01/12/2018: Report has been attached, please see below.

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

December 1, 2017

SENT VIA ELECTRONIC MAIL

The Honorable Louis Pate, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 311, Legislative Office Building
Raleigh, NC 27603

The Honorable Josh Dobson, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 301N, Legislative Office Building
Raleigh, NC 27603

The Honorable Donny Lambeth, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 303, Legislative Office Building
Raleigh, NC 27603

Dear Chairmen:

Session Law 2017-57, Section 11F.10 requires the North Carolina Department of Health and Human Services to submit an annual report on the performance of North Carolina's system for monitoring prescription drug abuse to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Justice and Public Safety and the Fiscal Research Division.

On behalf of Secretary Cohen, the Department is notifying you that this report will be delayed until December 15th, as the Department works to complete a comprehensive report.

Should you have any questions regarding this report, please contact Jason Vogler, Senior Director for the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, at Jason.Vogler@dhhs.nc.gov or 919-733-7011.

Sincerely,

Mark T. Benton

for Mandy Cohen, MD, MPH
Secretary

cc: Jason Vogler, Rod Davis, Mark Benton, Denise Thomas, Joyce Jones, Lisa Wilks, Marjorie Donaldson, Susan Perry-Manning, Pam Kilpatrick, Kolt Ulm, Leah Burns, Christen Linke Young, Theresa Matula, Ben Popkin, reports@ncleg.net

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Mr. Mark Trogdon, Director
Fiscal Research Division
Suite 619, Legislative Office Building
Raleigh, NC 27603-5925

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Sincerely,

Rod Davis /for me

Mandy Cohen, MD, MPH
Secretary

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Performance of North Carolina's System for Monitoring Opioid and Prescription Drug Abuse

Session Law 2017-57, Section 11F.10.(e)

Report to the

Joint Legislative Oversight Committee on Health and Human Services

And

Joint Legislative Oversight Committee on Justice and Public Safety

And

Fiscal Research Division

By

North Carolina Department of Health and Human Services

January 12, 2018

INTRODUCTION

According to Session Law 2015-241, Section 12F.16(q), and then updated in S.L. 2017-57, Section 11F.10, the NC Department of Health and Human Services (DHHS) "shall submit an annual report on the performance of North Carolina's system for monitoring opioid and prescription drug abuse to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Justice and Public Safety, and the Fiscal Research Division" beginning on December 1, 2016, and annually thereafter.

BURDEN OF THE OPIOID EPIDEMIC IN NC

In NC, as in the United States as a whole, deaths due to medication and drug overdoses have been steadily increasing since 1999, and the vast majority (~88%) of these are unintentional. The epidemic of medication and drug overdose is mostly driven by opiates, specifically prescription opioids. Historically, prescription opioids (drugs like hydrocodone, oxycodone, morphine) have contributed to an increasing number of medication/drug overdose deaths. More recently, other synthetic narcotics (heroin, fentanyl, and fentanyl analogues) are resulting in increased deaths. The number of deaths involving cocaine is also on the rise.

In 2016, an average of 4 people a day died from opioid overdose in North Carolina. Unintentional opioid deaths have increased from just over 100 deaths in 1999 to over 1,380 deaths in 2016. These numbers include deaths from both prescription and illicit opioids.

The statewide outpatient opioid dispensing rate for 2016 was 66.5 pills per resident. Previous analyses in NC have shown that opioid overdose deaths are more common in counties where more opioids are dispensed. Unintentional opioid deaths have increased from just over 100 deaths in 1999 to over 1,300 deaths in 2016. These numbers include deaths from both prescription and illicit opioids. Deaths involving illicit opioids are continuing to increase and are accounting for a larger proportion of the total opioid deaths.

BACKGROUND

Session Law 2015-241 mandated the development of a strategic plan and creation of the Prescription Drug Abuse Advisory Committee (PDAAC), which is tasked with implementing activities guided by strategies within the Plan. With the leadership of the NC DHHS, Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), and support from the National Governors Association (NGA) and the Substance Abuse and Mental Health Services Administration (SAMHSA), a group of more than 150 stakeholders worked together to develop the *2016 N.C. Strategic Plan to Reduce Prescription Drug Abuse*.

Session Law 2017-57 renamed the group to the ***Opioid and Prescription Drug Abuse Advisory Committee*** (OPDAAC), which in the last year has accomplished a number of actions to address the opioid epidemic in NC. These accomplishments are highlighted below.

OPIOID AND PRESCRIPTION DRUG ABUSE ADVISORY COMMITTEE

In accordance with Session Law 2015-241, Section 12F.16.(m), the PDAAC was established in early 2016, and met in Raleigh on March 18, June 17, September 30 and December 9. In 2017, meetings were held on March 10 and September 29. The 2017 Opioid Misuse and Overdose Prevention Summit took the place of the June meeting. A third meeting is scheduled for December 15, 2017.

The membership of the OPDAAC has grown significantly since its start and now has over 370 members from diverse disciplines, including representatives from: DHHS's Division of Medical Assistance (DMA), DMH/DD/SAS, Division of Public Health (DPH), and the Office of Rural Health; Division of Adult Correction and Juvenile Justice of the Department of Public Safety; the State Bureau of Investigation; the Attorney General's Office; health care regulatory boards with oversight of prescribers and dispensers of opioids and other prescription drugs; the UNC Injury Prevention Research Center; the substance use treatment and recovery community; the Governor's Institute; and the Department of Insurance's drug take-back program, Operation Medicine Drop.

NC OPIOID ACTION PLAN

Work of the OPDAAC in 2017 largely focused on the development of the new ***NC's Opioid Action Plan (2017-2021)***. The intent of the *NC Opioid Action Plan* is to identify specific and achievable steps that will have the greatest impact on reducing the burden of death from the opioid epidemic. Through a process lead by DPH, the *Action Plan* was developed over a period of months with feedback from many OPDAAC partners working on the opioid epidemic. The *Action Plan* is a concise document and thus does not capture all of the work going on in the state around this topic. NC DHHS staff received a wealth of valuable feedback on the *Action Plan* and was not able to incorporate all ideas presented due to considerations of *Action Plan* length and focus. However, the *Action Plan* is a living document that will be updated as NC makes progress on the epidemic and is faced with new issues and new solutions in a fast-changing environment. The full *NC Opioid Action Plan* can be found here https://www.ncdhhs.gov/opioids.

Given the complexity of the epidemic, numerous strategies outlined in the *Action Plan* will assist in reducing the impact of the opioid crisis. The *Action Plan* focus areas include: creating a coordinated infrastructure; reducing the oversupply of prescription drugs; reducing diversion and flow of illicit drugs; increasing community awareness and prevention; increasing naloxone availability and links to care; expanding access to treatment and recovery; and, measuring impact.

NC's fifth statewide conference on overdose prevention, the 2017 Opioid Misuse and Overdose Prevention Summit, was held in Raleigh at the NC State University's McKimmon Center on June 27-28, 2017. The 2-day Summit attracted over 600 individuals from diverse backgrounds, such as community leaders, educators, first responders, social and healthcare workers. The Summit was kicked off by Governor Roy Cooper and DHHS' Secretary Mandy Cohen, M.D., MPH. Attorney General Josh Stein also served as a keynote speaker. The Summit engaged partners in active discussion, educated participants on evidence-based/informed, promising, and innovative policies and practices that prevent opioid misuse, addiction, and overdose, and energized partners to get behind the *Action Plan* and strategies. http://www.opioidpreventionsummit.org

Another major milestone this year was adoption of S.L. 2017-74 or the Strengthen Opioid Misuse Prevention (STOP) Act. Some key provisions include: limiting the number of days opioids can be lawfully prescribed, requiring prescribers to check the NC Controlled Substance Reporting System, enabling broader access to community distributed naloxone, and allowing the use of local funds to support syringe exchange programs, among many others. The full text of the STOP Act can be found here: http://www.ncleg.net/EnactedLegislation/SessionLaws/HTML/2017-2018/SL2017-74.html

Opioid Action Plan Highlights

Select highlights for each of the seven *NC Opioid Action Plan* focus areas are below.

Strategy 1 – Create a Coordinated Infrastructure

A group of 50 key leaders from across the state were convened to serve as the advisory and coordination workgroup for the opioid response. The OPDAAC Coordinating Workgroup includes representatives from the NC Association of County Commissioners, the NC Sheriffs' Association, Chiefs of Police, the NC Board of Pharmacy, NC Medical Board, non-profit organizations and state, regional, and local government agencies.

In addition to convening the OPDAAC to implement the *NC Opioid Action Plan* as described above, DHHS is working to build and sustain local coalitions. For example, DPH supports local health department led coalitions with Centers for Disease Control and Prevention funding through Agreement Addenda. These coalitions are working to increase naloxone access, increase utilization of the NC Controlled Substances Reporting System (CSRS), educate patients on safe use of opioids, and promote safe prescribing of opioids.

Strategy 2 - Reduce Oversupply of Prescription Opioids

With support from DPH, the North Carolina Hospital Association (NCHA) is looking at how to improve care pathways for those suffering with opioid use disorders at a hospital and health system level. Beginning with the formation of the Coalition for Model Opioid Practices in Health Systems, the group assessed the current state of care delivery in NC hospitals and health systems and created a framework of tactics to implement.

Within the Coalition there are three working groups: 1) Prevention and Safe Pain Management; 2) Health System Response; and, 3) Healthcare Worker Diversion. This collaborative work helps frame the areas of focus NC health systems should be prioritizing as they move to develop best practices and tools to combat the ongoing opioid crisis in NC. Coalition members include representatives from all 130 hospitals in North Carolina, professional societies, and government agencies who are working to address the opioid crisis at a health system level. Many serve in their organizations' leadership structure for addressing opioids, including serving on hospital opioid safety committees, community task forces, the OPDAAC, and the NCHA Behavioral Health Work Group. A primary focus for this work is to ensure that there is communication across sectors so that there is a maximization of resources and that efforts are not duplicated. The framework developed and being implemented by the Coalition is designed to help hospitals align their efforts with other health systems and ensure that they are able to make the largest impact in their communities.

With DHHS funding, the Governors Institute (GI) trained 3,300 participants in FY 2017. These GI trainings occur in conjunction with complimentary NC Medical Board and regional Area Health Education Center educational events. It is projected that 3,500 individuals will be trained in FY 2018 through GI events alone.

Since enacting S.L. 2017-74, the STOP Act, there has been a large increase in the number of prescribers and pharmacists registering to use the Controlled Substances Reporting System (CSRS). An increase was seen from 22,047 in August 2016 to 29,411 registered prescribers in September 2017.

DHHS' DMH/DD/SAS also:

- Sent 1,829 proactive reports to prescribers who care for one or more patients at high risk for developing a substance use disorder.
- Sent the NC Medical Board (NCMB) over 60 names of prescribers who met NCMB reporting criteria and sent nearly 440 individual reports to the NC Board of Nursing regarding mid-level practitioners. Each Board will follow-up, as needed, with providers who may warrant further investigation or education.
- Published online several interactive population trend maps to assist stakeholders in better understanding prescription opioid use across the state.

DHHS has established a NC Payers Council to bring together health care payers across the state to partner on benefit design, member services, and pharmacy policies to reduce opioid overuse and overdose. The Payers Council has planned their first meeting for December 2017, and will then meet monthly from January to June 2018. The Payers Council will bring together large health payers in NC to identify prescription drug and clinical benefits policies, and treatment and recovery supports. Payers participating in the Council include Medicaid; Palmetto GBA as the Jurisdiction M Medicare Administrative Contractor for North Carolina; Blue Cross and Blue Shield of North Carolina; UnitedHealthcare; Aetna; Cigna and several workers' compensation insurers. Once assembled, the Payers Council will work to identify, align and implement policies to improve health outcomes by:

- Supporting providers in judicious prescribing of opioids;
- Promoting safer and more comprehensive alternatives to pain management;
- Improving access to naloxone, substance use disorder treatment and recovery supports; and,
- Engaging and empowering patients in the management of their health.

The Division of Medical Assistance (DMA) updated clinical coverage criteria for the use of opioids for pain management based on the Centers for Disease Control and Prevention (CDC) *Guideline for Prescribing Opioids for Chronic Pain* and to align clinical coverage criteria with the strategies of reducing the oversupply of prescription opioids available for diversion and misuse.

These updates began on May 1, 2017, when the refill threshold for all opioids and benzodiazepines prescriptions was increased from 75% to 85%. Then beginning August 27, 2017, prior approval is required for opioid analgesic doses which:

- Exceed 120 mg of morphine equivalents per day
- Are greater than a 14-day supply of any opioid, or,
- Are non-preferred opioids on the NC Medicaid Preferred Drug List (PDL)

Beneficiaries with a diagnosis of pain secondary to cancer are exempt from prior authorization requirements. Per federal law, pharmacies may dispense a 72-hour emergency supply to Medicaid beneficiaries to ensure beneficiary access to medically necessary medications while prior authorization is being requested and processed.

Starting in January 2018, DMA will align opioid quantity limits with the STOP Act and require prior authorization for any opioid prescription that exceeds a five-day supply for treatment of a patient for acute pain and seven-day supply for treatment of a patient for post-operative pain relief following a surgical procedure.

The NC Administrative Code, 10A NCAC 22F .0704 and 10A NCAC 22F .0104, Session Law 2015-241, Section 12F.16.(l), along with 42 CFR 431.54 and the NC Medicaid State Plan Amendment, supports the State's development of procedures for the control of beneficiary overutilization of Medicaid benefits which includes implementing a Beneficiary Management Lock-In program. Since implementation of this enhanced Lock-in Program more than 6,500 beneficiaries are now locked into the program. In accordance with Session Law 2015-268, Section 4.4., the lock-in period has been extended to two years and program capacity has been expanded to include all NC Medicaid beneficiaries that meet the inclusion criteria. This change applies to beneficiaries receiving notification letters beginning January 2017.

A Medicaid beneficiary identified for the lock-in program is restricted to a single prescriber and pharmacy in order to obtain opioid analgesics, benzodiazepines, and certain anxiolytics. The beneficiary must obtain all prescriptions for these medications from their lock-in prescriber and lock-in pharmacy in order for the claim to pay. Claims submitted that are written by a prescriber or filled at a pharmacy other than those listed on the lock-in file are denied. A beneficiary who qualifies for the program shall be notified and locked in for two years after which time they will be removed from the program if they no longer meet the criteria. Once released from the lock-in program, prescription claims continue to be monitored.

If a beneficiary meets the criteria again after being released from the program, they will be re-identified for the lock-in program. The beneficiary cannot change their lock-in prescriber or pharmacy without authorization from DMA. A NC Medicaid beneficiary shall be locked-in to one prescriber and one pharmacy for controlled substances categorized as opiates or benzodiazepines and certain anxiolytics when one or more of the following criteria is met: 1. Beneficiary has at least one of the following: A) Benzodiazepines and certain anxiolytics: greater than six claims in two consecutive months; B) Opiates: greater than six claims in two consecutive months; or 2. Receiving prescriptions for opiates and/or benzodiazepines and certain anxiolytics from greater than three prescribers in two consecutive months.

Strategy 3 – Reduce Diversion of Prescription Drugs and Flow of Illicit Drugs

An influx of synthetic fentanyl – a powerful opioid that is 50 to 100 times more potent than morphine is contributing to the surge in overdose deaths in NC. Although fentanyl is available by prescription, synthetic fentanyl is being trafficked into NC and combined with or sold as heroin. Many new forms of synthetic fentanyl, known as fentanyl analogs, did not meet the state definition of controlled substances and therefore could not be prosecuted. The Synthetic Opioid and Other Dangerous Drug Control Act (S.L. 2017-115) lists all known fentanyl derivatives as controlled substances and created a new "catch-all" provision describing the chemical backbone structure of the fentanyl molecule in order to capture any future fentanyl derivative that may be encountered in NC. Various other changes to update and modernize the controlled substance Act were also made at the request of law enforcement.

The Workforce Diversion Workgroup within the NCHA Coalition described above is working toward providing minimum diversion program standards and policy guidance for health systems and hospitals and has plans to create investigation protocols to reduce healthcare worker diversion.

Operation Medicine Drop is a partnership of Safe Kids North Carolina, Riverkeepers of North Carolina, NC State Bureau of Investigation, Community Anti-Drug Coalitions of North Carolina and local law enforcement agencies working together to encourage the public to safely dispose of unused, unwanted

and expired medication. By providing safe and secure ways for people to get rid of unwanted prescription and over-the-counter medications, Operation Medicine Drop helps prevent accidental poisonings and drug abuse while protecting our waters. Since 2010, Operation Medicine Drop has collected nearly 89.2 million pills at more than 2,000 events. The DEA also supported National Drug Take Back Day on October 28, 2017, with Operation Medicine Drop events scheduled all over NC.

In August 2015, the Office of National Drug Control Policy announced partnership among regional High Intensity Drug Trafficking Areas (HIDTA) programs to address the heroin threat facing communities through public health-public safety partnerships. In February of 2017, a full-time Drug Enforcement Agency funded analyst was placed in the DPH to support active surveillance and data sharing between public health and public safety to address the heroin and opioid epidemic.

In order to protect themselves from exposure to opioids on the job, DPH trained over 350 public sector employees in eight counties through nine training sessions. Trainings focused on increasing awareness about opiate and methamphetamine exposures in public workers. Seventeen additional training sessions are scheduled.

Strategy 4 – Increase Community Awareness and Prevention

Sixteen new county coalitions have been funded by DMH/DD/SAS for state fiscal year 2018 to provide youth-focused opioid use prevention in highly impacted areas. These include: New Hanover, Carteret, Dare, Mitchell, Avery, Haywood, Transylvania, Stokes, Surry, Yadkin, Nash, Richmond, Bladen, Columbus, Scotland, and Ashe counties.

Six high-functioning counties with subject matter expertise and demonstrated success in particular prevention strategies were identified to provide mentoring to new SAMHSA Opioid State Targeted Response (STR) funded sites. Specified areas include: prescribing policy (Burke County), medication disposal (Cleveland County), communication campaigns (Brunswick County), youth empowerment and advocacy (Rockingham County), community engagement (Robeson County), and partner involvement (Wilkes County). All sites and mentors have been trained on using the Strategic Prevention Framework (required by SAMHSA), and are currently in the process of updating needs assessments with the most current local data around prescription drugs to tailor strategies for their communities.

Counties who will lose dedicated Opioid prevention funding through the Strategic Prevention Framework-Partnership for Success grant are working on demonstrating successes and sustaining those efforts. All 13 counties have different plans for sustaining efforts. Three counties received funding from federal Drug Free Communities grants for an additional five years. Four counties received a mix of funding from County Commissioners, Hospitals, United Way, and LME-MCOs to continue opioid prevention efforts. The remaining counties are in the process of securing or solidifying funding agreements and cooperative efforts.

Strategy 5 – Increase Naloxone Availability and Link Overdose Survivors to Care

Under the NC Good Samaritan/Naloxone Access Laws (S.L. 2013-23, S.L. 2015-94, and S.L. 2017-74), the NC Harm Reduction Coalition has distributed 57,416 naloxone rescue kits as of September 30, 2017 and has recorded 8,181 community reversals.

As of September 30, 181 law enforcement agencies (LEAs) are carrying naloxone covering 77 counties. Records so far show LEAs have reported 677 reversals since their programs started.
NC emergency medical services administered naloxone more than 13,000 times in 2016.

People who are at risk of experiencing an opiate-related overdose, are a family member or friend of such a person, or are in the position to assist a person at risk of experiencing an opiate-related overdose, can request naloxone without a prescription at any pharmacy in NC under the State Health Director's standing order for naloxone. Naloxone is available by statewide standing order from over 1,400 pharmacies in NC (or 69% of retail pharmacies in the state which has a total of 2,026 retail pharmacies).

So far, 31 health departments in NC have adopted local standing orders for naloxone dispensing by public health nurses.

In October, DHHS purchased 39,588 units of nasal naloxone to help reduce the number of unintentional opioid-related deaths and make the overdose reversal drug more widely available. The naloxone has been distributed to partners across the state that work with individuals at high-risk of opioid overdose including Opioid Treatment Programs and other treatment providers, EMS agencies, Oxford Houses, and other community partners. In addition, Opioid STR funds in the amount of $135,254 were utilized to purchase 1,912 naloxone rescue kits for Community Corrections officers this fiscal year.

As of July 11, 2016, North Carolina (S.L. 2016-88) allows for the legal establishment of hypodermic syringe and needle exchange programs. The law encourages syringe return to ensure that they are disposed of in a safe and secure manner, but does not require participants to return used syringes. Syringe exchange programs (SEPs) in North Carolina are required to provide the following services:

- Syringe disposal
- Distribution of clean syringes and injection supplies at no cost and in sufficient quantities to prevent sharing or reusing
- Site, personnel and equipment security, including annual written plans to police and/or sheriffs' departments within whose jurisdictions they operate
- Education materials concerning the prevention of disease transmission, overdose and addiction; and, treatment options, including medication-assisted therapy (MAT) and referrals
- Naloxone distribution and training, or referrals to these services
- Consultations/referrals to mental health or substance use disorder (SUD) treatment

Since the legalization of SEPs in NC and at the end of the first year, there are 22 registered syringe exchange programs covering 28 counties, with individuals commuting from an additional 24 counties and out of state. More information can be found here: www.ncdhhs.gov/divisions/public-health/north-carolina-safer-syringe-initiative

Strategy 6 – Expand Treatment and Recovery Oriented Systems of Care

In 2015, 4,847 persons served by local management entity/managed care organizations (LME/MCOs) reported the primary drug at time of admission as heroin – almost twice as many as in 2005. For fiscal year 2018, $8.3M in Federal Opioid STR (commonly referred to as the CURES grant) funding was allocated through the seven LME/MCOs to expand treatment. Funding was allocated based on the population of their service areas, number of naloxone administrations by EMS, number of opioid-related emergency department visits, and number of opioid overdose deaths. Thus far, $2.7M of these funds has

been expended on services reaching 1,973 persons. Types of services provided include non-hospital medical detox, individual and group therapies, opioid treatment (medication administration), intensive outpatient treatment, group/supervised living, and recovery supports.

Law Enforcement Assisted Diversion (LEAD) programs allow law enforcement to redirect low-level, non-violent offenders engaged in drug use or sex work to community-based programs and services, instead of jail and prosecution. By diverting eligible individuals to services, LEAD programs are committed to improving public safety and public order, and reducing the criminal behavior of people who participate in the program. As of October 2017, two LEAD programs are operating, one in Fayetteville and one in Wilmington. Implementation of programs in Waynesville and Statesville are underway.

Over 400 interdisciplinary professionals attended "It Takes a Community, Too – Pregnancy and Opioid Exposure: Improving Outcomes for Women, Infants and Families" conference hosted by DMH/DD/SAS, UNC School of Social Work and UNC Horizons Program on October 3, 2017. Work continues to improve treatment for pregnant and parenting women with substance use disorders (SUD), including trainings for LME-MCOs on "Pregnancy and Substance Use," and raising awareness of the DMH/DD/SAS and DPH funded Perinatal Substance Use Project to provide information, screenings, referrals and advocacy for pregnant and parenting women who may have a SUD, families and professionals to identify substance use treatment services and supports statewide. Webinars, presentations and calls have been done through the Plan of Safe Care Interagency Collaborative to educate around new federal requirements and the implementation in NC, while using this as an opportunity to raise awareness on best practices for substance use screening during pregnancy and linking women with SUD to supportive resources.

In addition to regional training provided for medical directors and mid-levels in Opioid Treatment Programs (OTP) on best practices from experts in the field, monthly clinical case conference calls are conducted with all OTP physicians and mid-levels.

Over 250 social service participants attended the track "Opioid Use Disorder and Its Treatment" at North Carolina Association of County Boards of Social Services annual Social Services Institute in Hickory NC.

Through the DMH/DD/SAS, the Medication Assisted Treatment (MAT) Prescription Drug and Opioid Addiction grant from SAMHSA is providing treatment services to people under Community Corrections supervision who have an opioid use disorder in Iredell and Wilkes counties. Planning is underway to: 1) Conduct a statewide, web-based survey with Community Corrections personnel to gather information on MAT knowledge and how to improve referrals to treatment; 2) Deliver in-person training for Treatment Accountability for Safer Communities (TASC), Community Corrections, community treatment providers in Iredell and Wilkes counties and staff at DART-Cherry and Black Mountain Treatment Center for Women; and 3) Develop a webinar, based on the in-person training, for statewide dissemination to Community Corrections, TASC and other partners.

North Carolina Medicaid has removed the prior approval requirement for Suboxone Film, allowing physicians to start this life-saving treatment immediately when indicated. Suboxone Film is a prescription drug that combines buprenorphine, which helps reduce opioid cravings, and naloxone,

which helps prevent abuse and diversion of the drug. This change, effective November 1, 2017, allows treatment to begin immediately for patients who are ready to commit to treatment for their opioid use disorder.

Under the leadership of Chief Justice Martin, the Administrative Office of the Courts has convened an opioid work group. The work group is focused on ensuring all court personnel are educated about the opioid epidemic.

Strategy 7: Measure Impact and Revise Strategies Based on Results

DPH's Injury and Violence Prevention Branch is working with DMH/DD/SAS and other partners to track the metrics in the *NC Opioid Action Plan*. Key metrics are:

Metrics	Baseline Data
OVERALL	
Number of unintentional opioid-related deaths to NC Residents (ICD10)	1,384 (2016)
Number of ED visits that received an opioid overdose diagnosis (all intents)	4,182 (2016)
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)
Total number of opioid pills dispensed	675,315,375 (2016)
Percent of patients receiving more than an average daily dose of >90 MME of opioid analgesics, per quarter	6.7% (Q4 2016)
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)
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)
Increase Access to Naloxone	
Number of EMS naloxone administrations	13,103 (2016)
Number of community naloxone reversals	3,684 (2016)
Treatment and Recovery	
Number of buprenorphine prescriptions dispensed	478,403 (2016)
Number of uninsured individuals and Medicaid beneficiaries with an opioid use disorder served by treatment programs, per quarter	15,187 (Q4 2016)
Number of certified peer support specialists (CPSS) across NC	2,352 (2016)

SUMMARY

OPDAAC, led by the NC DHHS DPH and DMH/DD/SAS and guided by the *NC Opioid Action Plan*, is coordinating and implementing strategies to reduce the impact of North Carolina's deadly opioid crisis. NC has made progress in recent years and has more work to do. Given the complexity of the epidemic, maintaining and strengthening NC's coordinated infrastructure is vital to NC's success. With the STOP Act now in effect, NC expects to see decreases in overprescribing of opioids. However, emerging trends show a steep rise in illicit drug use.

One of the most powerful tools for addressing the opioid epidemic is providing access to health care through affordable insurance coverage, not only to individuals who already have substance use disorders but also to those who are at-risk of developing addictions in the future. One in five adults with an opioid addiction, however, is uninsured. Only 20% of uninsured people with opioid use disorders have received outpatient treatment for their addiction in the past year, compared with 37% of those with insurance. Evidence show that access to coverage is essential to turning the tide against opioid use disorders, overdose and death due to opioids.

NC will need to continue to ramp up efforts to increase access to and availability of the life-saving opioid overdose reversal medication naloxone and sustainably fund opioid use disorder treatment and recovery supports.