



OHIO'S PRESCRIPTION DRUG OVERDOSE EPIDEMIC:

APRIL 17, 2014

***EPIDEMIOLOGY,
CONTRIBUTING
FACTORS AND ONGOING
PREVENTION EFFORTS***

PRESENTATION OVERVIEW

- **Epidemiology of drug overdose deaths in Ohio**
- **Description of how this problem occurred in Ohio**
- **Description of Ohio's public health response**
- **Lessons learned**
- **Opportunities to become involved**
- **Questions and Answers**

UPDATED STATE AND COUNTY DATA

Examine statewide data and produce materials to raise awareness about this issue:

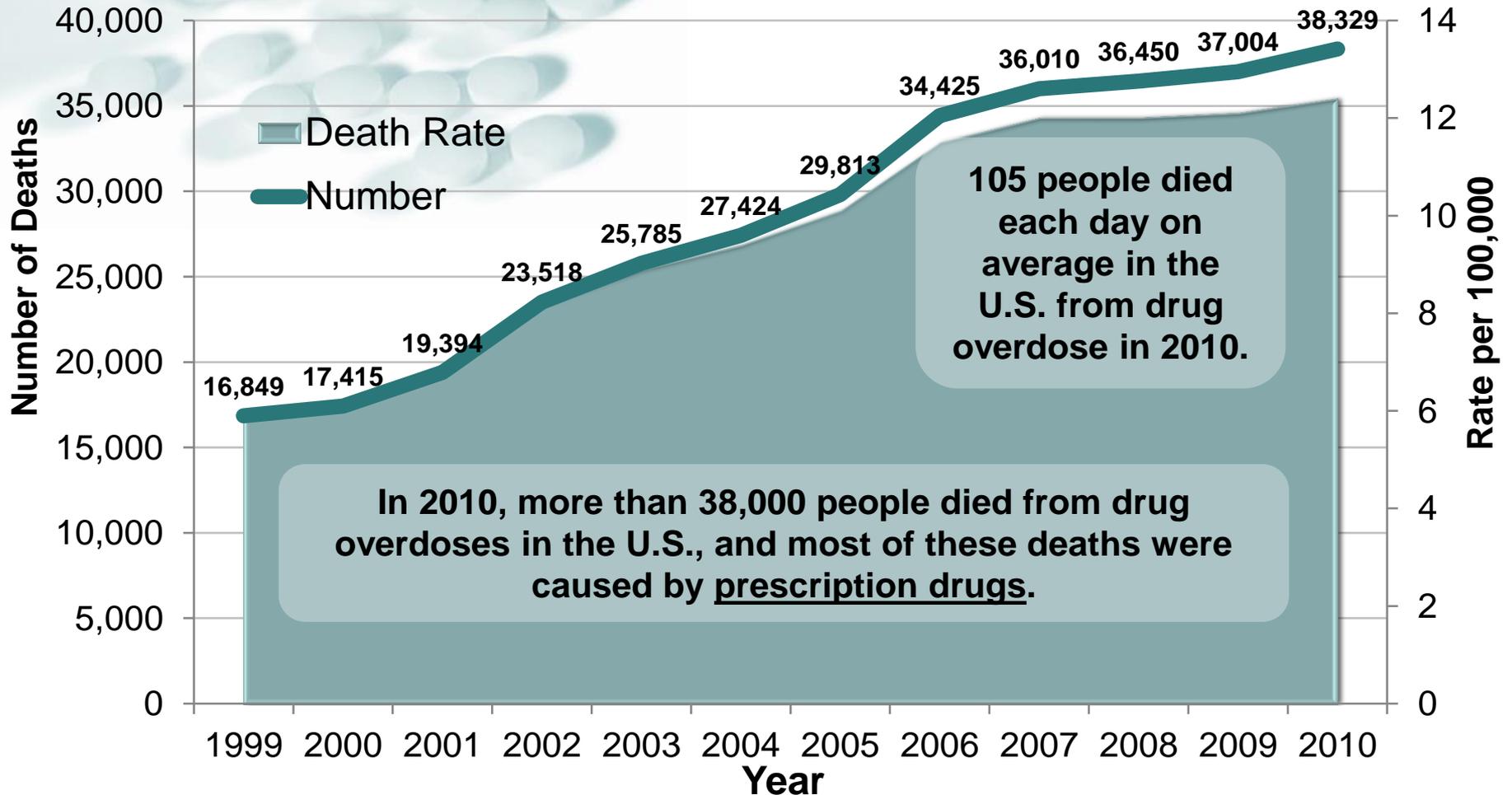
- **Web page:**

<http://www.healthyohioprogram.org/vipp/data/rxdata.aspx>

- State and County level data factsheets
- Presentations
- Resources

NATIONAL DATA

Number and Rate per 100,000 of Drug Overdose Deaths (all manners), U.S., 1999 – 2010*



*Source: CDC, WONDER Compressed Mortality File, NCHS

NATIONAL DATA: PUBLIC HEALTH IMPACT OF OPIOID OVERDOSE

In 2008, there were **14,800** prescription painkiller deaths.⁴

For every **1** death there are...



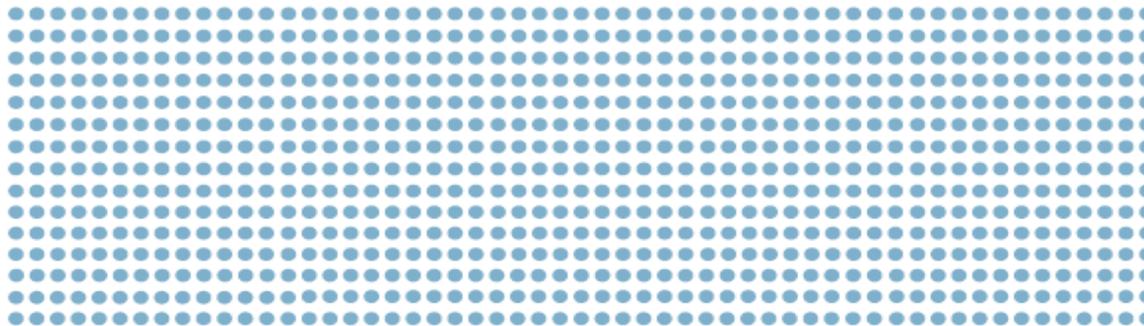
10 treatment admissions for abuse⁹



32 emergency dept visits for misuse or abuse⁶



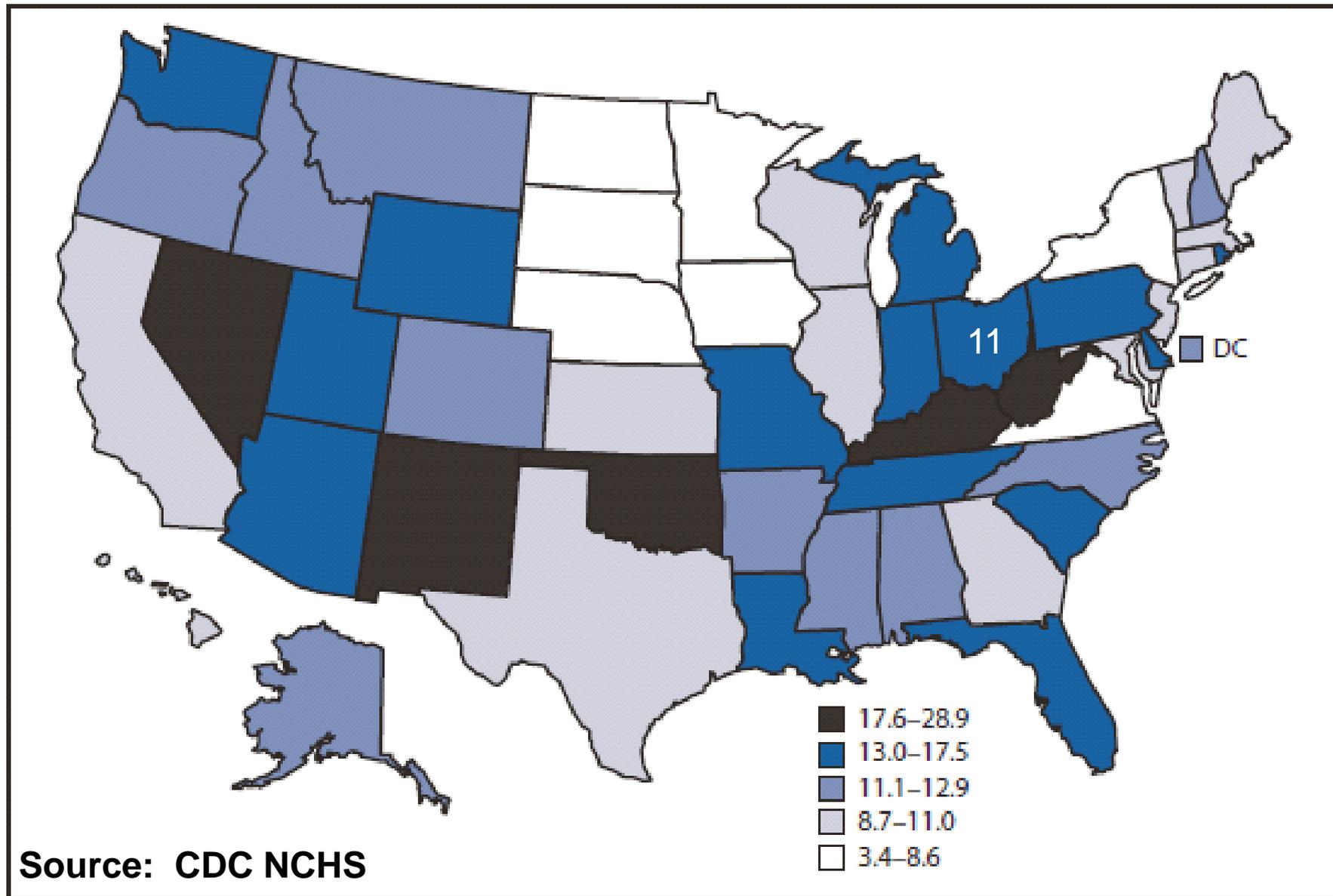
130 people who abuse or are dependent⁷



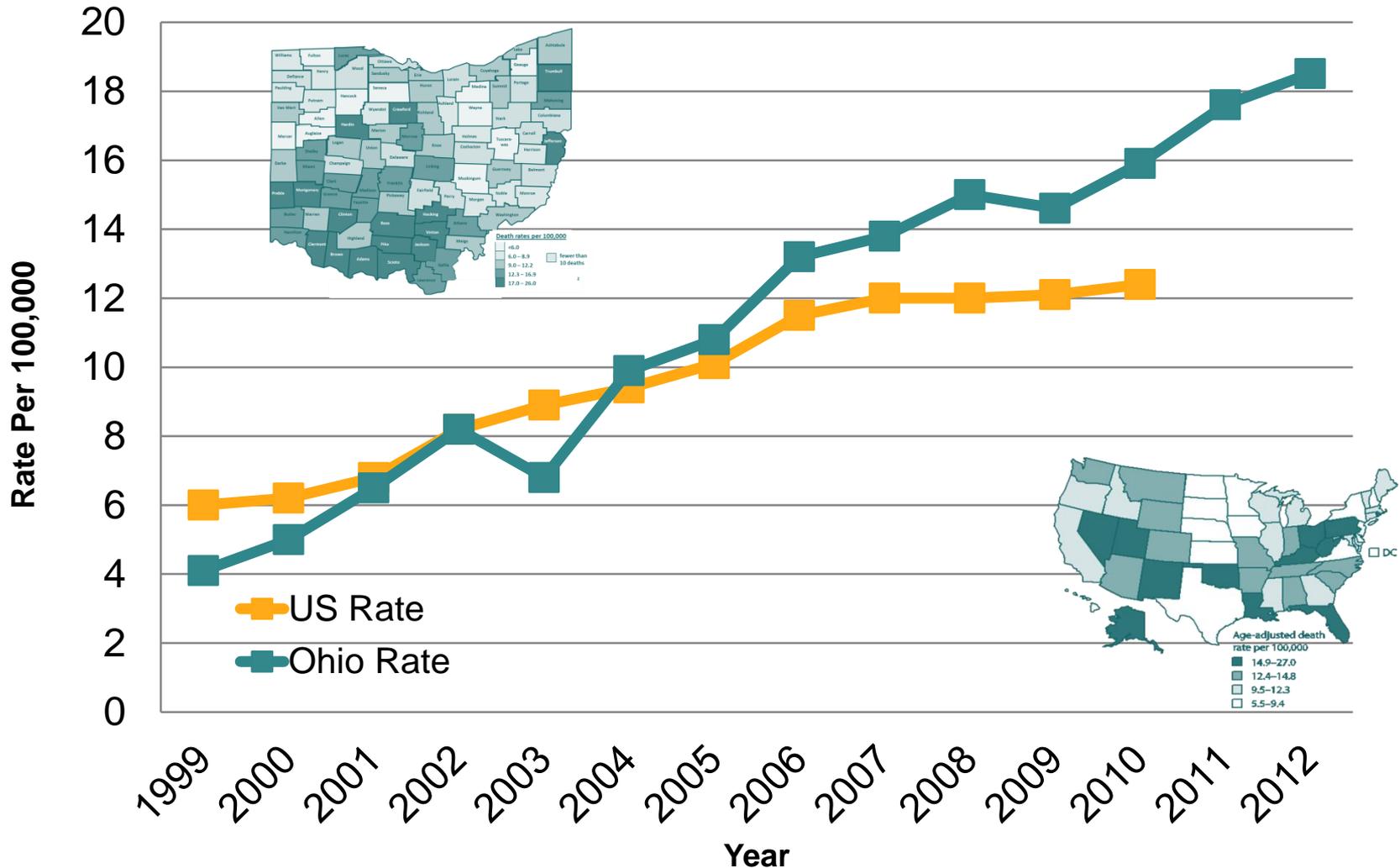
825
nonmedical
users⁷

Sources: ¹SAMHSA Treatment Episode Data Set (TEDS); ²Drug Abuse Warning Network (DAWN); ³National Survey of Drug Use in Households (NSDUH)

DRUG OVERDOSE DEATH RATES (ALL MANNER) PER 100,000 (2010), UNITED STATES

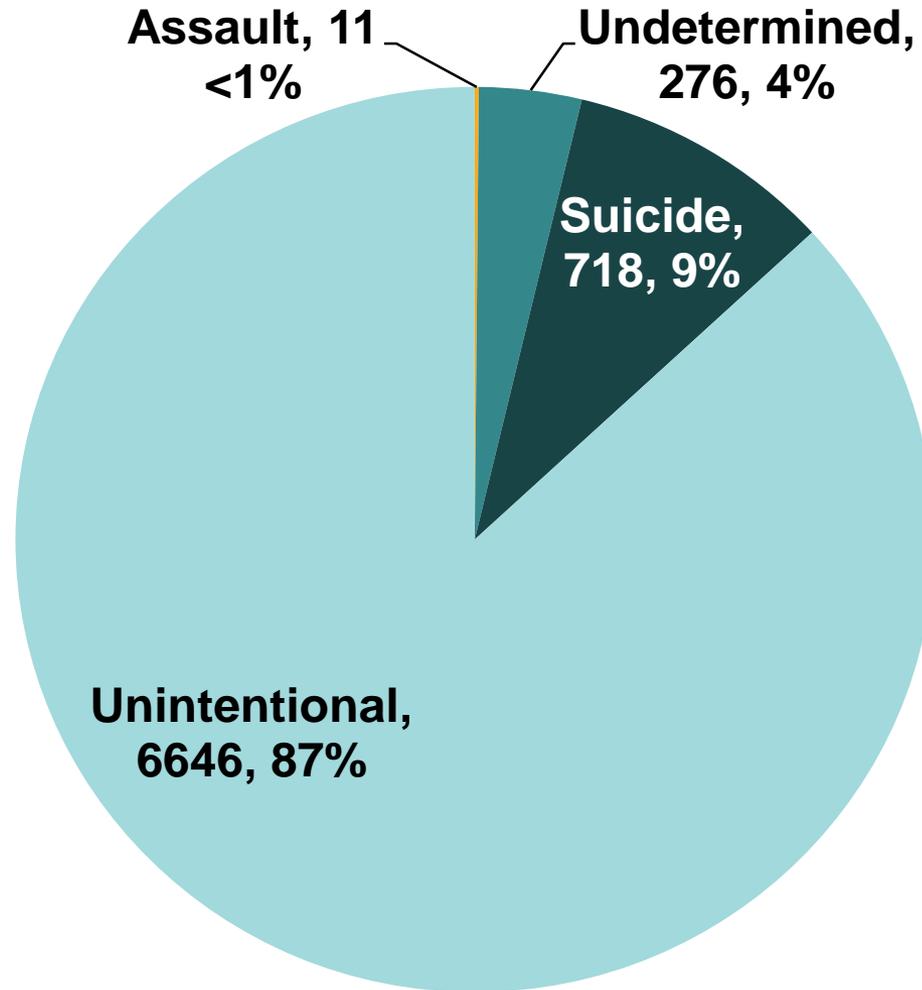


DEATH RATES PER 100,000 FOR DRUG POISONING (ALL MANNER), BY YEAR, OHIO VS. US, 1999-2012



¹Source: ODH Office of Vital Statistics

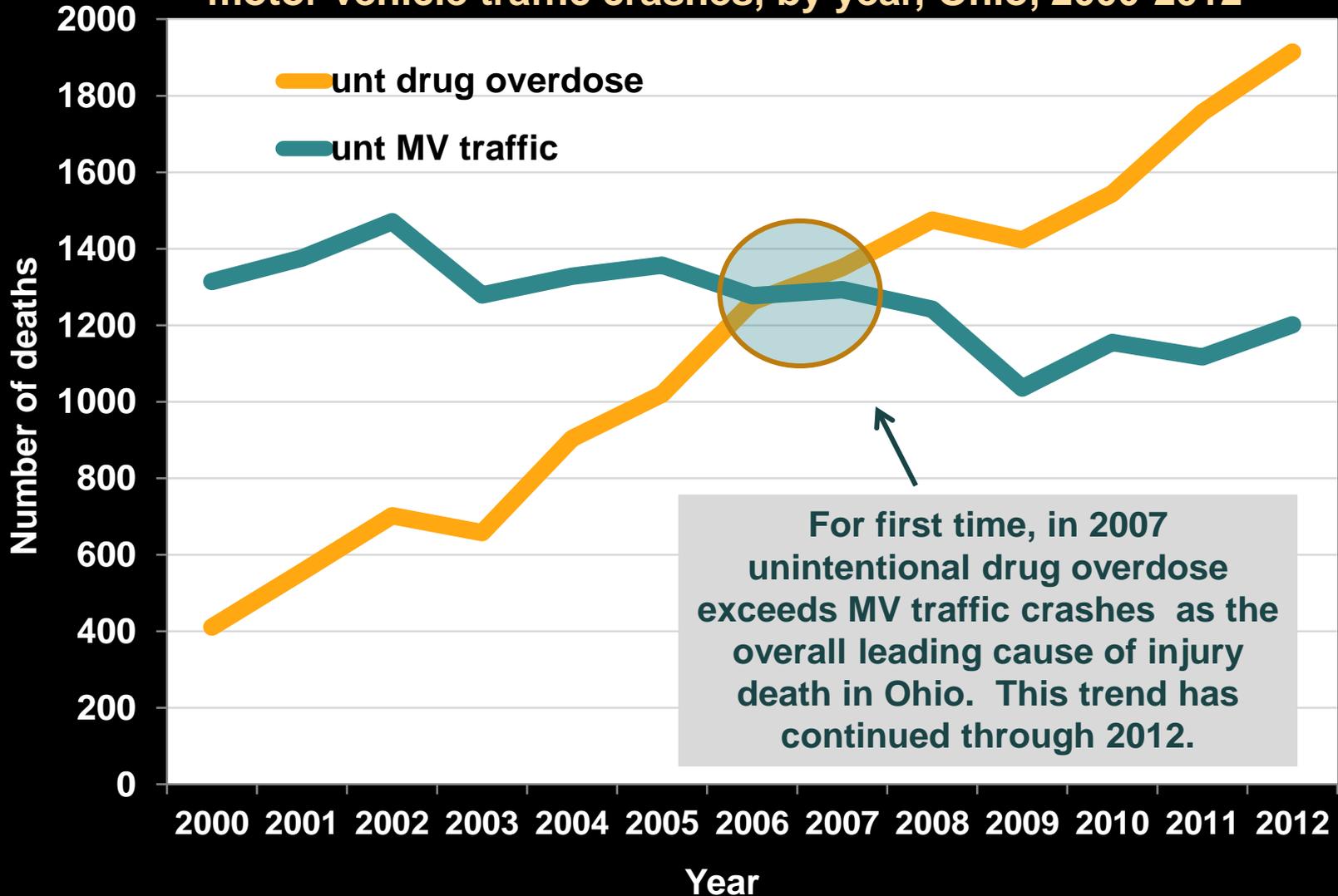
FATAL DRUG OVERDOSE BY INTENT, OHIO, 2009-12



¹Source: ODH Office of Vital Statistics,

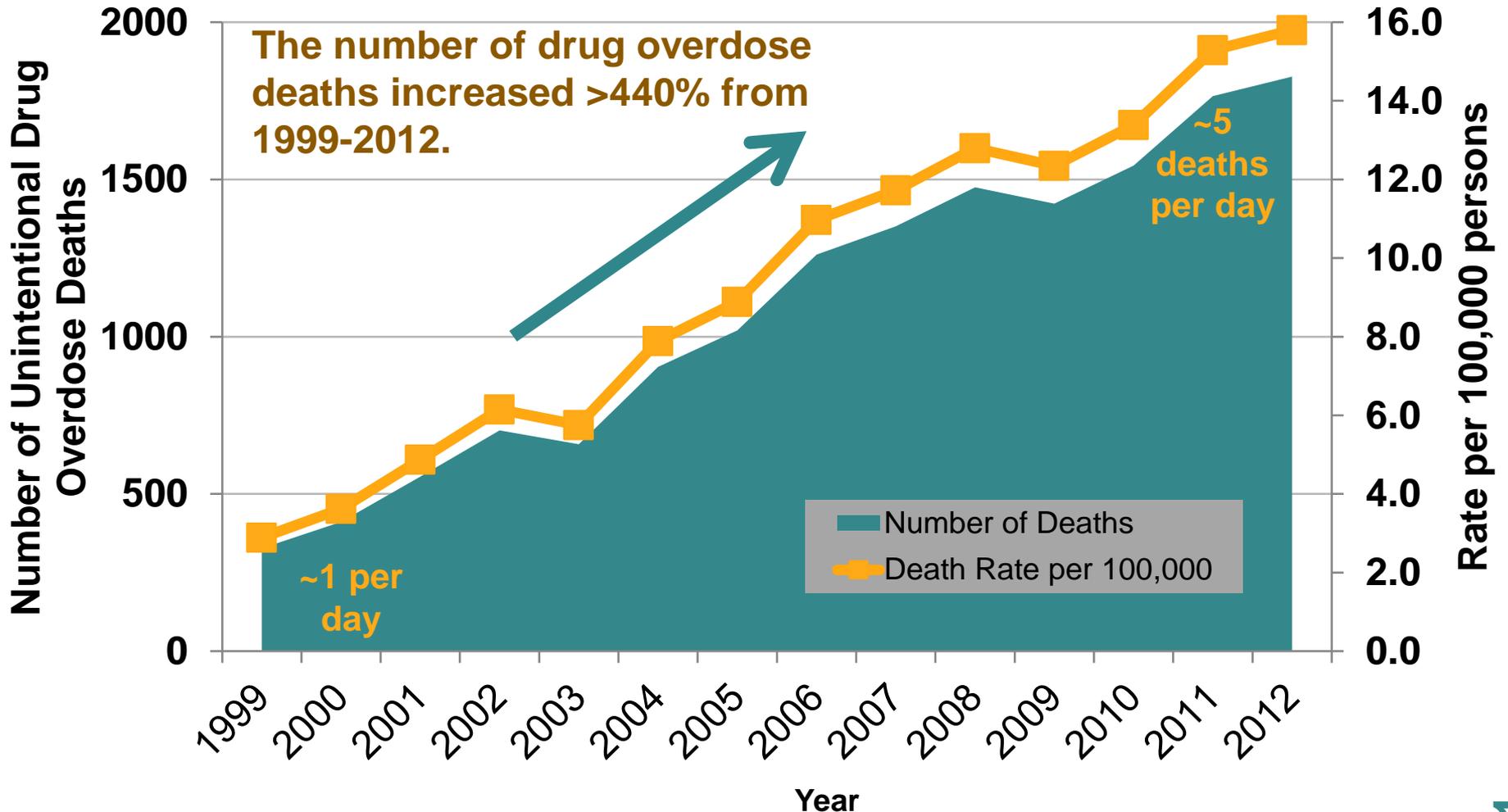
OHIO DATA

Number of deaths from unintentional drug overdoses & motor vehicle traffic crashes, by year, Ohio, 2000-2012



For first time, in 2007 unintentional drug overdose exceeds MV traffic crashes as the overall leading cause of injury death in Ohio. This trend has continued through 2012.

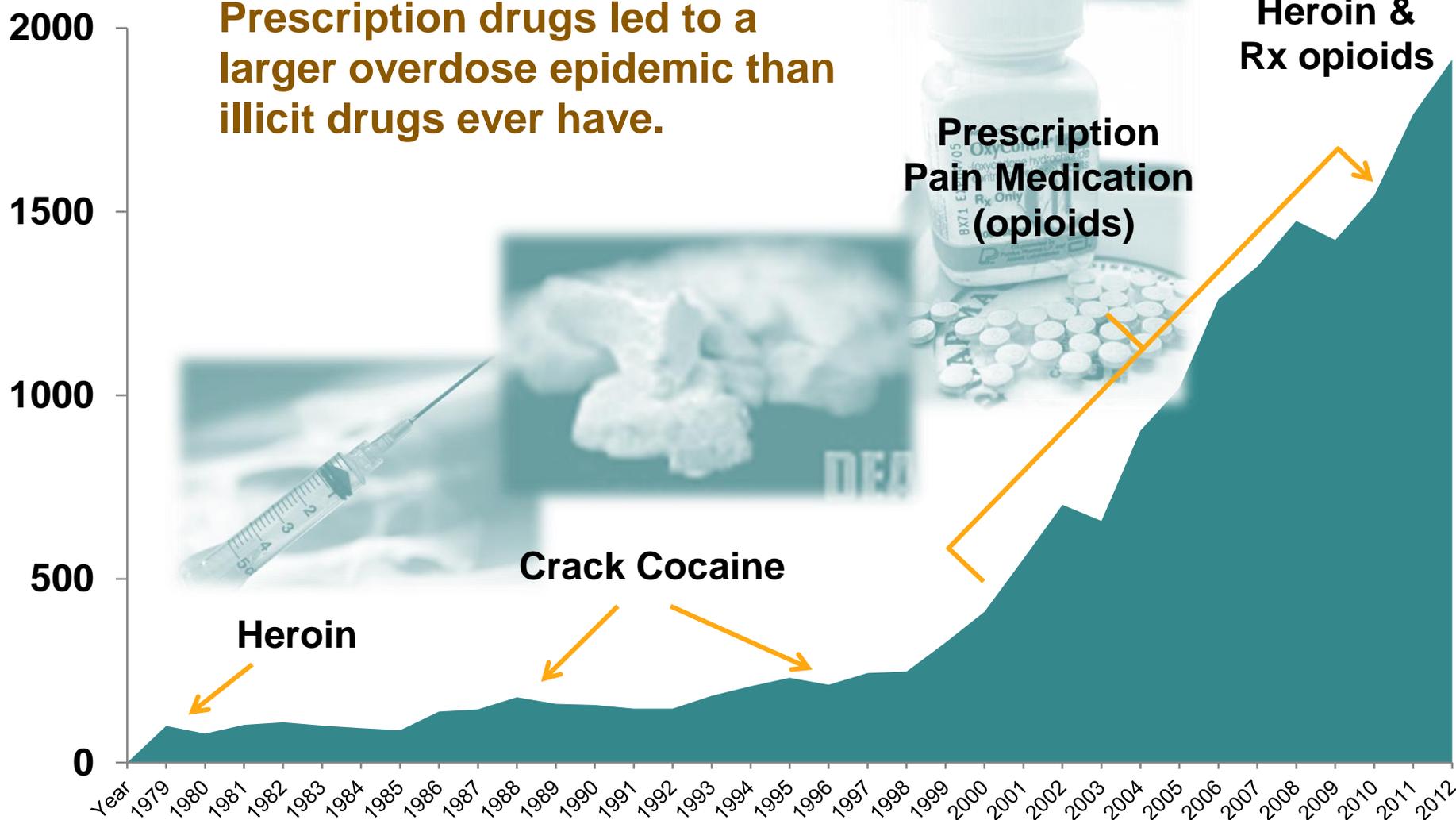
OHIO DEATHS AND DEATH RATES PER 100,000 DUE TO UNINTENTIONAL DRUG OVERDOSE BY YEAR, 1999-2012¹



¹Source: ODH Office of Vital Statistics,

EPIDEMICS OF UNINTENTIONAL DRUG OVERDOSES IN OHIO, 1979-2012^{1,2,3}

Prescription drugs led to a larger overdose epidemic than illicit drugs ever have.



Source: ¹WONDER (NCHS Compressed Mortality File, 1979-1998 & 1999-2005) ²2006-2011 ODH Office of Vital Statistics, ³Change from ICD-9 to ICD-10 coding in 1999 (caution in comparing before and after 1998 and 1999)

PRESCRIPTION DRUGS OVERDOSE

TYPE OF DRUGS AND REASONS FOR USE

Types of drugs

- **Drugs that depress breathing**
 - **Opioid analgesics – pain relievers**
 - Sedative/hypnotics
- **Usually multiple drugs involved**
- Often combined with illicit drugs

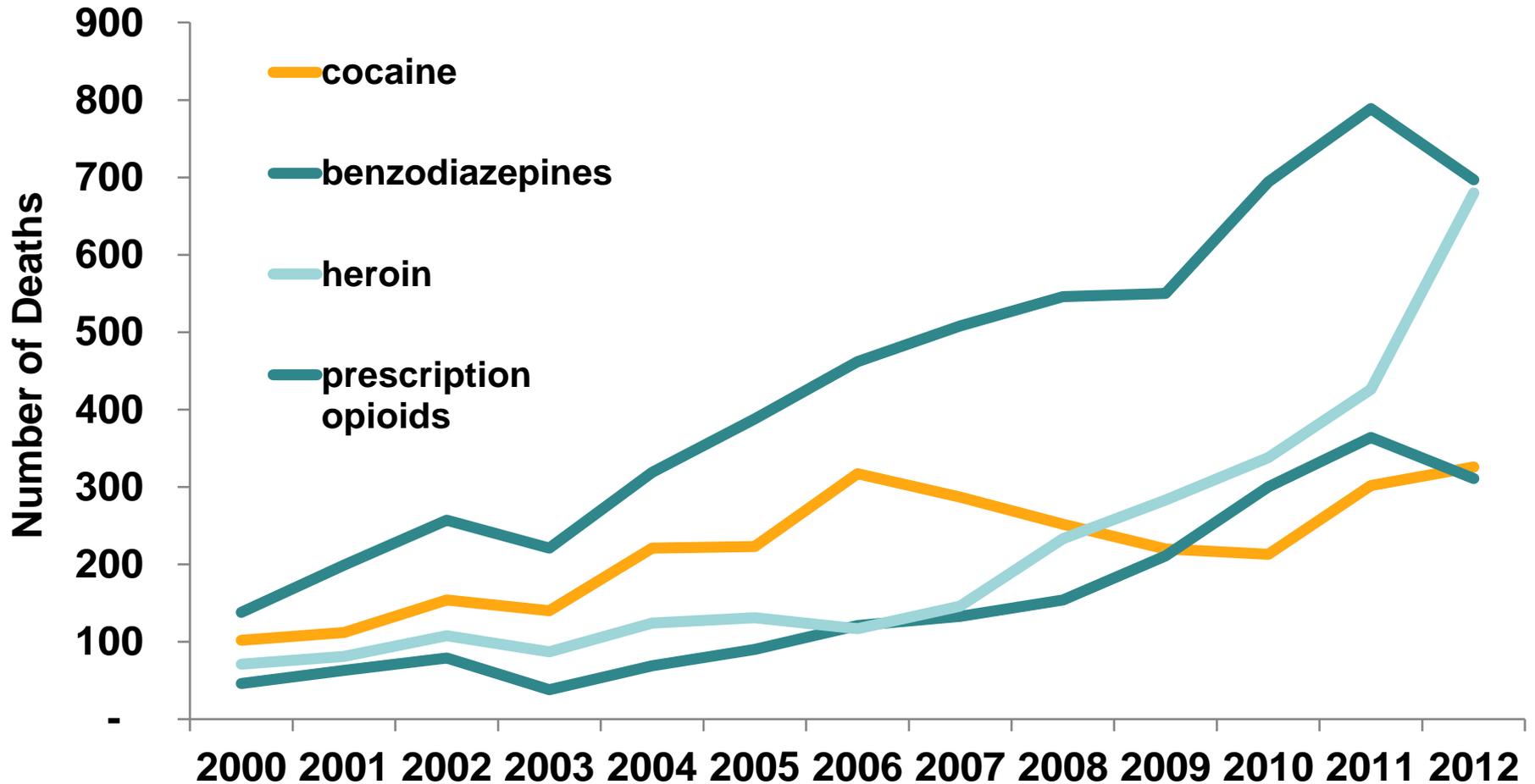


Reason for use

- **Original use of drug might have been their intended purpose: relief of pain or anxiety**
- Development of tolerance
- Escalated use for “high”

Unintentional drug overdose deaths of Ohio residents by specific drug(s) involved, by year, 2000-2012^{1,2}

Still more deaths from prescription opioids than from cocaine, heroin, and marijuana combined.

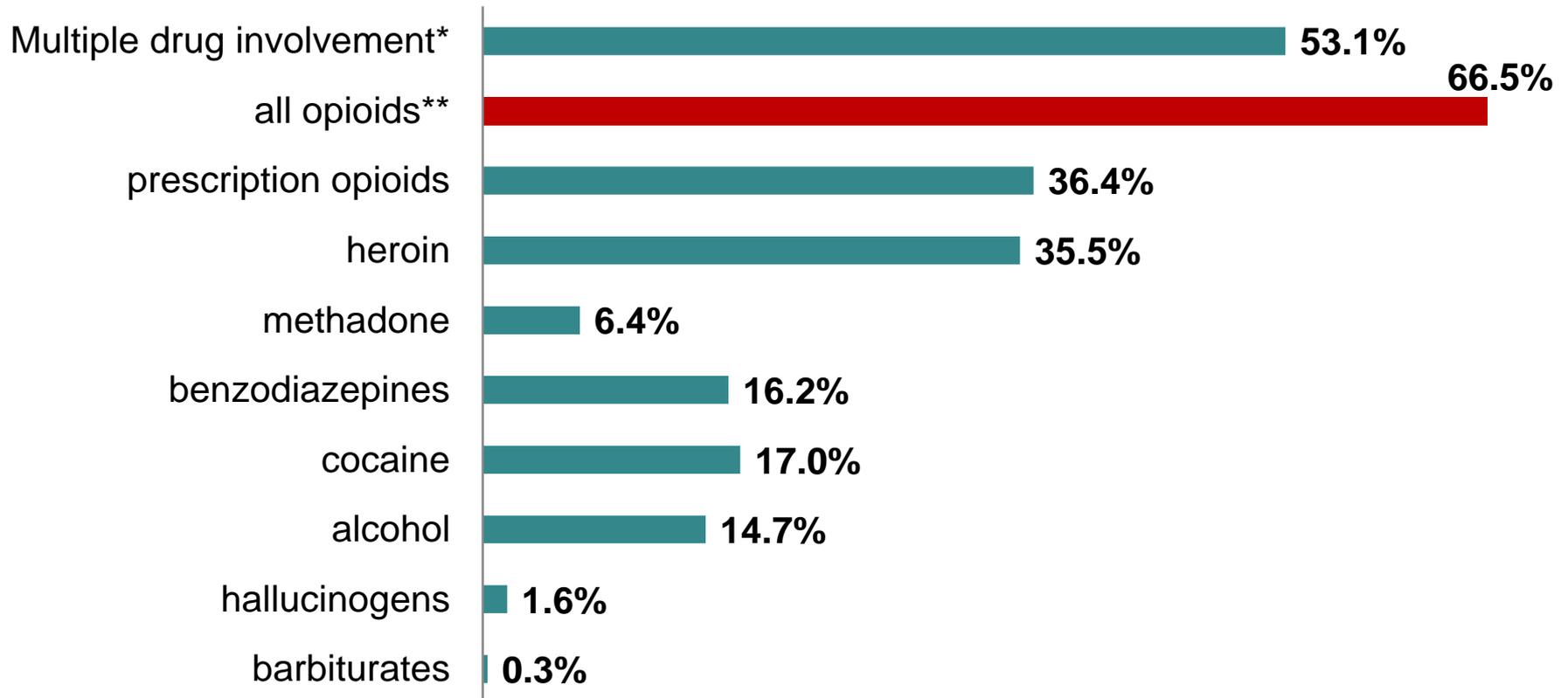


²Multiple substances are usually involved in one death.

PROPORTION OF ALL UNINTENTIONAL DRUG OVERDOSE DEATHS INVOLVING SELECTED DRUGS, OHIO, 2012^{1,2}

¹Source: ODH Office of Vital Statistics

²Multiple substances are usually involved in one death.



* Includes only deaths where the number of substances was specified; number unspecified in 20% of 2012 overdose deaths.

**Includes involvement of prescription opioids and/or heroin.

***No specific drug was identified

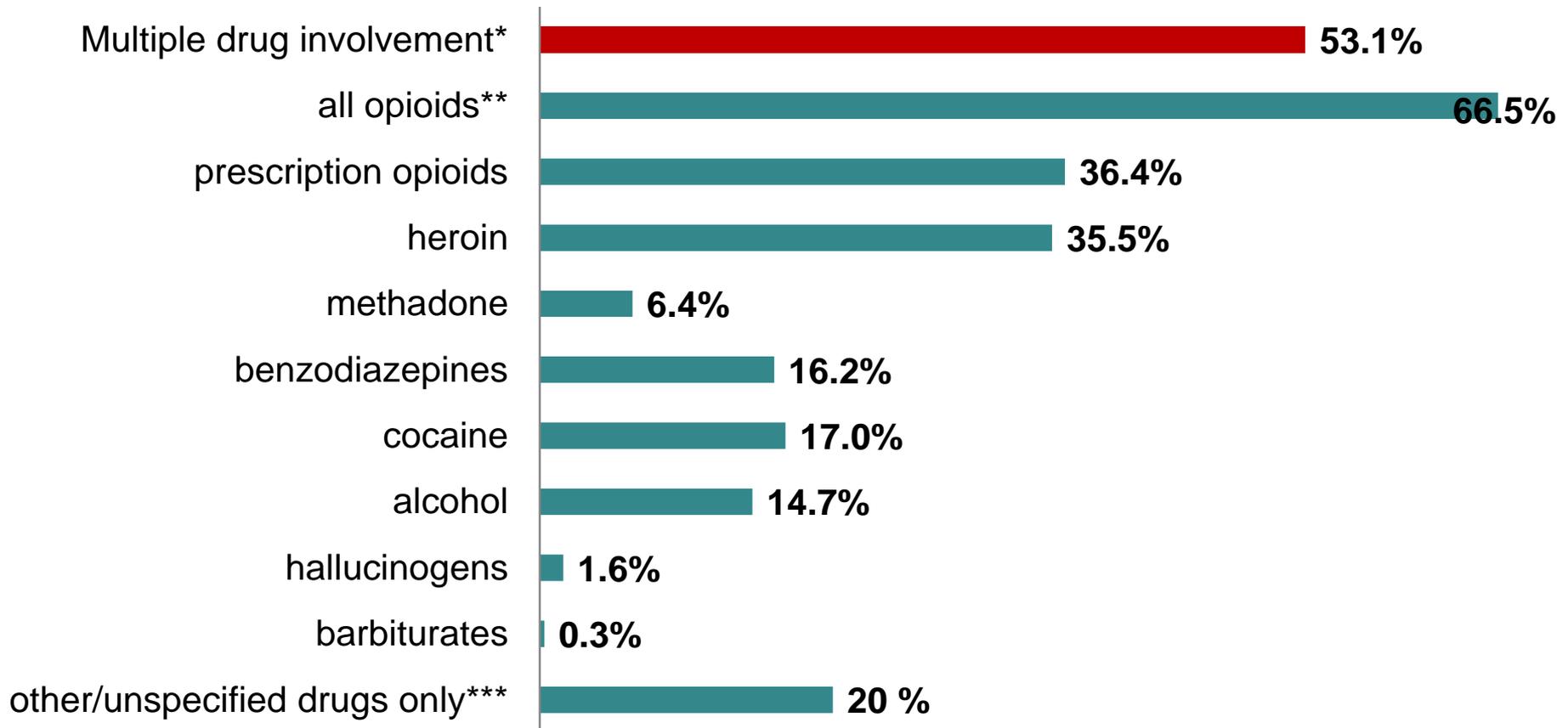


USE OF MULTIPLE DRUGS

PROPORTION OF ALL UNINTENTIONAL DRUG OVERDOSE DEATHS INVOLVING SELECTED DRUGS, OHIO, 2012^{1,2}

¹Source: ODH Office of Vital Statistics

²Multiple substances are usually involved in one death.



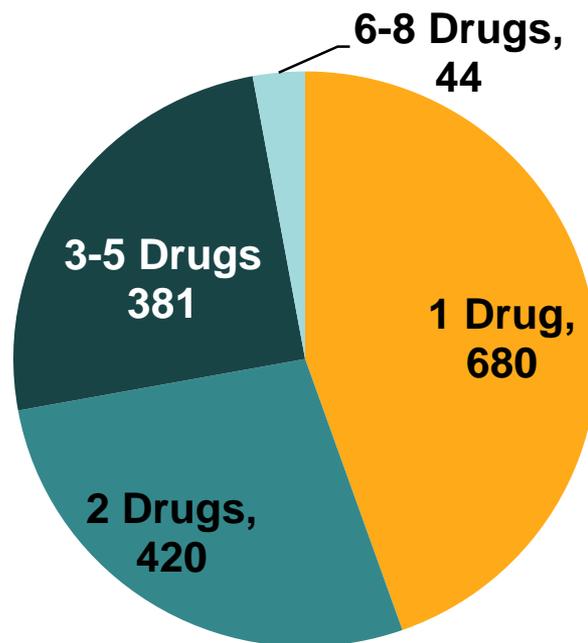
* Includes only deaths where the number of substances was specified; number unspecified in 20% of 2012 overdose deaths.

**Includes involvement of prescription opioids and/or heroin.

***No specific drug was identified

Number of Drugs Involved in Drug Overdose Deaths, Ohio Residents, 2012 (N=1,914)

- In 20% of deaths, the specific number of drugs was unknown.
- Multiple drugs are involved in most overdoses.
- Most (42%) involved 2-5 drugs.
- 36% had only 1 drug listed on the DC; 64% had more than 1

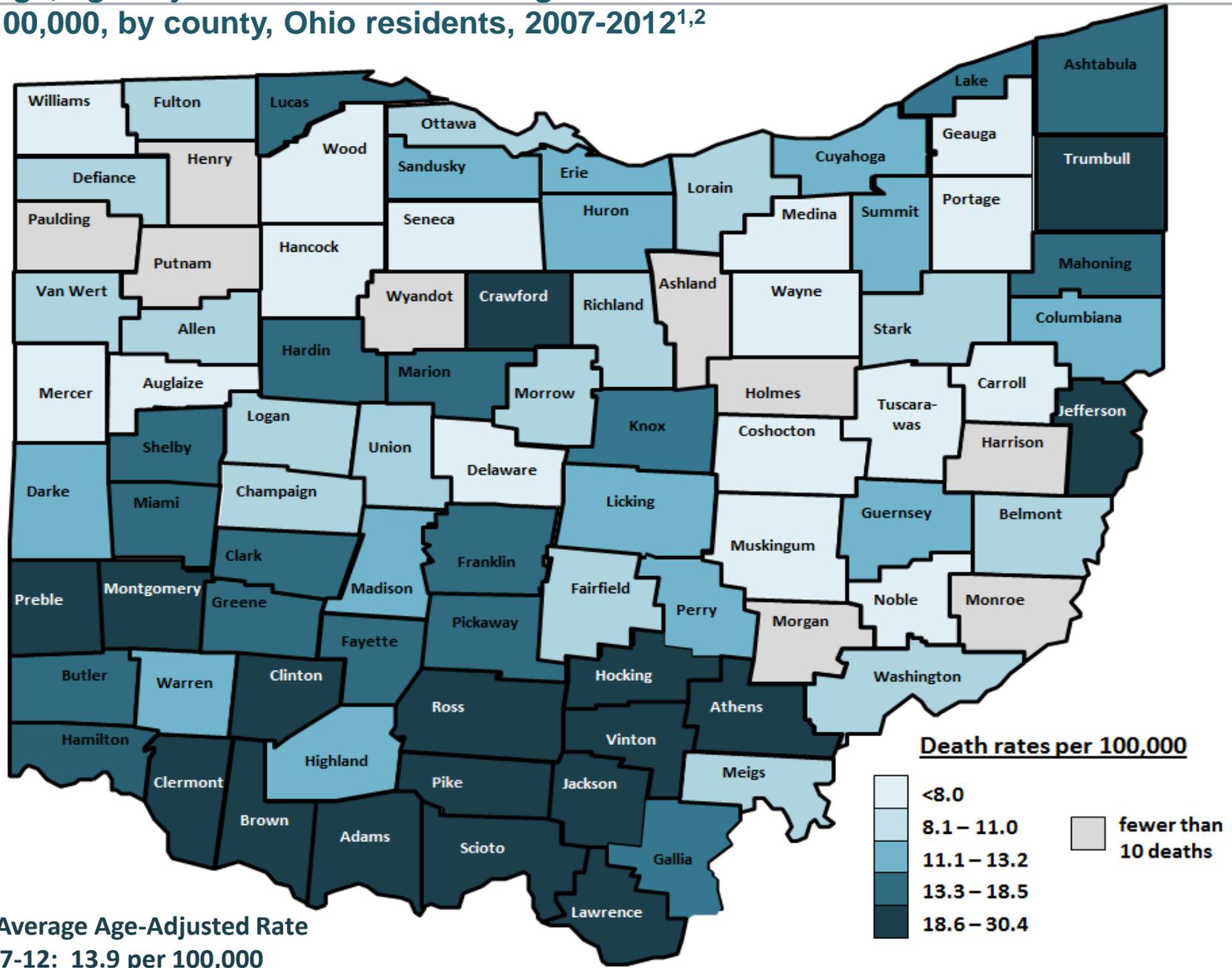


OHIO'S OPIOID EPIDEMIC

WHO IS IMPACTED?

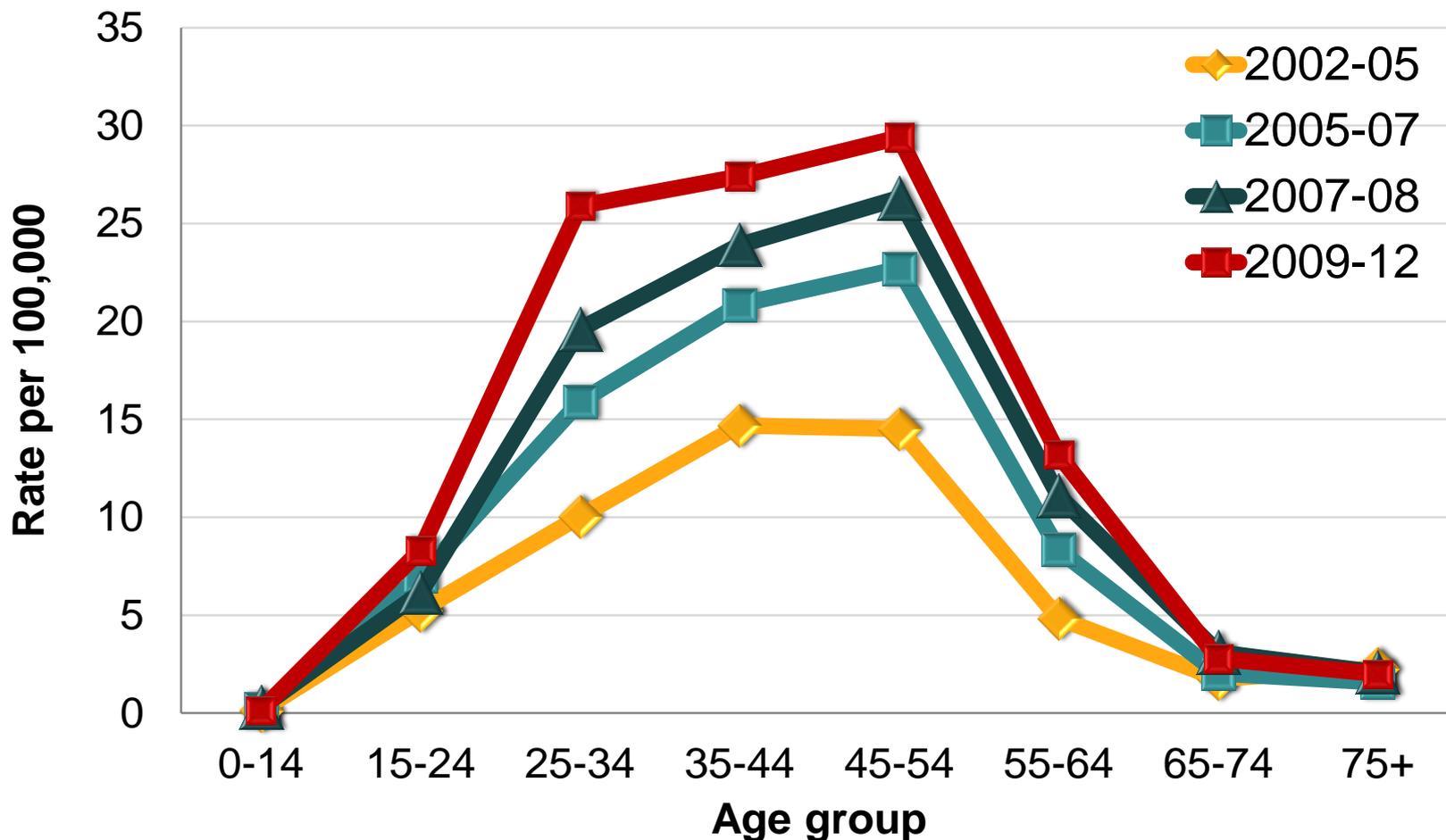


Average, age-adjusted unintentional drug overdose death rate per 100,000, by county, Ohio residents, 2007-2012^{1,2}



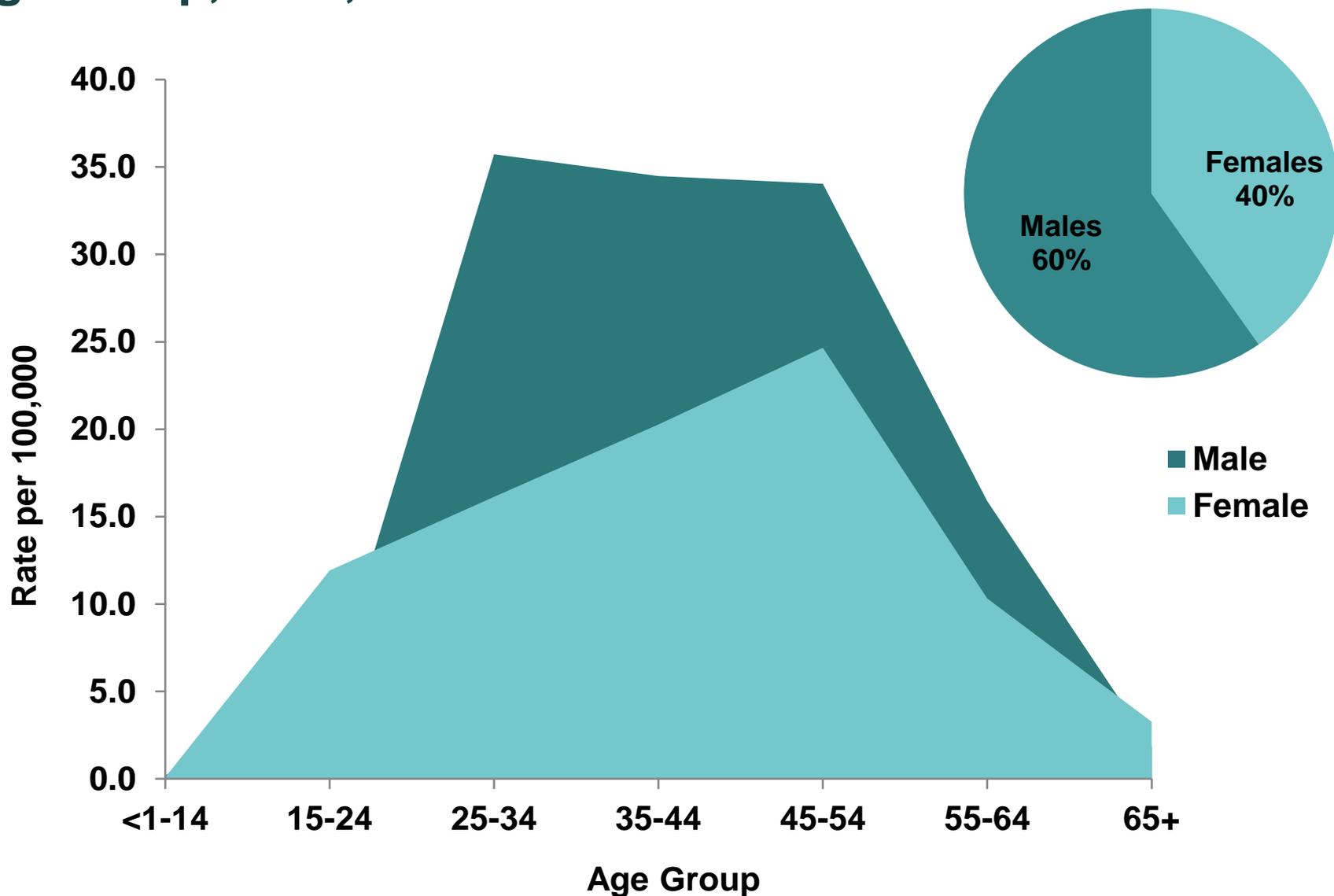
Ohio Average Age-Adjusted Rate
'07-12: 13.9 per 100,000

AVERAGE UNINTENTIONAL DRUG OVERDOSE DEATH RATE BY AGE GROUP, OVER TIME, OHIO RESIDENTS, 2002-2012



Source: Ohio Department of Health, Office of Vital Statistics

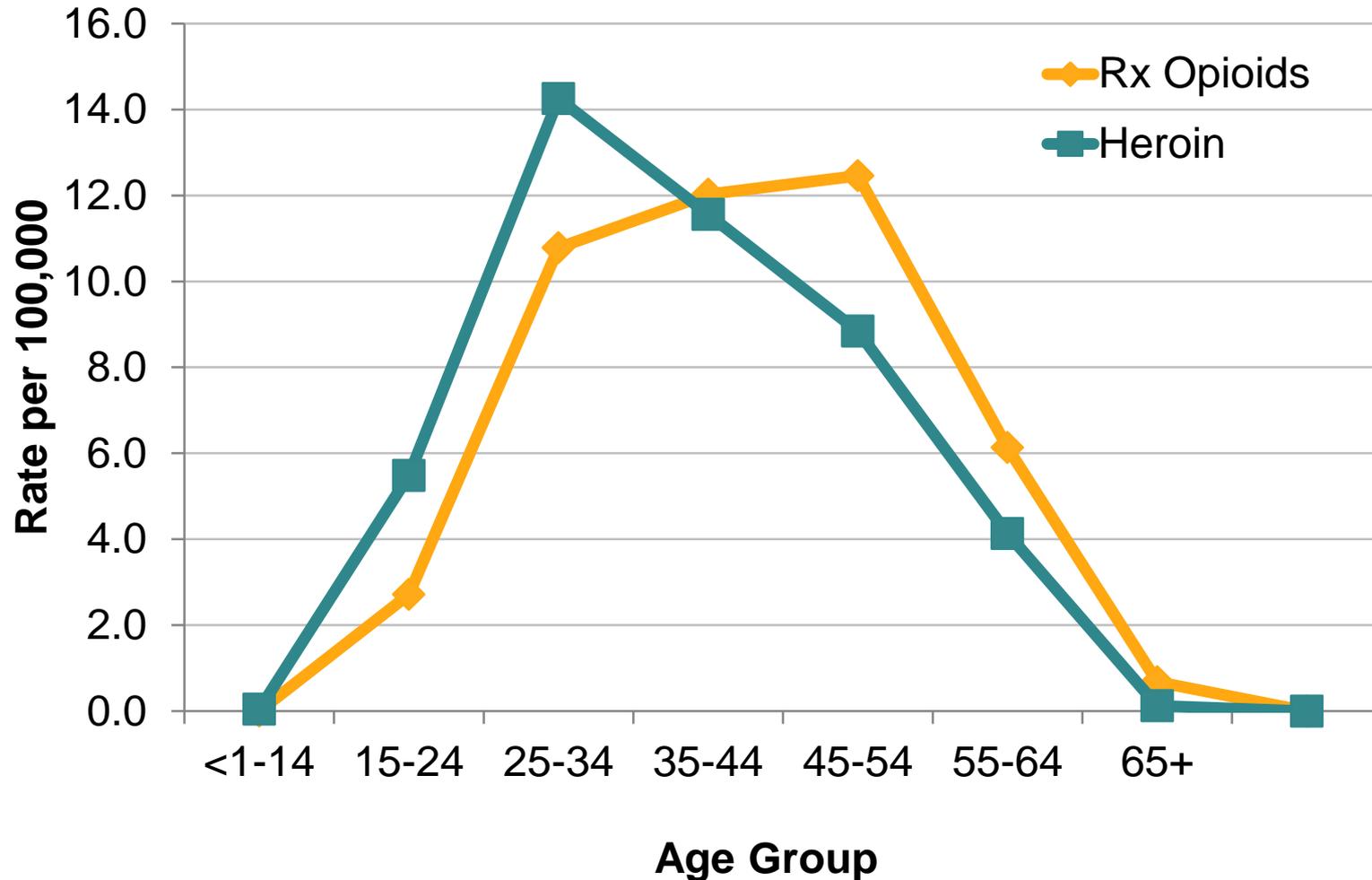
Average Annual Unintentional Fatal Overdose Rate¹ by Sex, Age Group, Ohio, 2009-12



Source: Ohio Department of Health, Vital Statistics

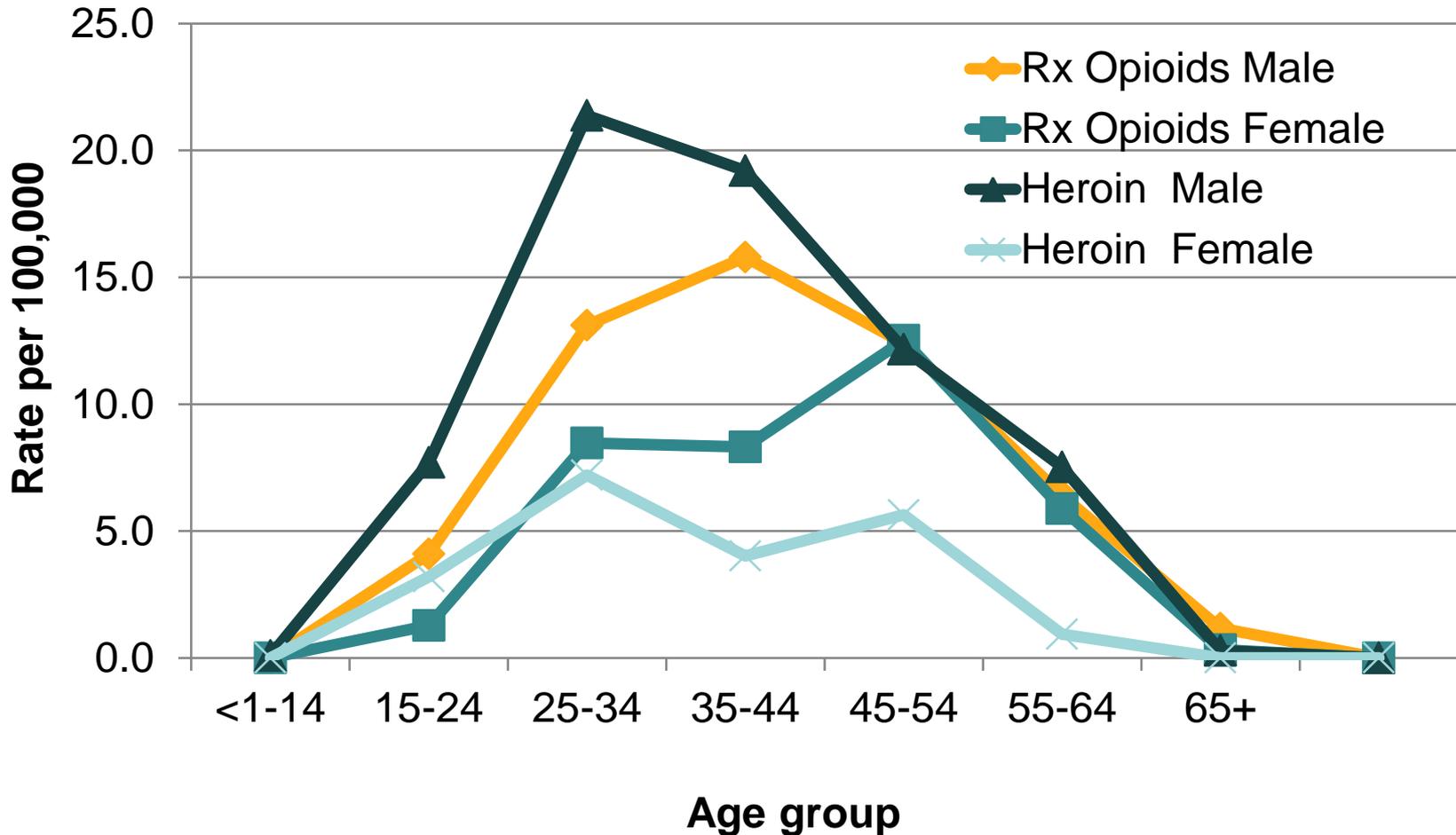
ODH Violence and Injury Prevention Program

DEATH RATES FROM UNINTENTIONAL OVERDOSE INVOLVING HEROIN AND PRESCRIPTION OPIOIDS, BY AGE GROUP, OHIO, 2012



Source: Ohio Department of Health, Vital Statistics

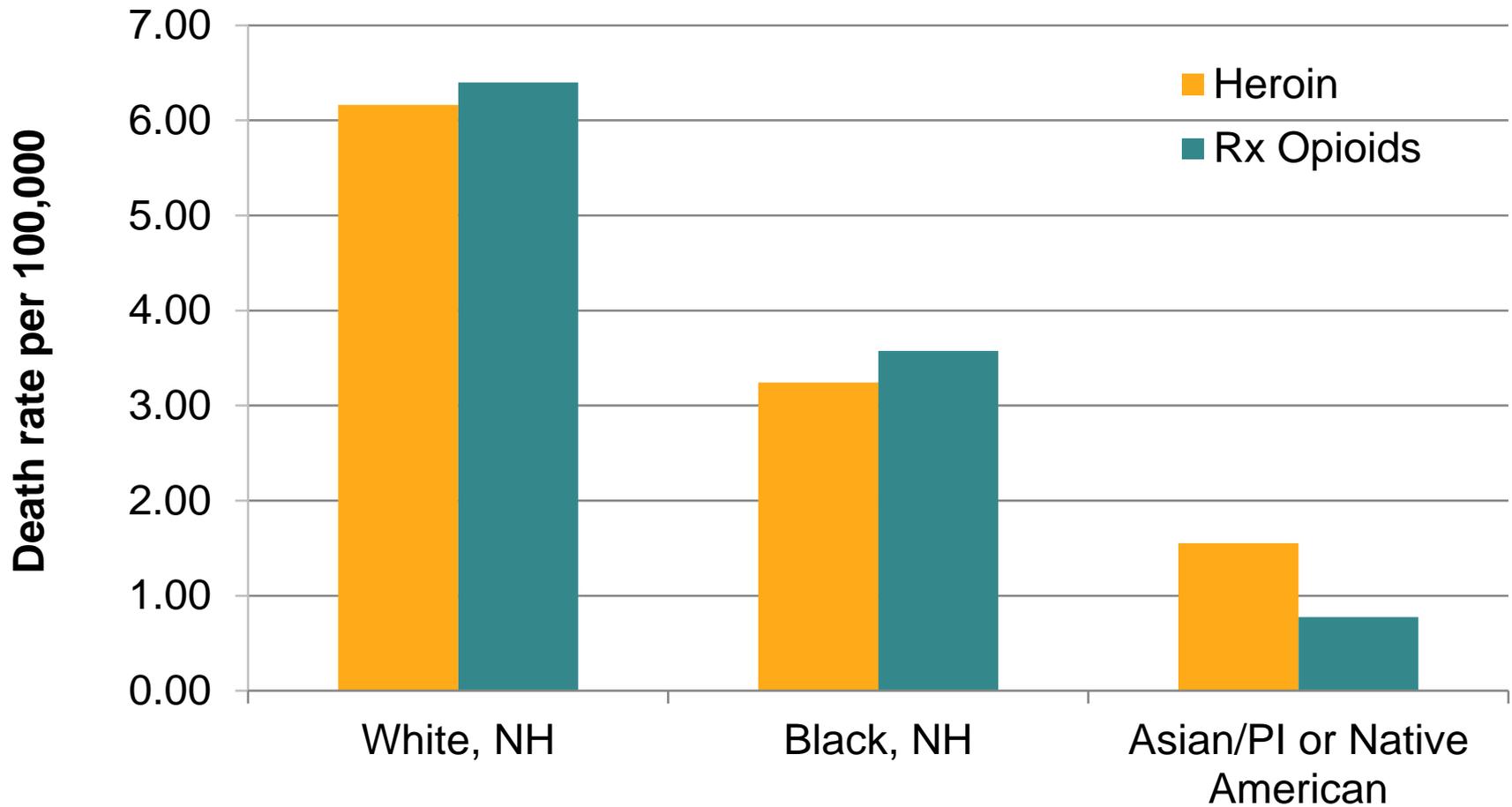
DEATH RATES FROM UNINTENTIONAL OVERDOSE INVOLVING HEROIN AND PRESCRIPTION OPIOIDS BY AGE AND SEX, OHIO, 2012



Source: Ohio Department of Health, Vital Statistics

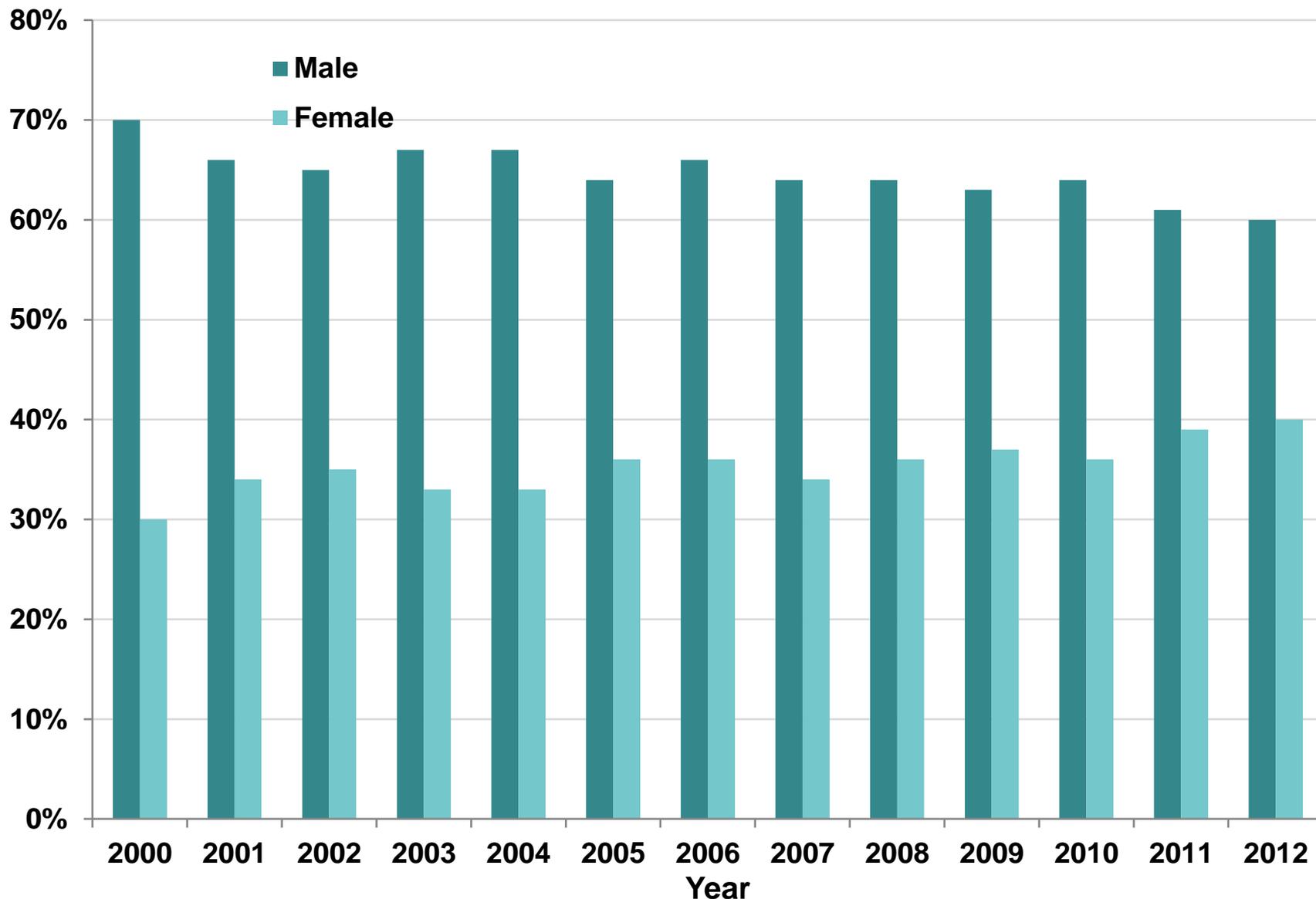
ODH Violence and Injury Prevention Program

DEATH RATES FROM UNINTENTIONAL OVERDOSES INVOLVING HEROIN AND PRESCRIPTION OPIOIDS, BY RACE, OHIO, 2012



Source: Ohio Department of Health, Vital Statistics

Proportion of Unintentional Overdose Deaths by Sex and Year, Ohio, 2000 - 2012^{1,2}



Source: Ohio Department of Health, Vital Statistics

HIGH RISK GROUPS FOR OPIOID ABUSE AND DEATH

White males ages 25-54

Females 45-54

Medicaid populations

Rural populations

Mentally ill, especially people with depression

Illness



HIGH RISK GROUPS FOR OPIOID ABUSE AND DEATH

Change in Tolerance

Using Alone

**Mixing with Other CNS
Depressants**



TEENS AND PRESCRIPTION DRUG ABUSE

According to surveys:

- In 2011, more than 1 in 5 (21%) Ohio high school students reported using a prescription drug without a doctor's prescription one or more times during their life. Of these teens, nearly half (49%) used narcotic pain relievers, 8 percent used multiple drugs and another 19 percent were unsure what they took.¹
- Every day, 2,700 teens abuse a prescription drug for the first time.²
- 8 out of 10 teens who misuse prescription drugs get the drugs from friends or relatives²

Sources: 1. ODH, Ohio Youth Risk Behavior Survey, 2011

2. SAMHSA's National Survey on Drug Use and Health

ODH Violence and Injury Prevention Program

OHIO'S OPIOID EPIDEMIC

HOW DID THIS OCCUR?



CONTRIBUTING FACTORS

SUPPLY



DEMAND

“Legal”

- Growth in Overall Rx Drug Use
- New Clinical Rx Pain Management Guidelines
- Aggressive marketing of new extended-release opioids
- General over prescribing
- Pressure to satisfy “customers” in HC

“Illegal”

- Widespread Diversion of Rx Drugs through multiple channels:
 - Internet “pharmacies”
 - “Pill mills” and unscrupulous prescribers

Perceived Safety of Prescription Drugs

Substance Misuse/Abuse

- Diversion
- Doctor Shopping

HC consumers seen as “customers”

CONTRIBUTING FACTORS:

INCREASE IN MEDICATION USE & MISUSE*

- 2 out of 3 patients who visit a doctor leave with at least one prescription for medication
- Close to 40% receive prescriptions for four or more medications.
- Half of the prescriptions taken each year in the US are used improperly
- 96% of patients nationwide fail to ask questions about how to use their medications.



Spending in the US for prescription drugs was \$234.1 billion in 2008, nearly 6 times the \$40.3 billion spent in 1990.

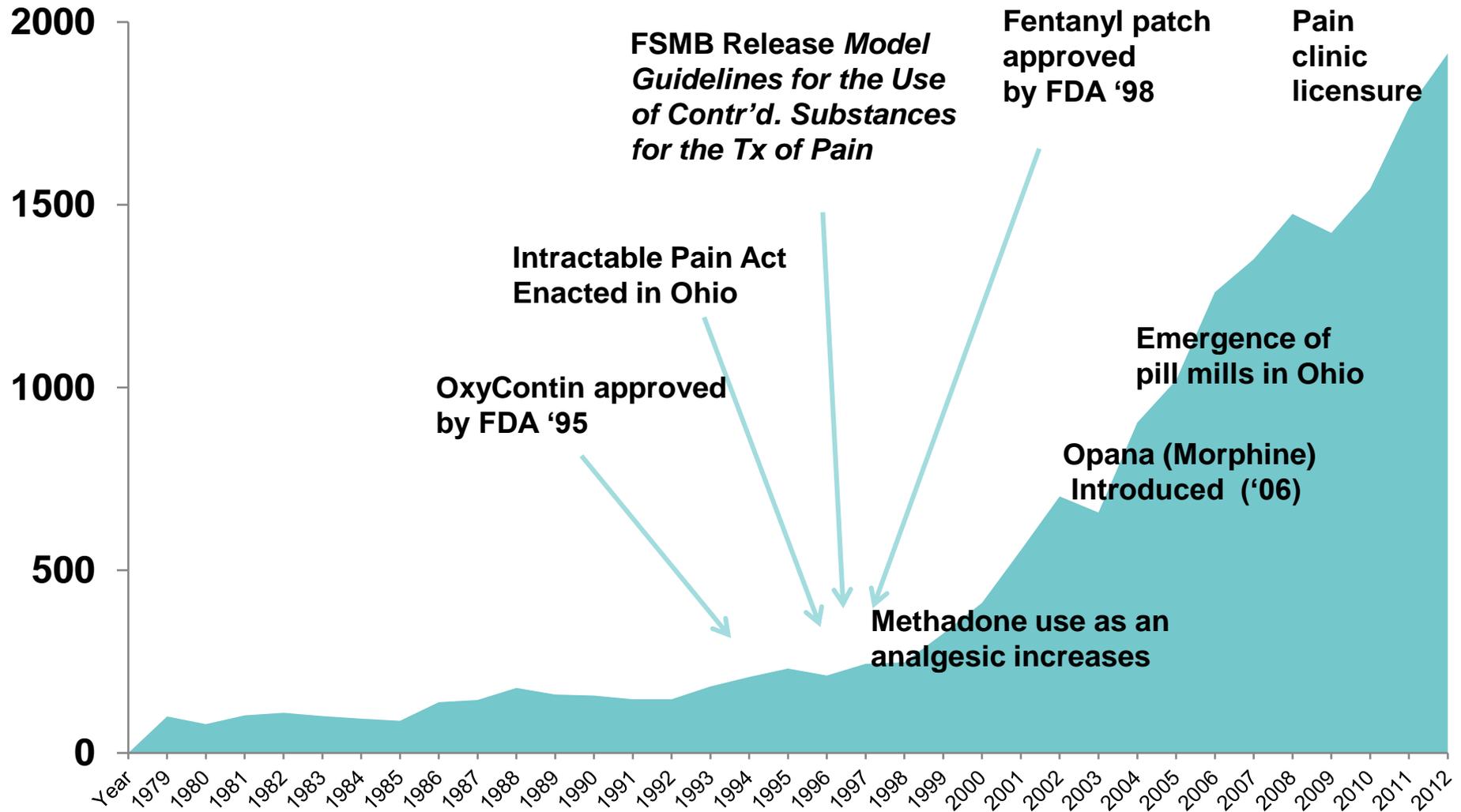
CONTRIBUTING FACTORS:

PAIN MANAGEMENT AND OPIOID PRESCRIBING TRENDS FROM LATE 1990'S TO PRESENT



CONTRIBUTING FACTORS:

EPIDEMICS OF UNINTENTIONAL DRUG OVERDOSE AND SIGNIFICANT EVENTS, OHIO 1979-2012^{1,2,3}



Source: ¹WONDER (NCHS Compressed Mortality File, 1979-1998 & 1999-2005) ²2006-2011 ODH Office of Vital Statistics, ³Change from ICD-9 to ICD-10 coding in 1999 (caution in comparing before and after 1998 and 1999)

CONTRIBUTING FACTORS:

NEW OPIOIDS RELEASED, 1990'S

New extended-release (e.g., OxyContin® fentanyl patches) and long-acting opioids for chronic pain.

New uses for drugs (e.g. methadone)

Aggressive marketing of these new opioids to PCPs for a wide variety of conditions without adequate warning of risks.^{1,2,3}

Sources:

1. FDA Warning Letters and Notice of Violation Letters to Pharmaceutical Companies; FDA issues warning letter to Purdue Pharma for the marketing of OxyContin, 2003.)
2. *OxyContin Class Action Lawsuit to Proceed*. CMAJ, SEPT. 30, 2003; 169 (7). 699-b.
3. Prescription Drugs: OxyContin Abuse and Diversion and Efforts to Address the Problem, US General Accounting Office, Report to Congressional Requestors, December 2003.
<http://www.gao.gov/new.items/d04110.pdf>

CONTRIBUTING FACTORS:

CHANGES IN CLINICAL PAIN MANAGEMENT PRESCRIBING PRACTICES IN LATE 1990'S

In 1998 the Federation of State Medical Boards of the United States, Inc. provided its policy document

- **Model Guidelines for the Use of Controlled Substances for the Treatment of Pain**

Recognition of Pain as the “5th Vital Sign”

Pain relief laws being pushed down to states to address liability concerns among prescribers.

- **Ohio Revised Code 4731.21 Drug Treatment of Intractable Pain, 1997**

Contributed to increased availability of potent pain medications in the community setting that had been previously restricted to hospital use for pain (e.g., end-stage cancer) patients.

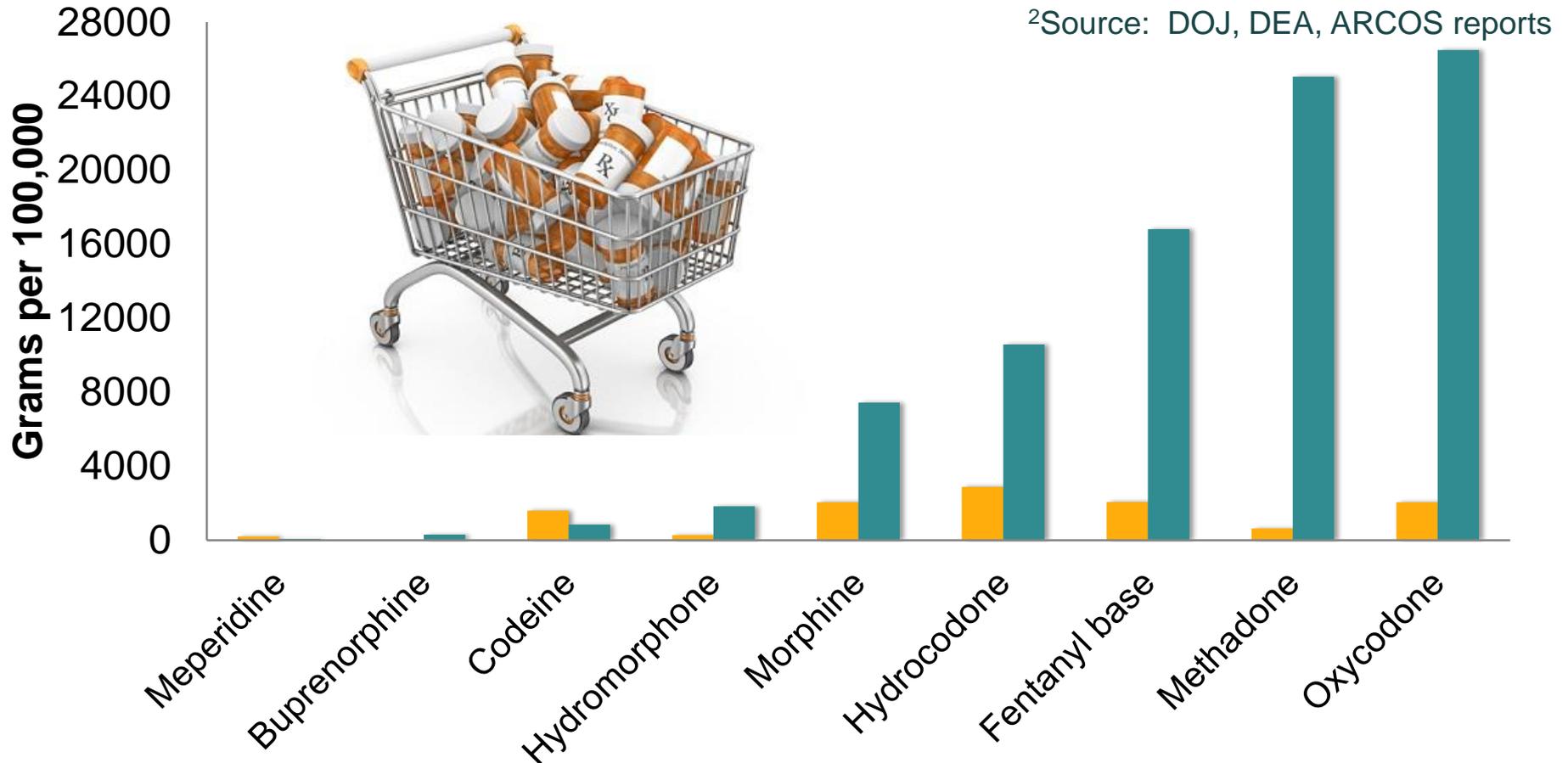
**Intractable Pain Relief Act*

FACTORS RESPONSIBLE FOR INCREASED DEMAND IN MANAGING CHRONIC PAIN

- Pharmaceutical companies marketing
- Numerous organizations providing clinical pain management guidelines
- Patient advocacy groups
 - Enactment of patient's bill of rights in many states
 - Perceived patient's right to pain relief
- Perceived legitimacy and safety prescription drugs
- Increasing prescription drug diversion
 - Increased availability to internet
 - "Pill Mills"
 - High street value of prescription drugs

CONTRIBUTING FACTORS:

Distribution of opioids¹ to retail pharmacies in grams per 100,000 by drug, Ohio, 1997 to 2011²



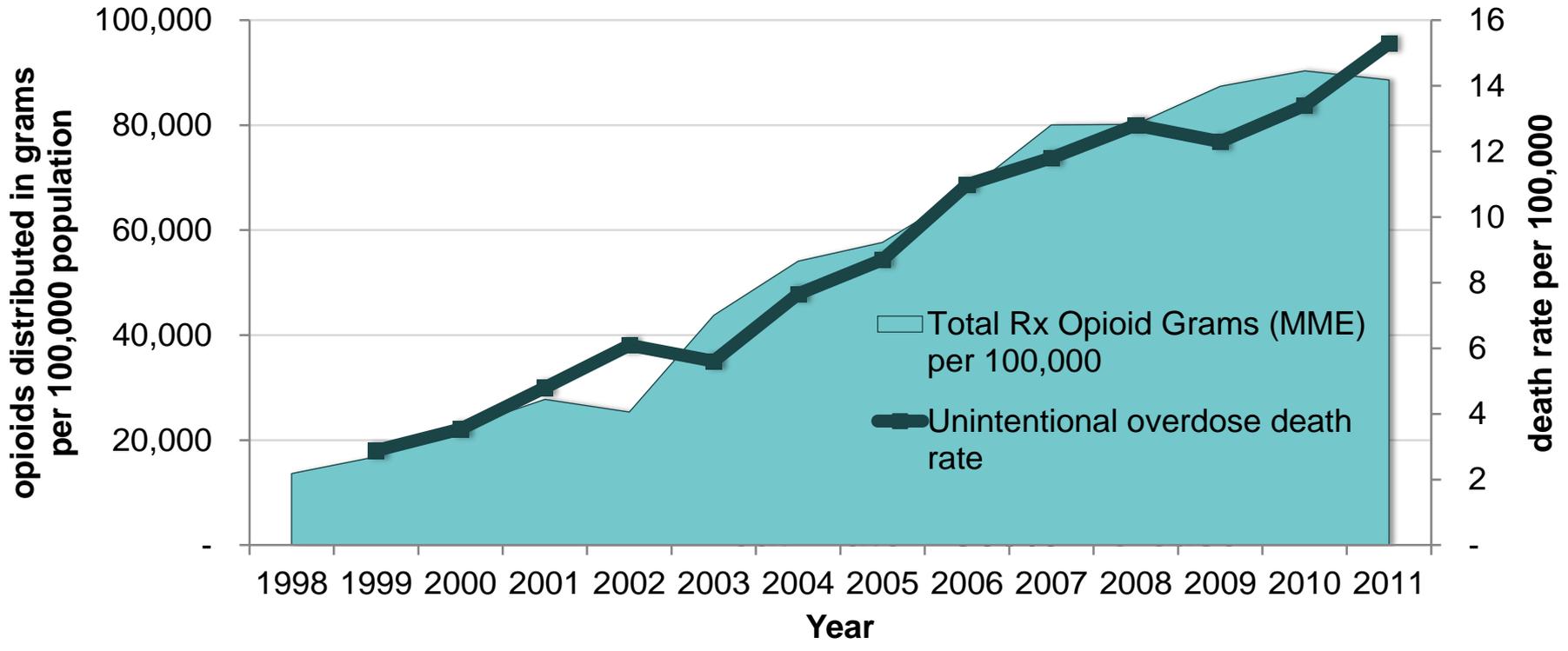
¹In oral morphine equivalents using the following assumptions: (1) All drugs other than fentanyl are taken orally; fentanyl is applied transdermally. 2) These doses are approximately equianalgesic: morphine: 30 mg; codeine 200 mg; oxycodone and hydrocodone: 30 mg; hydromorphone; 7.5 mg; methadone: 4 mg; fentanyl: 0.4 mg; meperideine: 300 mg.

CONTRIBUTING FACTORS:

OHIO DATA

There is a *strong* relationship between increases in exposure to prescription opioids and fatal unintentional overdose rates.

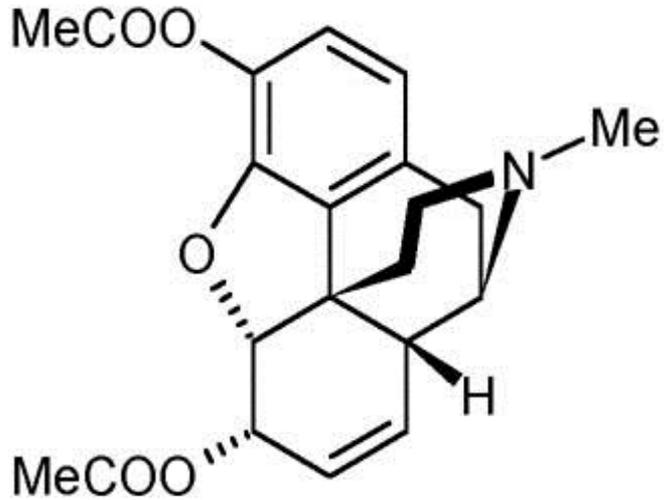
Unintentional drug overdose death rates and distribution rates of prescription opioids in grams per 100,000 population by year, Ohio, 1997-2011¹⁻³



Sources: 1. Ohio Vital Statistics; 2. DEA, ARCOS Reports, Retail Drug Summary Reports by State, Cumulative Distribution Reports (Report 4) Ohio, 1997-2007 http://www.deadiversion.usdoj.gov/arcos/retail_drug_summary/index.html; 3. Calculation of oral morphine equivalents used the following assumptions: (1) All drugs other than fentanyl are taken orally; fentanyl is applied transdermally. 2) These doses are approximately equianalgesic: morphine: 30 mg; codeine 200 mg; oxycodone and hydrocodone: 30 mg; hydromorphone; 7.5 mg; methadone: 4 mg; fentanyl: 0.4 mg; meperidine: 300 mg; 4. US Census Bureau, Ohio population estimates 1997-2007; 5. preliminary data for 2007

CONTRIBUTING FACTORS:

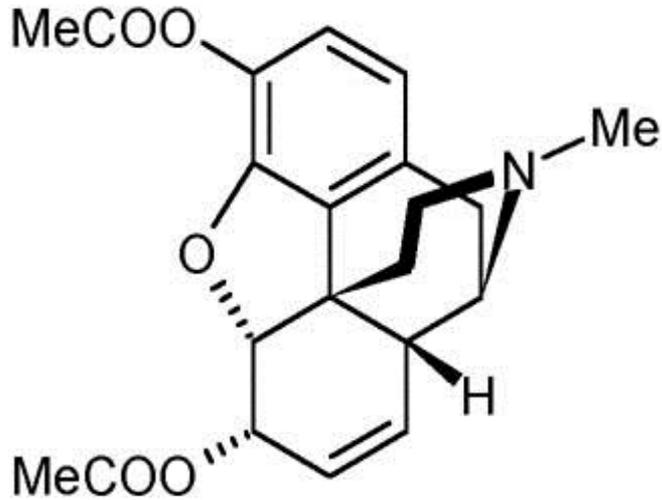
OPIOID CHEMICAL STRUCTURE



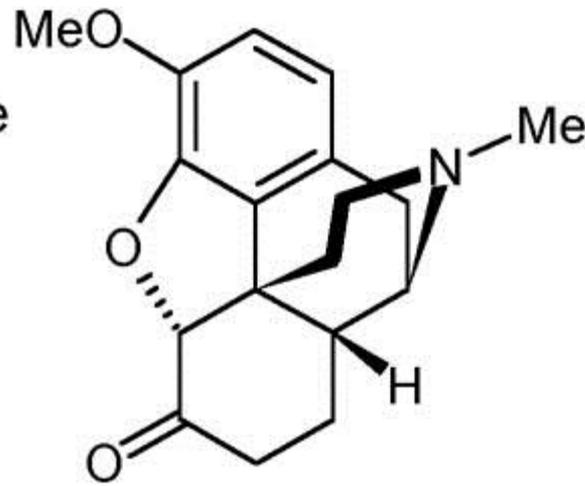
HEROIN

CONTRIBUTING FACTORS:

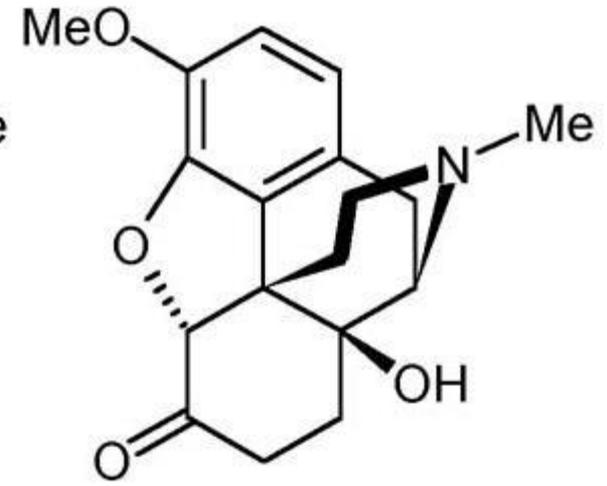
OPIOID CHEMICAL STRUCTURES



HEROIN

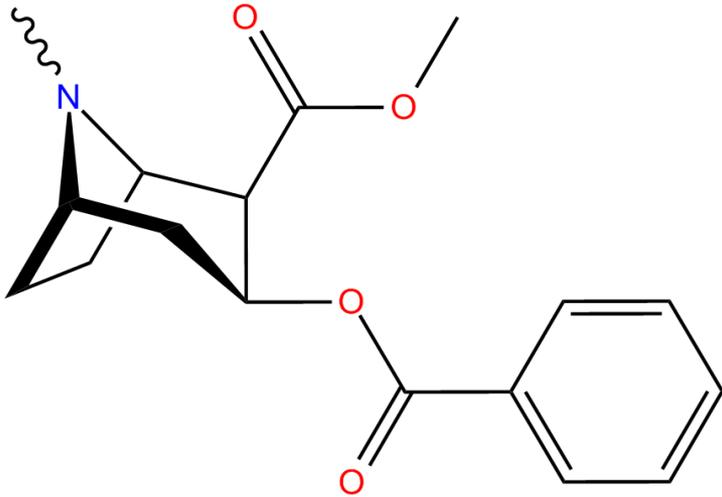


HYDROCODONE
(e.g., VICODIN®)

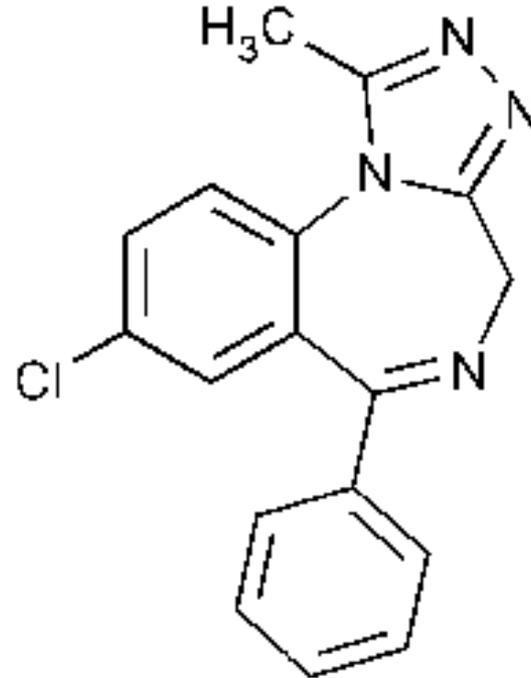


OXYCODONE
(e.g., OXYCONTIN®)

COCAINE AND BENZODIAZEPINE CHEMICAL STRUCTURE



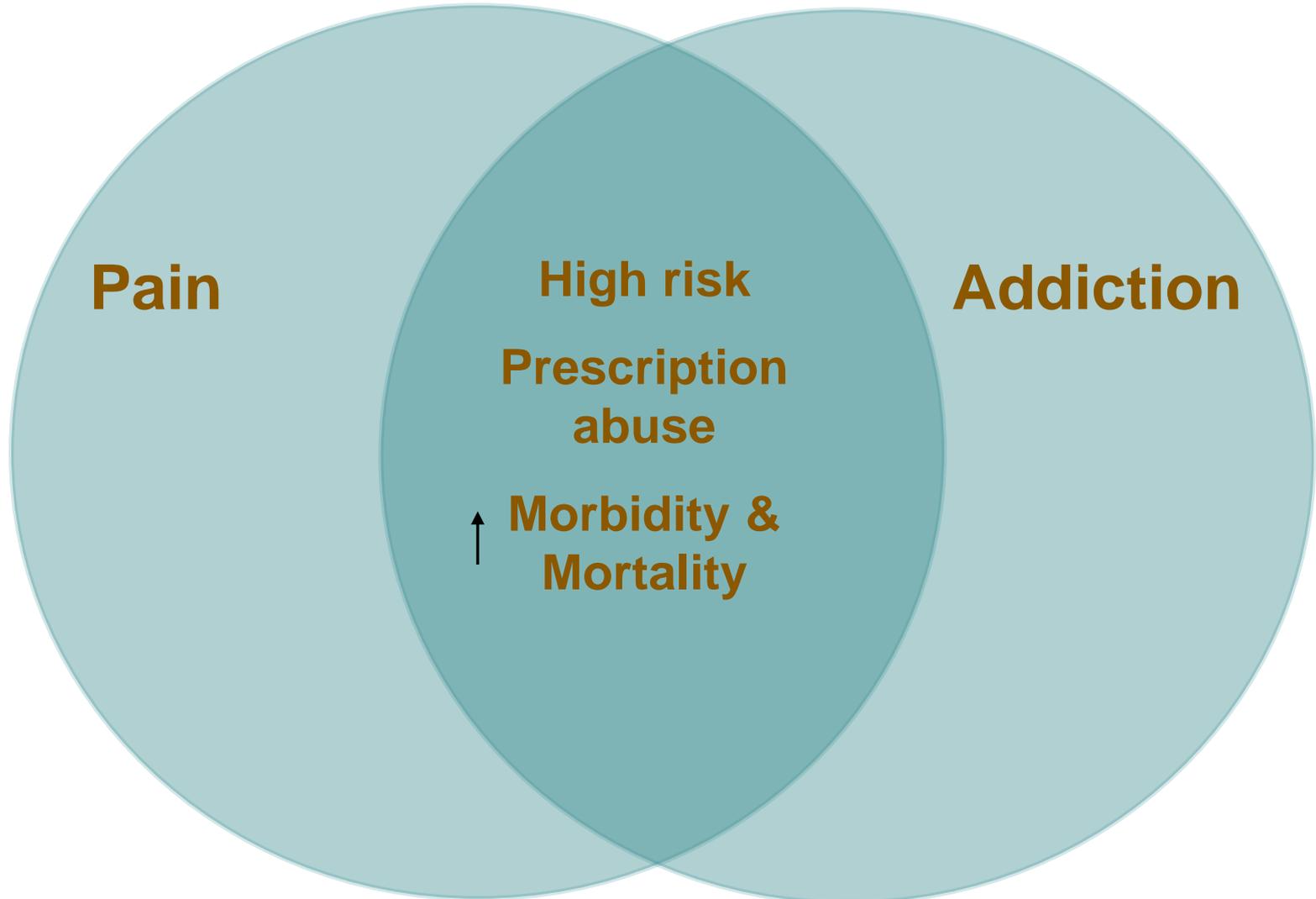
COCAINE



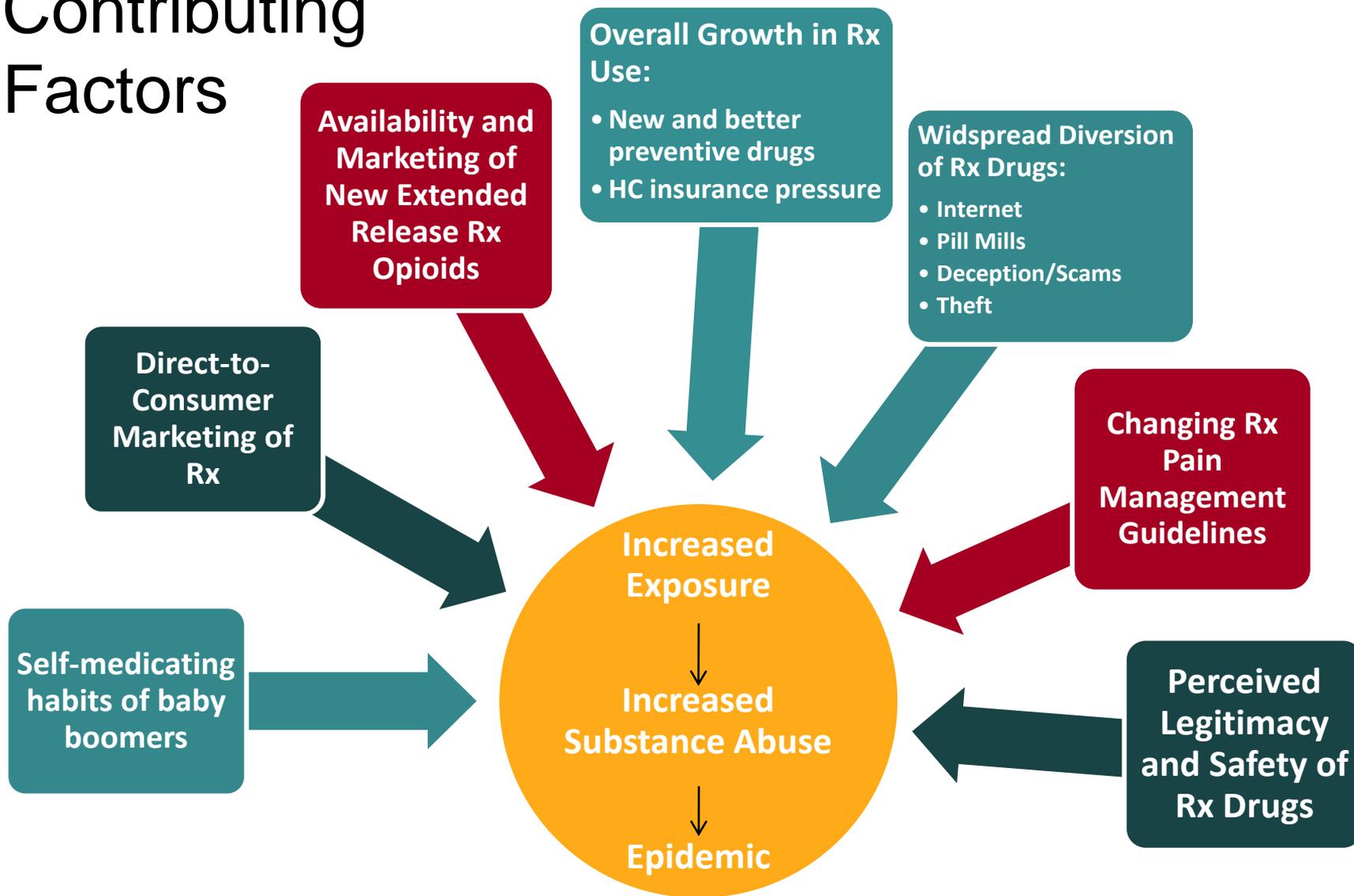
**ALPRAZOLAM
(XANAX®)**

CONTRIBUTING FACTORS:

The Relationship Of Pain And Addiction Is A Major **Contributor** To Current Epidemic



Contributing Factors





CONSEQUENCES: **COSTS OF THE EPIDEMIC**

Estimated average annual costs of unintentional drug overdose death in Ohio, 2012¹

Category	Deaths
Medical Cost	\$5.7 million
Work Loss Cost	\$2.0 billion
Total Cost	\$2.0 Billion

¹Source: CDC WISQARS Cost of Injury Reports, based on 2012 Ohio Overdose Incidents

STATE RESPONSE TO EPIDEMIC

INITIAL STRATEGIES FOR ODH VIOLENCE AND INJURY PREVENTION PROGRAM (VIPP)

- Determine drugs of abuse/responsible for increasing death rates/access issues
- Examine statewide data and communicate key findings for the purpose of action (i.e., report, fact sheets, press releases, news articles)
- Form a coalition as part of the Ohio Injury Prevention Partnership (OIPP) and recruit stakeholders
- **Conduct statewide and local forums in high risk areas to present data and discuss solutions**
- Develop policy recommendations and strategies for a state plan
- Implement prevention programs in high risk areas.



**OHIO INJURY PREVENTION
PARTNERSHIP**

Prescription Drug Abuse Action Group

STATE-LEVEL ACTIVITIES

PRESCRIPTION DRUG ABUSE ACTION GROUP (PDAAG)

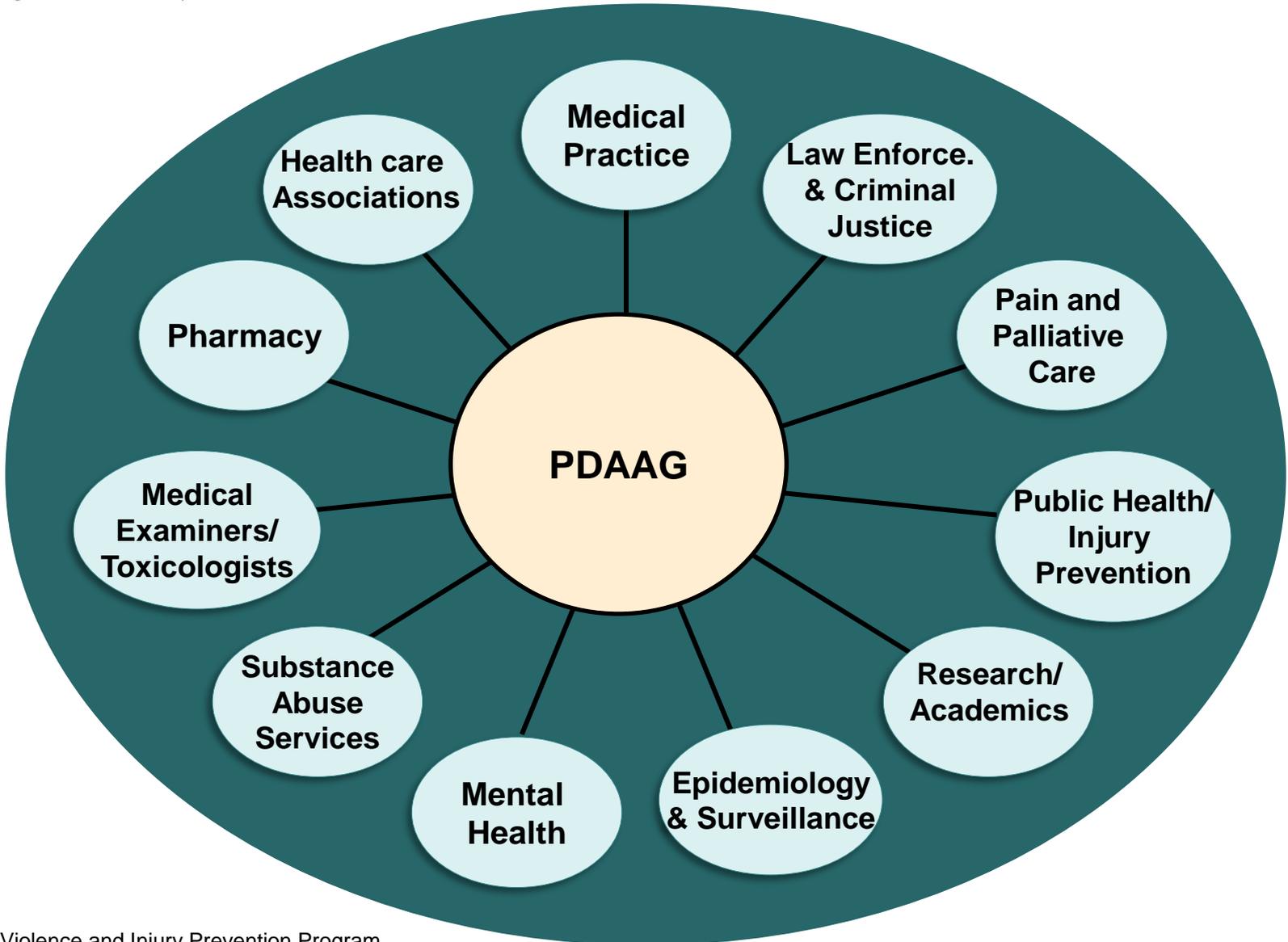
Convened by the:

Ohio Injury Prevention Partnership (OIPP)

ODH, VIPP

**Ohio Department of Mental Health and Addiction Services
(Ohio MHAS)**

PARTNERS





STATE-LEVEL ACTIVITIES

**Hosted statewide symposium in 2009 as a
“Call to Action”**

**Developed state level recommendations and
strategies for increasing capacity to respond
to this problem**

- PDAAG recommendations submitted to Directors of ODH and ODADAS and to the Governor
- 23 recommendations focused on
 - Prescriber/health care
 - Consumer/public
 - Legislative/Policy-maker
 - Data/Surveillance

STATE LEGISLATION

HB 93 addresses (Became law April 2011)*:

- Pain management clinic licensure (i.e., Pill mills) and related changes
- Sets In-office physician dispensing limits
- Medicaid and Bureau of Workers' Comp Lock-in Programs
- Requires changes to OARRS rules (Ohio's PMP)
- Drug Take-Back Programs
- Creates a patient safety and education fund that can accept donations.

***Regulatory/Policy recommendations from OPDATF**

GOVERNOR'S CABINET OPIATE ACTION TASK FORCE (GCOAT)



Established fall of 2011 to address the continuing epidemic of misuse, abuse and overdose from prescription opioids.

- 1. Treatment – includes Medication Assisted Treatment**
- 2. Professional Education**
- 3. Public Education**
- 4. Enforcement**
- 5. Recovery Supports**

RESPONSE TO THE EPIDEMIC: PROFESSIONAL EDUCATION WORKGROUP - GCOAT

Co-Chaired by

- **Dr. Ted Wymyslo, Director, ODH**
- **Bonnie Kantor-Burman, Director, Ohio Department of Aging**

Two subcommittees formed:

- **Opioid Prescribing Guidelines for Ohio Emergency/Acute Care Facilities - Lead: Director Wymyslo**
- **Reforming Prescribing Practices in Ohio– Lead: Director Kantor-Burman**

OPIOID PRESCRIBING GUIDELINES FOR E.D.'S & ACUTE CARE FACILITIES

POCKET CARDS



**Professional Education
Workgroup**

Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances (OOCs) PRESCRIBING GUIDELINES

These guidelines are to provide a general approach in the prescribing of OOCs. They are not intended to take the place of clinical judgment, which should always be utilized to provide the most appropriate care to meet the unique needs of each patient.

1. OOCs for acute pain, chronic pain and acute exacerbations of chronic pain will be prescribed in emergency/acute care facilities only when appropriate based on the patient's presenting symptoms, overall condition, clinical examination and risk for addiction.
 - a. Doses of OOCs for routine chronic pain or acute exacerbations of chronic pain will typically NOT be given in injection (IM or IV) form.
 - b. Prescriptions for chronic pain will typically NOT be provided if the patient has either previously presented with the same problem or received an OOCs prescription from another provider within the last month.
 - c. IV Demerol (Meperidine) for acute or chronic pain is discouraged.
2. Emergency medical clinicians will not routinely provide:
 - a. Replacement prescriptions for OOCs that were lost, destroyed or stolen.
 - b. Replacement doses of Suboxone, Subutex or Methadone for patients in a treatment program.
 - c. Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone).
3. Prior to making a final determination regarding whether a patient will be provided a prescription for OOCs, the emergency clinician or facility:
 - a. Should search the Ohio Automated Rx Reporting System (OARRS) database (<https://www.ohiopmp.gov/portal/Default.aspx>) or other prescription monitoring programs, per state rules.
 - b. Reserves the right to request a photo ID to confirm the identity of the patient. If no photo ID is available, the emergency or other acute care facility should photograph the patient for inclusion in the facility medical record.
 - c. Reserves the right to perform a urine drug screen or other drug screening.
4. Emergency/acute care facilities should maintain an updated list of clinics that provide primary care and/or pain management services for patients, as needed.

5. Prior to making a final determination regarding whether a patient will be provided a prescription for an OOCs, the emergency clinician should consider the following options:
 - a. Contact the patient's routine provider who usually prescribes their OOCs.
 - b. Request a consultation from their hospital's palliative or pain service (if available), or an appropriate sub-specialty service.
 - c. Perform case review or case management for patients who frequently visit the emergency/acute care facilities with pain-related complaints.
 - d. Request medical and prescription records from other hospitals, provider's offices, etc.
 - e. Request that the patient sign a pain agreement that outlines the expectations of the emergency clinician with regard to appropriate use of prescriptions for OOCs.
6. Emergency/acute care facilities should use available electronic medical resources to coordinate the care of patients who frequently visit the facility, allowing information exchange between emergency/acute care facilities and other community-care providers.
7. Except in rare circumstances, prescriptions for OOCs should be limited to a three-day supply. Most conditions seen in the emergency/acute care facility should resolve or improve within a few days. Continued pain needs referral to the primary care physician or appropriate specialist for re-evaluation.
8. Each patient leaving the emergency/acute care facility with a prescription for OOCs should be provided with detailed information about the addictive nature of these medications, the potential dangers of misuse and, the appropriate storage and disposal of these medications at home. This information may be included in the Discharge Instructions or another handout.
9. Emergency/acute care facilities should provide a patient handout and/or display signage that reflects the above guidelines and clearly states the facility position regarding the prescribing of opioids and other controlled substances.

Endorsed by:
Ohio Chapter of the American College of Emergency Physicians,
Ohio Association of Health Plans, Ohio Association of Physician Assistants,
Ohio Bureau of Workers' Compensation, Ohio Hospital Association,
Ohio Osteopathic Association, Ohio Pharmacists Association,
Ohio State Medical Association

Development Facilitated by:
Ohio Department of Health, Ohio Department of Aging

6/2012

Distributed in partnership with the Ohio Hospital Association and the Ohio Chapter, American College of Emergency Physicians, and upon request.

www.healthyohioprogram.org/ed/guidelines.aspx

SOME OF THE OHIO HOSPITALS ADOPTING THE ED GUIDELINES



MOUNT CARMEL



www.healthyohioprogram.org/ed/guidelines.aspx

REFORMING PRESCRIBING PRACTICES COMMITTEE

- **Working on guidelines for prescribing opioids for the treatment of chronic, non-terminal pain**
- **80 mg morphine equivalent daily (MED) dose will be the maximum “trigger point” at which point the prescriber should “press pause” and conduct additional actions:**
 - Reestablish informed consent
 - Review patients functional status
 - Review progress toward treatment objectives
 - Re-check OARRS
 - Consider a patient pain agreement
 - Consider referral to a pain or other appropriate specialist
- **OARRS data will be used to determine MEDs and to address prescribers who are not following the guidelines.**

ODH ACTIVITIES



Naloxone Distribution Programs

- In response to the growing fatal opioid overdoses, communities have implemented Naloxone Distribution Programs (NDPs).
- NDPs provide overdose training and take-home doses of naloxone to those who are deemed high-risk for an overdose.
- Programs have been established in 3 counties to date (Scioto, Hamilton and Cuyahoga) with additional counties (Montgomery) expressing interest.

Contact Christy.beeghly@odh.ohio.gov for more information

or visit:

<http://www.healthyohioprogram.org/vipp/drug/ProjectDAWN.aspx>

* Overdose * Prevention Kit



- * Kit with 2 doses of 1 mg/1 mL naloxone hydrochloride in pre-filled needleless syringes, nasal adaptors, breathing mask, instructions, referrals to local substance abuse/dependence treatment/owner card
- * Take-home DVD and instruction flipchart to share with significant others and friends

* Total cost=approx. **\$50- 75**

ACTIVITIES OF ODH VIPP

Pursuing Alternative and Sustainable Drug Disposal Options

- Ohio Prescription Drug Drop Box Program
- Collaboration among:
 - Ohio Attorney General's Office
 - Drug Free Action Alliance
 - ODH Violence and Injury Prevention Program
 - National Association of Drug Diversion Investigators
- In October 2012, this pilot project provided 66 community drug drop boxes to Ohio law enforcement agencies in high risk counties to encourage the disposal and destruction of unused medications.



ODH Activities: Raise Awareness



<http://www.P4Pohio.org>

- PSAs
- Educational Materials

PUBLIC HEALTH APPROACH

Key Lessons Learned

- **Data are important and can drive action. Use social math/CDC framing guide to frame issue.**
- **Personal impact (i.e., stories) is critical.**
- **Leverage Partnerships for Advocacy**
- **Educate at Multiple Levels**
 - **Internal***
 - **Media**
 - **Local**
 - **State**
 - **Parent and Professional Groups**
- **Sometimes the “hint” of regulation can be enough to cause system change. (e.g., mandated CEUs, ED Guidelines)**

WAYS TO HELP

- **Start or get involved in local prevention coalition.**
- **Encourage physicians and pharmacists to register and use OARRS (prescription monitoring program)**
- **Encourage health care providers to conduct SBIRT (Screening, Brief Intervention and Referral to Treatment)**
- **Encourage hospitals to adopt emergency department prescribing guidelines**
- **Encourage development of naloxone distribution programs like Project DAWN**

CONTACT ODH

Judi Moseley, PDAAG Coordinator

Violence and Injury Prevention Program

Ohio Department of Health

(614) 728-8016

Judi.moseley@odh.ohio.gov

Christy Beeghly, MPH, Program Administrator

Violence and Injury Prevention Program

Ohio Department of Health

(614) 728-4116

Christy.beeghly@odh.ohio.gov