NC Department of Health and Human Services

Opioid and Prescription Drug Abuse Advisory Committee

December 15, 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

- *Take breaks as needed*

Mary Beth Cox, Division of Public Health

Update: The Burden of the Opioid Epidemic in N.C. – Data Resources

N.C. Overdose Data: Updates and Resources

Division of Public Health
Injury and Violence Prevention Branch

Mary Beth Cox

OPDAAC Meeting
December 15, 2017

North Carolina
Injury & Violence
PREVENTION Branch

Overview

- Data updates
- Resources
  - County Tables
  - Core and County Slide Sets
  - Monthly Data Updates
  - Opioid Action Plan Metrics
  - Data Dashboards

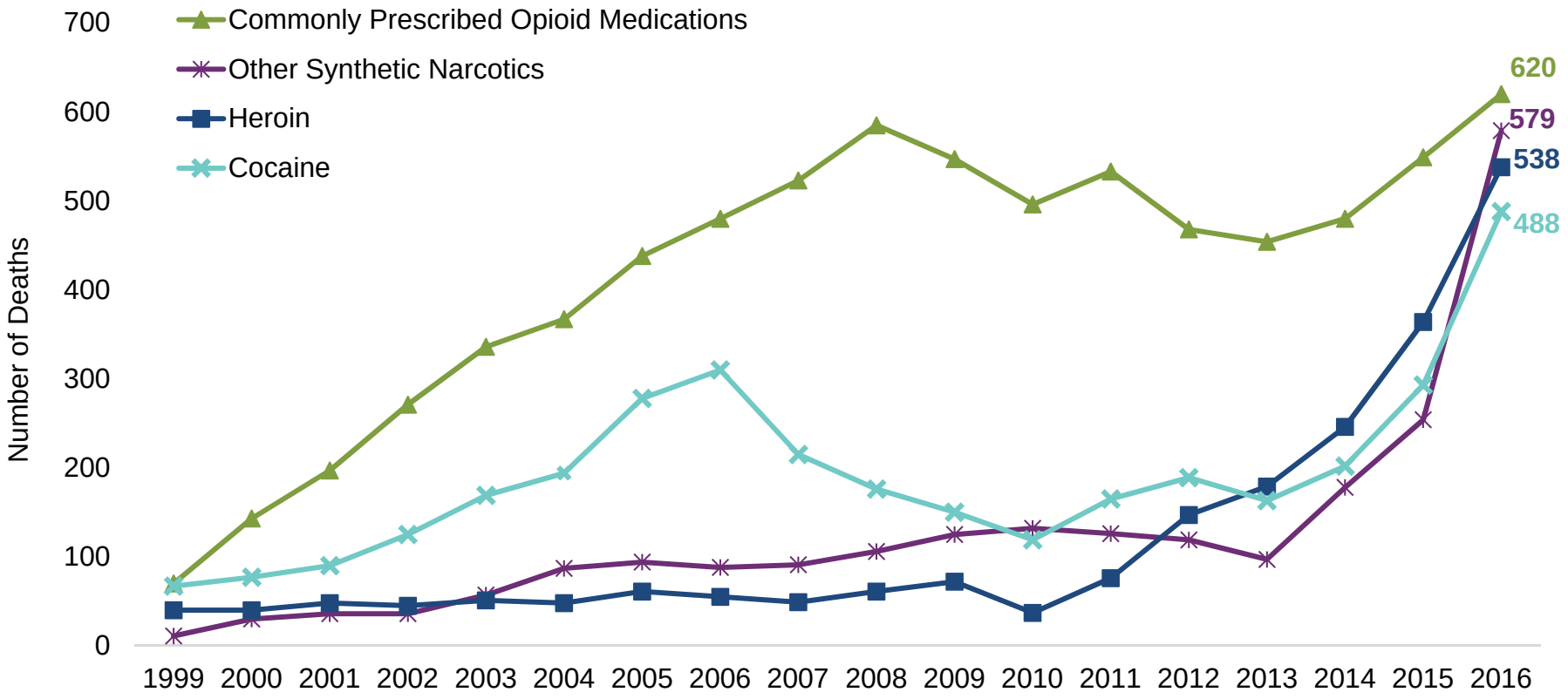
North Carolina
Injury & Violence
PREVENTION Branch

In 2016, nearly 4 North Carolinians died each day from unintentional opioid overdose.

Source: Deaths-N.C. State Center for Health Statistics, Vital Statistics, 2016, Unintentional medication or drug overdose: X40-X44 and any mention of T40.0 (Opium), T40.1 (Heroin), T40.2 (Other Opioids), T40.3 (Methadone) and/or T40.4 (Other synthetic opioid)
Analysis by Injury Epidemiology and Surveillance Unit

North Carolina Injury & Violence PREVENTION Branch

Substances* Contributing to Unintentional Medication and Drug Overdose Deaths, North Carolina Residents, 1999-2016



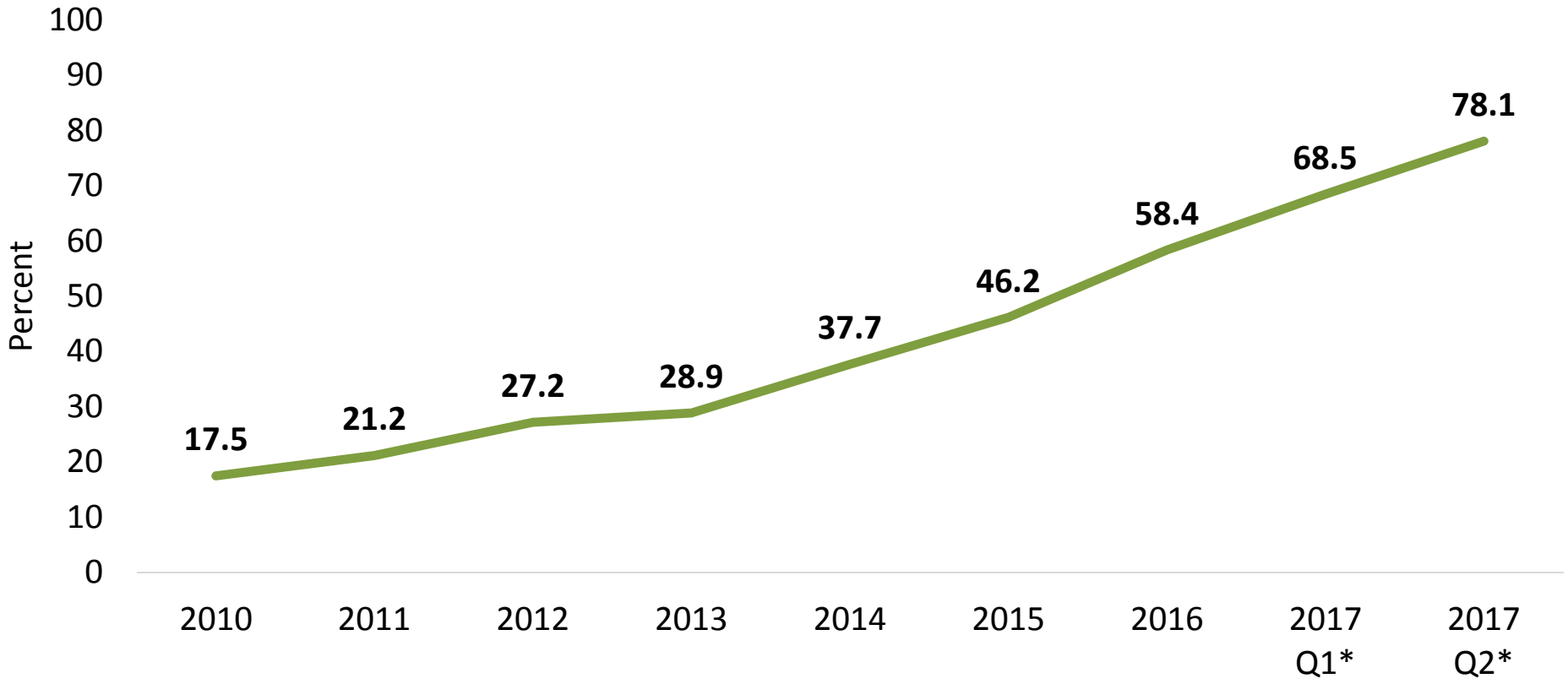
*These counts are not mutually exclusive. If the death involved multiple drugs it can be counted on multiple lines.

Source: N.C. State Center for Health Statistics, Vital Statistics-Deaths, 1999-2016,
Unintentional medication or drug overdose: X40-X44 with any mention of specific T-codes by drug type.
Analysis by Injury Epidemiology and Surveillance Unit

North Carolina Injury & Violence PREVENTION Branch

Percent of Opioid Overdoses Positive for Heroin, Fentanyl, and/or Fentanyl Analogues**

Office of Chief Medical Examiner Investigated Deaths, 2010-2017*



*2017 data are preliminary and subject to change

Source: NC Office of the Chief Medical Examiner (OCME) and the OCME Toxicology Laboratory, 2010-2017 Q2

**Fentanyl analogues include: Acetyl fentanyl, Butrylfentanyl, Furanylfentanyl, Fluorofentanyl, Acrylfentanyl, Fluoroisobutrylfentanyl, Beta-Hydroxythiofentanyl, Carfentanil. The presence of a drug does not necessarily indicate that it was attributed to the cause of death.

North Carolina Injury & Violence PREVENTION Branch

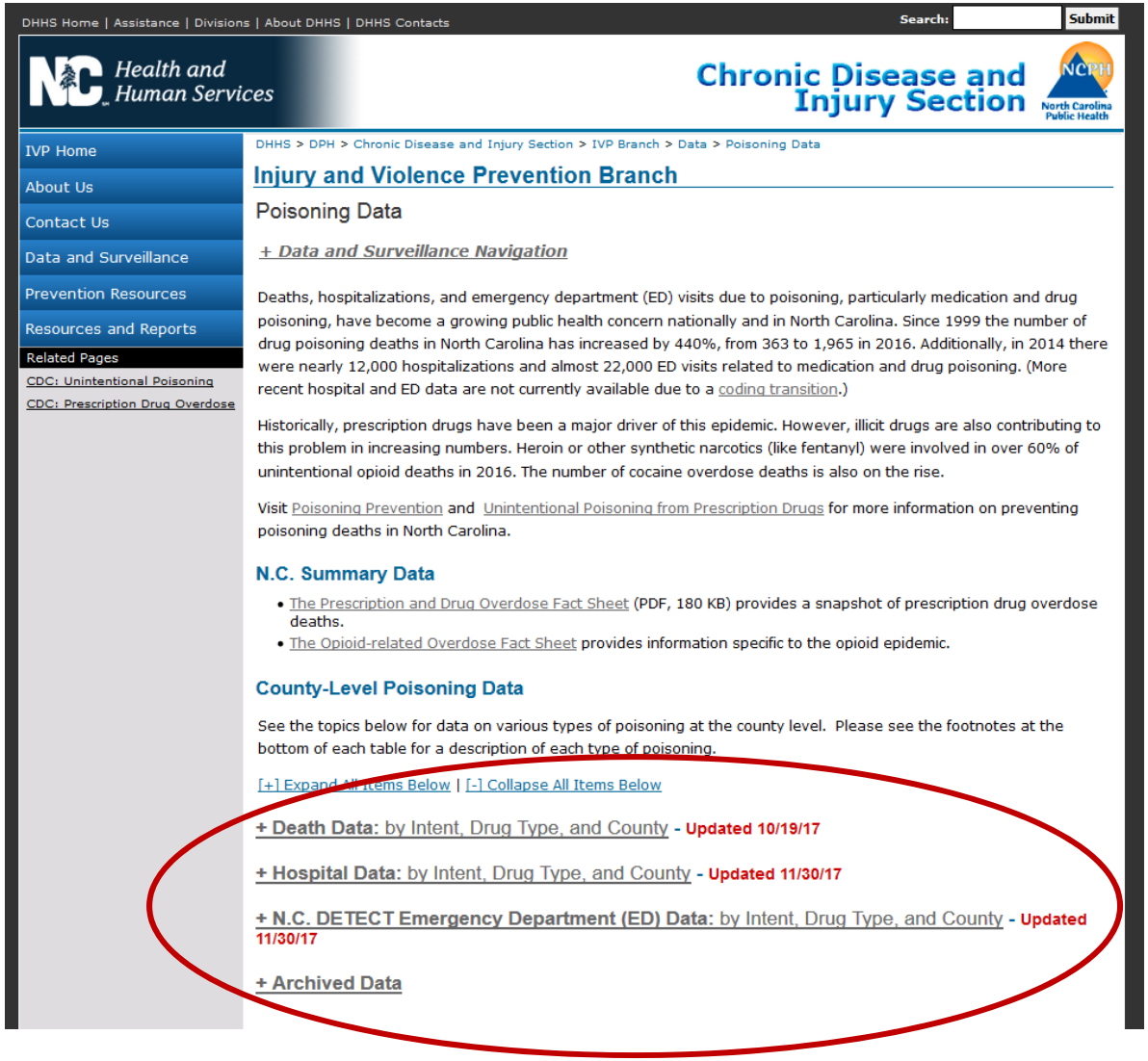
NORTH CAROLINA MEDICAL EXAMINER
OFFICE OF THE CHIEF MEDICAL EXAMINER, RALEIGH

County Tables

North Carolina
Injury & Violence
PREVENTION Branch

IVPB Poisoning Data Website

http://www.injuryfreenc.ncdhhs.gov/DataSurveillance/Poisoning.htm



- Death Data
- Hospital Data
- ED Data

North Carolina Injury & Violence PREVENTION Branch

IVPB Poisoning Data Website

http://www.injuryfreenc.ncdhhs.gov/DataSurveillance/Poisoning.htm

County-Level Poisoning Data

See the topics below for data on various types of poisoning at the county level. Please see the footnotes at the bottom of each table for a description of each type of poisoning.

[+] Expand All Items Below | [-] Collapse All Items Below

- Death Data: by Intent, Drug Type, and County **- Updated 10/19/17**

- All Intents

- All Poisoning Deaths by County, 1999-2016 (PDF, 221 KB)
- All Medication and Drug Poisoning Deaths by County, 1999-2016 (PDF, 209 KB)
- All Opiate Poisoning Deaths by County, 1999-2016 (PDF, 220 KB)
- All Commonly Prescribed Opioid Medication Poisoning Deaths by County, 1999-2016 (PDF, 221 KB)
- All Heroin Poisoning Deaths by County, 1999-2016 (PDF, 217 KB)
- All Methadone Poisoning Deaths by County, 1999-2016 (PDF, 381 KB)
- All Synthetic Opioid Poisoning Deaths by County, 1999-2016 (PDF, 304 KB)
- All Cocaine Poisoning Deaths by County, 1999-2016 (PDF, 305 KB)
- All Benzodiazepine Poisoning Deaths by County, 1999-2016 (PDF, 304 KB)

+ Unintentional

+ Self-Inflicted

+ Hospital Data: by Intent, Drug Type, and County **- Updated 11/30/17**

+ N.C. DETECT Emergency Department (ED) Data: by Intent, Drug Type, and County **- Updated 11/30/17**

North Carolina Injury & Violence PREVENTION Branch

IVPB Poisoning Data Website

http://www.injuryfreenc.ncdhhs.gov/DataSurveillance/Poisoning.htm

North Carolina Injury & Violence PREVENTION Branch

All Intents Heroin Poisoning Deaths by County: N.C. Residents, 1999-2016

County	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Total
	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Alamance	1	0	1	0	0	0	0	1	0	1	1	1	0	3	4	0	6	2	21
Alexander	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	2
Alleghany	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Anson	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ashe	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Avery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Beaufort	0	0	0	0	1	0	1	0	0	0	1	0	0	2	1	1	1	1	9
Bertie	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	2
Bladen	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Brunswick	1	1	0	1	1	1	2	2	2	2	3	1	2	5	10	5	10	10	59
Buncombe	1	1	0	0	0	2	4	2	1	0	2	1	0	0	3	13	14	26	70
Burke	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	3	7
Cabarrus	0	2	0	0	0	2	1	1	2	1	5	3	1	0	8	9	3	13	51
Caldwell	0	0	0	0	0	0	1	0	0	0	0	1	0	1	0	0	4	2	9
Camden	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	3
Carteret	0	0	1	0	1	0	0	0	0	0	1	0	1	0	1	1	4	4	14
Caswell	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Catawba	0	0	1	0	3	0	0	0	2	1	2	1	1	4	1	5	4	12	37
Chatham	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	1	3
Cherokee	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2
Chowan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Clay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cleveland	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	3	1	6
Columbus	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	2	4
Craven	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	2	5	9	18

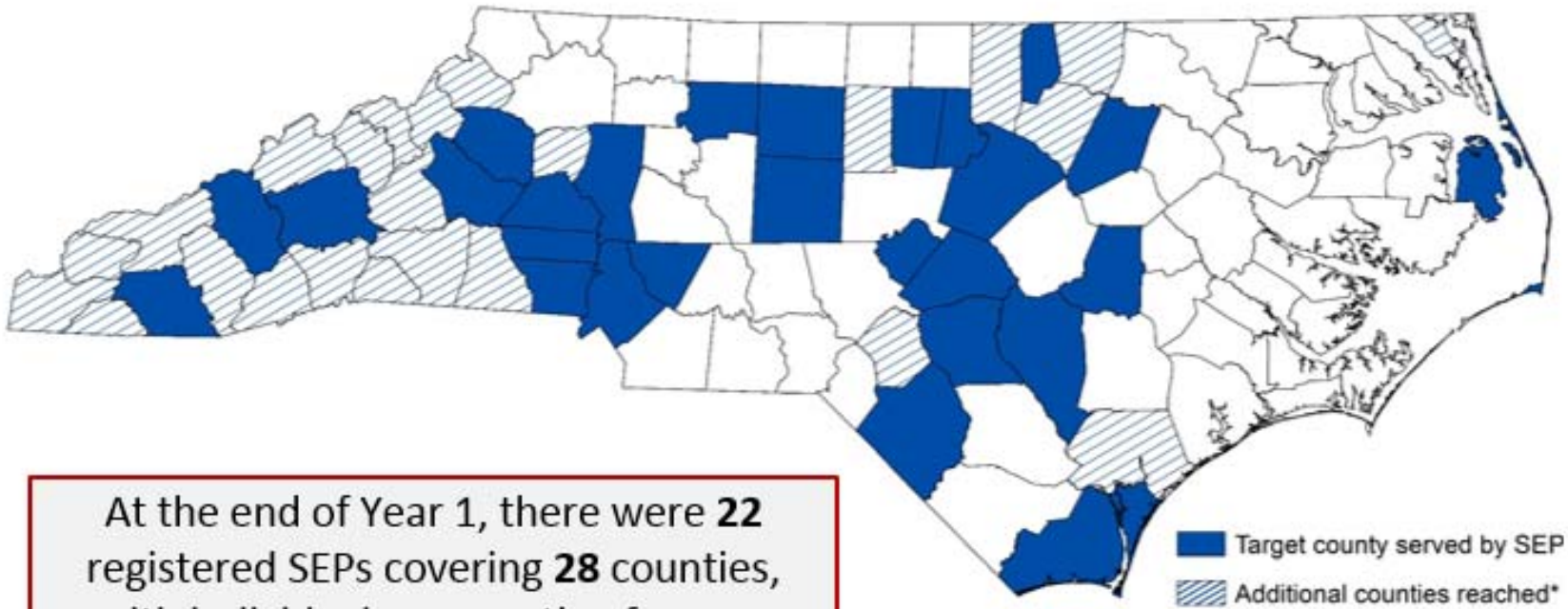
North Carolina Injury & Violence PREVENTION Branch

Core and County Slide Sets

North Carolina
Injury & Violence
PREVENTION Branch

Counties served by Syringe Exchange Programs (SEPs)

as of Year 1 Annual Reporting (June 2017)



At the end of Year 1, there were **22** registered SEPs covering **28** counties, with individuals commuting from an additional **24** counties and out of state

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

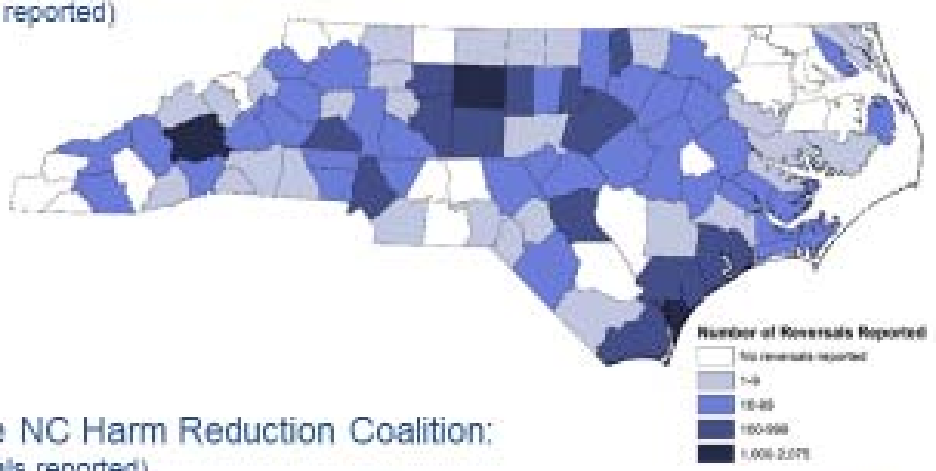
Source: North Carolina Division of Public Health, October 2017
Analysis: Injury Epidemiology and Surveillance Unit

North Carolina Injury & Violence PREVENTION Branch

Opioid Overdose Reversals with Naloxone

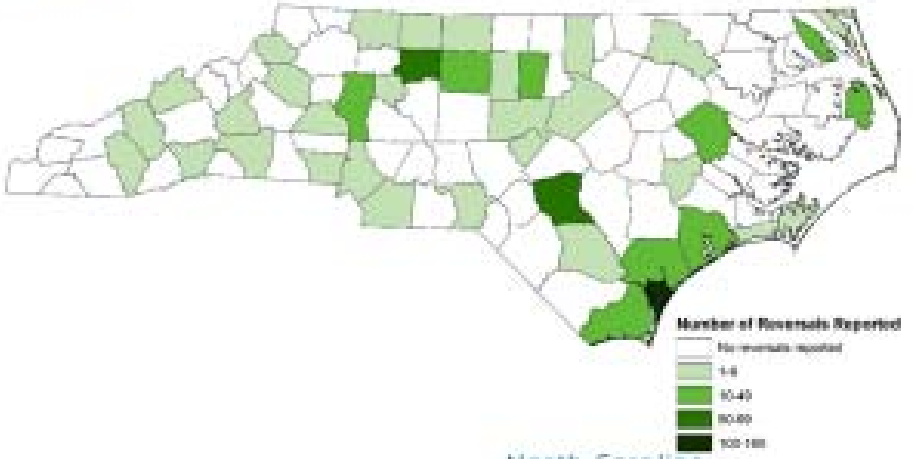
Community naloxone reversals reported to the NC Harm Reduction Coalition:
8/1/2013 - 9/30/2017 (8,181 total reversals reported)

Community Reversals in Wake County, as of 09/30/2017	292
Community Reversals in Local Health Director Region 7, as of 09/30/2017	714



Law Enforcement naloxone reversals reported to the NC Harm Reduction Coalition:
1/1/2015 - 9/30/2017 (677 total reversals reported)

Law Enforcement Reversals in Wake County, as of 09/30/2017	4
Law Enforcement Agencies in Wake County carrying naloxone, as of 09/30/2017	1
Law Enforcement Reversals in Local Health Director Region 7 as of 09/30/2017	12
Law Enforcement Agencies in Local Health Director Region 7 carrying naloxone, as of 09/30/2017	13



Source: North Carolina Harm Reduction Coalition, September 2017
Analysis: Injury Epidemiology and Surveillance Unit

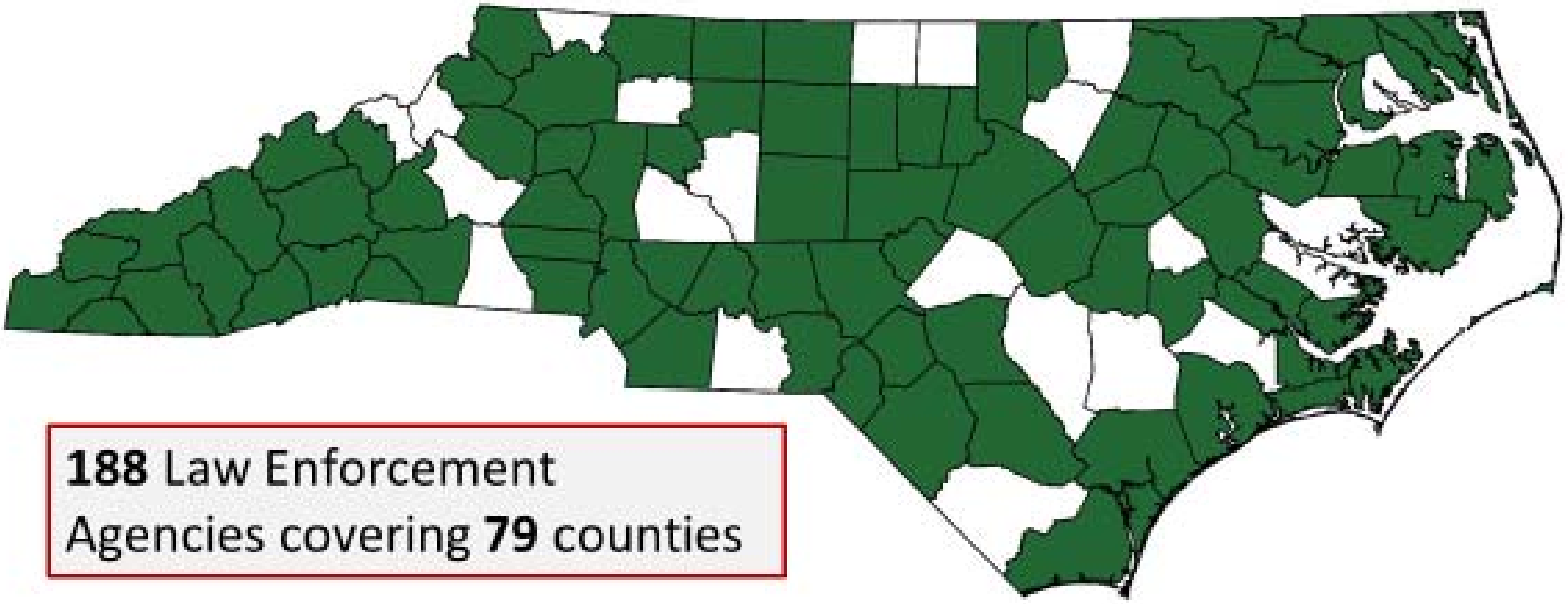
North Carolina
Injury & Violence
PREVENTION Branch

Monthly Data Updates

North Carolina
Injury & Violence
PREVENTION Branch

Counties with Law Enforcement Carrying Naloxone

as of November 30, 2017



188 Law Enforcement Agencies covering **79** counties

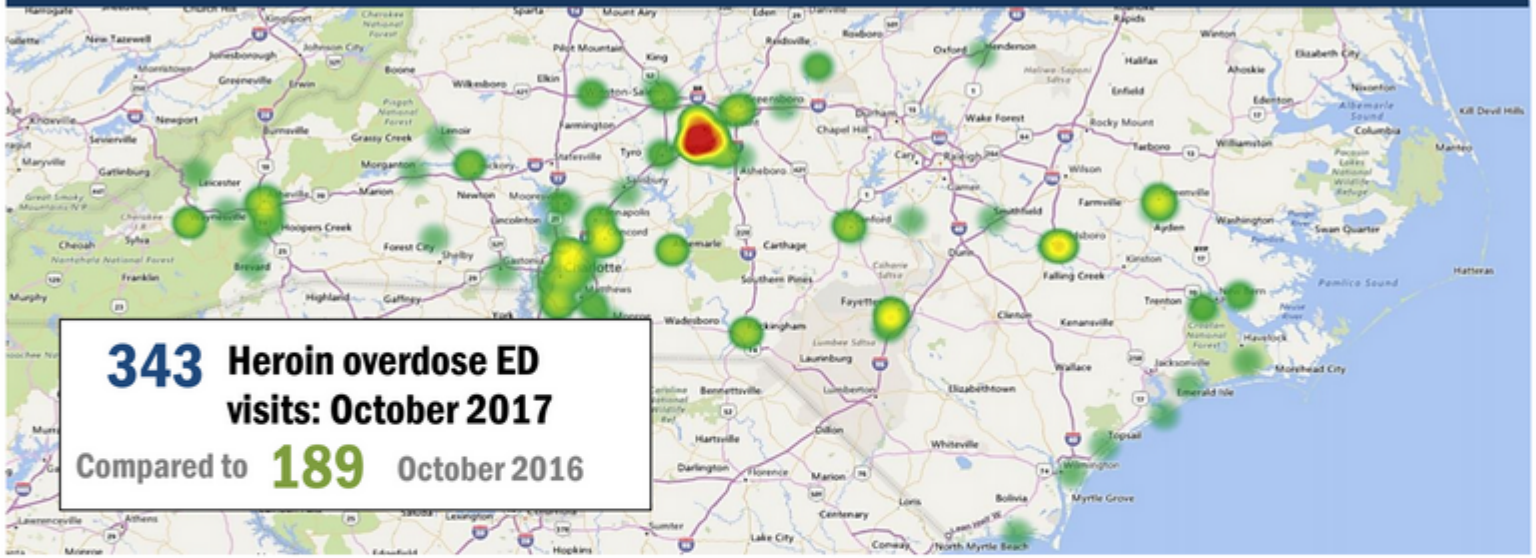
Source: North Carolina Harm Reduction Coalition (NCHRC), December 2017
Analysis by Injury Epidemiology and Surveillance Unit

North Carolina Injury & Violence PREVENTION Branch

nch

Heroin Overdose Emergency Department Visits: North Carolina, October 2017

North Carolina Injury & Violence PREVENTION Branch



The heat map shows the highest concentration of cases in Guilford, Mecklenburg, Buncombe, Cabarrus and Randolph counties. With the highest rates occurring in Wayne (10.5 per 100,000 residents) and Randolph (9.1 per 100,000 residents) counties.

Cases were predominantly **male (69%), white (90%),** and between **25-34 years of age (48%).**

Gender:	n	%
Male	236	69%
Female	104	30%

Race:	n	%
White	310	90%
Black	15	4%
Other	11	3%
Missing	7	2%

Age:	n	%
<15	0	0%
15-24	63	18%
25-34	164	48%
35-44	62	18%
45-54	33	10%
55-64	21	6%
65+	0	0%

Note: Emergency department visit data from NC DETECT are provisional and should not be considered final. There may be data quality issues affecting our counts: counties with <10 cases may not be true lack of opioid overdose cases but data quality issues; addtionally, some hospitals use non-specificic poisoning codes rather than specific opioid poisoning codes.

NORTH CAROLINA INJURY AND VIOLENCE PREVENTION | www.injuryfreenc.ncdhhs.gov | 11/15/2017

Opioid Action Plan Metrics

North Carolina
Injury & Violence
PREVENTION Branch

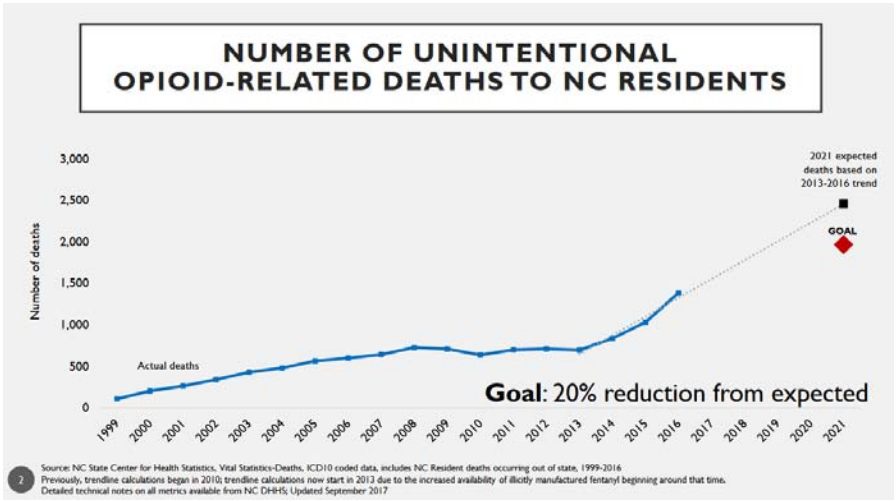
METRICS FOR NC'S OPIOID ACTION PLAN

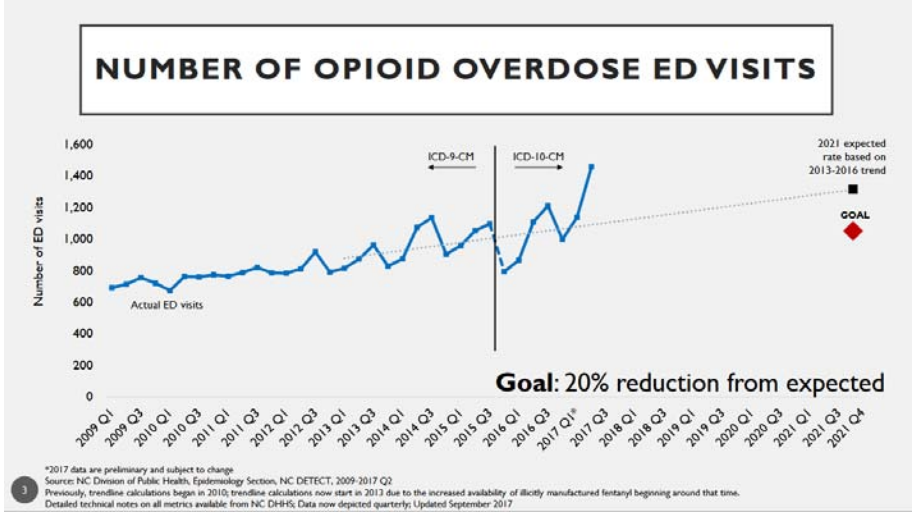
Metrics	Baseline Data	2021 Trend/Goal
OVERALL		
Number of unintentional opioid-related deaths to NC Residents (ICD10)	1,384 (2016)	20% reduction in expected 2021 number
Number of ED visits that received an opioid overdose diagnosis (all intents)	4,182 (2016)	20% reduction in expected 2021 number
Reduce oversupply of prescription opioids		
Average rate of multiple provider episodes for prescription opioids (times patients received opioids from ≥5 prescribers dispensed at ≥5 pharmacies in a six-month period), per 100,000 residents	34.3 per 100,000 residents (2016)	Decreasing trend
Total number of opioid pills dispensed	675,315,375 (2016)	Decreasing trend
Percent of patients receiving more than an average daily dose of >90 MME of opioid analgesics, per quarter	6.7% (Q4 2016)	Decreasing trend
Percent of prescription days any patient had at least one opioid AND at least one benzodiazepine prescription on the same day, per quarter	20.6% (Q4 2016)	Decreasing trend
Reduce Diversion/Flow of Illicit Drugs		
Percent of opioid deaths involving heroin or fentanyl/fentanyl analogues	58.4% (2016)	----------
Number of acute Hepatitis C cases	185 (2016)	Decreasing trend
Increase Access to Naloxone		
Number of EMS naloxone administrations	13,103 (2016)	----------
Number of community naloxone reversals	3,684 (2016)	Increasing trend
Treatment and Recovery		
Number of buprenorphine prescriptions dispensed	478,403 (2016)	Increasing trend
Number of uninsured individuals and Medicaid beneficiaries with an opioid use disorder served by treatment programs, per quarter	15,187 (Q4 2016)	Increasing trend
Number of certified peer support specialists (CPSS) across NC	2,352 (2016)	Increasing trend

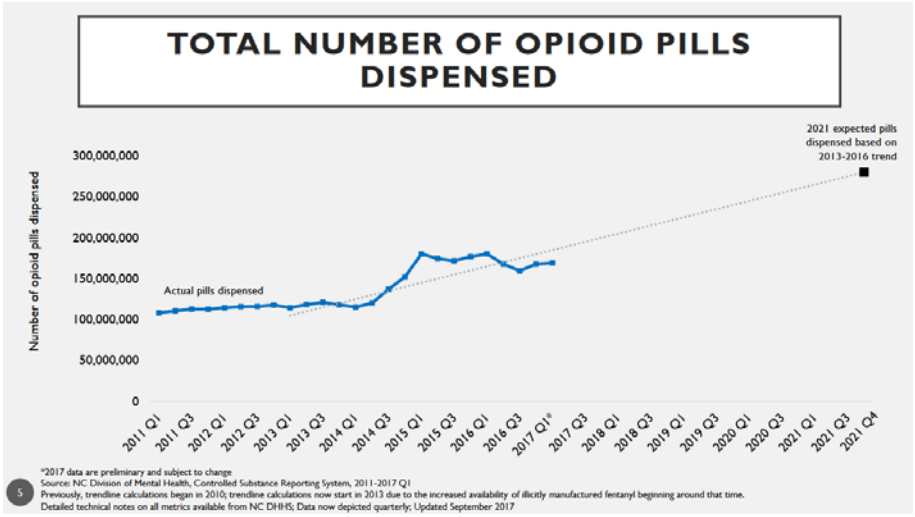
Source: North Carolina's Opioid Action Plan, October 2017
https://files.nc.gov/ncdhhs/Updated%20NC%20Opioid%20Action%20Plan%20Metrics_Oct%202017.pdf

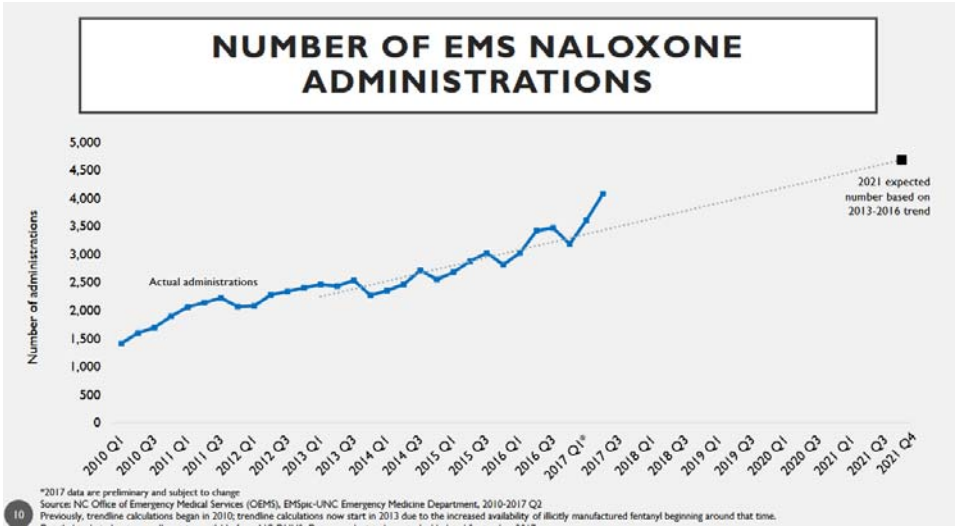
North Carolina Injury & Violence PREVENTION Branch

Opioid Action Plan Metrics









https://www.ncdhhs.gov/opioids

North Carolina's Opioid Action Plan

North Carolina's Opioid Action Plan was developed with community partners to combat the opioid crisis. It is a living document that will be updated as we make progress on the epidemic and are faced with new issues and solutions. Strategies in the plan include:

- Coordinating the state's infrastructure to tackle the opioid crisis.
- Reducing the oversupply of prescription opioids.
- Reducing the diversion of prescription drugs and the flow of illicit drugs.
- Increasing community awareness and prevention.
- Making naloxone widely available.
- Expanding treatment and recovery systems of care.
- Measuring the effectiveness of these strategies based on results.

Governor Cooper Announces Bold Action Plan to Turn the Tide of the Opioid Epidemic in North Carolina

Updated Metrics for North Carolina's Opioid Action Plan, October 2017

North Carolina's Opioid Action Plan, June 2017, Version 1

Fact Sheet: Highlights from North Carolina's Opioid Action Plan Fact Sheet

North Carolina Prescription Drug Abuse Advisory Committee

Opioid Misuse and Overdose Prevention Summit Wrap-up Video

To tackle this health crisis, the N.C. Department of Health and Human Services is working to connect people with preventative healthcare, substance use disorder treatment and community supports. This is a complex issue requiring partnership from many sectors and is an effort that

ePREVENTION Branch

Data Dashboards

North Carolina
Injury & Violence
PREVENTION Branch

ARIZONA DEPARTMENT OF HEALTH SERVICES

Californ

Home

Using the

State Da

County D

Explore

Data Def

Technica

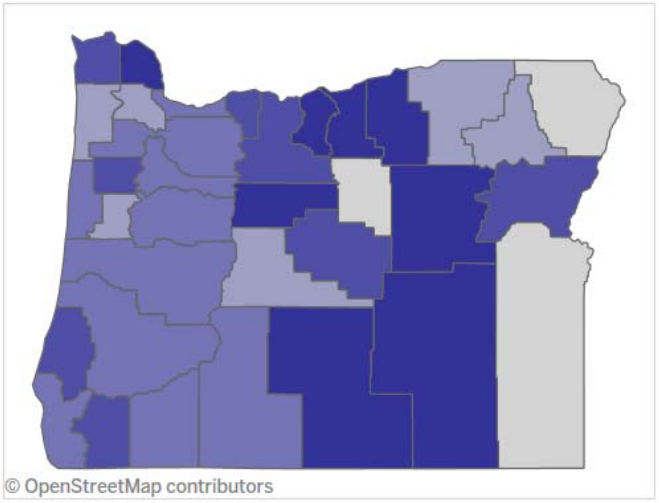
Other Helpfu

CA Dept.

〈 Oregon Injury and Violence Prevention - Profile

County Hospitalization | County Deaths | PDMP Measures | Non-Pharmaceutical Fentanyl... | Technic

Prescription Drug Monitoring Program Measures



PDMP Measure

- Number of Top Prescribers Enrolled
- Number of Top Prescribers Querying
- Percent of Top Prescribers Enrolled
- Percent of Top Prescribers Querying

Time Period

2017 Q1

Count or Percent

50.00 — 100.00

County PDMP Measures

PDMP Measure

- Number of Top Prescribers Enrolled
- Number of Top Prescribers Querying

using this Dashboard

BOARD UPDATES

017
ownloadable State
ot Report
he State Dashboard link
idebar, you will see a
ate Report button.
; this button will
e a downloadable
ot report of selected
ard indicators. The new
s based on the last 12
s, and will
tically update as new
released. Please email
edback on this new

Training

Reporting

Clinicians

Employers

lence
PREVENTION Branch

NC Data Dashboards

North Carolina Medicaid and Health Choice Enrollment

By County and Program Aid Category (PAC)

Navigation Guide:
Click on a county on the map to see that county's PAC enrollment in table.
Click on county again to clear the selection.
Select a PAC in the table to see distribution on state map and county rankings.
Click on PAC again to clear selection.

Select Date

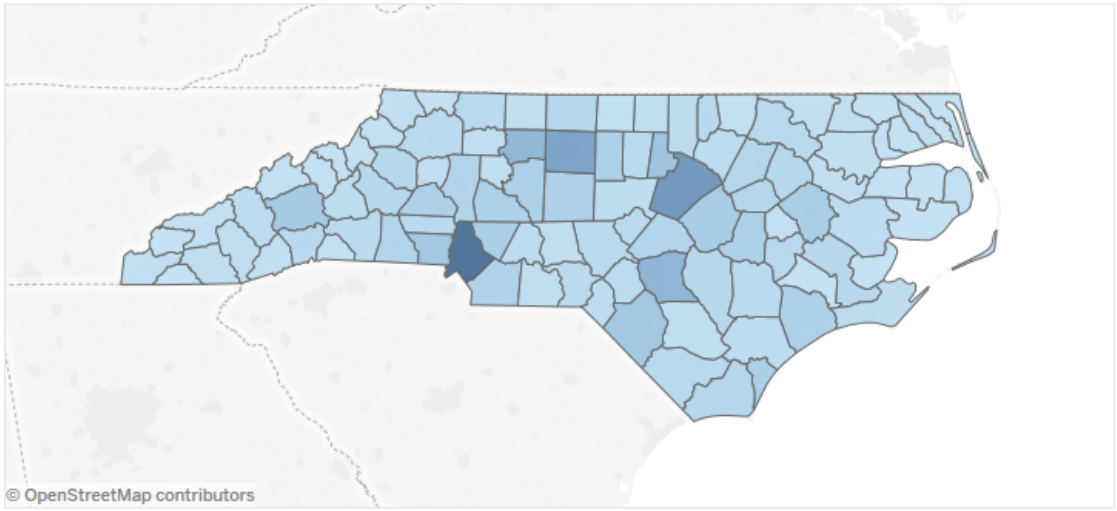
December - 2017

Select Plan

(All)

County Enrollment - * PAC

December - 2017



979 — 211,403

PAC Enrollment - All

December - 2017

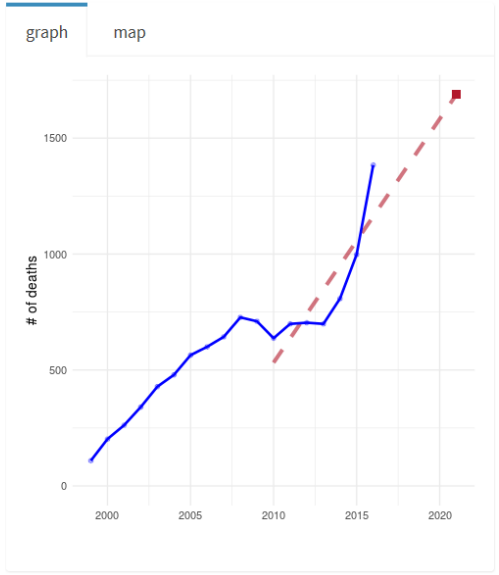
	Enrollment	% of Total
TANF (AFDC) 20 and Under	511,135	24.0%
Infants And Children	425,823	20.0%
Disabled	300,664	14.1%
Family Planning	222,285	10.4%
TANF (AFDC) 21 And Over	186,038	8.7%
MCHIP	138,515	6.5%
Aged	126,676	6.0%
MQBB	42,464	2.0%
MQBE	23,660	1.1%
Documented Aliens	19,973	0.9%
Pregnant Women	18,837	0.9%
MQBQ	8,254	0.4%
Other Child	6,076	0.3%
Blind	1,618	0.1%
BCC	464	0.0%
Refugees	179	0.0%
Undocumented Aliens	49	0.0%
Total	2,032,710	95.5%
Chip	95,386	4.5%
Chip Extended Coverage		
Total	95,386	4.5%
Grand Total	2,128,096	100.0%

Rank 1 - 20 Counties		Rank 21 - 40 Counties		Rank 41 - 60 Counties		Rank 61 - 80 Counties		Rank 81 - 100 Counties	
MECKLENBURG	211,403	UNION	32,413	RUTHERFORD	16,297	PERSON	9,238	MADISON	4,844

NC Opioid Dashboard

Opioid Deaths in NC

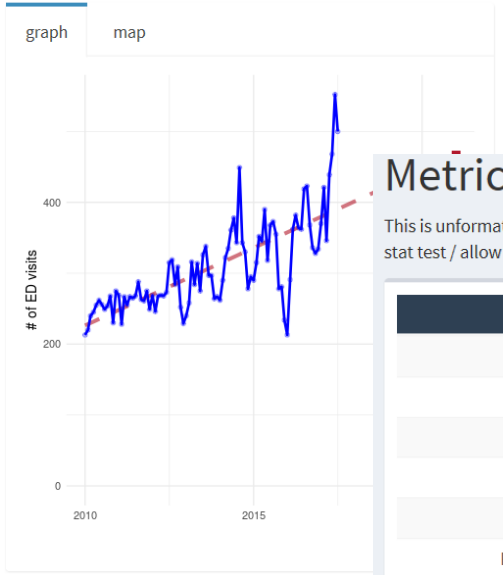
graph map



Data from January 1999 to ??????. Source: NC Vital Records / State Center for Health Statistics. Download opioid death data

ED Opioid Visit Rate in NC

graph map



Data from January 2010 to July 2017. Source: NC DETE data

Multi-Episodes in NC

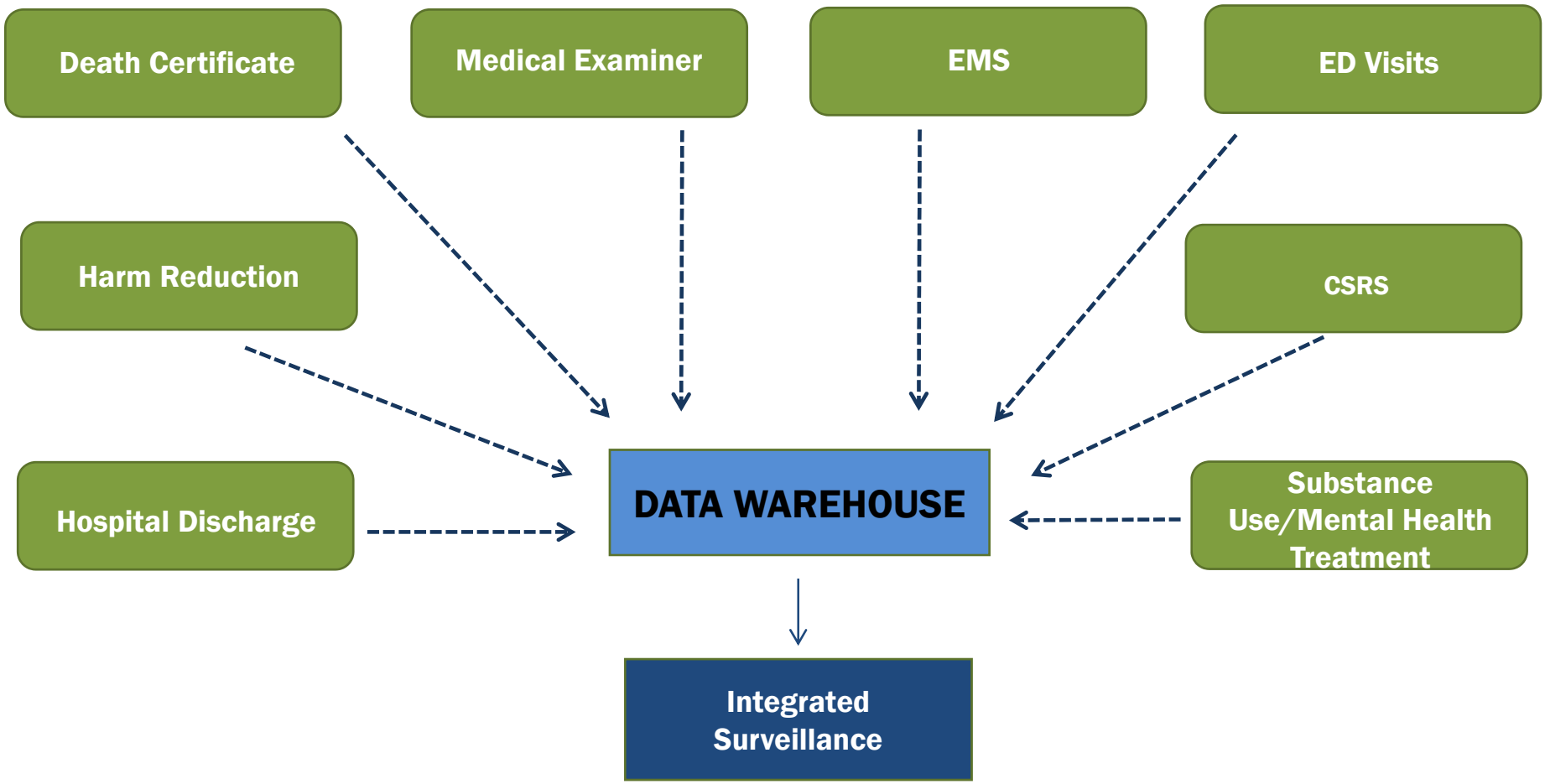
Opioid Pills Dispensed in NC

Metric Status

This is unformatted / colored, just focusing on data...WIP in general. Next: Get county data (currently *= stat test / allow for flat trends, custom / matching css, etc.

Focus Area / Strategy	Target	Current	Met.Target	Trend
Overall				
Reduce # of unintentional deaths / yr	971	1384	✖	↑
Reduce # of opioid ED visits	35.4	500	✖	↑
Reduce Supply				
Reduce multiple provider episode rate		1515	-	↓
Reduce # of opioid pills dispensed (millions)		169.15	-	↑
Reduce % of patients with >90 MME daily opioid dose		6.4	-	↓
Reuce % of Rx days had both opioids and benzos		20	-	↓
Reduce Diversions				
Reduce % opioid deaths involving heroin / fentanyl		78.1	-	↑
Reduce # of acute Hepatitis C cases		13	-	↑
Access & Naloxone				
# of EMS administrations (no target)		1435	-	↑
# of Community reversals (no target)		0	-	↑
Treatment				

DHHS Overdose Data Warehouse



Questions?

Mary Beth Cox, MPH

Injury and Violence Prevention Branch
NC Division of Public Health
MaryBeth.Cox@dhhs.nc.gov

www.injuryfreenc.ncdhhs.gov

North Carolina
Injury & Violence
PREVENTION Branch

Scott Proescholdbell, Division of Public Health
Meredith Henderson, Industrial Commission
Chris Grubb, East Carolina Pain Consultants
and East Carolina Anesthesia Associates

Spotlight: Workers' Comp

Workers' Compensation and Opioids

Division of Public Health
Injury and Violence Prevention Branch

Scott Proescholdbell

December 15, 2017

North Carolina
Injury & Violence
PREVENTION Branch

Overview

- Brief WC & Opioids history
- NCIC and DHHS collaboration
  - NCIC special session study ~2015-2016
  - NCIC & DHHS Review of overdose deaths 2017
  - NCIC creation of Task Force 2017

Overview-WA and Franklin

GARY M. FRANKLIN, MD, MPH

Research Professor, Env. and Occ. Health Sciences (Primary department)

Adjunct Research Professor, Health Services

Research Professor, Health Services

Dr. Franklin is a Research Professor in the Department of Environmental and Occupational Health Sciences and in the Department of Medicine (Neurology), as well as Adjunct Research Professor in the Department of Health Services, at the University of Washington (UW). Dr. Franklin has served as the Medical Director of the Washington State Department of Labor and Industries (L&I) from 1988 to the present, and has more than a 25-year history of developing and administering workers' compensation health care policy and conducting outcomes research. He has served as Director or Co-Director of the NIOSH-funded ERC Occupational Health Services Research training program since its inception.

Key articles

Am J Ind Med. 2005 Aug;48(2):91-9.

- **Opioid dosing trends and mortality in Washington State workers' compensation, 1996-2002.**

  Franklin GM[1], Mai J, Wickizer T, Turner JA, Fulton-Kehoe D, Grant L.

  Am J Ind Med. 2013 Dec;56(12):1452-62. doi: 10.1002/ajim.22266. Epub 2013 Oct 10.

- **Opioid poisonings and opioid adverse effects in workers in Washington state.**

  Fulton-Kehoe D[1], Garg RK, Turner JA, Bauer AM, Sullivan MD, Wickizer TM, Franklin GM.

  Phys Med Rehabil Clin N Am. 2015 Aug;26(3):453-65. doi: 10.1016/j.pmr.2015.04.005.

- **Guideline for Prescribing Opioids to Treat Pain in Injured Workers.**

  Mai J[1], Franklin G[2], Tauben D[3].

  Am J Ind Med. 2012 Apr;55(4):313-24. doi: 10.1002/ajim.21021. Epub 2011 Nov 8.

- **Opioid use and dosing in the workers' compensation setting. A comparative review and new data from Ohio.**

  Dembe A[1], Wickizer T, Sieck C, Partridge J, Balchick R.

National

State Workers' Comp Bureaus Taking Measures to Battle Opioid Addiction

Posted on: April 18, 2017 by Caitlin Morgan

Last yea
opioid e
We're ta
Comp bo
issue.

Accordi
group that seeks to control Workers' Compensation spend
more than $1.5 billion was spent on opioids b
Compensation insurers in 2015, with prescriptions for injured workers accounting for 13% of to
pharmacy costs in the U.S. that year. Survey respondents cited opioids and addiction as their mo
concern. (According to the Department of Labor, about 2.8 million private industry workers and
sector employees suffered non-fatal workplace injuries in 2015, more than half resulting in time

In addition, a separate study of 337,000 workers compensation claims in 25 states published las
independent Workers Compensation Research Institute (WCRI) found that 55% to 85% of injur
missed seven days or more of work received at least one opioid prescription.

States Taking Action in Fight Against Opioid Addiction in the Workplace

Rates of longer-term opioid use varied widely among states, the WCRI study found, including on
workers in Louisiana, and one in 10 in California, New York, and Pennsylvania, but only one in 30
Missouri.

As a result of widespread use of opioids among workers, a number of states are taking steps thro
Workers' Compensation systems to stem the overprescribing of the powerful painkillers to employees injure

07-06-2017 | 05:54 PM **Author:** Roger Rabb

Latest Data on Opioid Use in Workers' Compensation Claims Reported

The 2017 WCRI Report Looks at Data in 26 States to See How Opioid Abuse Reform Efforts are Faring in Workers' Compensation Claims

LexisNexis® Legal Newsroom
Workers Compensation Law

—Type your sear
Search All Com

Select your Topic

Portal › Workers Compensation Law › Recent Cases, News, Trends & Developments ›
North Carolina: Worker's Death from Accidental Overdose of Narcotics is Compensable

10-06-2017 | 12:58 PM **Author:** Thomas A. Robinson

North Carolina: Worker's Death from Accidental Overdose of Narcotics is Compensable

In an unpublished opinion, the Court of Appeals of North Carolina affirmed an award, inter alia, of death benefits to dependents of an injured employee who suffered a compensable back injury in June 2010 and died some four years later, as a result of an accidental overdose of prescribed medications and a previously unknown lung infection. At the time of his death, decedent had been prescribed a cocktail of drugs—narcotics to treat his compensable low back injury, additional medication for treatment of his depression, and other prescription medications.

Meredith Henderson, Industrial Commission

North Carolina Industrial Commission and Workers' Compensation Opioid Task Force

Background of the NC Workers' Compensation Opioid Task Force

- North Carolina Industrial Commission is a quasi-judicial administrative agency with jurisdiction over all workers' compensation claims in North Carolina.
- NC Workers' Compensation Opioid Task Force (WCOTF) was created by Chairman Charlton L. Allen of the North Carolina Industrial Commission in February 2017 to study and recommend solutions for the problems arising from the intersection of the opioid epidemic and related issues in workers' compensation claims.
- WCOTF is composed of representatives of various stakeholders, including injured employees, self-insured employers, insurance carriers, attorneys, physicians, hospitals, and public health officials.

Work of the NC Workers' Compensation Opioid Task Force

- WCOTF met 1-3 times per month beginning April 2017.
- After several meetings, the WCOTF determined that utilization rules would have a meaningful effect on the use of opioids and related issues in WC claims and could be developed through reasonable stakeholder compromise.
- WCOTF spent months reviewing the NC STOP Act, the CDC Guidelines for Prescribing Opioids for Chronic Pain, other professional opioid guidelines, and the opioid rules and guidelines promulgated by other state WC authorities.
- WCOTF then developed draft opioid utilization rules for WC claims for consideration by the Industrial Commission.

Legal Authority for WC Opioid Utilization Rules

- Industrial Commission has the statutory authority under N.C. Gen. Stat. § 97-25.4 to promulgate utilization rules and guidelines for medical treatment in WC claims.
- Session Law 2017-203, Section 4, the General Assembly directed the Industrial Commission to adopt "rules and guidelines, consistent with G.S. 97-25.4, for the utilization of opioids and related prescriptions, and pain management treatment."

Public Feedback and Rulemaking

- On November 17, 2017, the Industrial Commission posted the draft opioid utilization rules on its website and distributed them by email to request preliminary public feedback by December 6, 2017.
- WCOTF is reviewing the feedback and revising the draft rules where appropriate for the Industrial Commission's consideration.
- Formal administrative rulemaking by the Industrial Commission will be required to put the rules in place.
- The earliest possible effective date is May 1, 2018.

Chris Grubb, East Carolina Pain Consultants
and East Carolina Anesthesia Associates

Brief Summary of Proposed Rules

General Provisions

- The rules only apply to treatment of pain in workers compensation claimants.
- They do not apply to in-patient treatment or to treatment of cancer pain.
- Primarily, the rules impact the prescribing of Schedule II and III opioids.
  - These are the same prescriptions covered by STOP Act

Acute and Chronic Phases

- Prescribing rules divided into those for the acute phase (first 12 weeks of pain treatment) and those for the chronic phase (post 12 weeks)
- Rationale of rules: desire to prevent transition from acute phase to chronic phase of opioid treatment wherever possible
- Prescribing rules cover claimants who have been treated with opioids for ≤ 12 weeks on effective date of rules
  - Patients already in chronic phase of pain treatment as of effective date of rules will be exempted from prescribing rules

Examples of Prescribing Limitations

- Key requirement: Before prescribing a Class II or III opioid, prescriber must document in the medical record that non-pharmacologic and non-opioid therapies are insufficient to treat the pain
- Other requirements
  - Checking of Controlled Substances Reporting System (CSRS)
  - Day limits (5/7 day initial prescription, 30 days subsequent prescriptions)
  - 50 MME/day limit (with exceptions in both acute and chronic phases meant to cover patients who have built tolerance to lower doses)
  - Opioid risk assessments
  - Urine drug screens
    - Need for balance: limit on number and type to be reimbursed without approval
  - Need to consider results of risk assessment and urine drug screen before prescribing

Additional Prescribing Limitations

- Limit on number of opioid prescriptions
  - Acute phase: No more than 1 at a time
  - Chronic phase: No more than 1 short-acting and 1 long-acting at a time
- Must use caution in prescribing opioids with benzodiazepines and carisoprodol.
- May not prescribe benzodiazepines for pain or as muscle relaxers.
- May not prescribe transcutaneous, transdermal, transmucosal, or buccal opioid preparations without documentation that oral opioids are inadequate.

Rules Covering All Claimants Without Exemption

- Naloxone co-prescribing
  - Prescribers shall consider co-prescribing naloxone to patients at risk for an overdose, e.g., patients with a history of overdose or substance use disorder, patients taking benzodiazepines currently, patients taking ≥50 MME/day
- Prescribing of non-opioid treatments for pain
  - Prescribers shall consider non-pharmacological treatments for pain, including but not limited to:
    - Physical therapy
    - Chiropractic
    - Massage
    - Cognitive behavioral therapy
    - Biofeedback
    - Functional restoration programs
- May refer for evaluation for substance use disorder or for assistance in tapering or discontinuing opioids

Stacy A. Smith, Division of Mental Health/DD/SAS
Tessie Castillo, NC Harm Reduction Coalition
Kenny Gibbs, Division of Vocational Rehabilitation
Karen Kelley, TROSA

Spotlight: Employment/Supported Employment

Individual Placement and Support- Supported Employment and Medication Assisted Therapies

Stacy A. Smith, Adult Mental Health Team Lead
Division of Mental Health, Developmental Disabilities & Substance Abuse Services

Individual Placement and Support-Supported Employment (IPS-SE)

- IPS-SE is an evidence based practice, originally developed for adults with severe and persistent mental illness.

- It is a behavioral health service that focuses on supporting individuals find and maintain competitive employment, or supporting individuals in advancing their education/training to improve their employment opportunities.

- Teams that provide IPS services that closely align with the best practice model (Exceptional Practice) typically have competitive employment rates of 40% or higher of individuals receiving services.

IPS-SE

- Why it works?
- There are 8 practice principles that make IPS-SE effective:
  - Focus is on competitive employment
  - IPS-SE services are integrated with treatment
  - Zero exclusion
  - Honoring personal preferences
  - Benefits counseling is critical
  - Rapid job search
  - Systematic job development
  - Time unlimited support

Employment and Recovery

- Historically, employment was seen as a 'carrot' to motivate people to engage in what professional staff felt was important:
  - 'Take your medicine'
  - 'Don't use drugs'
  - 'Keep yourself clean'
  - 'Do these things for however many days and THEN you're ready for work'

Employment and Recovery

- IPS-SE flips this concept and positions employment as a tool just as valuable and meaningful as medication and therapy in supporting people achieve recovery and become integrated in their community
- Employment can be the key that puts all other services into context:

I really like my job, what can I do to make sure I keep it?

Employment and Wellness

EMOTIONAL
Coping effectively with life and creating satisfying relationships

FINANCIAL
Satisfaction with current and future financial situations

SOCIAL
Developing a sense of connection, belonging, and a well-developed support system

SPIRITUAL
Expanding our sense of purpose and meaning in life

OCCUPATIONAL
Personal satisfaction and enrichment derived from one's work

PHYSICAL
Recognizing the need for physical activity, diet, sleep and nutrition

INTELLECTUAL
Recognizing creative abilities and finding ways to expand knowledge and skills

ENVIRONMENTAL
Good health by occupying pleasant, stimulating environments that support well-being

Adapted from Swarbrick, M. (2006). A Wellness Approach. *Psychiatric Rehabilitation Journal,* 29(4), 311–314.

IPS-SE and MAT- what could access do?

- Employment could be a motivating factor to remain actively engaged in treatment
- Engaging in employment could result in individuals receiving benefits from their employer
- Employment can expand an individual's community/social supports

IPS-SE and AMH- Early data findings

- While our data set is incomplete, we have been able to show that:
  - IPS-SE is effective at supporting individuals in employment, and helping them sustain employment
  - Individuals that are employed typically are making higher than minimum wage
  - Roughly 1/3 of people working are receiving some type of benefits from their employment (health insurance, dental insurance, etc.)

IPS-SE and Community

- IPS-SE connects people to community, in some cases, new community
- How many of you are friends with some of your co-workers?
- How many of you hang out with co-workers outside of work?
- How important is finding new community and supports to recovery from substance use?

IPS-SE and MAT

- What could implementation look like?
- A MAT clinic could start an IPS-SE team, where the primary source of referrals would be individuals receiving services from the MAT clinic
- MAT staff and IPS-SE staff would meet internally once a week to review individuals that are receiving services that would benefit from and be interested in learning more about IPS-SE

IPS-SE and MAT

- Once an individual agrees to IPS-SE services, the IPS-SE team would meet in the community with the individual to work on their employment/education goals
- Weekly meetings would begin to focus on employment/education progress as well as possible new referrals
- The IPS-SE team would (ideally) be contracted with the managing LME-MCO to receive Medicaid and State reimbursement for services

IPS-SE and MAT

- The IPS-SE team would also apply to be a DVR contractor.
- Once the DVR contract is in place, the IPS-SE team would (when consent is in place) refer individuals to DVR for additional services that enhance the IPS-SE services. This also would open up an additional funding stream for the IPS-SE team

IPS-SE and MAT

- Stanford University has completed research on implementation of IPS-SE in an MAT setting
- The study found:

	% employed at 6 months	% employed at 12 months
Receiving IPS-SE	50%	50%
Control Group (no IPS-SE)	5%	22%

Lones, Carrie E, et al. "Individual Placement and Support (IPS) for Methadone Maintenance Therapy Patients: A Pilot Randomized Controlled Trial." *Administration and Policy in Mental Health*, 17 Feb. 2017.

IPS-SE and MAT

Any questions?

Stacy A. Smith, LPC-S, LCAS, NCC

Adult Mental Health Team Lead

Stacy.smith@dhhs.nc.gov

Tessie Castillo, NC Harm Reduction Coalition

Spotlight: Employment/Supported Employment

Kenny Gibbs, Division of Vocational Rehabilitation

Spotlight: Employment/Supported Employment

Karen Kelley, TROSA

Spotlight: Employment/Supported Employment

TROSA

TROSA: A Unique Program

- A two-year residential Therapeutic Community
- Services at no cost to clients
- Founded over 20 years ago with only 13 residents
- Last year we served 988 with an average daily census of over 475 people
- Serving Women and Men, ages 18 +

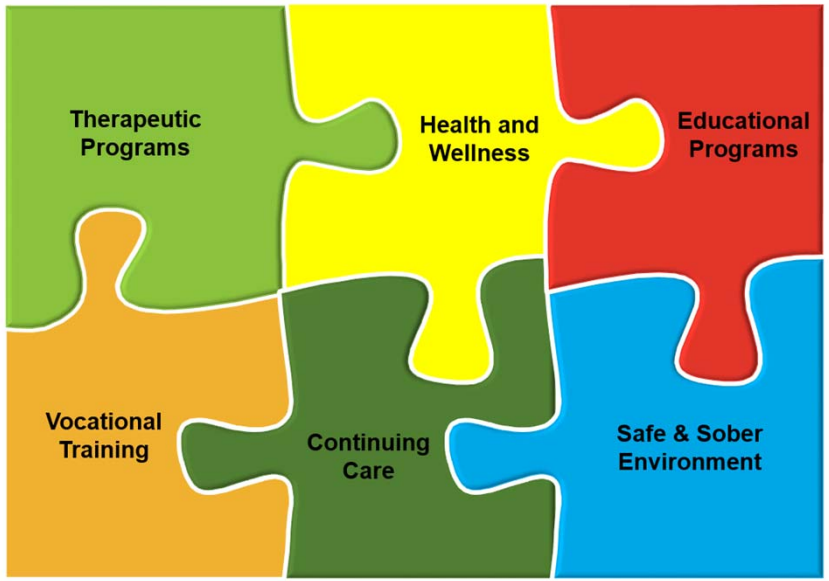
What is a Therapeutic Community?

- Mutual Self-Help (Community as method)
- Residents hold each other accountable and take responsibility for their actions and behaviors
- TROSA is considered a “modified TC”
  - Evidence Based Therapies
  - Medical
  - clinical counseling
  - psychiatric services

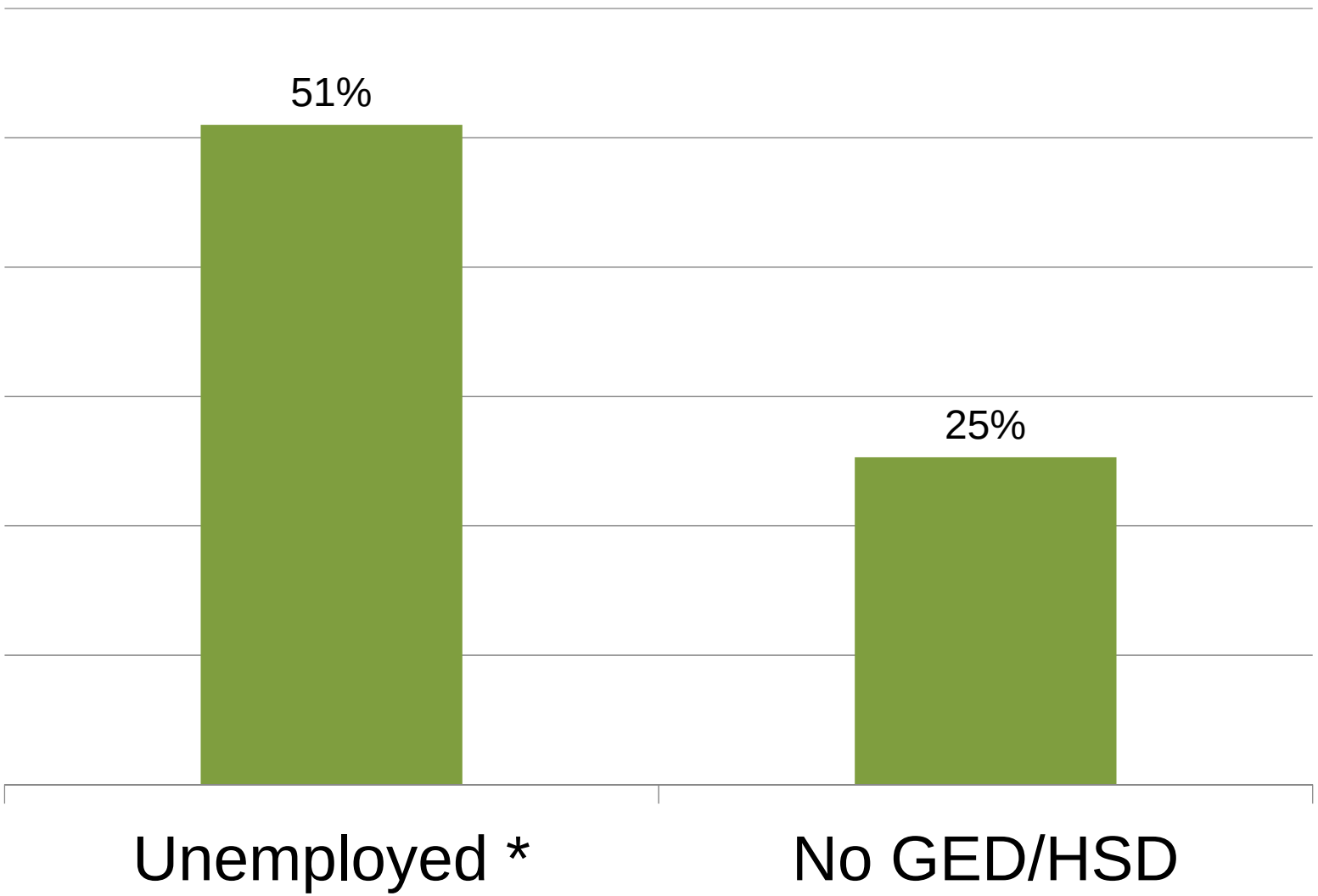
TROSA: A Comprehensive Care Model

Holistic Model

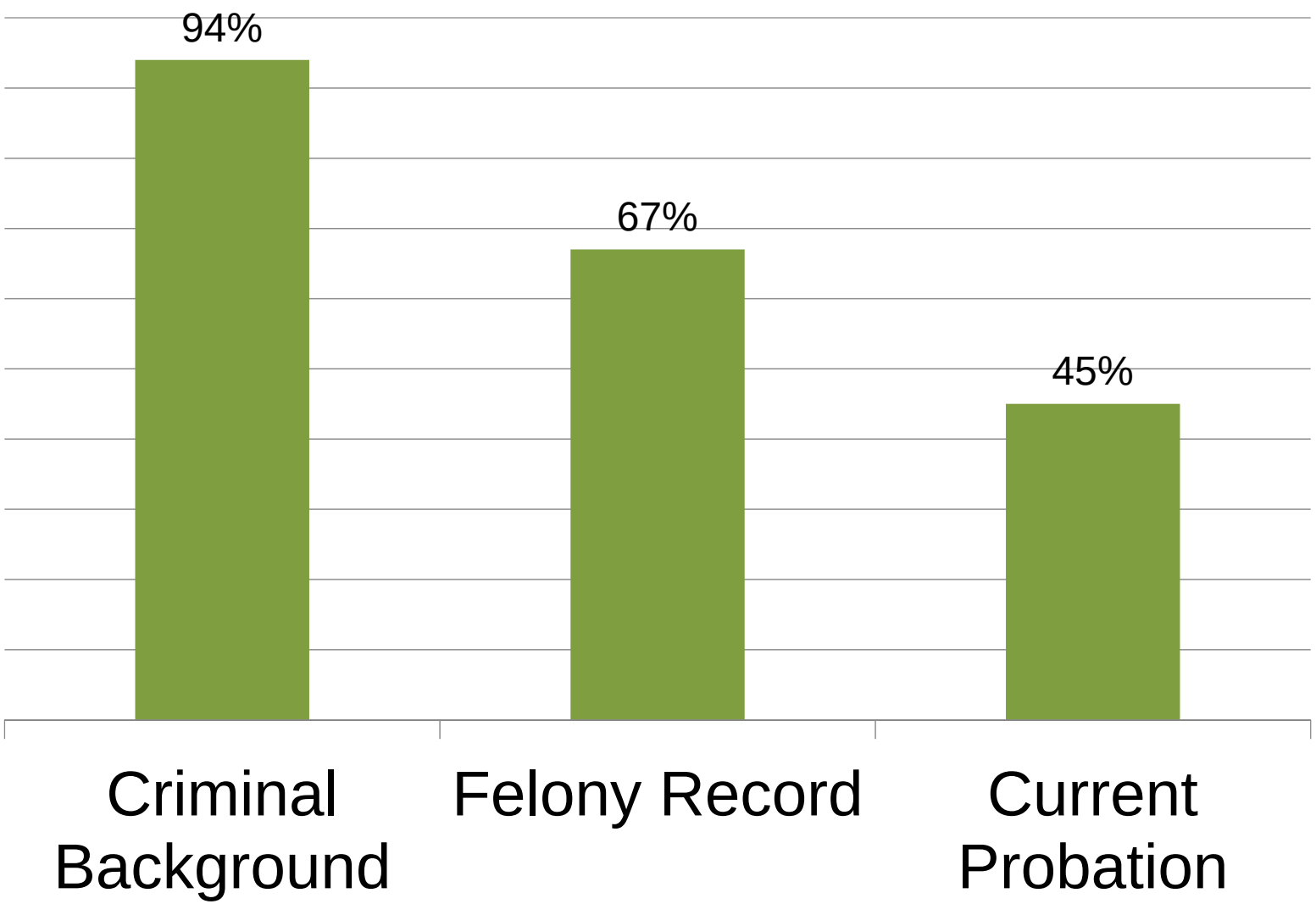
- Therapeutic Substance Abuse Treatment
- Safe & Sober Housing
- Health & Wellness
- Vocational Training
- Educational Programming
- Continuing Care



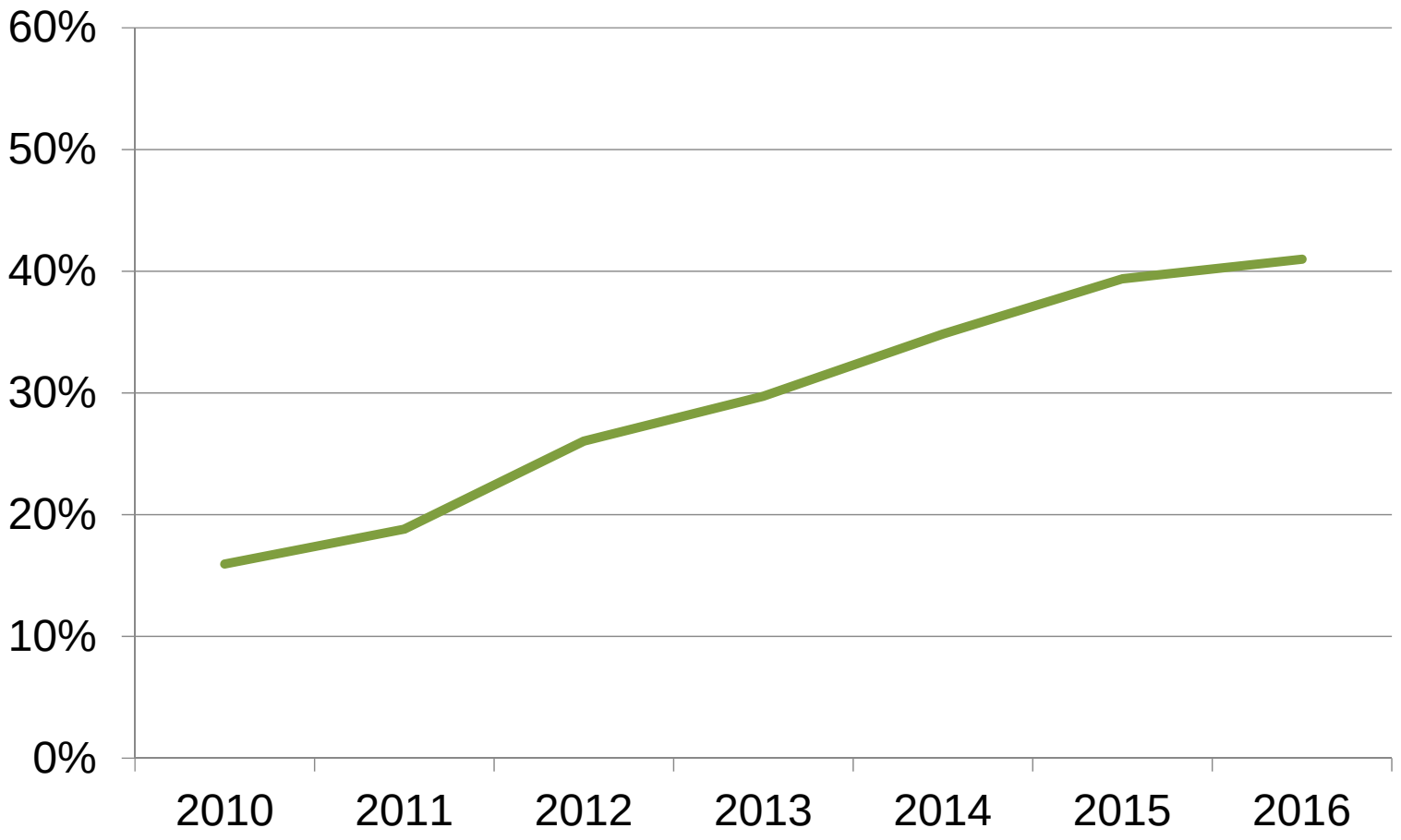
Who TROSA Serves (2016)



Who TROSA Serves (2016)

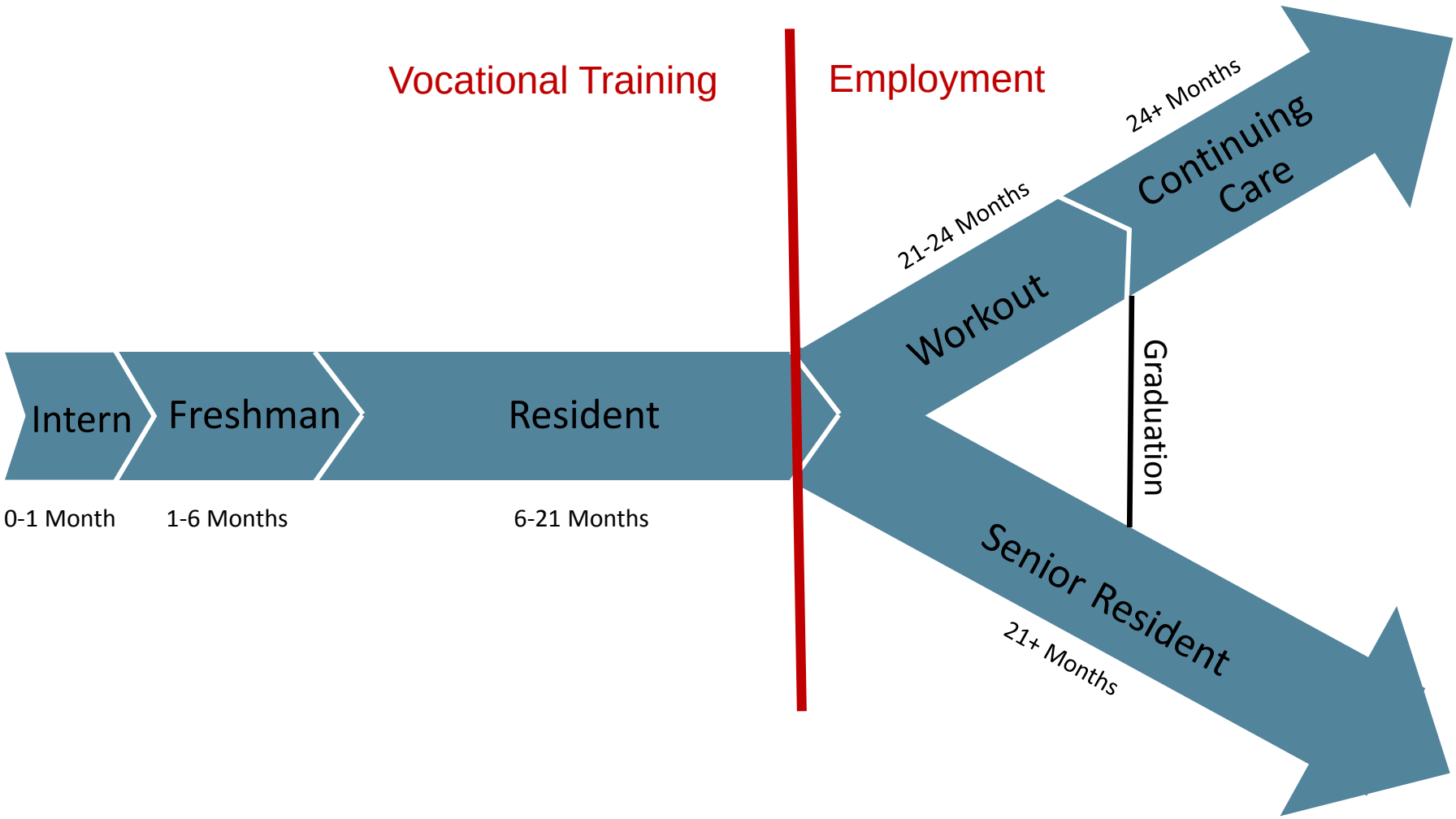


Heroin/Opiates as Primary Drug of Addiction



Over 50% report Heroin/Opiates as one of their drugs of addiction

Program Overview



Vocational Training (hard and soft skills)

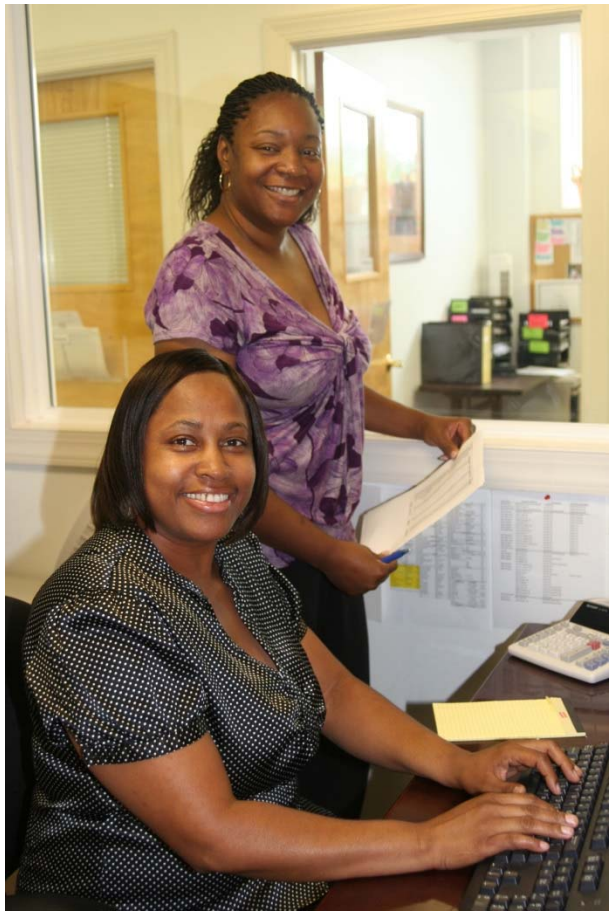
- Moving
- Construction/Property Maintenance
- Lawn Care/Maintenance
- Office Administration
- Auto/Truck Repair
- Retailing & Sales
- Picture Framing
- Finance/Accounting
- Warehousing
- Food Services/Catering

Certifications/Trainings

- Commercial Driver's Licenses (Class A & B)
- Culinary Arts & Serv-Safe
- State Auto Inspector & ASE Certifications
- Computer Skills Training
- Turf Management (NC Cooperative Extension)
- Adult Basic Education (ABE)
- High School Equivalency (GED)
- Community College Courses

“Work-out” Phase

- Resume writing
- Interviewing
- Personal finance
- Job search skills
- Outside Employment

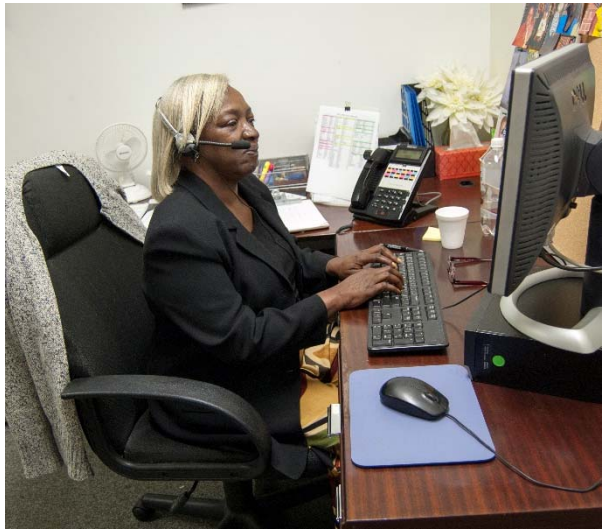


Barriers to Employment

- Criminal Record / Felony Record
- Gap in employment
- Poor references
- Transportation Issues (loss of driver's license)
- Reduced access to education and work training

Graduate Services (employment focused)

- Low cost transportation to and from work (1 yr)
- Free access to “work-out” computer lab
- Grant “work-out extensions” for those struggling with finding adequate employment



Employment Outcomes

- Nearly all graduates obtain full-time employment by graduation
- 88% graduates are employed one year after graduation
- Median Income at graduation is $11.00 ($0 at Intake)

Resources

- DHHS – Know your Rights (focus on hiring rights)
  - http://lac.org/wp-content/uploads/2014/12/Know-Your-Rights-English-2007.pdf
- Benefits of Ban the Box (Southern Coalition for Social Justice)
  - http://www.southerncoalition.org/program-areas/criminal-justice/ban-the-box-community-initiative-guide/benefits-ban-box/
- The Sentencing Project (effects of felony ban for federal benefits)
  - http://www.sentencingproject.org/publications/a-lifetime-of-punishment-the-impact-of-the-felony-drug-ban-on-welfare-benefits/
- Legal Action Center (NY)
  - https://lac.org/wp-content/uploads/2014/11/AreYouBrochureHIV-SUD.pdf

Contact Information

Karen Kelley, Chief Program Officer

kkelley@trosainc.org

919-419-1059

Q&A/Discussion – Employment/Supported Employment

Angela Harper King, Division of Mental Health/DD/SAS
Karen Kelley, TROSA
Tony Sowards, Oxford House
Amy Borskey, Mary Benson House
Denise Weegar, Insight Human Services Perinatal Program

Spotlight: Housing/Residential Treatment

Angela Harper King, Division of Mental Health/DD/SAS

Spotlight: Housing/Residential Treatment

Supportive Housing Overview

Housing / Residential Treatment Panel

Angela Harper King, MA
Community Mental Health Section
NC DHHS-DMH/DD/SAS

Presented at OPDAAC Meeting: December 15, 2017

Permanent Supportive Housing

- Successful partnership between Housing and Supportive Services

Residency in Long-Term Licensed Settings

- Residential Treatment/Rehabilitation for Individuals with SUDs
  - *27G .3401 SCOPE*

    (a) A residential treatment or rehabilitation facility for alcohol or other drug abuse disorders is a 24-hour residential service which provides active treatment and a structured living environment for individuals with substance abuse disorders in a group setting.
    (b) Individuals must have been detoxified prior to entering the facility.
    (c) Services include individual, group and family counseling and education.

- Supervised Living for Individuals of All Disability
  - *27G .5601 SCOPE*

    (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence.
    (b) A supervised living facility shall be licensed if the facility serves either:
    (1) or more minor clients; or
    (2) or more adult clients.
    Minor and adult clients shall not reside in the same facility.
    (c) Each supervised living facility shall be licensed to serve a specific population
    (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnosis;....

Rules for MH,DD, and SAF and Services found at: http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2027%20-%20mental%20health%2C%20community%20facilities%20and%20services/subchapter%20g/subchapter%20g%20rules.html

Considering Licensed Facilities or Supportive Housing

Licensed Facilities

- Diagnostic and Level of Care eligible
- Room and board as part of a program
- Service compliance
- Supervision
- Residential “rate” paid to provider
- Discharge/termination from service

Supportive Housing Setting

- Ability to pay rent and live within a lease (no time limitation)
- Tenant responsible for own costs/expenses
- Access to services
- Unsupervised
- Services reimbursed separate from housing costs
- Eviction

Why Permanent Supportive Housing?

- Permanent Supportive Housing
  - It is a proven evidence-based best practice model
  - Makes housing affordable to persons on very low income
  - Provides opportunity for housing stability
  - Promotes personal choice in housing and living arrangements
  - Encourages connections within communities
  - Participation in support services is encouraged, but is not a condition of continued tenancy
  - There are different models of supportive housing
    - Three primary forms of supportive housing are;
      - Single-site housing
      - Scattered-site housing
      - Mixed housing

Homeless in North Carolina

North Carolina Point-In-Time Count conducted the last week of January 2017 revealed:

8,862 individuals were identified as homelessness

- 73% sleeping in emergency shelters or transitional housing
- 27% sleeping in places not meant for human habitation i.e. outside on park benches
- 40% were females
- 11% were identified as veterans and their families

NC 2017 Point-in-Time Count published by North Carolina Coalition to End Homelessness Data Center

State and Local Collaboration

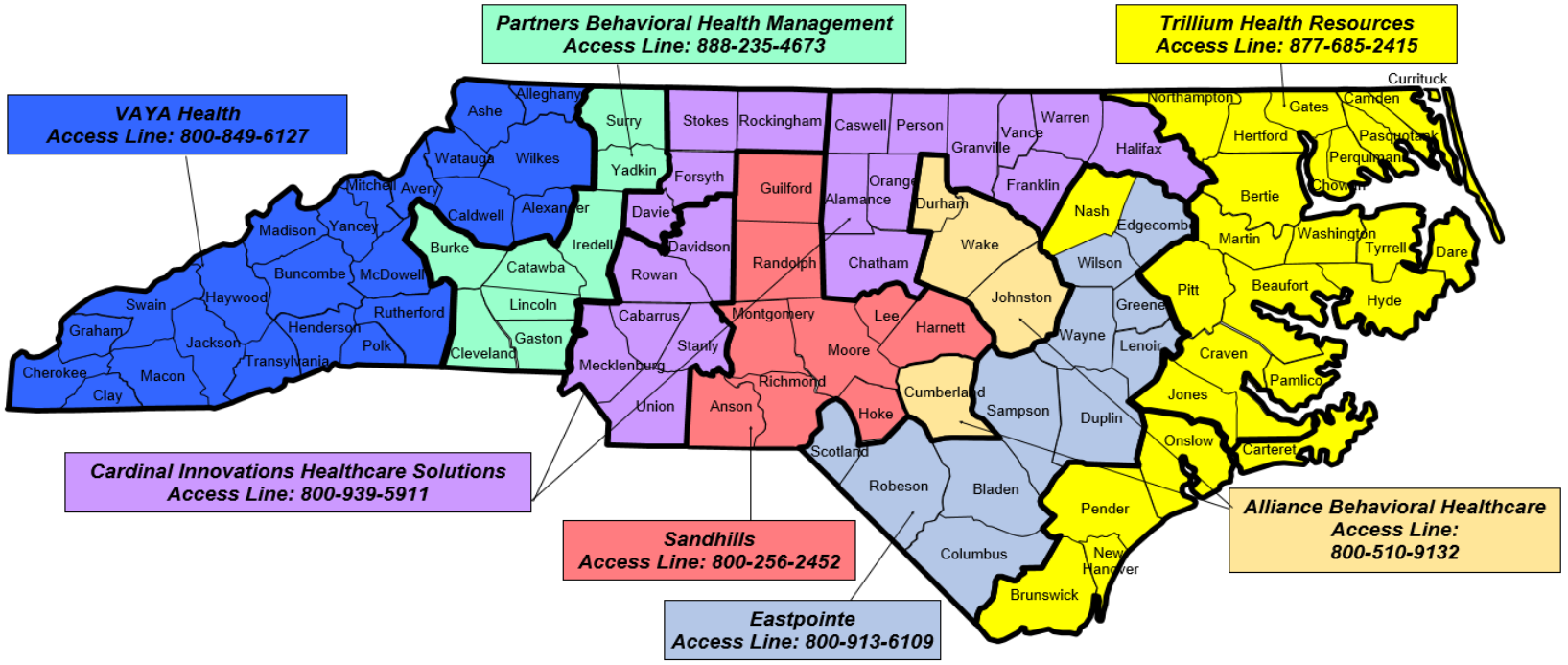
- The DMH/DD/SAS (the Division) contracts with seven Local-Management Entities, Managed Care Organizations (LME-MCOs) to manage behavioral health services to:
  - Support self-determination for individuals with intellectual and or developmental disabilities and;
  - Deliver quality services to promote treatment and recovery for individuals with mental illness and or substance use disorders.
- Each LME-MCO has dedicated staff that support housing coordination duties.

NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services State webpage for LME-MCOs at: https://www.ncdhhs.gov/divisions/mhddsas/LME-MCOs

LME-MCO Access Lines

Local Management Entity - Managed Care Organizations (LME-MCOs)

DHHS currently has -- Seven-- LME-MCOs operating under the 1915 b/c Waiver



Collaborative Response – To Meet the Need

NC Oxford Houses

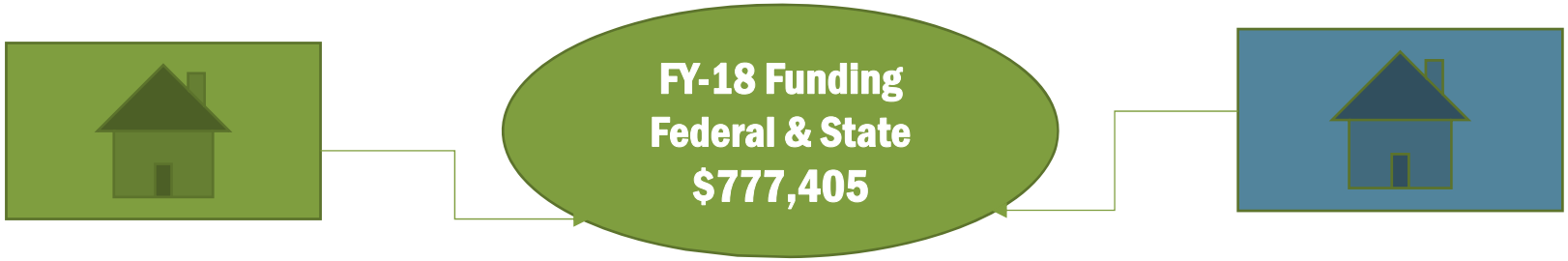
- FY-18, as part of our state's response to the Opioid Crisis (Opioid STR), the Division has expanded the federal contract with Oxford House, Inc. to support two new positions.

Re-Entry Coordinator Position	Training and Education Coordinator Position
Transition and mentor individuals from incarceration, to re-enter the community into NC Oxford Houses.	Training sessions will be targeted to educate house members and NC Oxford House contract staff on the risk of opioid misuse, appropriate use of an FDA approved product for emergency treatment, and other pertinent areas.

Expansion of Recovery Housing

NC Oxford Houses

- FY-18 Oxford House, Inc. with the support of the Division has sustained an extensive history of filling the gap for much needed recovery housing.



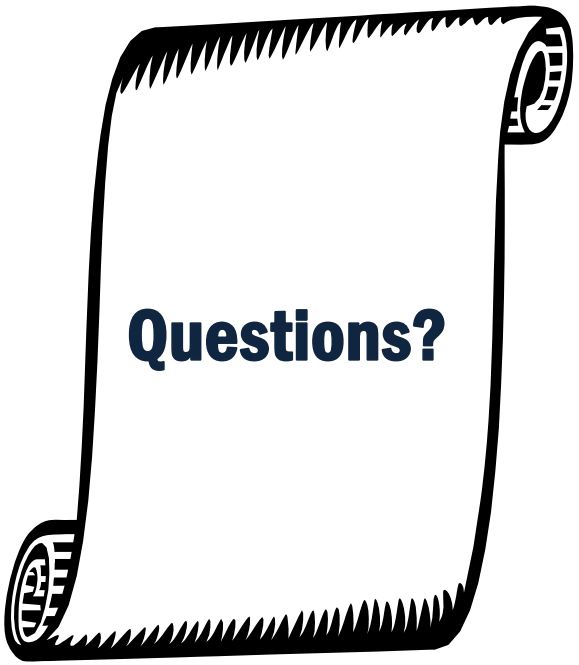
Nov. 30, 2017 Cumulative Total Houses 231	Nov. 30, 2017 Cumulative Total Beds 1,784
Men's Houses 167	Men's Beds 1,295
Women's Houses 55	Women's Beds 449
Women and Children 9	Children Beds 40

Housing and Recovery

Recovery

Safe Decent → Accessible Supports → Affordable Integrated

The End



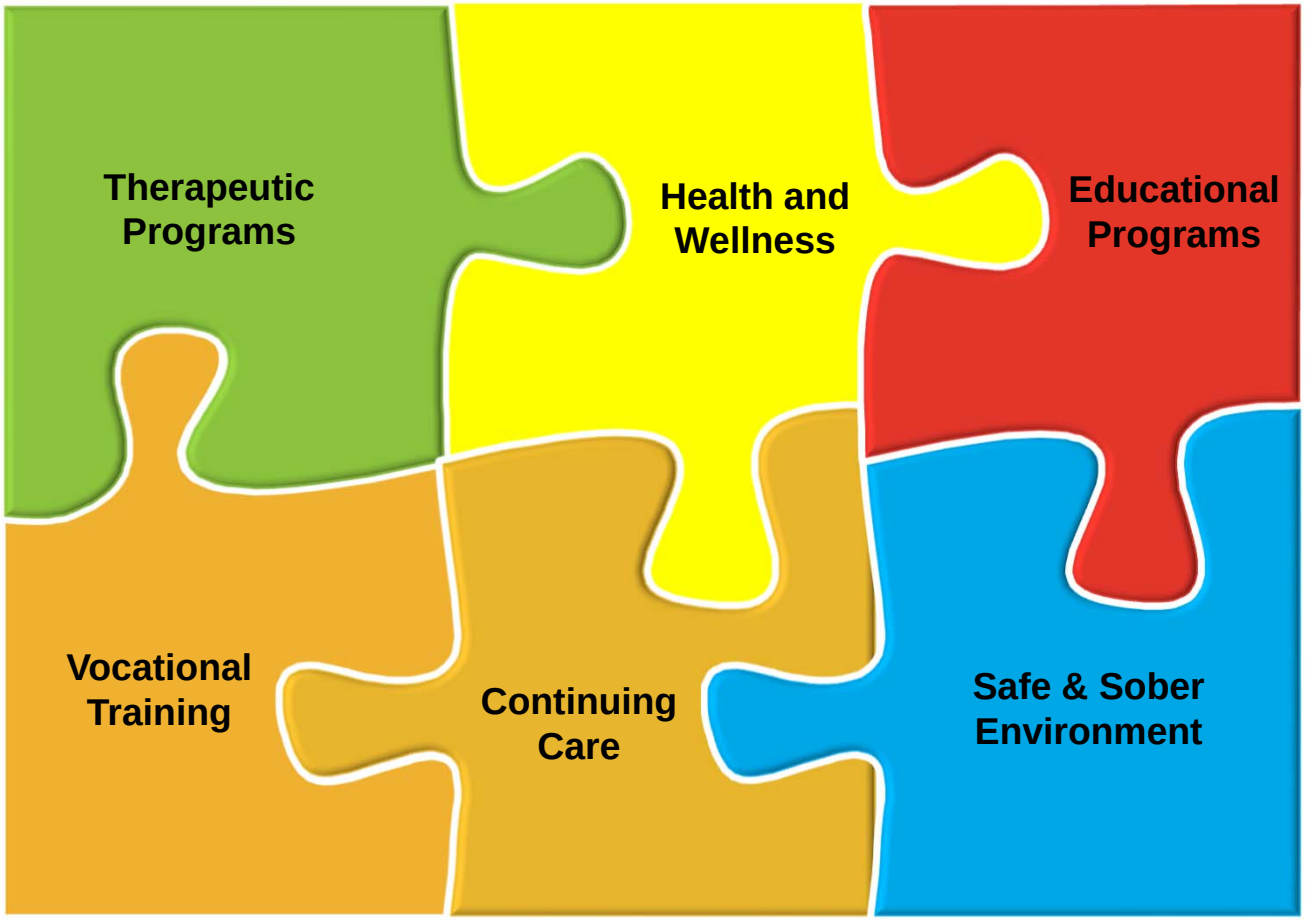
Angela Harper King
Community Development Specialist/Supportive Housing Specialist
NC DHHS-DMH/DD/SAS, Community Services and Supports
(919) 715-2357

Karen Kelley, TROSA

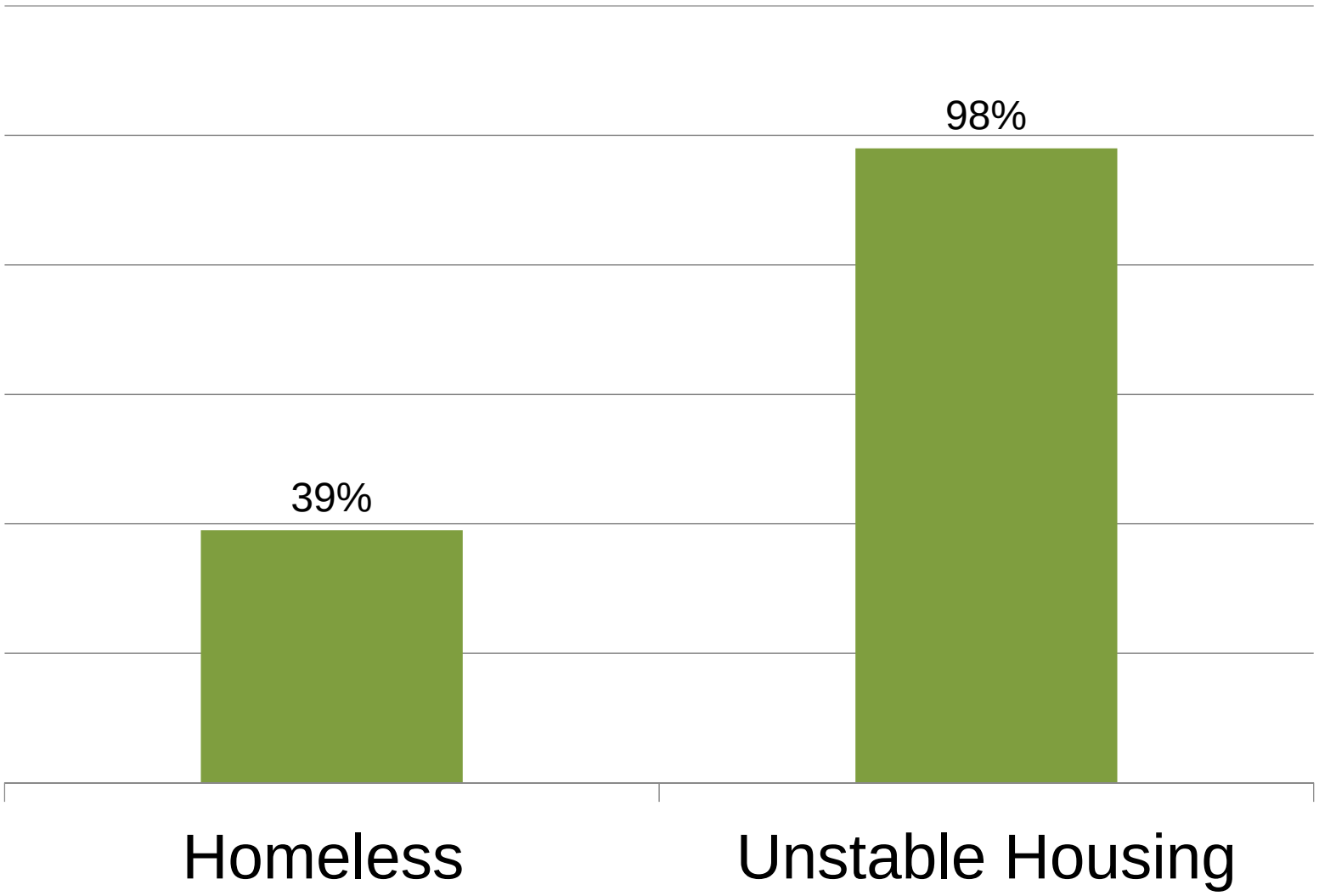
Spotlight: Housing/Residential Treatment

TROSA

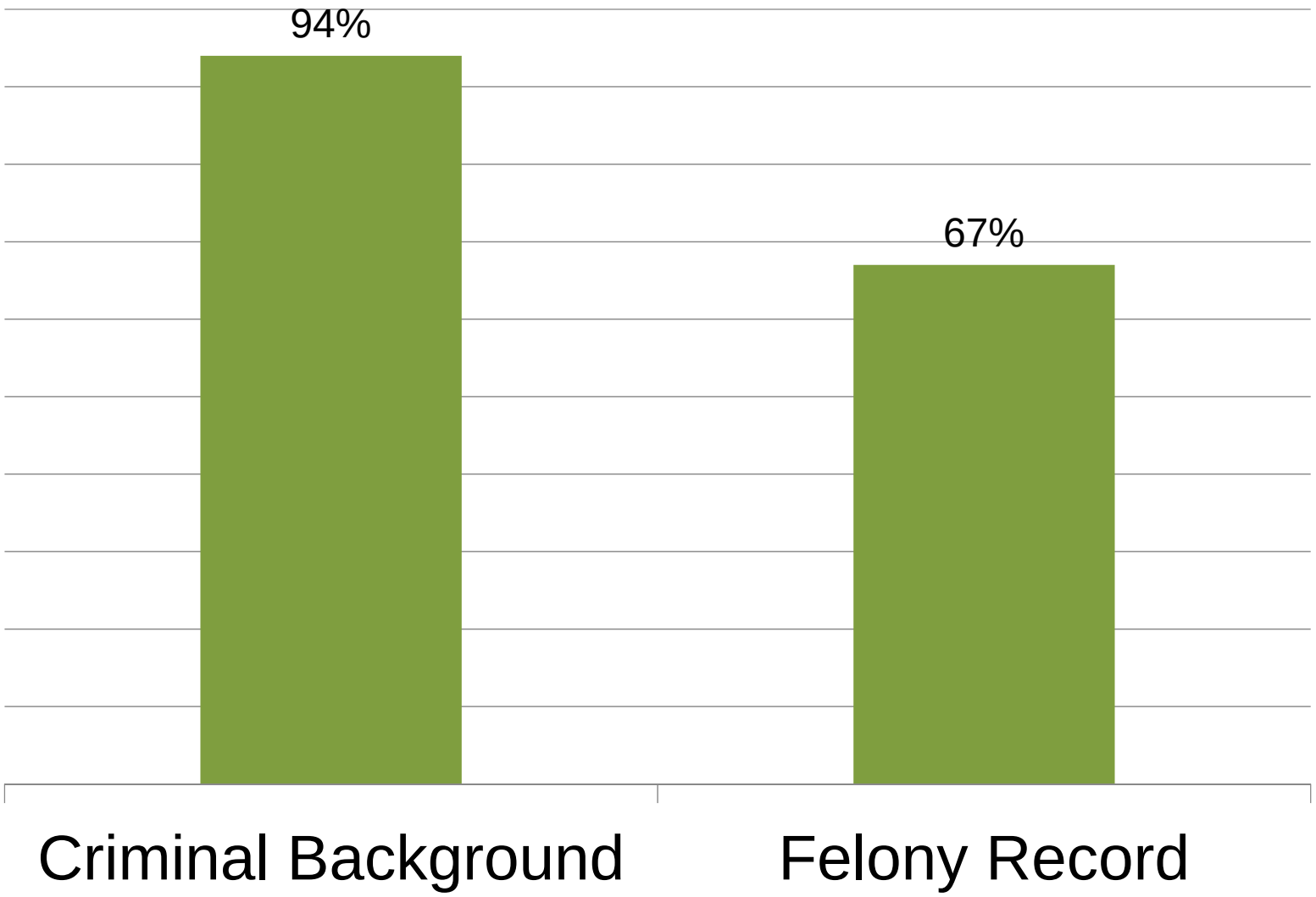
TROSA: A Comprehensive Care Model



Who TROSA Serves (2016)



Who TROSA Serves (2016)



Barriers to Housing

- Criminal Record / Felony Record
  - Public & Private Housing
- Lack of stable rental history
- Lack of financial stability
- Savings for security deposit, etc.

Program Overview

Safe & Sober Environment

- Basic Needs
  - Food
  - Clothing and Toiletries
  - Shelter
  - Transportation

- Three Cardinal Rules
  - No Drugs or Alcohol
  - No Threats of Violence
  - No Acts of Violence

Graduate Services (housing focused)

- 3 or more months to build “nest-egg”
- Low cost supportive housing (1 yr, post graduation)
- Bi-weekly support groups
- Grant “housing extensions” for those struggling with finding adequate housing
- Provide complete furnishings for first apartment or home when move out

Housing Outcomes

- 95% Stable Housing 1 yr post graduation (2% at Intake)

2016	US*	TROSA
Median Length of Stay in Long-Term Treatment (> 30 days)	56 days	253 days

- TROSA saves North Carolina $7.4 million annually by preventing arrests, incarcerations, and ER visits

* Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set, 2013
** Independent study by RTI International, 2017

Resources

- DHHS – Know your Rights (focus on hiring rights)
  - http://lac.org/wp-content/uploads/2014/12/Know-Your-Rights-English-2007.pdf
- Benefits of Ban the Box (Southern Coalition for Social Justice)
  - http://www.southerncoalition.org/program-areas/criminal-justice/ban-the-box-community-initiative-guide/benefits-ban-box/
- The Sentencing Project (effects of felony ban for federal benefits)
  - http://www.sentencingproject.org/publications/a-lifetime-of-punishment-the-impact-of-the-felony-drug-ban-on-welfare-benefits/
- Legal Action Center (NY)
  - https://lac.org/wp-content/uploads/2014/11/AreYouBrochureHIV-SUD.pdf

Contact Information

Karen Kelley, Chief Program Officer

kkelley@trosainc.org

919-419-1059

Tony Sowards, Oxford House

Spotlight: Housing/Residential Treatment

OXFORD HOUSES OF NORTH CAROLINA

What is Oxford House?

- Oxford Houses are self-run, self-supported recovery houses for individuals recovering from alcoholism and/or drug addiction.
- There is no time limit placed on residency which allows the individual to achieve comfortable sobriety without the worry of leaving a safe drug and alcohol free environment.
- Each Oxford House is managed and run by the residents themselves, which creates a real responsibility for each person living in one.
- Oxford House, Inc. (OHI) is the umbrella organization for the more than 2,200 individual Oxford Houses.

Three Core Principles

Oxford House, Inc. Charter Requirements:

- Each house must be democratically run
- The house membership is responsible for all household expenses
- The house must immediately expel any member who returns to using alcohol or drugs

How It Works

- Over forty-two years of experience of what works
- Three core charter requirements
- Nine traditions to follow
- House manual
- Chapter support
- State Association support
- Alumni support
- Outreach support
- Oxford House World Services Support

Houses

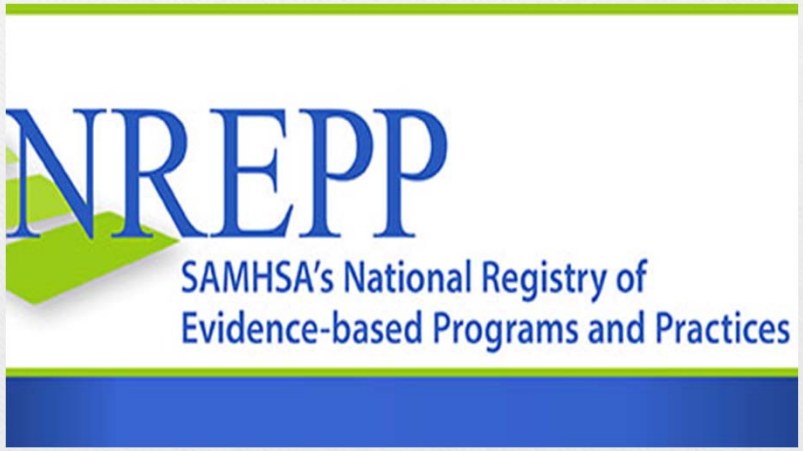
- North Carolina has 243 Oxford Houses providing more than 1850 recovery beds.
- In Durham County there are 15 Oxford Houses providing over 100 recovery beds.
- 13 for Men, 1 of which is designated for men w/ children.
- 2 for Women, 1 of which is designated for women w/ children.

ADDRESSING THE OPIOD EPIDEMIC

- All houses have been supplied with Narcan/Naloxone along with proper training and education material which is now included in the orientation for new members.
- In the coming months each house in the State will attend a training and education program regarding Overdose Prevention and Medication Assisted Treatment.
- All Houses of Durham County have attended this training.

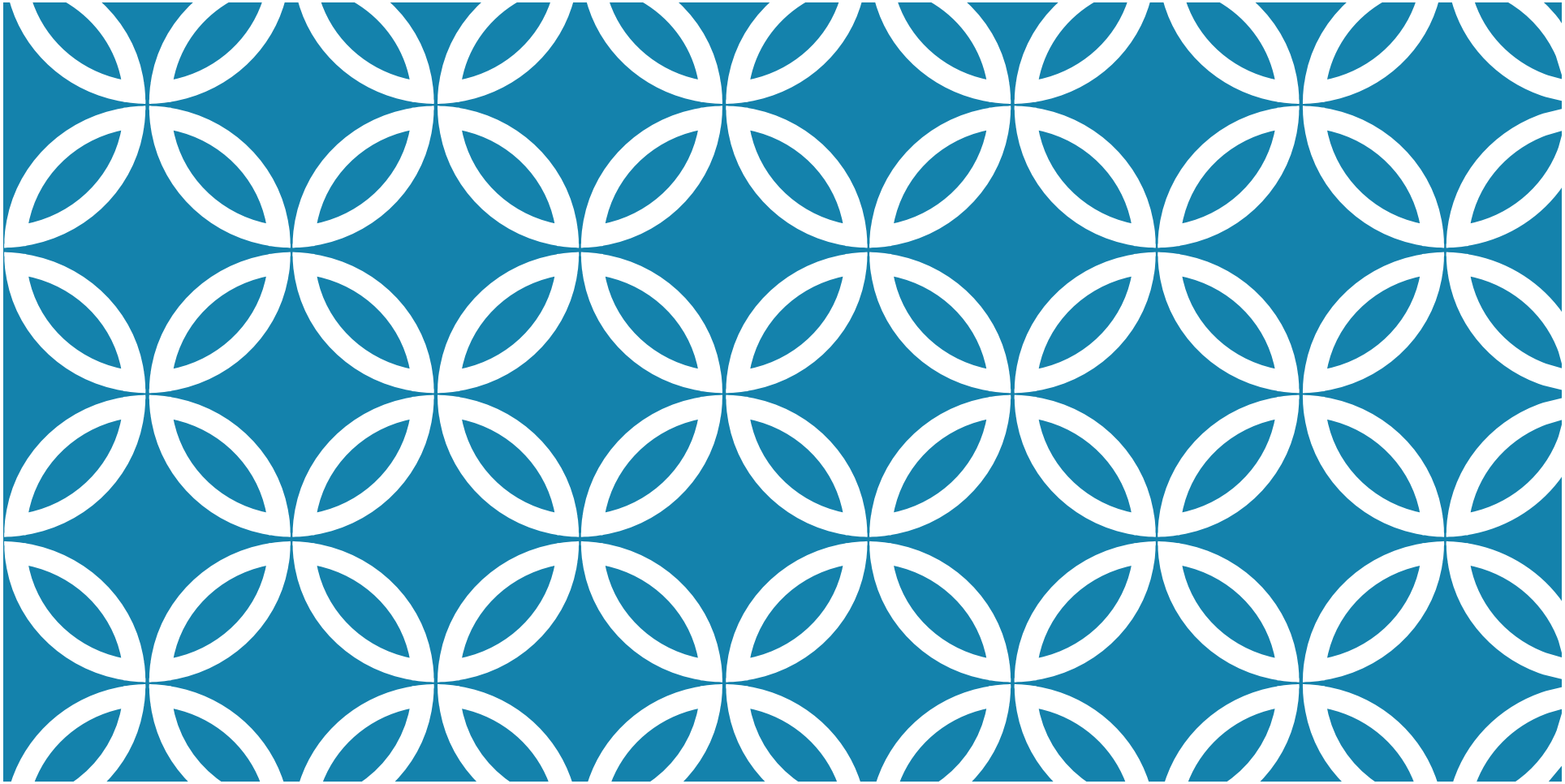
In Conclusion

- Oxford Houses gives alcoholics and addicts from all backgrounds the best chance at long -term recovery.
- Oxford House continues to grow and thrive, in spite of budget cuts and times of recession.
- Oxford House has over 42 years of experience and is listed on SAMHSA's National Registry of Evidence Based Programs and Practices.



Amy Borskey, Mary Benson House

Spotlight: Employment/Supported Employment



MARY BENSON HOUSE

A recovery haven for mothers and mothers-to-be.

ADMISSION CRITERIA:

Women must be…

At least 18 years old

Pregnant and/or parenting a child under 5 years of age

Have a primary substance use disorder diagnosis

Medicaid and Work First eligible

Resident of North Carolina

*Priority is given to pregnant women who use substances intravenously

WHO CAN REFER?:

Anyone!

HOW DOES THE ADMISSION PROCESS WORK?

After a woman has been referred, the clinician at MBH follows up with her and schedules a screening that is completed over the phone.

The information obtained from the screening is staffed with MBH Clinical Supervisor to determine if the woman meets all criteria for admission.

The woman is then asked to come for a tour of the program (if distance and situation permits). She is given a tour of the house and is able to meet the residents of the program.

After the tour, if the woman feels MBH is the right place for her and the MBH team does not have any concerns, she is given a move-in date for the soonest time possible.

Women coming for admission must be detoxed before their move-in date.

If there are no beds available, MBH will put the woman on their waiting list.

WHAT IS THE COST OF THE PROGRAM?

Residents live at the Mary Benson House free of charge.

SERVICES OFFERED:

- Person-Centered Treatment Planning
- Weekly Parenting Classes using Nurturing Parenting Program
- Weekly Group Therapy/skills group
- Weekly Individual Therapy by Licensed Clinical Professionals
- Weekly Self-Care Group
- Comprehensive Case Management
- Transportation

WHAT ARE THE MAIN FOCUSES FOR TREATMENT?:

- SACOT @ Women's Recovery Center
  - All of our residents are required to attend this 12-14 week program
- Parenting Skills
- Recovery Skills
- Independent Living Skills
- AFTERCARE!!! This includes finding safe, affordable housing after graduation

HOW LONG DOES A RESIDENT STAY AT MBH?:

Our program is structured to be one year. Women are free to leave anytime.

OTHER DETAILS ABOUT THE PROGRAM:

- Number of beds
  - 7
- How many children can a woman bring?
  - We can technically have up to 11 children. This means that some women may be able to bring 2 children.
- Location
  - We are located in the Historic District of Montford, just off of downtown Asheville
- Daily structure
  - Every woman's day may be structured differently depending on whether or not she has completed SACOT and where she is in her pregnancy. When able (after SACOT and/or when child is in daycare) women in our program are required to work, volunteer, go to school, and/or attend job readiness and skill building programs and classes.
- Staffing
  - We have staff present 24/7/365, and a clinical on-call person is always available.
- Safety
  - We have a curfew that residents are required to abide by and an alarm system that is utilized at night. Staff do hourly room checks every night. Residents earn pass privileges and inform staff of where they will be on their outings.

IF WE HAD THE FUNDS…


EXIT

Denise Weegar, Insight Human Services Perinatal Program

Spotlight: Employment/Supported Employment

Q&A/Discussion – Housing/Residential Treatment

Announcements and News

Scott Proescholdbell, Epidemiologist, Injury and Violence Prevention Branch, Division of Public Health

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

- THANK YOU!

(Please take food and travel safely!)

Questions

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

North Carolina Division of Public Health
Nidhi.Sachdeva@dhhs.nc.gov
919.707.5428

Sara J. Smith, MA, CHES
Communication Consultant
Injury and Violence Prevention Branch

North Carolina Division of Public Health
Sara.j.smith@dhhs.nc.gov
919.707.5431

Thank you!