NORTH CAROLINA'S OPIOID ACTION PLAN

2017-2021

June 2017, Version 1

UNDERSTANDING THE CRISIS

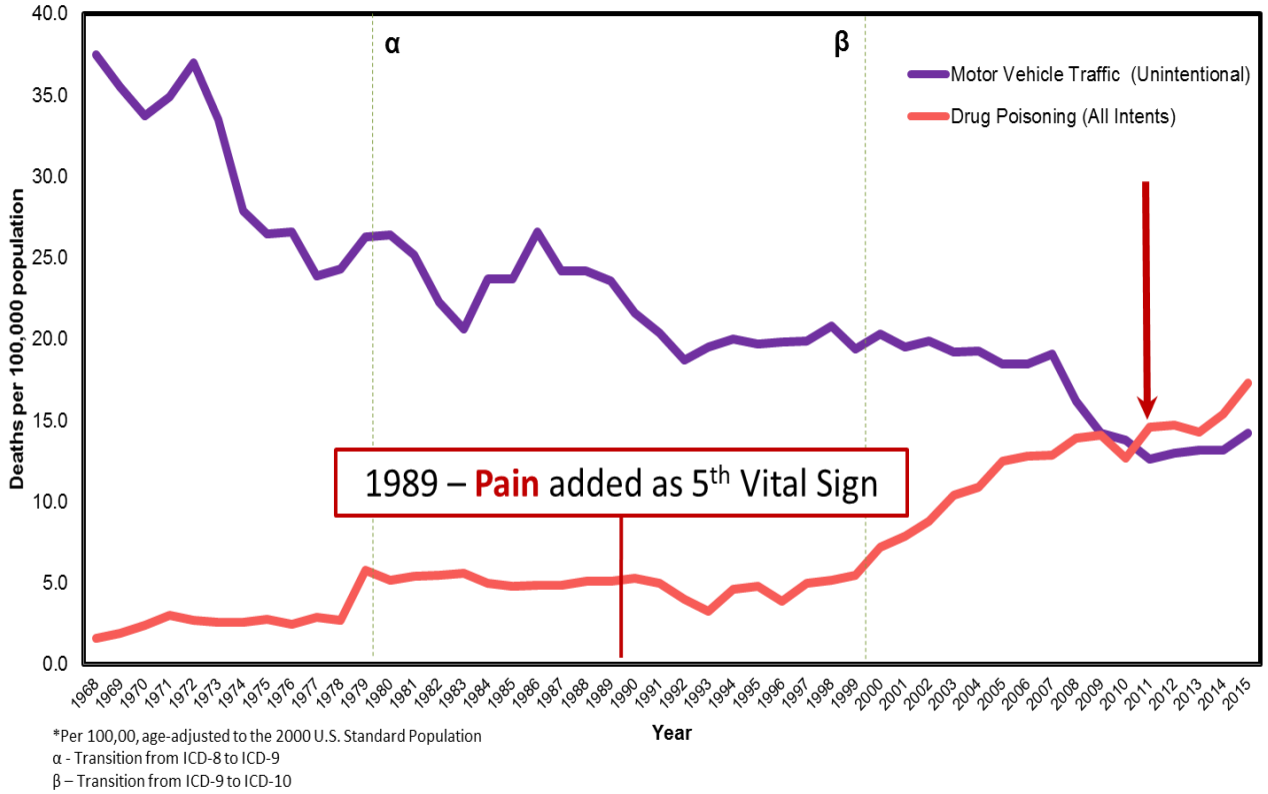
3 PEOPLE **DIE** EACH DAY FROM **OPIOID OVERDOSE** IN NC

Source: Average daily deaths using N.C. State Center for Health Statistics, Vital Statistics-Deaths, 2015-2016.

NC is experiencing the **consequences** of 25+ years of prescribing **more opioids at higher doses.**

Death Rates* for Two Selected Causes of Injury,

North Carolina, 1968-2015



*Per 100,00, age-adjusted to the 2000 U.S. Standard Population
α - Transition from ICD-8 to ICD-9
β – Transition from ICD-9 to ICD-10

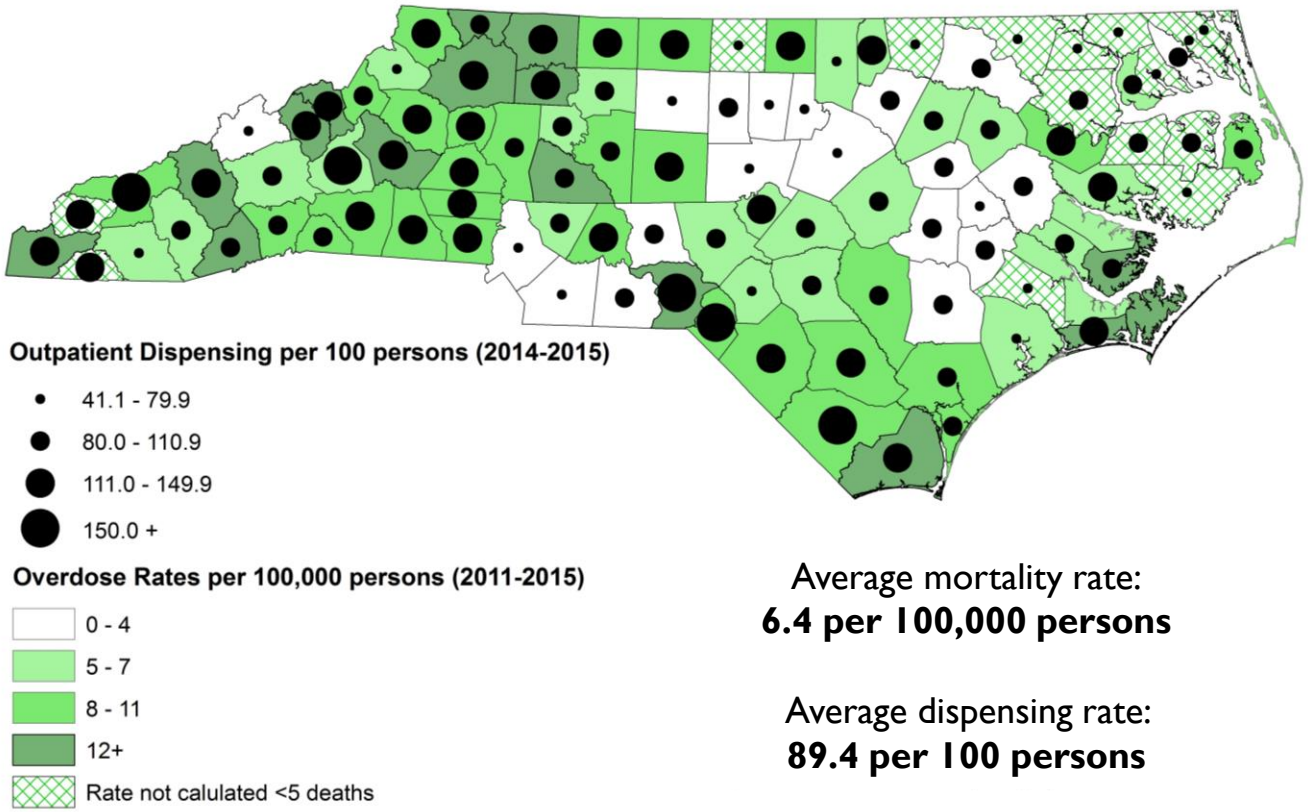
National Vital Statistics System, http://wonder.cdc.gov, multiple cause dataset
Source: Death files, 1968-2015, CDC WONDER
Analysis by Injury Epidemiology and Surveillance Unit

While this medical practice has improved pain control for some…

…it has also contributed to **opioid addiction, overdose, and death.**

Opioid overdose is more common in counties where more prescriptions are dispensed

North Carolina Residents, 2011-2015



Average mortality rate:
6.4 per 100,000 persons

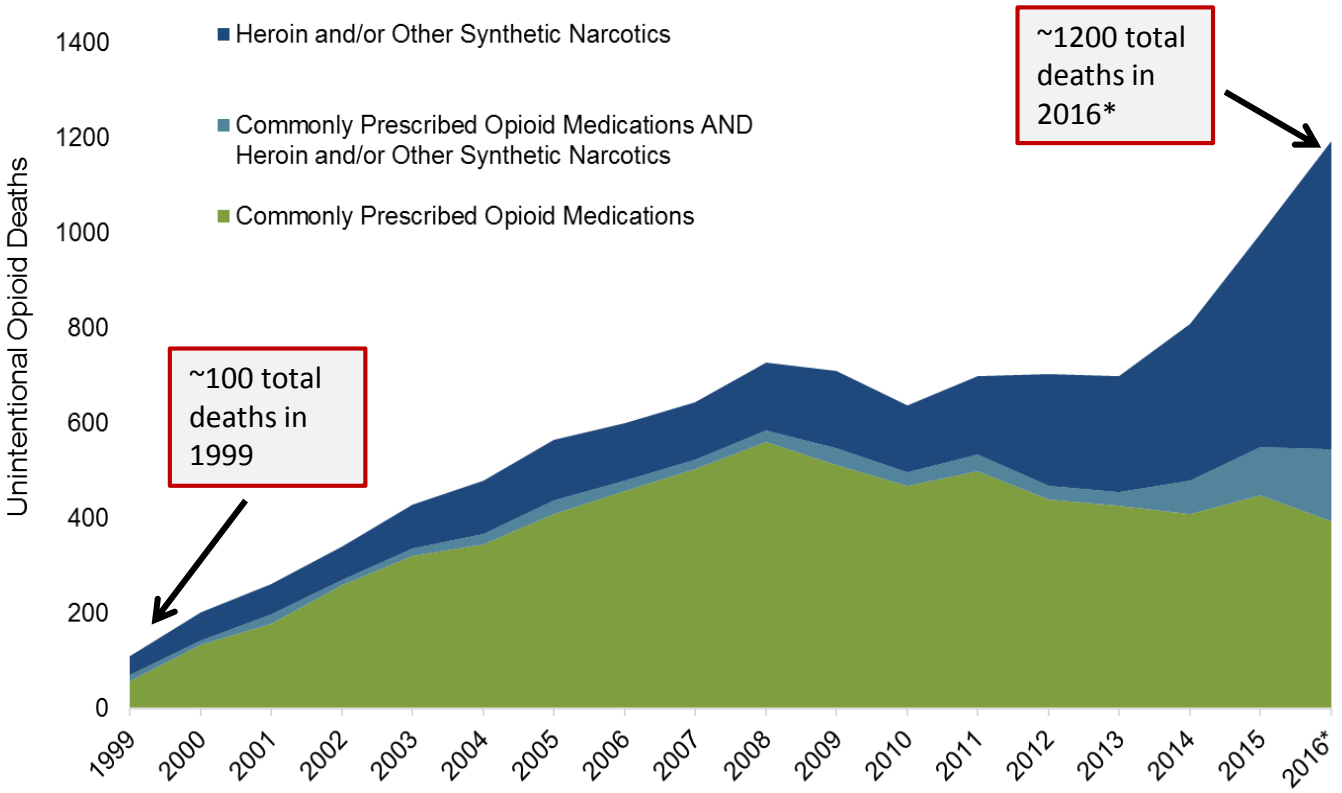
Average dispensing rate:
89.4 per 100 persons

Data Source: Proescholdbell SK, Cox ME, Asbun A. Death Rates from Unintentional and Undetermined Prescription Opioid Overdoses and Dispensing Rates of Controlled Prescription Opioid Analgesics-2011-2015. NC Med J. 2017 Mar-Apr; 78(2):142-143.

With unprecedented availability of cheap **heroin** and **fentanyl**...

MORE PEOPLE ARE DYING.

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



*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

FOR EVERY OPIOID POISONING DEATH

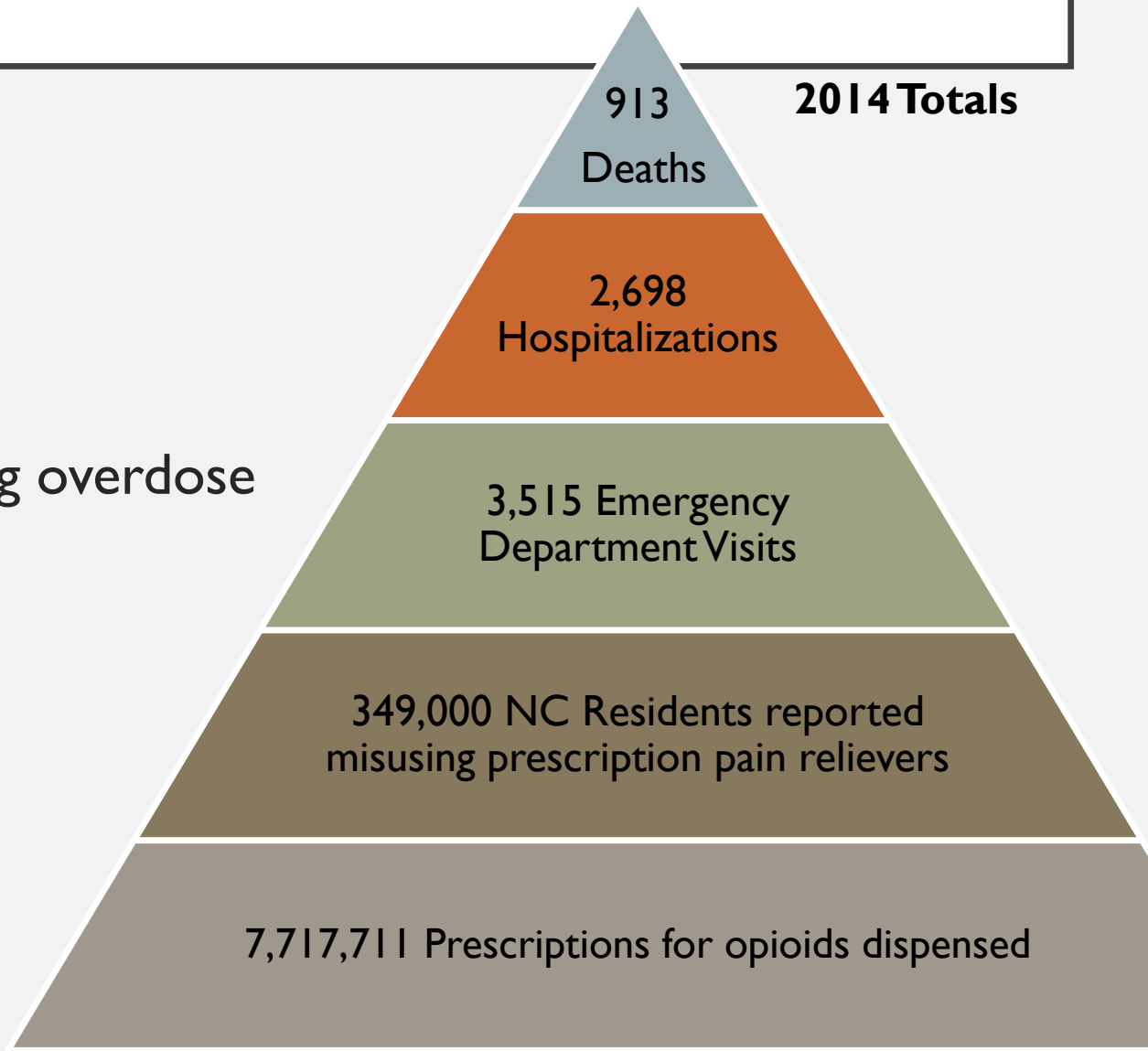
There were…

just under 3 hospitalizations

nearly 4 ED visits due to medication or drug overdose

over **380 people who misused** prescription pain relievers

and almost **8,500 prescriptions** for opioids dispensed

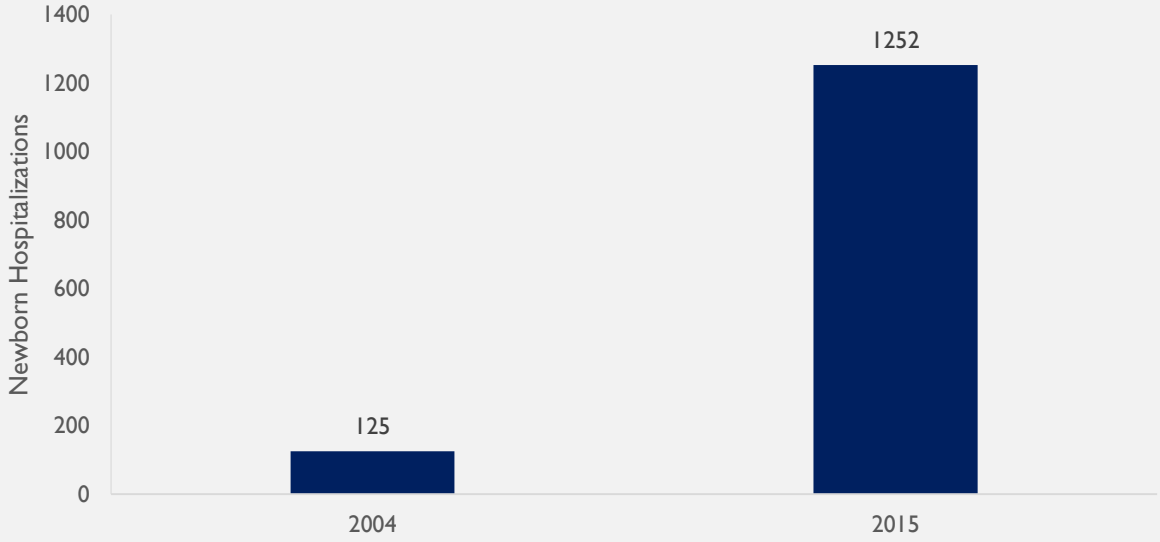


Source: N.C. State Center for Health Statistics, Vital Statistics-Deaths, 2014; N.C. State Center for Health Statistics, Vital Statistics- Hospitalizations, 2014; NC DETECT, 2014.NSDUH 2013-2014. CSRS 2014. Analysis: N.C. Injury Epidemiology and Surveillance Unit

THE EPIDEMIC IS DEVASTATING OUR **FAMILIES**

Number of Hospitalizations Associated with Drug Withdrawal in Newborns

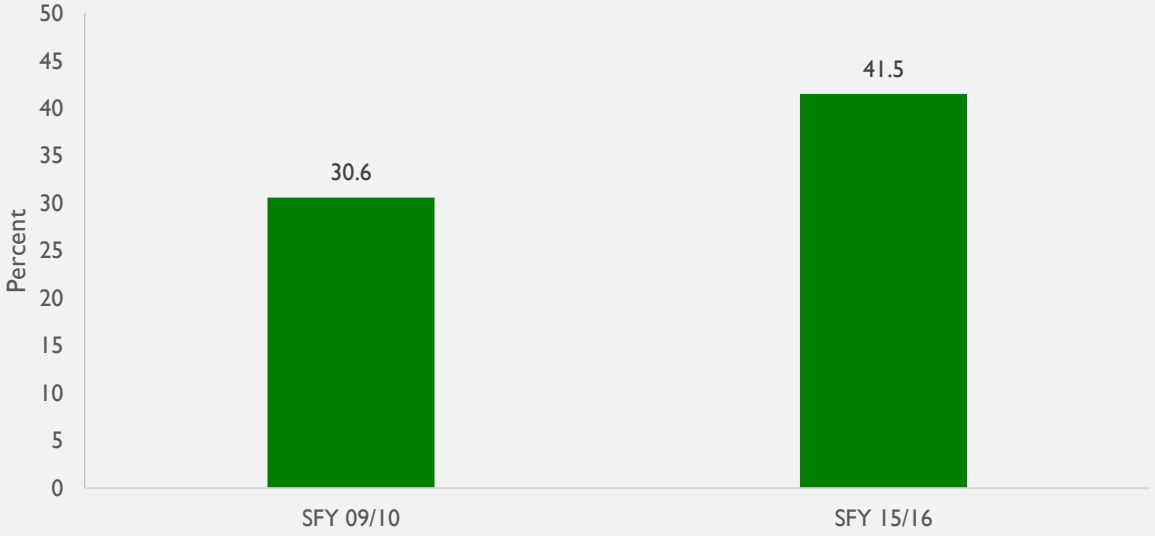
North Carolina Residents, 2004-2015



Source: N.C. State Center for Health Statistics, Hospital Discharge Dataset, 2004-2015 and Birth Certificate records, 2004-2015
Analysis by Injury Epidemiology and Surveillance Unit

Percent of Children Entering Foster Care in NC with Parental Substance Use as a Factor in Out-of-Home Placement

SFY 09/10-15/16



Source: NC DHHS Client Services Data Warehouse, Child Placement and Payment System
Prepared by Performance Management/Reporting & Evaluation Management, July 2016

Many organizations* across NC are addressing the opioid overdose epidemic.

*Logos not all inclusive

North Carolina has achieved some **successes** …

AND HAS MORE WORK TO DO.

Overdose death is preventable.

FOCUS AREAS

Given that the opioid epidemic is complex, we plan to implement comprehensive strategies in the following focus areas to reduce opioid addiction and overdose death:

1. **Create a coordinated infrastructure**
2. **Reduce oversupply of prescription opioids**
3. **Reduce diversion of prescription drugs and flow of illicit drugs**
4. **Increase community awareness and prevention**
5. **Make naloxone widely available and link overdose survivors to care**
6. **Expand treatment and recovery oriented systems of care**
7. **Measure our impact and revise strategies based on results**

PRESCRIPTION DRUG ABUSE ADVISORY COMMITTEE (PDAAC)

- Session Law 2015-241, Section 12F.16.(m), established PDAAC
- PDAAC is convened by the NC Department of Health and Human Services and has met quarterly since March 2016
- Over 215 members represent a variety of organizations and fields
- This Action Plan builds on recommendations from the PDAAC, which will lead coordination and implementation of the Plan
- This Plan does not include all efforts or partners, but outlines certain key actions to reduce opioid addiction and overdose death

ACTION PLAN

1. COORDINATED INFRASTRUCTURE

Strategy	Action	Leads
PDAAC leadership	Designate an Opioid Action Plan Executive Chair for the PDAAC to lead NC Opioid Action Plan	DHHS
Advisory council	Convene a group of current and former opioid users and others in recovery to guide Plan components and implementation of strategic actions	DHHS, NCHRC, RCOs, DPS
Build and sustain local coalitions	Convene local stakeholders and facilitate activities to: 1) Increase naloxone access; 2) Establish syringe exchange programs; 3) Increase linkages to SUD and pain treatment support; 4) Establish peer recovery support services; 5) Organize drug takeback programs and events/encourage safe storage of medications; 6) Promote the adoption of fair chance hiring practices; 7) Promote education to prevent youth substance use initiation in schools and other venues; and, 8) Identify and advocate for local funding	NCACC, LHDs, Local coalitions, DPH, DMH, AHEC, LME/MCOs

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, linking to PCPs)	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

COORDINATED ACTIONS

To successfully combat this epidemic, the Action Plan envisages coordinated actions among:

- **First Responders and Communities**
- **Health Care/Payers**
- **Treatment and Recovery Providers**
- **Data, Surveillance, and Research Teams**

North Carolina Opioid Action Plan

Prescription Drug Abuse Advisory Committee (PDAAC)

- Public education
- Advisory council

First Responders/ Communities

Law Enforcement

- Law Enforcement Assisted Diversion
- Trafficking investigation & response
- LE naloxone administration
- Post-reversal response

Local Response

- Build & sustain local coalitions
- Community naloxone distribution
- Safer syringe initiative
- Community paramedicine
- Drug takeback, disposal, storage
- Youth primary prevention

Health Care

Health Systems & Providers

- Safe prescribing
- Pain management
- CSRS
- Care linkages
- Diversion prevention & response
- Naloxone co-prescribing
- Pharmacist naloxone dispensing

Payers

- Medicaid & commercial payer policies
- Workers' comp policies

Treatment and Recovery Providers

Treatment Access

- Treatment access
- MAT access: OBOT
- Telemedicine: SUD & MAT
- Transportation
- Special population: Pregnant women
- Special population: Justice-involved persons

Recovery Support

- Community based support
- Housing
- Employment
- Recovery courts

Data, Surveillance, & Research Teams

Data

- Track metrics
- Surveillance

Research/ Evaluation

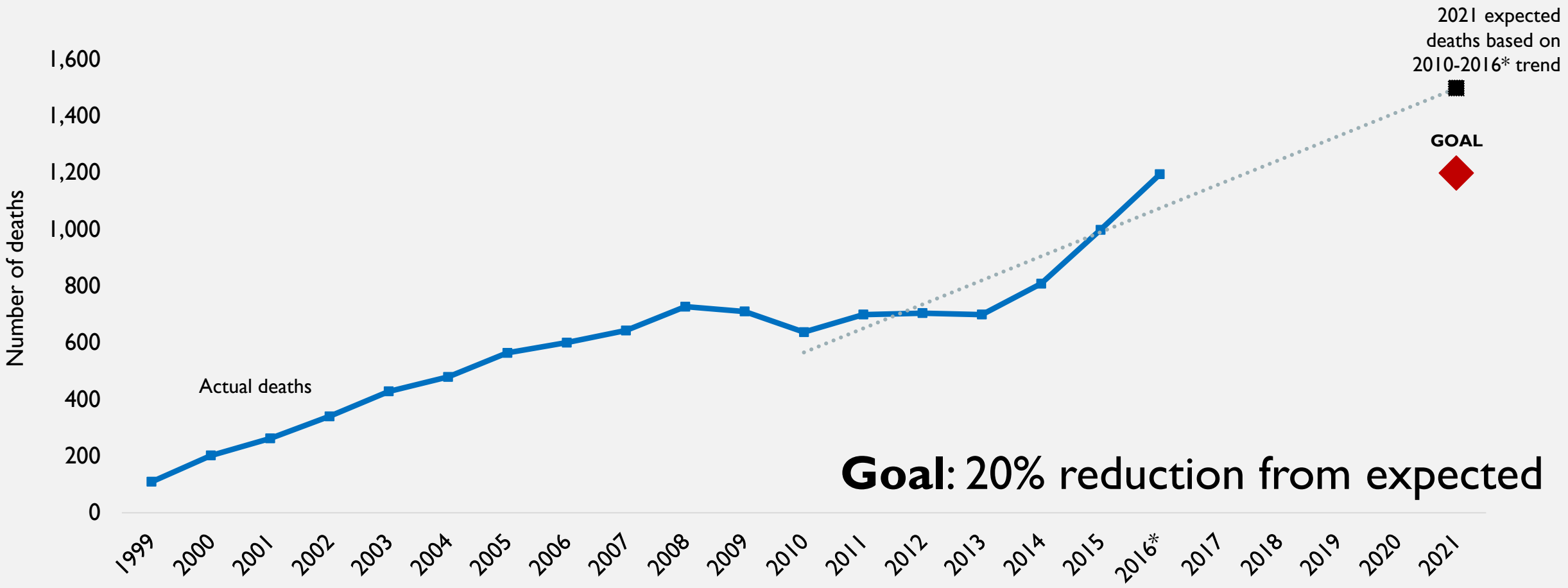
- Consortium

MEASURING PROGRESS

METRICS FOR NC'S OPIOID ACTION PLAN

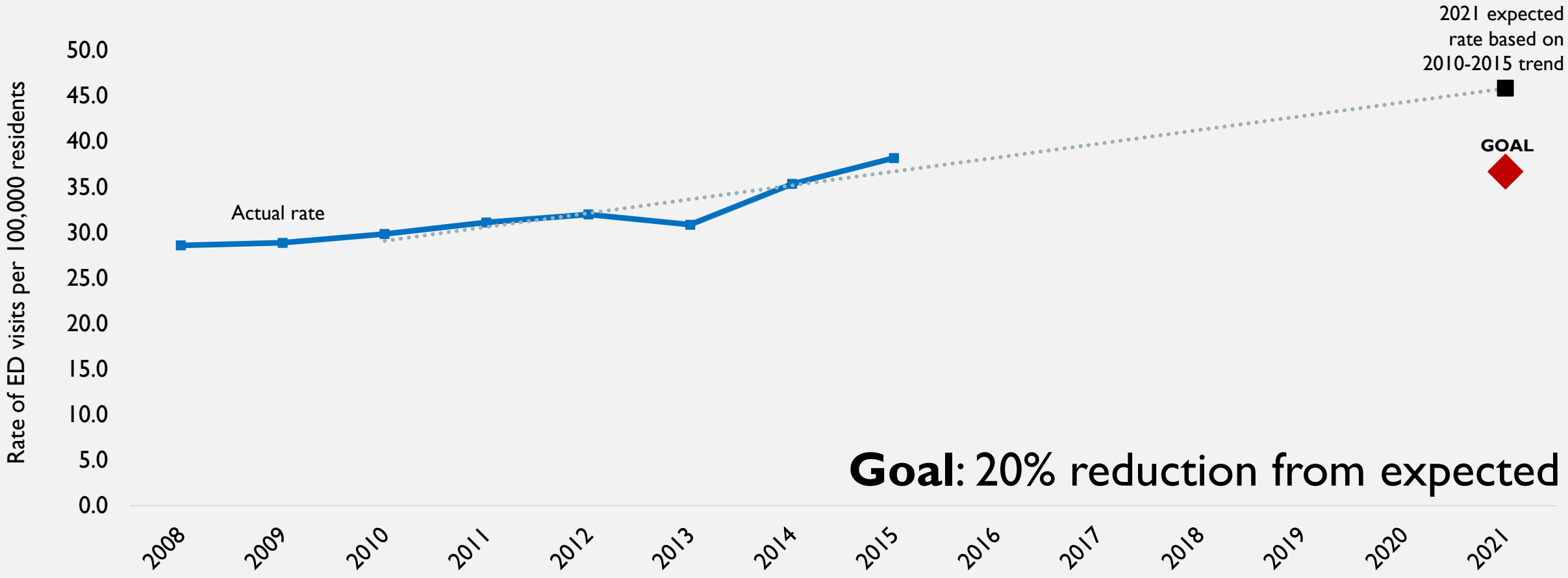
Metrics	Current Data	2021 Trend/Goal
OVERALL		
Number of unintentional opioid-related deaths (ICD10)	1,194 (2016, provisional)	20% reduction in expected 2021 number
Rate of opioid ED visits (all intents)	38.2 per 100,000 residents (2015)	20% reduction in expected 2021 rate
Reduce oversupply of prescription opioids		
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	27.3 per 100,000 residents (2016)	Decreasing trend
Total number of opioid pills dispensed	555,916,512 (2016)	Decreasing trend
Percent of patients receiving more than an average daily dose of >90 MME of opioid analgesics, per quarter	12.3% (Q1 2017)	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	21.1% (Q1 2017)	Decreasing trend
Reduce Diversion/Flow of Illicit Drugs		
Percent of opioid deaths involving heroin or fentanyl/fentanyl analogues	58.4% (2016, provisional)	----------
Number of acute Hepatitis C cases	182 (2016, provisional)	Decreasing trend
Increase Access to Naloxone		
Number of EMS naloxone administrations	13,069 (2016, provisional)	----------
Number of community naloxone reversals	3,616 (2016)	Increasing trend
Treatment and Recovery		
Number of buprenorphine prescriptions dispensed	467,243 (2016)	Increasing trend
Number of uninsured individuals with an opioid use disorder served by treatment programs	12,248 (SFY16)	Increasing trend
Number of certified peer support specialists (CPSS) across NC	2,383 (2016)	Increasing trend

NUMBER OF UNINTENTIONAL OPIOID-RELATED DEATHS



*2016 data are preliminary and subject to change, current as of June 1, 2017
Source: NC State Center for Health Statistics, Vital Statistics-Deaths, 1999-2016* (ICD10 coded data)
Detailed technical notes on all metrics available from NC DHHS

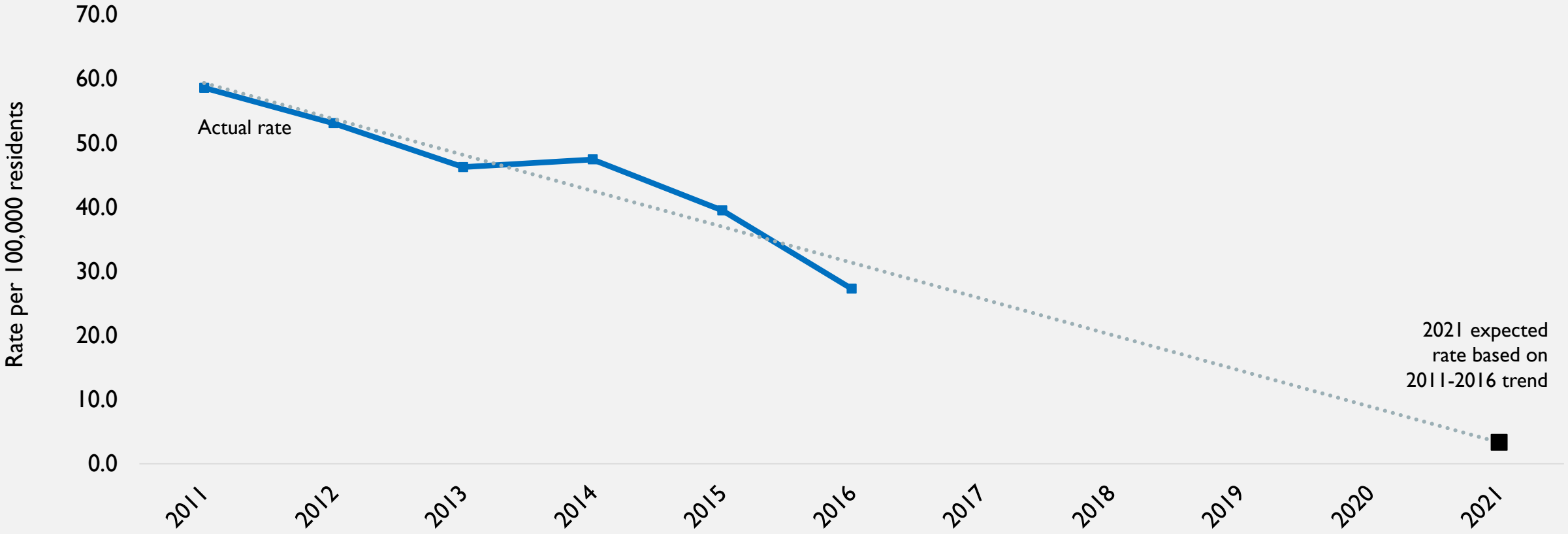
RATE OF OPIOID ED VISITS



Goal: 20% reduction from expected

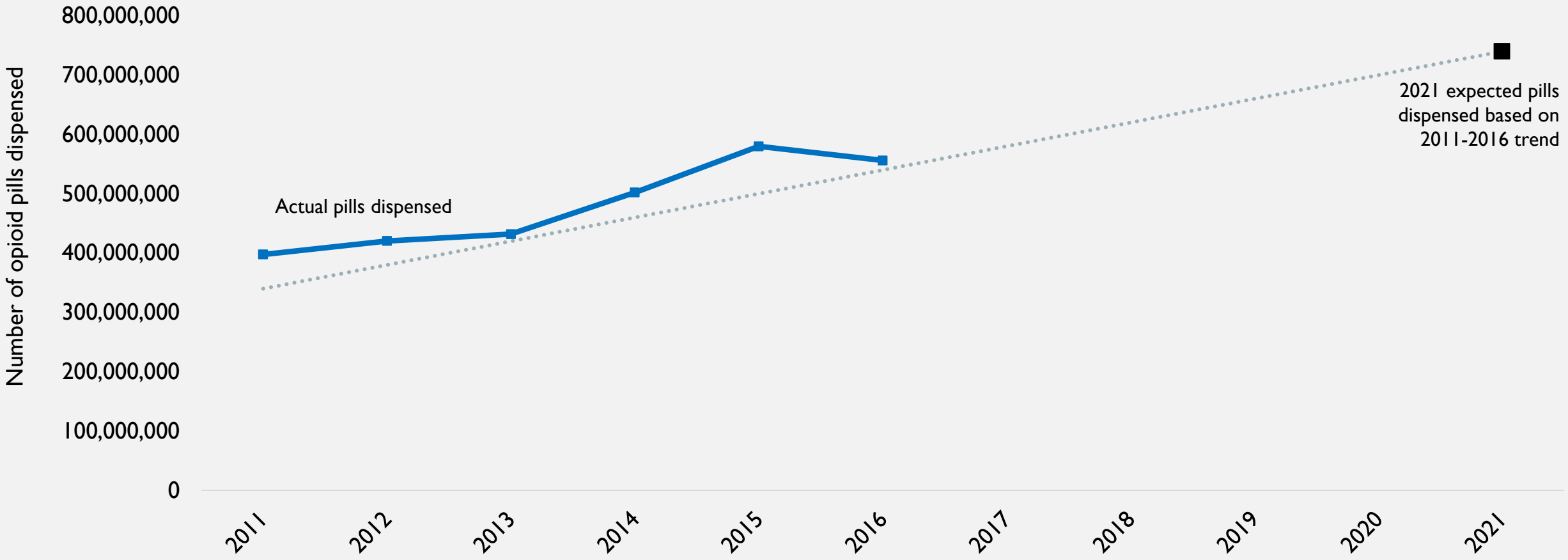
Source: NC Division of Public Health, Epidemiology Section, NC DETECT, 2008-2015
Detailed technical notes on all metrics available from NC DHHS

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



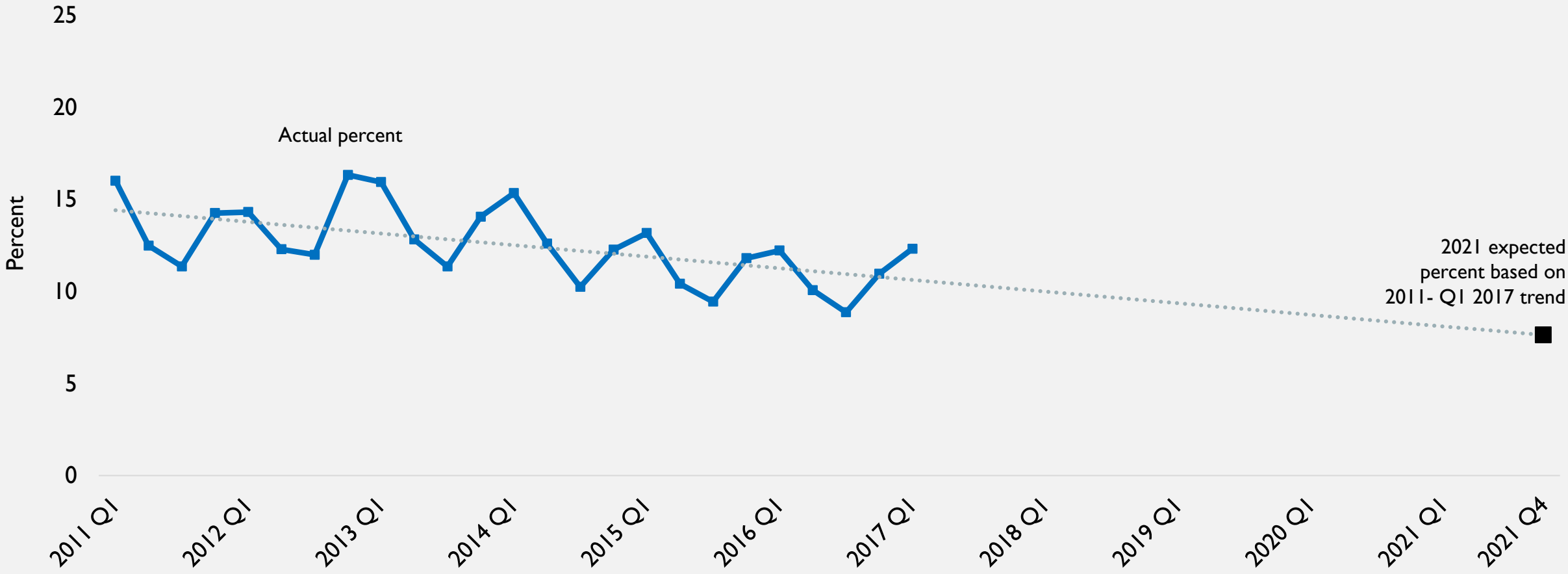
Source: NC Division of Mental Health, Controlled Substance Reporting System, 2011-2016
Detailed technical notes on all metrics available from NC DHHS

TOTAL NUMBER OF OPIOID PILLS DISPENSED



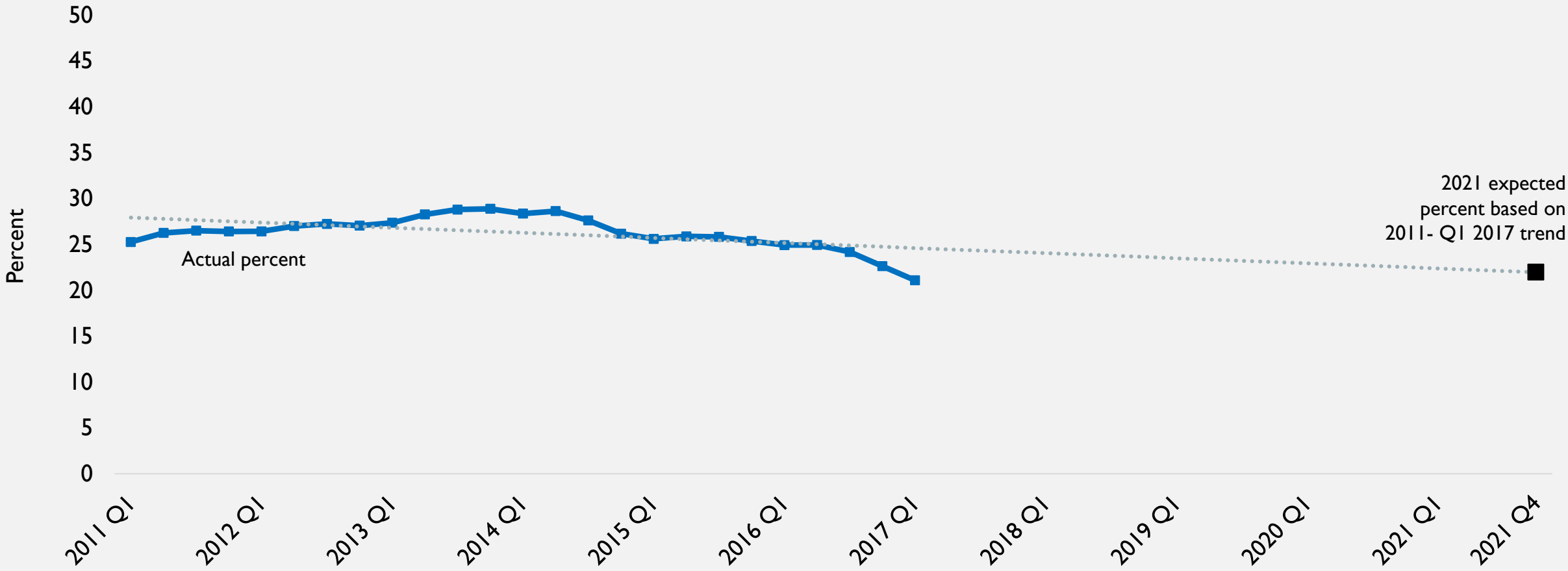
Source: NC Division of Mental Health, Controlled Substance Reporting System, 2011-2016
Detailed technical notes on all metrics available from NC DHHS

PERCENT OF PATIENTS RECEIVING MORE THAN AN AVERAGE DAILY DOSE OF >90 MME OF OPIOID ANALGESICS, PER QUARTER



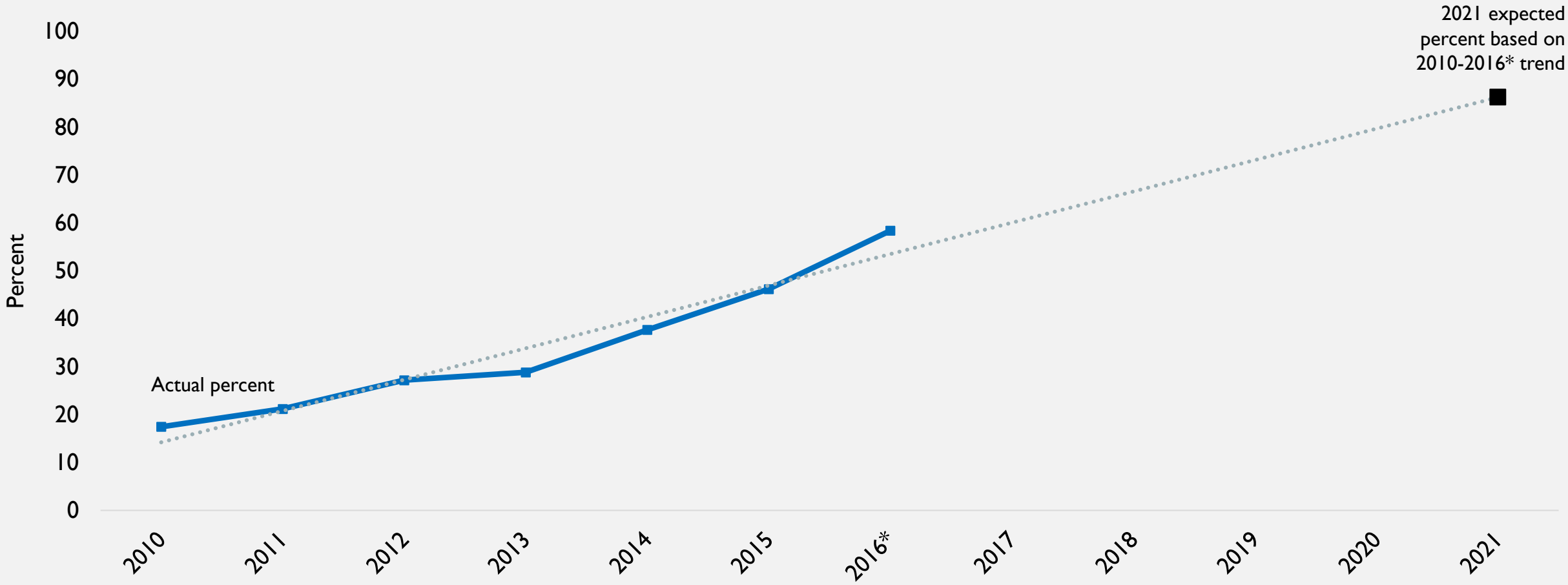
Source: NC Division of Mental Health, Controlled Substance Reporting System, 2011-Q1 2017
Detailed technical notes on all metrics available from NC DHHS

PERCENT OF PRESCRIPTION DAYS ANY PATIENT HAD AT LEAST ONE OPIOID AND AT LEAST ONE BENZODIAZEPINE PRESCRIPTION ON THE SAME DAY, PER QUARTER



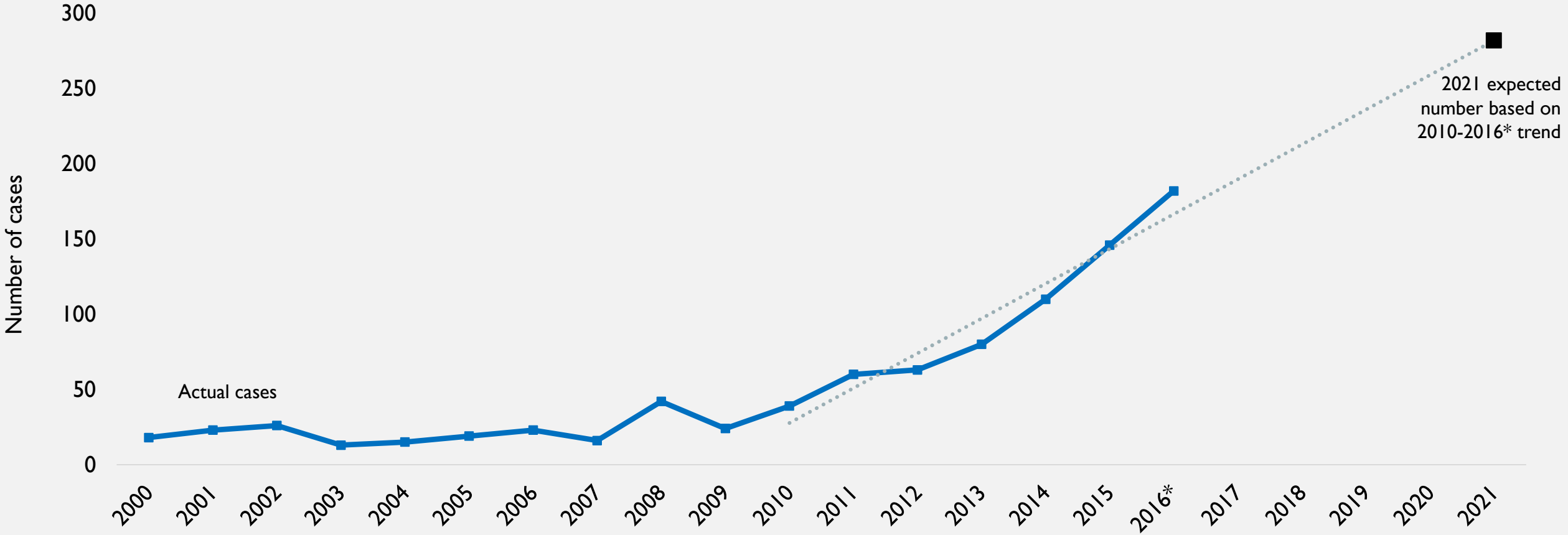
Source: NC Division of Mental Health, Controlled Substance Reporting System, 2011-Q1 2017
Detailed technical notes on all metrics available from NC DHHS

PERCENT OF OPIOID DEATHS INVOLVING HEROIN OR FENTANYL/FENTANYL ANALOGUES



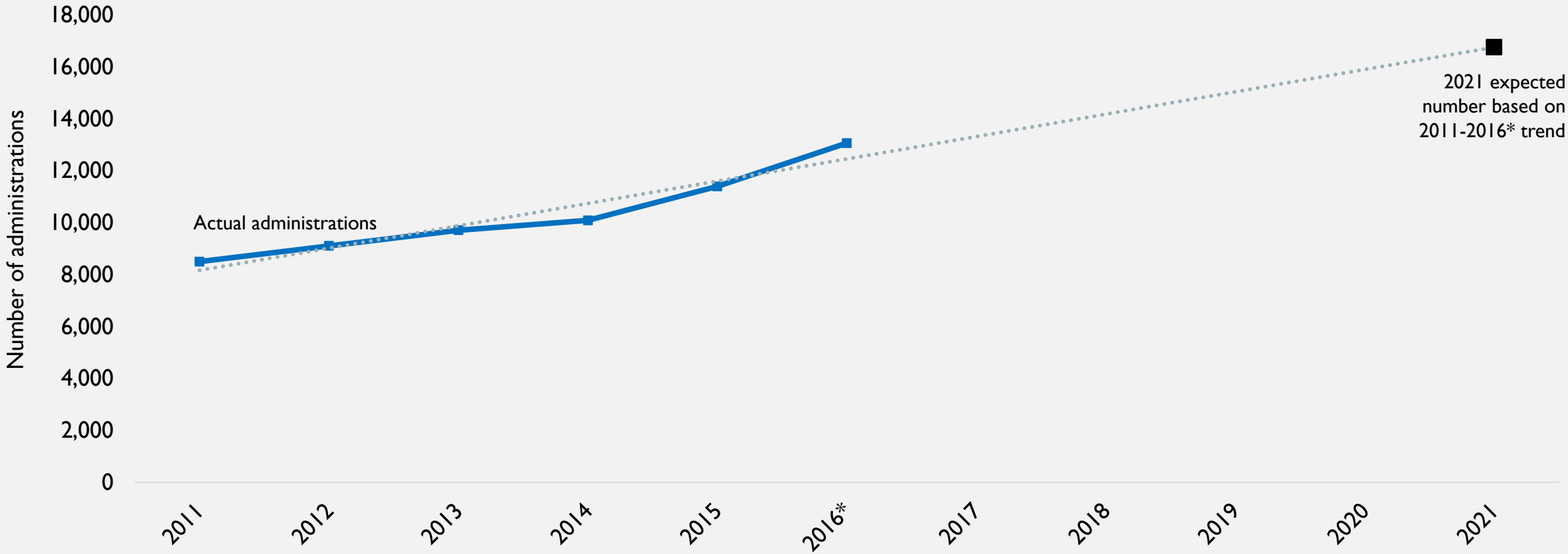
*2016 data are preliminary and subject to change, current as of June 1, 2017
**Increasing numbers of deaths due to other classes of designer opioids are expected
Source: NC Office of the Chief Medical Examiner (OCME) and the OCME Toxicology Laboratory, 2010-2016*
Detailed technical notes on all metrics available from NC DHHS

NUMBER OF ACUTE HEPATITIS C CASES



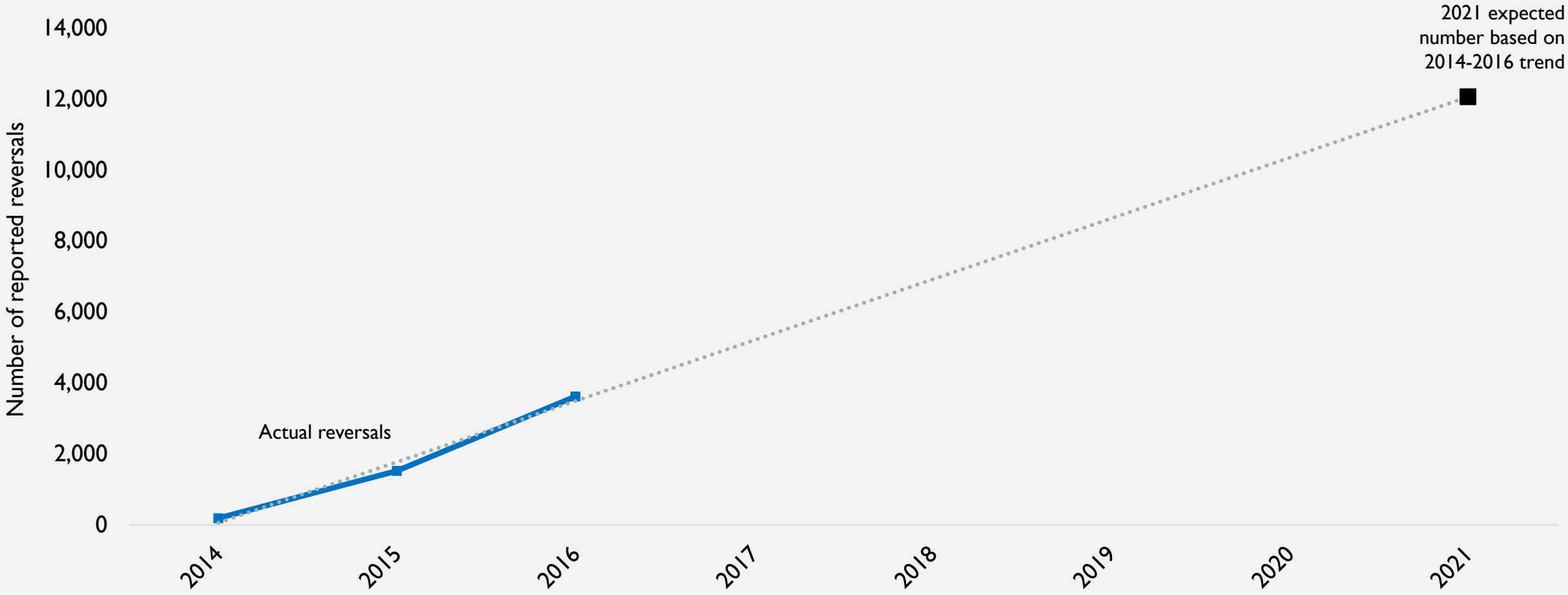
*2016 data are preliminary and subject to change, current as of April 1, 2017
Source: NC Division of Public Health, Epidemiology Section, NC EDSS, 2000-2016*
Detailed technical notes on all metrics available from NC DHHS

NUMBER OF EMS NALOXONE ADMINISTRATIONS



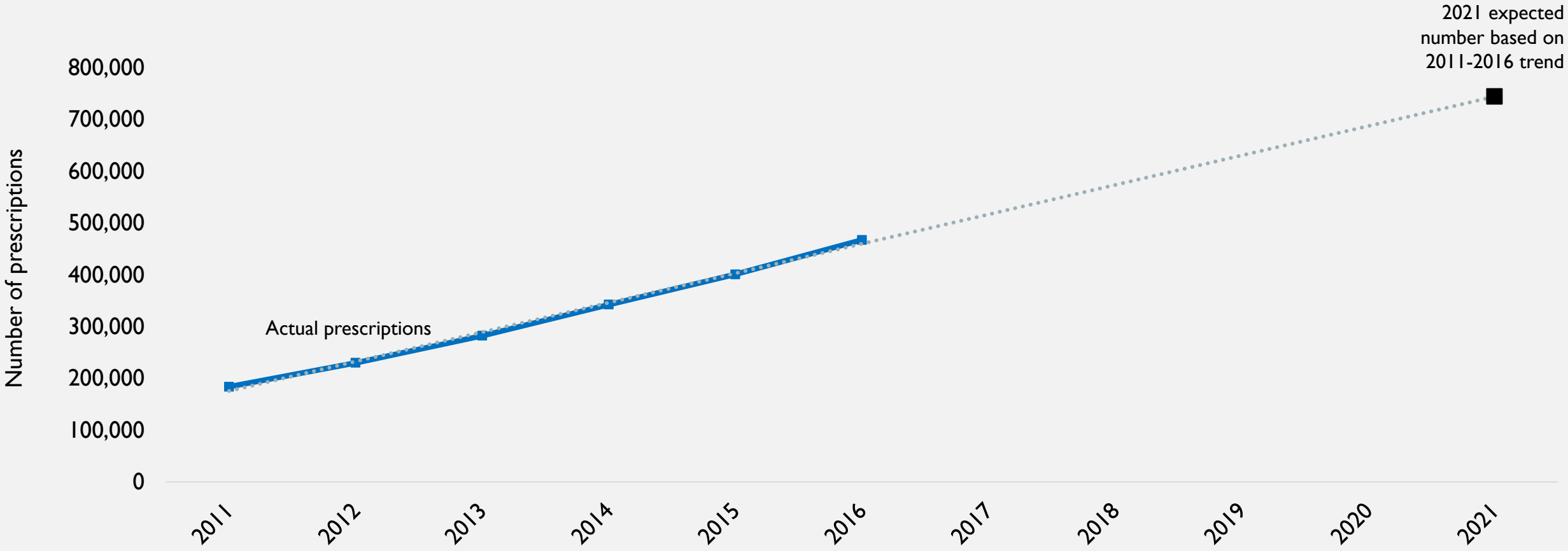
*2016 data are preliminary and subject to change
Source: NC Office of Emergency Medical Services (OEMS), EMSpic-UNC Emergency Medicine Department, 2012-2015
Detailed technical notes on all metrics available from NC DHHS

NUMBER OF REPORTED COMMUNITY NALOXONE REVERSALS



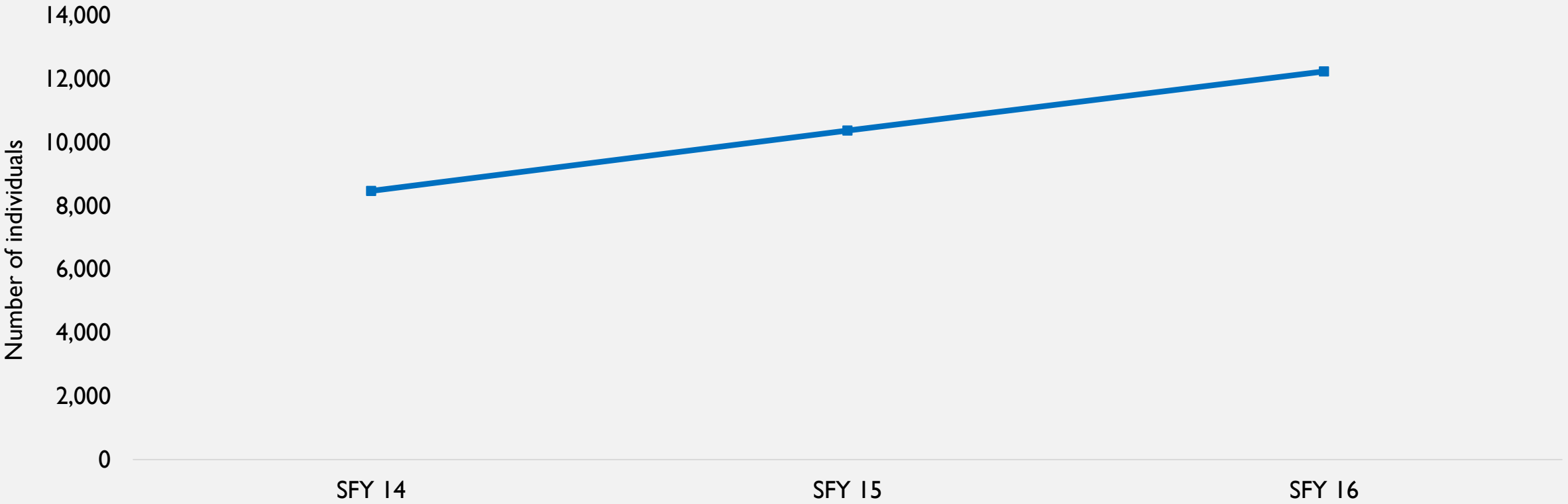
Source: NC Harm Reduction Coalition (NCHRC), 2014-2016
Detailed technical notes on all metrics available from NC DHHS

NUMBER OF BUPRENORPHINE PRESCRIPTIONS DISPENSED



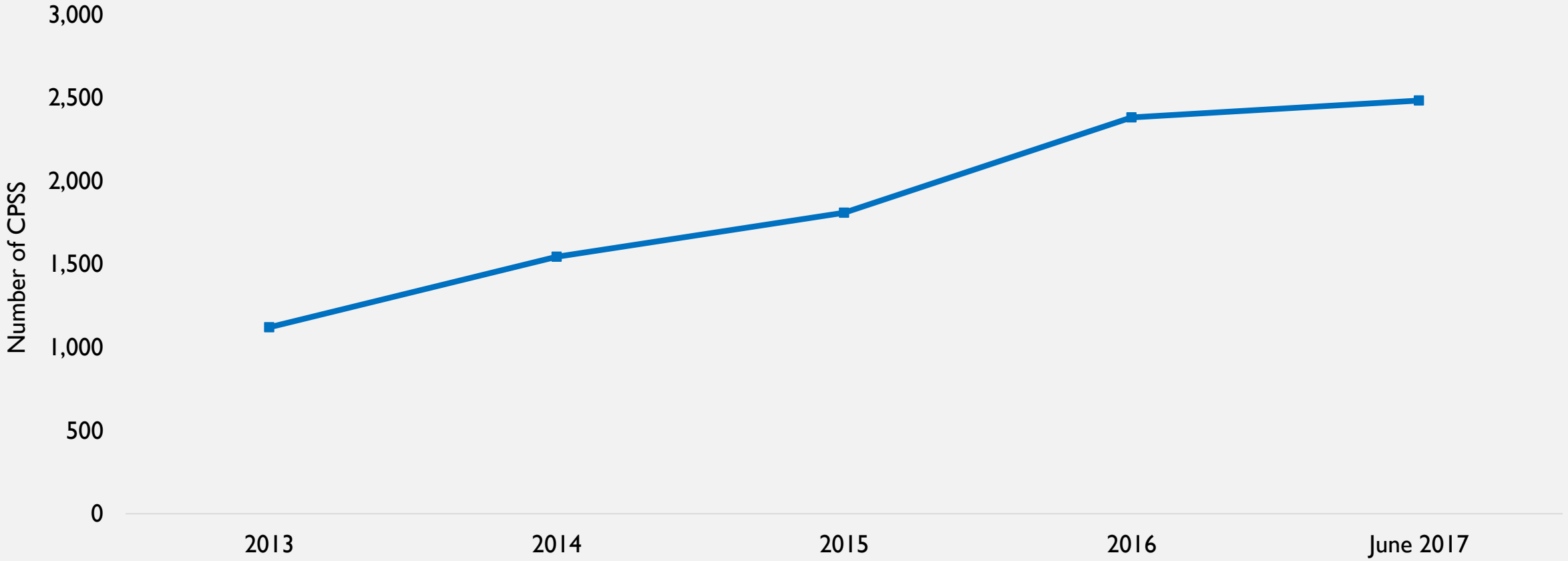
Source: NC Division of Mental Health, Controlled Substance Reporting System, 2011-2016
Detailed technical notes on all metrics available from NC DHHS

NUMBER OF UNINSURED INDIVIDUALS WITH AN OPIOID USE DISORDER SERVED BY TREATMENT PROGRAMS



Source: NC Division of Mental Health, Claims Data, 2014-2016
Detailed technical notes on all metrics available from NC DHHS

NUMBER OF CERTIFIED PEER SUPPORT SPECIALISTS (CPSS) ACROSS NC



Source: UNC-Chapel Hill, School of Social Work, Behavioral Health Springboard, 2013-June 2017
Detailed technical notes on all metrics available from NC DHHS

ACRONYMS

- **AG**: Attorney General's Office
- **AHEC**: Area Health Education Centers
- **AOC**: Administrative Office of the Courts
- **APNC**: Addiction Professionals of NC
- **BCBSNC**: Blue Cross Blue Shield of NC
- **CCNC**: Community Care of NC
- **CHS**: Carolinas Healthcare System
- **CPC**: Carolinas Poison Center
- **CSRS**: Controlled Substances Reporting System
- **DA**: District Attorney
- **DATA**: Drug Addiction Treatment Act of 2000
- **DEA**: Drug Enforcement Administration
- **DHHS**: Department of Health and Human Services
- **DMA**: Division of Medical Assistance
- **DMH**: Division of Mental Health, Developmental Disabilities & Substance Abuse Services
- **DIT**: Department of Information Technology
- **DOI**: Department of Insurance
- **DPH**: Division of Public Health
- **DPS**: Department of Public Safety
- **DSS**: Division of Social Services
- **ECHO**: Extension for Community Healthcare Outcomes
- **ED**: Emergency Department
- **EMS**: Emergency Medical Services
- **FQHC**: Federally Qualified Health Center
- **GDAC**: Government Data Analytics Center
- **GI**: Governor's Institute on Substance Abuse
- **HIDTA**: High Intensity Drug Trafficking Areas
- **IPRC**: Injury Prevention Research Center
- **LEAD**: Law Enforcement Assisted Diversion
- **LHD**: Local Health Department
- **LMEs/MCOs**: Local Management Entities/Managed Care Organizations
- **MAT**: Medication Assisted Treatment

ACRONYMS

- **NC**: North Carolina
- **NC DETECT**: Disease Event Tracking and Epidemiologic Collection Tool
- **NCACC**: NC Association of County Commissioners
- **NCAFP**: NC Academy of Family Physicians
- **NCAP**: NC Association of Pharmacists
- **NCATOD**: NC Association for the Treatment of Opioid Dependence
- **NCBP**: NC Board of Pharmacy
- **NCHA**: NC Hospital Association
- **NCHRC**: NC Harm Reduction Coalition
- **NCMB**: NC Medical Board
- **NCOGS**: North Carolina Obstetrical and Gynecological Society
- **NCRMA**: NC Retail Merchants Association
- **NP**: Nurse Practitioner
- **OCME**: Office of the Chief Medical Examiner
- **OEMS**: Office of Emergency Medical Services
- **ORH**: Office of Rural Health
- **OTP**: Opioid Treatment Program
- **PA**: Physician Assistant
- **PCP**: Primary Care Provider
- **PDAAC**: Prescription Drug Abuse Advisory Committee
- **RCOs**: Recovery Community Organizations
- **RTI**: Research Triangle Institute
- **SBI**: State Bureau of Investigation
- **SEP**: Syringe Exchange Program
- **SCHS**: State Center for Health Statistics
- **SHP**: State Health Plan
- **SUD**: Substance Use Disorder
- **TASC**: Treatment Accountability for Safer Communities
- **UNC**: University of North Carolina at Chapel Hill

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