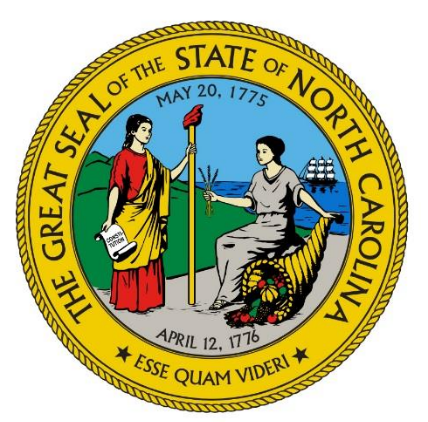

NC Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Tackling the Opioid Epidemic

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Opioid Action Plan: An Update on Progress to Date & Areas for Growth

Opioid Action Plan

- In 2014, House Bill 97 was introduced with several sections directly addressing prescription drug misuse
- While it did not pass, DMHDDSAS, in collaboration with stakeholders from across the state, began the work of developing the North Carolina Strategic Plan to Reduce Prescription Drug Abuse, which was supported by the National Governor's Association and Substance Abuse and Mental Health Services Administration (SAMHSA) policy academies

Opioid Action Plan

- The following year, Session Law 2015-241, mandated not only the development of the strategic plan, but also the creation of the Prescription Drug Abuse Advisory Committee (PDAAC), which is tasked with implementing activities guided by strategies within the plan
- Collaboration among over 300 agencies, including DMHDDSAS, DPH, LME-MCOs, treatment providers, healthcare systems, law enforcement, regulatory boards, local health departments, community coalitions, etc.

Opioid Action Plan

- Goals
  - Create a framework to capture state-wide priorities to combat the epidemic and who was doing what
  - Establish collective metrics and targets to measure progress toward goals
- Launched July 2017; 5 year span of 2017-2021
- Developed by DHHS team; reviewed and edited by OPDAAC and external stakeholders
- Expectation that it would be a living document

Ways Opioid Action Plan has been used

- Determine where to put new funding, e.g.,
  - Opioid Action Plan RFA to communities
  - Local Health Department RFA
  - Contract with NCHA for ED Peer Support Services pilot
  - Contract with MAHEC for Data Waiver Training for residency programs
- Determine where to devote time and leadership effort, e.g.,
  - Payers Council
- Used by partners to see the body of work and who is doing what and where to plug in
- Used by local coalitions to identify strategies
- Create collective understanding of progress through common metrics

Opioid Action Plan

The Action Plan contains seven (7) areas of focus:

1. Coordinated Infrastructure
2. Reduce the Oversupply of Prescription Drugs
3. Reduce Diversion and Flow of Illicit Drugs
4. Increase Community Awareness and Prevention
5. Increase Naloxone Availability
6. Expand Treatment Access
7. Expand Recovery Supports and
8. Measure Impact

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) **In Progress**	NCHA, DMA, Licensing boards and professional societies
	Create and maintain continuing education opportunities and resources for prescribers to manage chronic pain **Ongoing**	GI, AHEC, CCNC, DMA, Licensing boards and professional societies
CSRS utilization	Register 100% of eligible prescribers and dispensers in CSRS **In Progress**	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 **In Progress**	DMH, GDAC, NCHA, DIT
	Report data to all NC professional boards so they can investigate aberrant prescribing or dispensing behaviors **In Progress**	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 **Ongoing**	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 **Ongoing**	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 **Ongoing**	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 **Ongoing**	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) **Ongoing**	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 **In Progress**	NCHRC, DPS, OEMS, Local law enforcement, AG
Community naloxone distribution	Increase the number of naloxone overdose rescue kits distributed through communities to lay people **Ongoing**	NCHRC, DPH, LHDs, LME/MCOs, OTPs, CCNC
Naloxone co-prescribing	Create and adopt strategies to increase naloxone co-prescribing within health systems, PCPs **In Progress**	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 **In Progress**	NCAP, NCBP, CCNC
Safer Syringe Initiative	Increase the number of SEP programs and distribute naloxone through them **Ongoing**	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 **In Progress**	NCHA, LME/MCOs
	Link patients receiving office-based opioid treatment to counseling services for SUD using case management or peer support specialists **In Progress**	DMH, RCOs, APNC, CCNC, LME/MCOs, NCATOD
Treatment access	Increase state and federal funding to serve greater numbers of North Carolinians who need treatment **Ongoing**	All
MAT access: Office-based opioid treatment	Offer DATA waiver training in all primary care residency programs and NP/PA training programs in NC **In Progress**	DHHS, NCHA, AHEC, NCAFP, Medical Schools
	Increase providers' ability to prescribe MAT through ECHO spokes and other training opportunities **In Progress**	DMH, UNC, ORH, AHEC, FQHCs
	Increase opportunities for pharmacists to collaborate with PCPs and specialty SUD providers to coordinate MAT **Ongoing**	NCAP, NCBP, AHEC, UNC
Integrated care	Increase access to integrated physical and behavioral healthcare for people with opioid use disorder **In Progress**	DHHS, Health systems, LHDs

6. Expand Treatment Access, Cont'd

Strategy	Action	Leads
Transportation	Explore options to provide transportation assistance to individuals seeking treatment **Ongoing**	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 **In Progress**	NCHRC, AG, DAs, DMH
Special Populations: Pregnant women	Increase number of OB/GYN and prenatal prescribers with DATA waivers to prescribe MAT **Ongoing**	NCOGS, Professional societies
	Support pregnant women with opioid addiction in receiving prenatal care, SUD treatment, and promoting healthy birth outcomes **Ongoing**	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 **Ongoing**	DPS, DMH, NCHRC
	Expand in-prison/jail and post-release MAT and on-release naloxone for justice involved persons with opioid use disorder **Ongoing**	DPS, DMH, Local government

6. Expand Recovery Supports

Strategy	Action	Leads
Community paramedicine	Increase the number of community paramedicine programs whereby EMS links overdose victims to treatment and support **Ongoing**	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 **Ongoing**	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) **In Progress**	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 **Ongoing**	DMH, LME/MCOs, Local government and coalitions
Employment	Reduce barriers to employment for those with criminal history **In Progress**	Local government and coalitions
Recovery Courts	Maintain and enhance therapeutic (mental health, recovery and veteran) courts **In Progress**	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 **Ongoing**	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 **Ongoing**	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 **In Progress**	UNC, Duke, RTI, other Universities/colleges, DPH, DMH, AHEC/Academic Research Centers

Opioid Action Plan

Updated metrics:

https://files.nc.gov/ncdhhs/NC-Opioid-Action-Plan-Metrics-July-2018.pdf

Opioid Action Plan:

https://files.nc.gov/ncdhhs/NC%20Opioid%20Action%20Plan%208-22-2017.pdf

Dashboard:

https://injuryfreenc.shinyapps.io/OpioidActionPlan/

Opioid Action Plan Version 2 Process

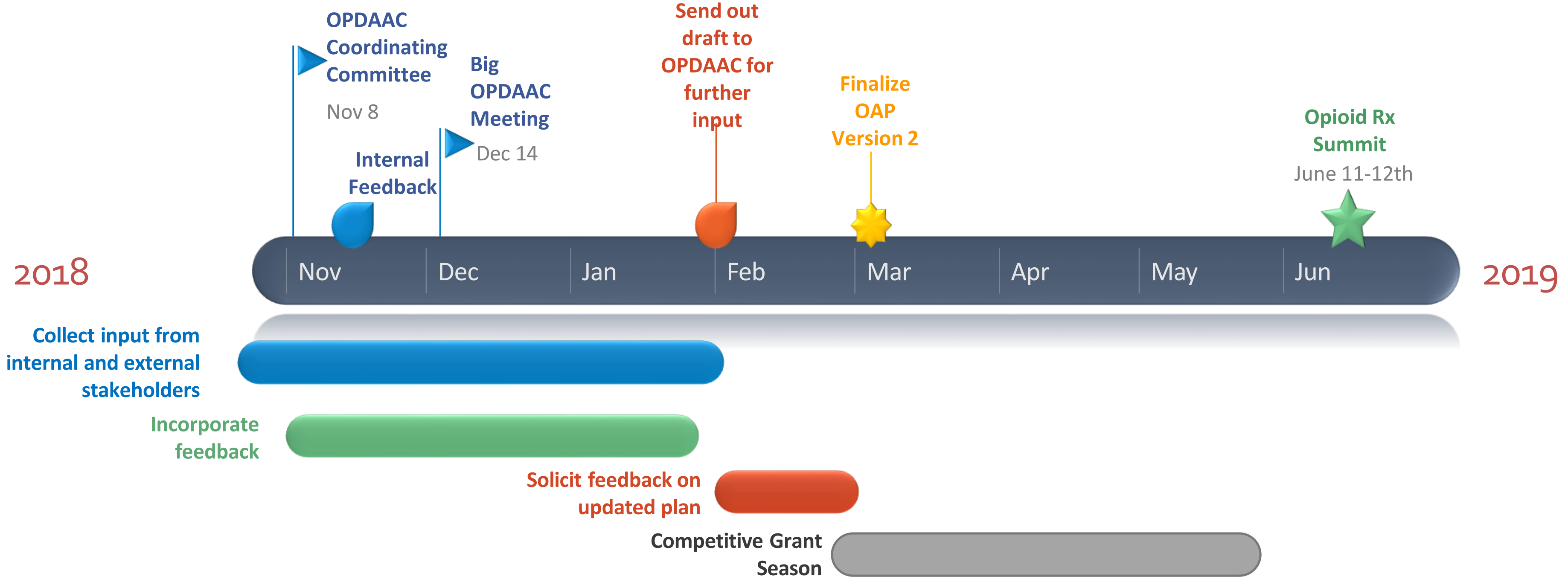
Opioid Action Plan 2.0

- **Build on requirements for creation of strategic plan through OPDAAC**

- **Opportunity to determine:**
  - Areas that are ongoing priorities
  - Areas that are new priorities
  - Areas that are no longer priorities

- **To determine priorities, consider:**
  - **Impact:** How does this impact our 2021 goal to reduce opioid overdose deaths?
  - **Measurable:** How will we define success/completion?
  - **Feasible:** Can we realistically achieve by 2021?
  - **Owner:** Who is the lead for priority?

Opioid Action Plan 2.0 Timeline



Upcoming Opportunities

- Next OPDAAC Coordinating Meetings
  - Thursday, January 10, 2019 at NC Healthcare Association
- Next Full OPDAAC Meeting
  - Friday, December 14, 2018 at NC State McKimmon's Center
- SAVE THE DATE! 2019 Opioid Misuse and Overdose Prevention Summit
  - June 11-12, 2019 at NC State's McKimmon Center

1115 Substance Use Waiver

Initiative from the Centers for Medicare and Medicaid Services in November of 2017 intended to combat the opioid crisis

Requirements:

- Full continuum of care
- Quality measurement
- Coordination across systems and levels of care
- Benefit management strategy

Other states approved:

- California
- Massachusetts
- Virginia
- Maryland
- West Virginia
- Utah
- Indiana

1115 Substance Use Waiver

- NC submitted waiver request to CMS in September
- Very quick turn-around, no questions, “well done”
- 2 year process to include rule and policy updates

ASAM Levels of Care

- 0.5 – Early Intervention
- 1 – Outpatient Services
- 2.1 – Intensive Outpatient Services
- 2.5 – Partial Hospitalization Services
- 3.1 – Clinically Managed Low Intensity Residential Services
- 3.3 – Clinically Managed Population Specific High Intensity Residential Services
- 3.5 – Clinically Managed High-Intensity Residential Services
- 3.7 – Medically Monitored Intensive Inpatient Services
- 4 – Medically Managed Intensive Inpatient

ASAM Levels of Care

- OTP – Opioid Treatment Program
- 1-WM – Ambulatory Withdrawal Management without Extended On-Site Monitoring
- 2-WM – Ambulatory Withdrawal Management with Extended On-Site Monitoring
- 3.2-WM – Clinically Managed Residential Withdrawal Treatment
- 3.7-WM – Medically Monitored Inpatient Withdrawal Management
- 4-WM – Medically Managed Intensive Inpatient Withdrawal Management

Evidence Based Patient Placement Criteria

- All providers of SUD services and all providers of CCA and DA would be required to document American Society of Addiction Management (ASAM) Criteria training.
- Medicaid or their vendors will monitor the PIHPs for compliance with use of ASAM Criteria.
- Medicaid will continue to support beneficiaries remaining connected to SUD treatment and supports.

Length of Stay

- Retention in treatment is the factor most consistently associated with positive client outcomes.
- The appropriate length of a treatment varies based on the needs of the individual.
- National Institute of Drug Addiction (NIDA) states:
- "Participation in residential or outpatient treatment for less than 90 days is of limited effectiveness and treatment lasting significantly longer is recommended for maintaining positive outcomes. For methadone maintenance, 12 months is considered a minimum, and some individuals with opioid use disorders continue to benefit from methadone maintenance for many years."

Provider Qualifications

- Revise and update ASAM Level 2.1 and 2.5 (.4400 and .4500 rules).
- Develop a new rule for ASAM Level 3.1 to replace the .5600E rule.
- Develop a new rule for ASAM Level 3.3.
- Develop a new rule for ASAM Level 3.5 for adults or adolescents in addition to .4100 for individuals with children.
- Revise the Therapeutic Community rule (10A NCAC 27G .4300) for ASAM Level 3.5.
- Revise the .3400 rule to be consistent with the expectations of ASAM Level 3.7. This will need to include adult and adolescent regulations.
- Revise .3600 rule for ASAM Opioid Treatment Program (OTP) Level of Care.
- Revise .3300 Outpatient Detox rule for ASAM Level 1-WM. Consider including 2-WM in this rule (Ambulatory withdrawal management with and without extended on-site monitoring).
- Revise .3200 Social Setting Detox rule for ASAM Level 3.2-WM.
- Revise .3100 Non-Hospital medical detox rule for ASAM Level 3.7-WM.

Opioid Funding Synopsis

Opioid STR Grant

- The 21st Century Cures Act identified $500m to address the opioid crisis in 2017 through 2019
- Called the Opioid State Targeted Response grant
- NC received $31,173,448,
  - awards were based on the number of opioid overdose deaths and unmet treatment needs
- May to April cycle
  - Year 1 = May 1, 2017 – April 30, 2018
  - Year 2 = May 1, 2018 – April 30, 2019

Opioid STR Grant

- Similar to SABG, the majority of STR dollars are allocated to the LME-MCOs to coordinate and pay for treatment
- Funding for special projects:
  - UNC ECHO
  - NCHA's ED peer support specialist initiative
- Over 5000 individuals received treatment services in Year 1
  - Over 2000 began medication-assisted recovery
- In Year 2, over 3000 have continued or begun MAR

Recently reauthorized in the Support for Patients and Communities Act

Support for Patients and Communities Act

- Support Act - “Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act” (P.L. 115-271)
- Authorizes $500 million for each of FY 2019 - FY 2021 for STR

Other components of the Support Act:

- Creates a grant program to establish at least 10 Comprehensive Opioid Recovery Centers (CORCs) throughout the US
- Develop and disseminate best practices for recovery housing
- Student loan repayment for SUD treatment professionals in shortage areas or counties that have been hardest hit by drug overdoses

Support for Patients and Communities Act

- Reauthorizes SAMHSA's Residential Treatment for Pregnant and Postpartum Women (PPW) program for FY 2019-FY 2023
- Temporarily (FY 2019-FY 2023) repeals the IMD exclusion, allowing State Medicaid programs to receive federal reimbursement for up to 30 total days of care in an IMD during a 12-month period for eligible individuals with a substance use disorder
- Adds clinical nurse specialists, certified nurse anesthetists, certified nurse midwifes, and allopathic and osteopathic doctors to the category of qualifying practitioners who can prescribe buprenorphine
- Reauthorizes the Office of National Drug Control Policy (ONDCP), as well as the Drug-Free Communities (DFC) and High-Intensity Drug Trafficking Areas (HIDTA) programs

State Opioid Response Grant

- Authorized under Title II Division H of the Consolidated Appropriations Act of 2018
- Total of one billion dollars each year for 2 years
- Similar to STR grant – allotment based on unmet treatment need and drug poisoning deaths
- NC’s allotment is $23,033,363 annually
- Will run on a federal fiscal year
- Language is stronger re utilization of MAT; will only allow detox services to be included/covered by these funds IF the individual receives naltrexone (injectable) prior to discharge
- Must address how to improve retention in care

Questions?

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Thank you!!