NC Department of Health and Human Services
NC Opioid and Prescription Drug Abuse Advisory Committee (OPDAAC)

September 17, 2020
Welcome and Introductions of Attendees

Alan Dellapenna, Head, Injury and Violence Prevention Branch, Chronic Disease and Injury Section, Division of Public Health
N.C. Overdose Data: Trends and Surveillance

Scott Proescholdbell
Trends in since March - ED visits and alerts
This year, NC has experienced a **19% decrease** in overall ED visits

**Note:** Provisional data, limited to NC residents
Weeks begin at 01/01
Source: NC DETECT ED Visits, 2019-2020
Yet, NC has seen a **21% increase** in Med/Drug\(^{\text{^}}\) Overdose ED visits in 2020

**Note:** \(^{\text{^}}\)Unintentional/undetermined intent cases of drugs and medicaments with dependency potential within ICD10CM overdose codes (T40, T42, T43, T50.7, and T50.9). Restricted to N.C. residents between ages 15-65 years. **Source:** NC DETECT ED Visits, provisional data 2019-2020.
This trend is largely driven by a **24% increase** in opioid overdose ED visits

**Note:** All intents opioid overdose cases within ICD10CM codes (T40.0-4, T40.6, T40.69), initial encounters only.

**Source:** NC DETECT ED Visits, provisional data 2019-2020.
Epidemiologist track signals of unusually high numbers of overdose and alert partners

- Syndromic Surveillance Signal
- Epidemiologists review
- Alert

- IVBP Prevention Team
- Local Health Directors
- EMS Directors
- SSP Staff and Harm Reduction Partners
High number of county alerts for response to overdoses in March and April 2020

Note: Signal notification protocol modified in May 2020 to reduce county notification fatigue.
Other Statewide Drug Overdoses Trends
Provisional Unintentional Poisoning Deaths
NC Residents, 2017-2019* -- as of July 2020

(X40-X49)
PROVISIONAL DATA: Cases for 2019 are still being processed. Data subject to change.
Last year at this time

2017: 1,884 deaths  
2018: 1,785 deaths

Estimated 5% decrease (estimated 99 deaths) from 2017 to 2018

Unintentional Opioid Overdose Deaths, N.C. Residents

*Unlikely, but possible that some of these cases are overdoses

Technical Notes: Unintentional medication and drug poisoning: X40-X44 and any mention of T40.0 (opium), T40.2 (Other Opioids), T40.3 (Methadone), T40.4 (Other synthetic opioid) and/or T40.6 (Other/unspecified narcotics)

Source: Office of the Chief Medical Examiner and N.C. State Center for Health Statistics, Vital Statistics
The majority of unintentional opioid overdose deaths now involve multiple substances

North Carolina’s Data Dashboard
Measure our impact: **N.C.’s Opioid Action Plan Data Dashboard** tracks quarterly N.C. Opioid Action Plan metrics

<table>
<thead>
<tr>
<th>Metrics*</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of unintentional opioid-related deaths to N.C. Residents (ICD-10)</td>
<td>1,384</td>
<td>1,884</td>
</tr>
<tr>
<td>Number of ED visits that received an opioid overdose diagnosis (all intents)</td>
<td>4,323</td>
<td>5,850</td>
</tr>
<tr>
<td><strong>Reduce oversupply of prescription opioids</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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</td>
<td>34.2</td>
<td>16.2</td>
</tr>
<tr>
<td>Total number of opioid pills dispensed</td>
<td>580,275,380</td>
<td>523,250,000</td>
</tr>
<tr>
<td>Percent of patients receiving more than an average daily dose of &gt;90 MME of opioid analgesics</td>
<td>6.8%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Percent of prescription days any patient had at least one opioid AND at least one benzodiazepine prescription on the same day</td>
<td>27.2%</td>
<td>22.4%</td>
</tr>
<tr>
<td><strong>Reduce Diversion/Flow of Illicit Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of opioid deaths involving heroin or fentanyl/fentanyl analogues</td>
<td>58.7%</td>
<td>75.4%</td>
</tr>
<tr>
<td>Number of newly diagnosed acute Hepatitis C cases</td>
<td>200</td>
<td>187</td>
</tr>
<tr>
<td><strong>Increase Access to Naloxone</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of EMS naloxone administrations</td>
<td>13,103</td>
<td>15,282*</td>
</tr>
<tr>
<td>Number of community naloxone reversals</td>
<td>3,684</td>
<td>4,176</td>
</tr>
<tr>
<td><strong>Treatment and Recovery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of buprenorphine prescriptions dispensed</td>
<td>478,845</td>
<td>590,491</td>
</tr>
<tr>
<td>Number of uninsured individuals and Medicaid beneficiaries with an opioid use disorder served by treatment programs</td>
<td>28,968</td>
<td>31,758</td>
</tr>
<tr>
<td>Number of certified peer support specialists (CPSS) across N.C.</td>
<td>2,352</td>
<td>2,778</td>
</tr>
</tbody>
</table>

*Data are continually updated as additional cases, visits, claims, and other data points are finalized in each system.

*EMS data currently transitioning to a new system resulting in a decrease in counts during this period.*
The N.C. Opioid Action Plan (N.C. OAP) has seven focus areas to reduce addiction and overdose death:

- Create a coordinated infrastructure
- Reduce oversupply of prescription opioids
- Reduce diversion of prescription drugs and flow of illicit drugs
- Increase community awareness and 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

## OAP 2.0 tracks metrics and local actions

<table>
<thead>
<tr>
<th>Metrics</th>
<th>Questions to inform Local Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Track progress and measure our impact</strong></td>
<td></td>
</tr>
<tr>
<td>Number of unintentional opioid-related deaths to NC Residents (ICD-10)</td>
<td>Does your county have a dedicated point person to coordinate overdose response and prevention programs?</td>
</tr>
<tr>
<td>Number of ED visits that received an opioid overdose diagnosis (all intents)</td>
<td>Does your county use resources from DHHS to inform your programs?</td>
</tr>
<tr>
<td><strong>Reduce the supply of inappropriate prescription and illicit opioids</strong></td>
<td></td>
</tr>
<tr>
<td>Total number of opioid pills dispensed</td>
<td>Does the county have a prescription drug disposal permanent dropbox in more than one setting?</td>
</tr>
<tr>
<td>Percent of opioid deaths involving heroin or fentanyl/fentanyl analogues</td>
<td>Is there fentanyl test strip distribution in the county?</td>
</tr>
<tr>
<td><strong>Prevent future opioid addiction by supporting children and families</strong></td>
<td></td>
</tr>
<tr>
<td>Percent of children in foster care due to parental substance use disorder</td>
<td>Does the county have START (Sobriety Treatment and Recovery Teams) or another similar program for families with a parental SUD?</td>
</tr>
<tr>
<td>Number of newborns engaged in CC4C (CMARC) affected by substance use as a result of Plan of Safe Care referral</td>
<td>Does the county DSS have a Community Response Program?</td>
</tr>
<tr>
<td><strong>Advance harm reduction</strong></td>
<td></td>
</tr>
<tr>
<td>Number of community naloxone reversals</td>
<td>Does the county have naloxone access?</td>
</tr>
<tr>
<td>Number of newly diagnosed acute Hepatitis C cases</td>
<td>Do county residents have access to low/no-cost sterile syringes?</td>
</tr>
<tr>
<td><strong>Address non-medical drivers of health and eliminate stigma</strong></td>
<td></td>
</tr>
<tr>
<td>Number of individuals experiencing homelessness living in a shelter</td>
<td>Does the county have a Housing First or related program to connect people who use drugs to housing services?</td>
</tr>
<tr>
<td>Rate of Unemployment</td>
<td>Does the county have Fair Chance Hiring policies in place?</td>
</tr>
<tr>
<td><strong>Address the needs of justice-involved populations</strong></td>
<td></td>
</tr>
<tr>
<td>Rate of incarceration</td>
<td>Does the county have a pre-arrest diversion program?</td>
</tr>
<tr>
<td>Number of naloxone reversals reported by Law Enforcement Agencies</td>
<td>Does the county have MAT in the county jail/detention center?</td>
</tr>
<tr>
<td><strong>Expand access to treatment and recovery supports</strong></td>
<td></td>
</tr>
<tr>
<td>Number of buprenorphine prescriptions dispensed</td>
<td>Does the county have programs where peer support specialists refer people who are at risk of overdose to social and medical services (e.g., harm reduction, treatment, recovery supports)?</td>
</tr>
<tr>
<td>Number of uninsured individuals and Medicaid beneficiaries with an opioid use disorder served by treatment programs</td>
<td>Does the county have MAT providers who take uninsured patients and Medicaid beneficiaries?</td>
</tr>
</tbody>
</table>
Intro to the NC Opioid Action Plan

North Carolina’s Opioid Action Plan was released in June 2017 with community partners to combat the opioid crisis, with an updated Opioid Action Plan 2.0 launched in June 2019 to continue this address issue.


North Carolina’s Opioid Action Plan 2.0 updates the 2017 plan with feedback from partners and stakeholders. Action Plan 2.0 newly includes local actions that counties, coalitions and stakeholders can use to fight the opioid epidemic, which claimed nearly five lives a day in North Carolina to unintentional overdose in 2018.

The plan focuses on three areas of focus to fight the epidemic:

Prevention
- Reducing the supply of inappropriate prescriptions and illicit opioids
- Preventing future opioid addiction by supporting children and families

Reducing Harm
- Advancing harm reduction
- Addressing non-medical doctors of health and eliminating stigma

Connecting to Care
- Expanding access to treatment and recovery supports
- Addressing the needs of justice-involved populations

Central to these three focus areas and their related priorities is our effort to track progress and measure our impact to ensure that our efforts are informed by data. The North Carolina Opioid Action Plan 2.0 aims to identify impactful, feasible strategies to reduce opioid overdoses in North Carolina and prevent the next wave of the epidemic.

https://photos.google.com/photos/AFIQioiW0cUQUrLjQGdXJZmAME8r4Wv7Gx7hFr6h
Measure our impact: **IVPB Poisoning Data Website** provides monthly and annual data updates

**Injury and Violence Prevention Branch**

**Poisoning Data**

++ Data and Surveillance Navigation ++

Deaths, hospitalizations, and emergency department (ED) visits due to poisoning, particularly medication and drug poisoning, have become a growing public health concern nationally and in North Carolina. Since 1999 the number of drug poisoning deaths in North Carolina has increased by 440%, from 363 to 1,965 in 2016. Additionally, in 2014 there were nearly 12,000 hospitalizations and almost 22,000 ED visits related to medication and drug poisoning. (More recent hospital and ED data are not currently available due to a coding transition.)

Historically, prescription drugs have been a major driver of this epidemic. However, illicit drugs are also contributing to this problem in increasing numbers. Heroin or other synthetic narcotics (like fentanyl) were involved in over 60 percent of unintentional opioid deaths in 2016. The number of cocaine overdose deaths is also on the rise.

Visit [Poisoning Prevention](#) and [Unintentional Poisoning from Prescription Drugs](#) for more information on preventing poisoning deaths in North Carolina.

**N.C. Summary Data**

- [NC Overdose Data: Trends and Surveillance](#) is a recorded presentation of core overdose data.
  - Download the slides: [Core Overdose Data Slides January 2018](#) (PPTX, 6.7 MB)
- [The Prescription and Drug Overdose Fact Sheet](#) (PDF, 180 KB) provides a snapshot of prescription drug overdose deaths.
- [The Opioid-related Overdose Fact Sheet](#) provides information specific to the opioid epidemic.
Questions?

SubstanceUseData@dhhs.nc.gov

Injury and Violence Prevention Branch
NC Division of Public Health

www.injuryfreenc.ncdhhs.gov
DHHS’ COVID Response for People with SUD

Elyse Powell
DHHS COVID Response for People with SUD

• COVID19 presented new challenges, and exacerbated existing gaps in our treatment system

• Federal and state changes allowed new flexibilities
  – DEA flexibility to allow initial MAT prescription in person
  – Expansion of take-home doses for OTPs
  – Telehealth flexibilities for behavioral and psychosocial supports

• Many behavioral health providers and SSPs were declared essential services under the Stay at Home Order
Memo noting SSPs as essential services under COVID-19 Stay at Home Order

April 6, 2020

To whom it may concern:

This letter serves to inform interested parties that the NC Division of Public Health considers syringe services programs an “Essential Business and Operation” under Governor Roy Cooper’s Executive Order No. 121—“Stay at Home Order and Strategic Directions for North Carolina in Response to Increasing COVID-19 Cases.”

NC General Statute § 90-113.27 requires syringe services programs to provide participants with “needles, hypodermic syringes, and other injection supplies at no cost and in quantities sufficient to ensure [they] are not shared or reused,” in addition to disposal of injection supplies, educational materials, and access to naloxone. These services are provided in order to reduce the spread of HIV, viral hepatitis, and other bloodborne diseases and to reduce the number of drug overdoses in North Carolina.
COVID-19 Support Services Program

• Goal: Support individuals in targeted counties who need access to primary medical care and supports to successfully quarantine or isolate due to COVID-19

• Identified 20 counties with highest rates of COVID-19 cases, and included contiguous counties to scale available resources

• Eligible individuals will be able receive supports such as:
  − Nutrition assistance (e.g., home-delivered meals, groceries)
  − One-time COVID-19 relief payment
  − Private transportation to/from
  − Medication delivery
  − COVID supplies (e.g., masks, hand sanitizer, thermometer)
COVID19 exacerbated already existing challenges to supporting people with SUD

• COVID19 added new challenges to an already underfunded treatment and care system

• Both health services and human services shifted service delivery, hours of operation, and/or ability to take on new people

• Some of the hardest hit sectors of the economy were often a point of entry for people re-entering the workforce

• We know that more than 500,000 North Carolinians are uninsured
  - More than half of people admitted to the emergency department with an overdose are uninsured

Goal of today: Lift up successes and lessons learned in providing treatment during COVID19
Substance Use Disorder Treatment Response due to COVID-19

Smith Worth
Overview

• Review of General SUD Flexibilities
• Review of Flexibilities Specific to Specialized Women’s Services
• Review of Flexibilities Specific to Opioid Treatment Programs
General Flexibilities

1. Telehealth – 2-way audio/video & telephonic interventions for outpatient and select enhanced services (e.g., individual, group, SAIOP, SACOT, physician eval at location-based detox, OBOT/prescriber services).

2. Allow telehealth services at home, including services that typically occur in a congregate day setting (SAIOP, SACOT) to maximize access and minimize risk of COVID exposure.

3. Allow for flexibility in hours/structure of programming to accommodate the needs of providers & clients.
General Flexibilities, cont.

4. Allow for flexibility in staffing & training to ensure programing does not shut down if staff are unavailable during the pandemic.

5. Permit virtual supervision where onsite supervision was previously required to accommodate for new telehealth modalities & to reduce the need for additional on-site staff.

6. Waive prior and concurrent authorization for some services to lessen the strain on providers.

7. Increase take home allowances and payments for OTPs.
Specialized Women’s Services

1. Women’s Services Coordinator & Perinatal, Maternal, CASAWORKS program managers initial preparations including addressing needs of current caseload, screening protocols, admissions considerations, potential isolation and quarantine protocols, access to PPEs, etc.

2. Each agency submitted an initial COVID-19 protocols & have updated as information has changed.

3. Weekly conference calls w/managers providing information from DHHS, CDC, SAMHSA, CMS and other relevant agencies.

4. Consultation & technical assistance related to program operations, funding concerns, billing clarifications & access to PPEs.
North Carolina OTP Census

North Carolina Lighthouse Central Registry 03-01-2020 to 09-01-2020
Flexibilities Specific to Opioid Treatment Programs

1. Continuity of service plans
2. Weekly Zoom meetings with OTP Medical Staff and Program Directors
3. Central Registry COVID reporting of staff & patients
4. Increased availability of naloxone
5. Telehealth/telecounseling increased contact between patients & clinic staff
6. Sunday closure as requested to give staff a break
SAMHSA Guidelines for Increased Flexibilities for Opioid Treatment Programs

1. Scheduled conference calls with SAMHSA & the DEA
2. Take-home dosing for stable & less stable patients
3. Telephonic buprenorphine inductions
4. Continue to treat existing OTP patients using methadone/buprenorphine via telehealth/phone
5. Mid-level practitioner dispensing MAT in OTP absent the direct supervision of an OTP physician
6. Curbside dosing and home deliveries
Policy Flexibilities for Substance Use Disorder (SUD)

Deborah Goda
Agenda

- How We Got Here
- Flexibilities
- Timelines
- Q & A
How We Got Here
## COVID Implementation Authority

- 1115 Waiver
- 1135 Waiver (Round 1)
- 1135 Waiver (Round 2)
- Appendix K (Round 1) Innovations and TBI
- Appendix K (Round 2) Innovations and TBI
- Concurrence Letter
- Disaster SPA (Round 1)
- Disaster SPA (Round 2)
- Disaster SPA (Round 3)
- Existing State Authority
The Circuit Breaker Approach

What triggers flipping provisions on and off?
What is the timeline for lead and lag for a change?

The Circuit Breaker

What is the transition time for the organization to flip provisions on/off?
Where are the decision rights on flipping a provision on/off?
Who must be informed to support the decision to flip provision on/off?

Kelly

EVALUATION

Julie

PLANNING & STRATEGY

Debra

COMMUNICATION: Beneficiaries, Providers, Legislature, Stakeholders

Melanie

SYSTEM IMPACT/CHANGE

CLINICAL POLICY: Medical, Dental, Pharmacy, OMH, Behavioral, Waiver Populations, LTCC
Sandy/Sarah

What Stays On?

Temporary Modifications TURN OFF with Switch
Permanent Modifications STAY ON with Switch
Financial Review
Authority Issue
Authority Granted

IF YES, PROCEED

ELIGIBILITY AND PROVIDER:
Melanie

What Stays On?

Temporary Modifications TURN OFF with Switch
Permanent Modifications STAY ON with Switch
Financial Review
Authority Issue
Authority Granted

IF YES, PROCEED

COMPLIANCE/REGULATORY
Lotta

How do we audit?
How do we track appeals?
How do we track CMS changes?
Temporary Modifications TURN OFF with Switch
Permanent Modifications STAY ON with Switch
Financial Review
Authority Issue
Authority Granted

IF YES, PROCEED

FINANCE
Adam

What rates get changed back?
How do we apply payment reforms?
How and when will we undo provider supports?
Temporary Modifications TURN OFF with Switch
Permanent Modifications STAY ON with Switch
Financial Review
Authority Issue
Authority Granted

IF YES, PROCEED
The Circuit Breaker Process Steps, Ownership & Timeline

**Step 1:** Finalize Policy Statement
- Sr. Executive Team
- MAY 11 - 15

**Step 2:** Identify All COVID Changes – Use a Standard Template
- Workstream Business Leads

**Step 3:** Assign Changes to Lead(s) for Recommendation
- Assigned Business Leads & Their Teams / Leadership Team
- MAY 18 - 29

**Step 4A:** Assigned lead(s) and their teams send Recommendations to Leadership Team
- Step 4B: Leadership Team Modifies, as necessary and sends Recommendations to Sr. Executive Team

**Step 5:** Sr. Executive Team Review
- JUNE 2

**Step 6:** Detailed Financial and Authorities Review of Changes selected as “Recommend keep”
- Finance & Authority
- JUNE 2 - 12

**Step 7:** Wind Down Review, mandatory for changes selected as “Recommend to not keep”
- ADs
- JUN 19

**Step 8:** Assign end dates for changes selected as “Recommend to not keep” and “Cannot continue” based on authority granted (e.g., end of NC State of Emergency, end of Federal Public Health Emergency)
- Operations [Melanie’s team]

**Step 9:** Detailed Financial and Authorities Review of Changes selected as “Consider keep”
- Finance & Authority

**Step 10:** Ongoing: Assigned lead(s) and their teams update Recommendations based on increased understanding of quality and utilization
- Business Leads

**Step 11:** Ongoing: Sr. Executive Team Reviews Recommendations on weekly basis
- Ongoing

**Step 11 - Ongoing:** Sr. Executive Team

**Step 12:** Sr. Executive Team Reviews
- Finance & Authority

Flexibilities
(Keep, Keep with Changes, and Not Keep)
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended Keep</td>
<td>Has significant potential for improvement to quality and access beyond COVID</td>
</tr>
<tr>
<td>Recommend Keep with Changes</td>
<td>Has significant potential for improvement to quality and access beyond COVID, with changes to the flexibility</td>
</tr>
<tr>
<td>Recommend to Not Keep</td>
<td>No improvement except as response to COVID</td>
</tr>
</tbody>
</table>
1-H Telehealth Update

• Remove limits on origination/distant sites
• Remove requirement for consultation/referral-only model
• Tablets/cell phones allowed
• Other “telepsychiatry” codes taken out of 1H and housed in 8C but with 1H guidelines/requirements applying to 8C codes eligible for telehealth
• Other policies have ‘tele’ sections.
# Other Telehealth Update

<table>
<thead>
<tr>
<th>Service</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile Crisis Management</td>
<td>Deleted “face-to-face” and replaced with “in-person”</td>
</tr>
<tr>
<td></td>
<td>Added Community Support Team as an exclusion.</td>
</tr>
<tr>
<td>Diagnostic Assessment</td>
<td>This service may be provided to the beneficiary in-person or via telehealth.</td>
</tr>
<tr>
<td>Professional Treatment Services in Facility-Based Crisis Program</td>
<td>Increased calendar year limits from 30 to 45.</td>
</tr>
<tr>
<td>Substance Abuse Non-Medical Community Residential Treatment</td>
<td>Increased calendar year limits from 30 to 45.</td>
</tr>
<tr>
<td>Substance Abuse Medically Monitored Community Residential Treatment</td>
<td>The physician’s assessment must be conducted within 24 hours of admission.</td>
</tr>
<tr>
<td></td>
<td>Increased calendar year limits from 30 to 45.</td>
</tr>
</tbody>
</table>
# Other Telehealth Update

<table>
<thead>
<tr>
<th>Service</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detoxification Services</td>
<td>The physician’s assessment must be conducted within 24 hours of admission in-person or via telehealth.</td>
</tr>
<tr>
<td>Non-Hospital Medical Detoxification</td>
<td>Increased calendar year limits from 30 to 45.</td>
</tr>
<tr>
<td></td>
<td>Physician assessments may be conducted in-person or via telehealth.</td>
</tr>
<tr>
<td>Medically Supervised or ADATC Detoxification</td>
<td>Increased calendar year limits from 30 to 45.</td>
</tr>
<tr>
<td>Crisis Stabilization</td>
<td></td>
</tr>
<tr>
<td>Outpatient Opioid Treatment</td>
<td>Allows for one dose in person and up to seven take home doses to be billed in one day.</td>
</tr>
<tr>
<td></td>
<td>Note that no more take homes can be given then as outlined in 10A NCAC 27G.3600.</td>
</tr>
<tr>
<td>Facility Based Crisis for Children and Adolescents</td>
<td>Added telehealth components</td>
</tr>
<tr>
<td></td>
<td>Increased calendar year limits from 30 to 45.</td>
</tr>
</tbody>
</table>
### Other Telehealth Update

<table>
<thead>
<tr>
<th>Service</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>Added telehealth for therapy.</td>
</tr>
<tr>
<td></td>
<td>Added telephone option with PA for specific circumstances.</td>
</tr>
</tbody>
</table>
Timelines
• Policy Changes are posted
• 45 Day Public Comment
• SPA Changes in process
• Policies to be effective 1/1/21
Q & A
Provider’s Panel & Open Discussion
Wrap up and THANK YOU!

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

Next Virtual OPDAAC Meeting: Thursday, October 8, 2020
Theme: Safer Syringe Initiative