UNDERSTANDING THE CRISIS
3 PEOPLE DIE EACH DAY FROM OPIOID OVERDOSE IN NC

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


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

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
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

THE EPIDEMIC IS DEVASTATING OUR FAMILIES

Number of Hospitalizations Associated with Drug Withdrawal in Newborns

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
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
PRESRIPTION 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

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Action</th>
<th>Leads</th>
</tr>
</thead>
<tbody>
<tr>
<td>PDAAC leadership</td>
<td>Designate an Opioid Action Plan Executive Chair for the PDAAC to lead NC Opioid Action Plan</td>
<td>DHHS</td>
</tr>
<tr>
<td>Advisory council</td>
<td>Convene a group of current and former opioid users and others in recovery to guide Plan components and implementation of strategic actions</td>
<td>DHHS, NCHRC, RCOs, DPS</td>
</tr>
<tr>
<td>Build and sustain local coalitions</td>
<td>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</td>
<td>NCACC, LHDs, Local coalitions, DPH, DMH, AHEC, LME/MCOs</td>
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## 2. REDUCE OVERSUPPLY OF PRESCRIPTION DRUGS

<table>
<thead>
<tr>
<th>Strategy</th>
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<tbody>
<tr>
<td>Safe prescribing policies</td>
<td>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)</td>
<td>NCHA, DMA, Licensing boards and professional societies</td>
</tr>
<tr>
<td></td>
<td>Create and maintain continuing education opportunities and resources for prescribers to manage chronic pain</td>
<td>GI, AHEC, CCNC, DMA, Licensing boards and professional societies</td>
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<tr>
<td>CSRS utilization</td>
<td>Register 100% of eligible prescribers and dispensers in CSRS</td>
<td>DMH, Licensing boards and professional societies</td>
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<td></td>
<td>Provide better visualization of the data (easy to read charts and graphs) to enable providers to make informed decisions at the point of care</td>
<td>DMH, IPRC, CHS, GDAC, DIT</td>
</tr>
<tr>
<td></td>
<td>Develop connections that would enable providers to make CSRS queries from the electronic health record</td>
<td>DMH, GDAC, NCHA, DIT</td>
</tr>
<tr>
<td></td>
<td>Report data to all NC professional boards so they can investigate aberrant prescribing or dispensing behaviors</td>
<td>Licensing boards and professional societies</td>
</tr>
<tr>
<td>Medicaid and commercial payer policies</td>
<td>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</td>
<td>DHHS, DMA, BCBSNC, SHP and other payers, CCNC, LME/MCOs</td>
</tr>
<tr>
<td>Workers’ compensation policies</td>
<td>Identify and implement policies to promote safer prescribing of opioids to workers’ compensation claimants</td>
<td>Industrial Commission, workers’ compensation carriers</td>
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</table>
## 3. REDUCE DIVERSION AND FLOW OF ILLICIT DRUGS

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<thead>
<tr>
<th>Strategy</th>
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<tbody>
<tr>
<td>Trafficking investigation and response</td>
<td>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</td>
<td>AG, HIDTA, SBI, DEA, Local law enforcement</td>
</tr>
<tr>
<td>Diversion prevention and response</td>
<td>Develop model healthcare worker diversion prevention protocols and work with health systems, long-term care facilities, nursing homes, and hospice providers to adopt them</td>
<td>NCHA, AG, DMH, Licensing boards and professional societies</td>
</tr>
<tr>
<td>Drug takeback, disposal, and safe storage</td>
<td>Increase the number of drug disposal drop boxes in NC – including in pharmacies, secure funding for incineration, and promote safe storage</td>
<td>DOI Safe Kids NC, SBI, Local law enforcement, AG, NCAP, NCRMA, CCNC, LHDs</td>
</tr>
<tr>
<td>Law enforcement and public employee protection</td>
<td>Train law enforcement and public sector employees in recognizing presence of opioids, opioid processing operations, and personal protection against exposure to opioids</td>
<td>DPH, Local law enforcement</td>
</tr>
</tbody>
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## 4. INCREASE COMMUNITY AWARENESS AND PREVENTION

<table>
<thead>
<tr>
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</table>
| 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

<table>
<thead>
<tr>
<th>Strategy</th>
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</thead>
<tbody>
<tr>
<td>Law enforcement naloxone administration</td>
<td>Increase the number of law enforcement agencies that carry naloxone to reverse overdose among the public</td>
<td>NCHRC, DPS, OEMS, Local law enforcement, AG</td>
</tr>
<tr>
<td>Community naloxone distribution</td>
<td>Increase the number of naloxone overdose rescue kits distributed through communities to lay people</td>
<td>NCHRC, DPH, LHDs, LME/MCOs, OTPs, CCNC</td>
</tr>
<tr>
<td>Naloxone co-prescribing</td>
<td>Create and adopt strategies to increase naloxone co-prescribing within health systems, PCPs</td>
<td>NCHA, NCAP, CCNC, Licensing boards and professional societies</td>
</tr>
<tr>
<td>Pharmacist naloxone dispensing</td>
<td>Train pharmacists to provide overdose prevention education to patients receiving opioids and increase pharmacist dispensing of naloxone under the statewide standing order</td>
<td>NCAP, NCBP, CCNC</td>
</tr>
<tr>
<td>Safer Syringe Initiative</td>
<td>Increase the number of SEP programs and distribute naloxone through them</td>
<td>NCHRC, DPH, LHDs</td>
</tr>
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## 6. EXPAND TREATMENT ACCESS

<table>
<thead>
<tr>
<th>Strategy</th>
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<tbody>
<tr>
<td>Care linkages</td>
<td>Work with health systems to develop and adopt model overdose discharge plans to promote recovery services and link to treatment care&lt;br&gt;Link patients receiving office-based opioid treatment to counseling services for SUD using case management or peer support specialists</td>
<td>NCHA, LME/MCOs&lt;br&gt;DMH, RCOs, APNC, CCNC, LME/MCOs, NCATOD</td>
</tr>
<tr>
<td>Treatment access</td>
<td>Increase state and federal funding to serve greater numbers of North Carolinians who need treatment</td>
<td>All</td>
</tr>
<tr>
<td>MAT access: Office-based opioid treatment</td>
<td>Offer DATA waiver training in all primary care residency programs and NP/PA training programs in NC&lt;br&gt;Increase providers’ ability to prescribe MAT through ECHO spokes and other training opportunities&lt;br&gt;Increase opportunities for pharmacists to collaborate with PCPs and specialty SUD providers to coordinate MAT</td>
<td>DHHS, NCHA, AHEC, NCAFPA, Medical Schools&lt;br&gt;DMH, UNC, ORH, AHEC, FQHCs&lt;br&gt;NCAP, NCBP, AHEC, UNC</td>
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## 6. EXPAND TREATMENT ACCESS, Cont’d

<table>
<thead>
<tr>
<th>Strategy</th>
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</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>Explore options to provide transportation assistance to individuals seeking treatment</td>
<td>DMH, LME/MCOs, DSS, Local government</td>
</tr>
<tr>
<td>Law Enforcement Assisted Diversion</td>
<td>Implement additional Law Enforcement Assisted Diversion (LEAD) programs to divert low level offenders to community-based programs and services</td>
<td>NCHRC, AG, DAs, DMH</td>
</tr>
<tr>
<td>Special Populations: Pregnant women</td>
<td>Increase number of OB/GYN and prenatal prescribers with DATA waivers to prescribe MAT</td>
<td>NCOGS, Professional societies</td>
</tr>
<tr>
<td></td>
<td>Support pregnant women with opioid addiction in receiving prenatal care, SUD treatment, and promoting healthy birth outcomes</td>
<td>DMA, CCNC, DPH, DMH, LME/MCOs, DSS</td>
</tr>
<tr>
<td>Special populations: Justice-involved persons</td>
<td>Provide education on opioid use disorders and overdose risk and response at reentry facilities, local community corrections, and TASC offices</td>
<td>DPS, DMH, NCHRC</td>
</tr>
<tr>
<td></td>
<td>Expand in-prison/jail and post-release MAT and on-release naloxone for justice involved persons with opioid use disorder</td>
<td>DPS, DMH, Local government</td>
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</tbody>
</table>
## 6. EXPAND RECOVERY SUPPORT

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</thead>
<tbody>
<tr>
<td>Community paramedicine</td>
<td>Increase the number of community paramedicine programs whereby EMS links overdose victims to treatment and support</td>
<td>OEMS, DMH, LMEs/MCOs</td>
</tr>
<tr>
<td>Post-reversal response</td>
<td>Increase the number of post-reversal response programs coordinated between law enforcement, EMS, and/or peer support/case workers</td>
<td>NCHRC, Local LE, OEMS, RCOs, AG, LME/MCOs</td>
</tr>
<tr>
<td>Community-based support</td>
<td>Increase the number of community-based recovery supports (e.g. support groups, recovery centers, peer recovery coaches)</td>
<td>DMH, RCOs, ORH, LME/MCOs</td>
</tr>
<tr>
<td>Housing</td>
<td>Increase recovery-supported transitional housing options to provide a supportive living environment and improve the chance of a successful recovery</td>
<td>DMH, LME/MCOs, Local government and coalitions</td>
</tr>
<tr>
<td>Employment</td>
<td>Reduce barriers to employment for those with criminal history</td>
<td>Local government and coalitions</td>
</tr>
<tr>
<td>Recovery Courts</td>
<td>Maintain and enhance therapeutic (mental health, recovery and veteran) courts</td>
<td>Local government, Judges and DAs</td>
</tr>
</tbody>
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## 7. MEASURE IMPACT

<table>
<thead>
<tr>
<th>Strategy</th>
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<th>Leads</th>
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</thead>
<tbody>
<tr>
<td><strong>Metrics/Data</strong></td>
<td>Create publicly accessible data dashboard of key metrics to monitor impact of this plan</td>
<td>DPH, DMH</td>
</tr>
<tr>
<td><strong>Surveillance</strong></td>
<td>Establish a standardized data collection system to track law enforcement and lay person administered naloxone reversal attempts</td>
<td>OEMS, Law Enforcement, CPC, NCHRC</td>
</tr>
<tr>
<td></td>
<td>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</td>
<td>HIDTA, SBI, DEA, DPH, OEMS, CPC, LHDs, Local law enforcement</td>
</tr>
<tr>
<td><strong>Research/Evaluation</strong></td>
<td>Establish an opioid research consortium and a research agenda among state agencies and research institutions to inform future work and evaluate existing work</td>
<td>UNC, Duke, RTI, other Universities/colleges, DPH, DMH, AHEC/Academic Research Centers</td>
</tr>
</tbody>
</table>
To successfully combat this epidemic, the Action Plan envisions 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)

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
- Recovery Support
  - Community based support
  - Housing
  - Employment
  - Recovery courts
  - Special population: Pregnant women
  - Special population: Justice-involved persons

Data, Surveillance, & Research Teams
- Data
  - Track metrics
- Research/Evaluation
  - Consortium
  - Surveillance
MEASURING PROGRESS
<table>
<thead>
<tr>
<th>Metrics</th>
<th>Current Data</th>
<th>2021 Trend/Goal</th>
</tr>
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<tbody>
<tr>
<td><strong>OVERALL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of unintentional opioid-related deaths (ICD10)</td>
<td>1,194 (2016, provisional)</td>
<td>20% reduction in expected 2021 number</td>
</tr>
<tr>
<td>Rate of opioid ED visits (all intents)</td>
<td>38.2 per 100,000 residents (2015)</td>
<td>20% reduction in expected 2021 rate</td>
</tr>
<tr>
<td><strong>Reduce oversupply of prescription opioids</strong></td>
<td></td>
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<tr>
<td>Rate of multiple provider episodes for prescription opioids (times</td>
<td>27.3 per 100,000 residents (2016)</td>
<td>Decreasing trend</td>
</tr>
<tr>
<td>patients received opioids from ≥5 prescribers dispensed at ≥5</td>
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<tr>
<td>pharmacies in a six-month period), per 100,000 residents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of opioid pills dispensed</td>
<td>555,916,512 (2016)</td>
<td>Decreasing trend</td>
</tr>
<tr>
<td>Percent of patients receiving more than an average daily dose of &gt;90</td>
<td>12.3% (Q1 2017)</td>
<td>Decreasing trend</td>
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<tr>
<td>MME of opioid analgesics, per quarter</td>
<td></td>
<td></td>
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<tr>
<td>Percent of prescription days any patient had at least one opioid AND</td>
<td>21.1% (Q1 2017)</td>
<td>Decreasing trend</td>
</tr>
<tr>
<td>at least one benzodiazepine prescription on the same day, per quarter</td>
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<tr>
<td><strong>Reduce Diversion/Flow of Illicit Drugs</strong></td>
<td></td>
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<tr>
<td>Percent of opioid deaths involving heroin or fentanyl/fentanyl</td>
<td>58.4% (2016, provisional)</td>
<td></td>
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<tr>
<td>analogues</td>
<td></td>
<td></td>
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<tr>
<td>Number of acute Hepatitis C cases</td>
<td>182 (2016, provisional)</td>
<td>Decreasing trend</td>
</tr>
<tr>
<td><strong>Increase Access to Naloxone</strong></td>
<td></td>
<td></td>
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<tr>
<td>Number of EMS naloxone administrations</td>
<td>13,069 (2016, provisional)</td>
<td></td>
</tr>
<tr>
<td>Number of community naloxone reversals</td>
<td>3,616 (2016)</td>
<td>Increasing trend</td>
</tr>
<tr>
<td><strong>Treatment and Recovery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of buprenorphine prescriptions dispensed</td>
<td>467,243 (2016)</td>
<td>Increasing trend</td>
</tr>
<tr>
<td>Number of uninsured individuals with an opioid use disorder served by</td>
<td>12,248 (SFY16)</td>
<td>Increasing trend</td>
</tr>
<tr>
<td>treatment programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of certified peer support specialists (CPSS) across NC</td>
<td>2,383 (2016)</td>
<td>Increasing trend</td>
</tr>
</tbody>
</table>
**NUMBER OF UNINTENTIONAL OPIOID-RELATED DEATHS**

**Goal**: 20% reduction from expected 2021 deaths based on 2010-2016* trend

*2016 data are preliminary and subject to change, current as of June 1, 2017


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

2021 expected rate based on 2011-2016 trend

Actual rate
TOTAL NUMBER OF OPIOID PILLS DISPENSED

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

2021 expected pills dispensed based on 2011-2016 trend
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
PERCENT OF OPIOID DEATHS INVOLVING HEROIN OR FENTANYL/FENTANYL ANALOGUES

Percent


2021 expected percent based on 2010-2016* trend

Actual percent

*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 NA LOXONE 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

Number of reported reversals


2021 expected number based on 2014-2016 trend

Actual 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
- 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
- **NC ACC**: NC Association of County Commissioners
- **NC AFP**: NC Academy of Family Physicians
- **NC AP**: NC Association of Pharmacists
- **NC ATOD**: NC Association for the Treatment of Opioid Dependence
- **NC BP**: NC Board of Pharmacy
- **NC HA**: NC Hospital Association
- **NC HRC**: NC Harm Reduction Coalition
- **NC MB**: NC Medical Board
- **NC OGS**: North Carolina Obstetrical and Gynecological Society
- **NC RMA**: 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
- **RI**: 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