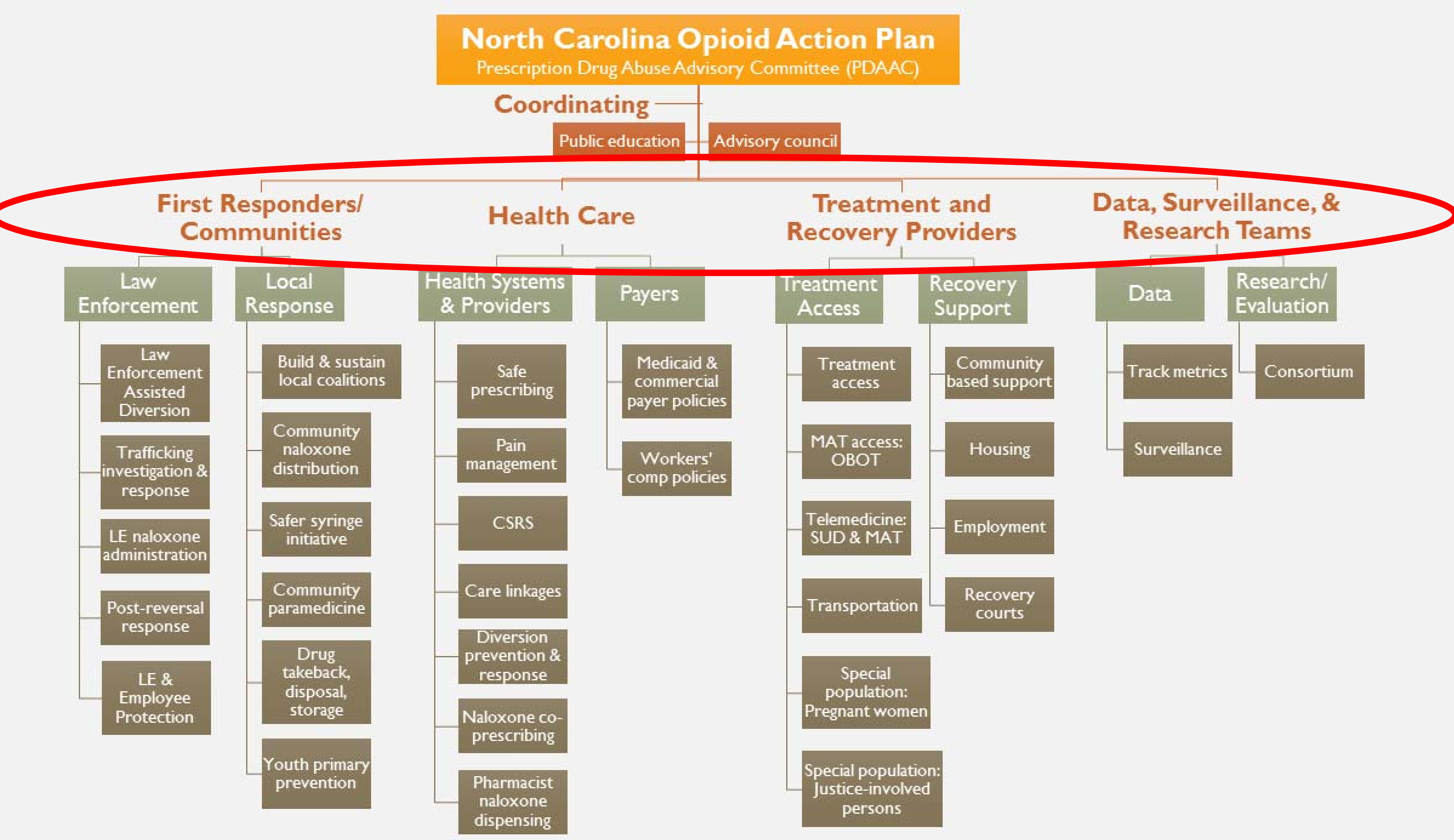
6. EXPAND RECOVERY SUPPORT

Strategy	Action	Leads
Community paramedicine	Increase the number of community paramedicine programs whereby EMS links overdose victims to treatment and support	OEMS, DMH, LMEs/MCOs
Post-reversal response	Increase the number of post-reversal response programs coordinated between law enforcement, EMS, and/or peer support/case workers	NCHRC, Local LE, OEMS, RCOs, AG, LME/MCOs
Community-based support	Increase the number of community-based recovery supports (e.g. support groups, recovery centers, peer recovery coaches)	DMH, RCOs, ORH, LME/MCOs
Housing	Increase recovery-supported transitional housing options to provide a supportive living environment and improve the chance of a successful recovery	DMH, LME/MCOs, Local government and coalitions
Employment	Reduce barriers to employment for those with criminal history	Local government and coalitions
Recovery Courts	Maintain and enhance therapeutic (mental health, recovery and veteran) courts	Local government, Judges and DAs

7. MEASURE IMPACT

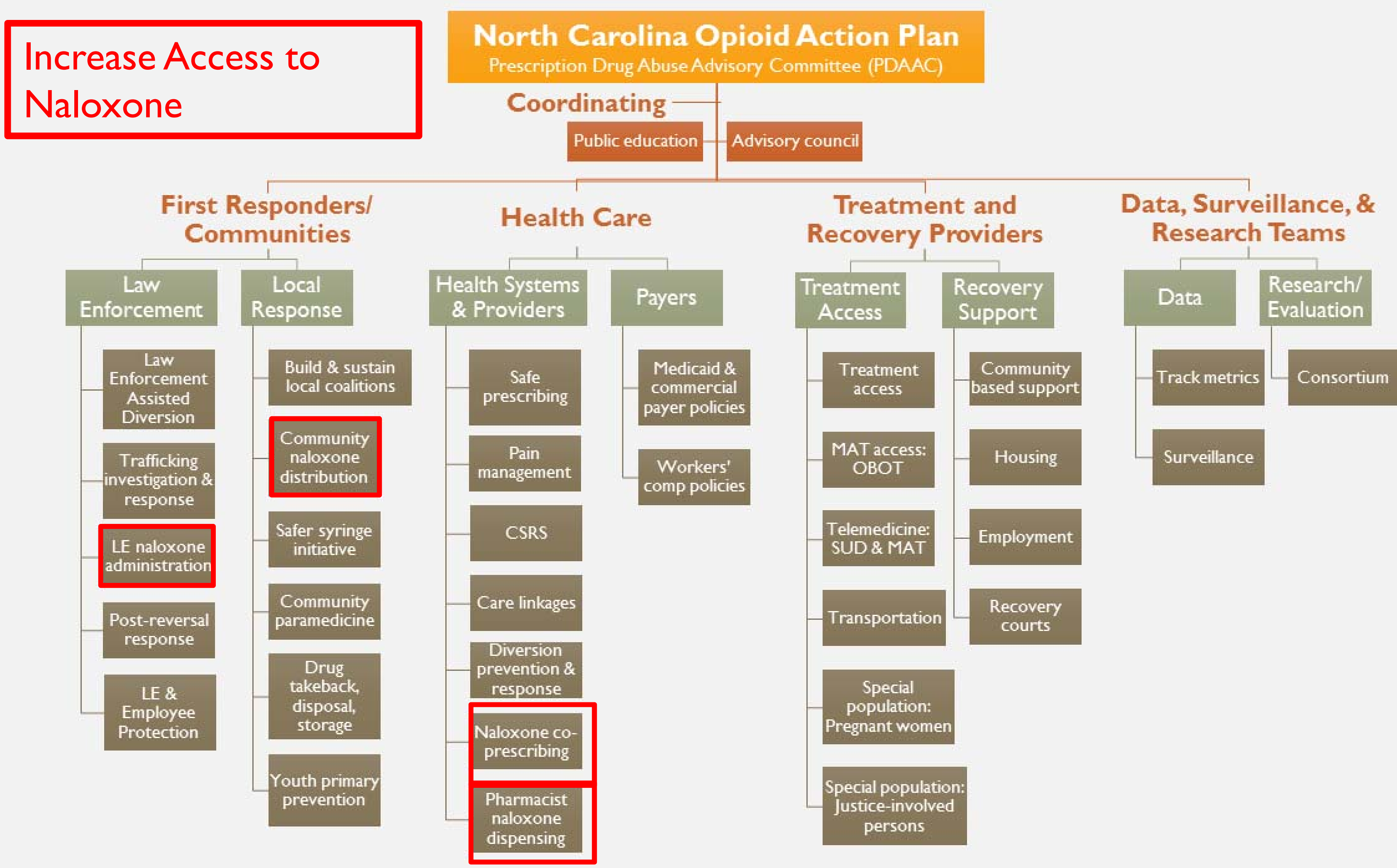
Strategy	Action	Leads
Metrics/Data	Create publicly accessible data dashboard of key metrics to monitor impact of this plan	DPH, DMH
Surveillance	Establish a standardized data collection system to track law enforcement and lay person administered naloxone reversal attempts	OEMS, Law Enforcement, CPC, NCHRC
	Create a multi-directional notification protocol to provide close to real-time information on overdose clusters (i.e. EMS calls, hospitalizations, arrests, drug seizures) to alert EMS, law enforcement, healthcare providers	HIDTA, SBI, DEA, DPH, OEMS, CPC, LHDs, Local law enforcement
Research/ Evaluation	Establish an opioid research consortium and a research agenda among state agencies and research institutions to inform future work and evaluate existing work	UNC, Duke, RTI, other Universities/colleges, DPH, DMH, AHEC/Academic Research Centers

OPDAAC



OPDAAC

Increase Access to Naloxone



WORKGROUP

- Review action plan items in your workgroup
- Determine priorities/opportunities

OPDAAC COORDINATING WORKGROUP

- Co-chairs and a few members of each committee

- Share emerging data/trends
- Raise needs of workgroup/barriers
- Provide input on new strategies
- Report back to this group on progress
- Problem solve

OPDAAC COORDINATING WORKGROUP

- Next Cross Cutting Topic

- Post-Reversal Response
  - What should this look like?
  - What is already happening in our state?
  - How fund?
  - Where to focus?

Workgroups Today

- Review action plan items in your workgroup
- Determine priorities/opportunities

OPDAAC Coordinating workgroup

- Co-chairs and a few members of each committee

- Share emerging data/trends
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OPDAAC Coordinating workgroup

- Next Cross Cutting Topic

- Post-Reversal Response
  - What should this look like?
  - What is already happening in our state?
  - How fund?
  - Where to focus?

RETURN at 12:00PM

OPDAAC Workgroup Time

Workgroup Name	DHHS Facilitators	Meeting Room
Prevention and Public Awareness, *Group A: Community*	**Nidhi Sachdeva** Sarah Potter	Computer Training Rom (2nd Floor)
Prevention and Public Awareness, *Group B: Law enforcement*	**Melinda Pankratz** Donnie Varnell (Steve Mange)	Cardinal Room B (Yonder)
Treatment and Recovery	**Dede Severino** Smith Worth Donald McDonald	Eagle Room (3rd Floor)
Professional Training and Coordination (Health Care)	**Anna Stein** Sara McEwen Alex Asbun	Cardinal Room A (Here)
Core Data and Surveillance	**Scott Proescholdbell** Steve Marshall	Sparrow Room (same floor, down hall)

BREAK and Transition!

Announcements and News

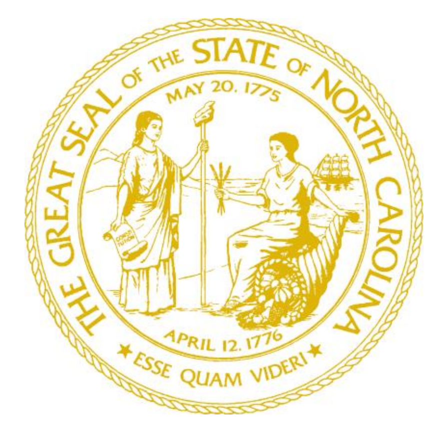
Nidhi Sachdeva, Injury Prevention Consultant, Injury and Violence Prevention Branch, NC Division of Public Health

- PDAAC Website: https://sites.google.com/view/ncpdaac

- THANK YOU!!

(Please return your name badges, take food, and travel safely!)

Questions



Nidhi Sachdeva, MPH
Injury Prevention Consultant
Injury and Violence Prevention Branch

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919.707.5428

Thank you!