CSAM
CALIFORNIA SOCIETY OF ADDICTION MEDICINE

How to Build a Controlled Substance Review Committee in Your Primary Care Clinic: Why? Who? How?

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Disclosures

- None

Acknowledgements

- LOTS
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    - Diana Coffa
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    - Scott Steiger
    - Barb Wismer
    - Doug Price-Hanson
    - Claire Horton

Roadmap

- Audience questions
- Why develop a controlled substance review committee?
- How could we do it?
- Who will this benefit?
- Take-home points

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Audience Questions

- Does your clinic currently have a controlled substance review committee?
  - Yes
  - No

Audience Questions

- Do you have in your clinic, or are you member to, a behavioral health team?
  - Yes
  - No

Audience Questions

- Do you have pharmacy support in your clinic?
  - Yes
  - No

Audience Questions

- Have you taken care of ≥ 5 patients suffering from chronic pain?
  - Yes
  - No

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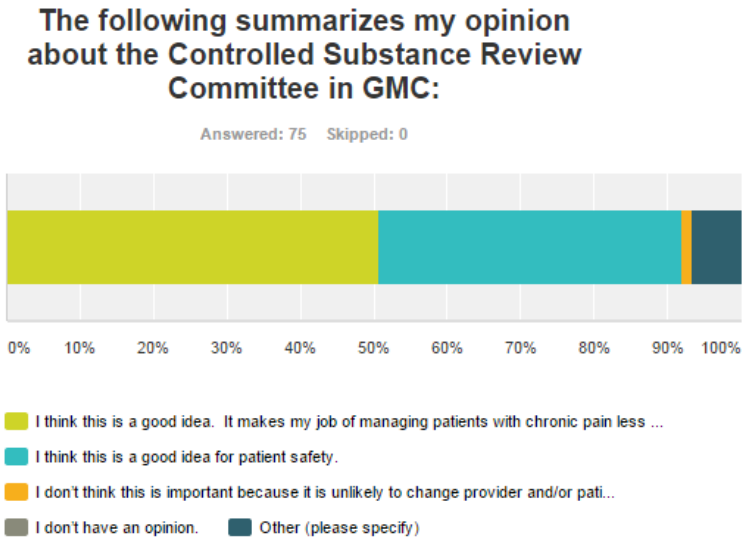
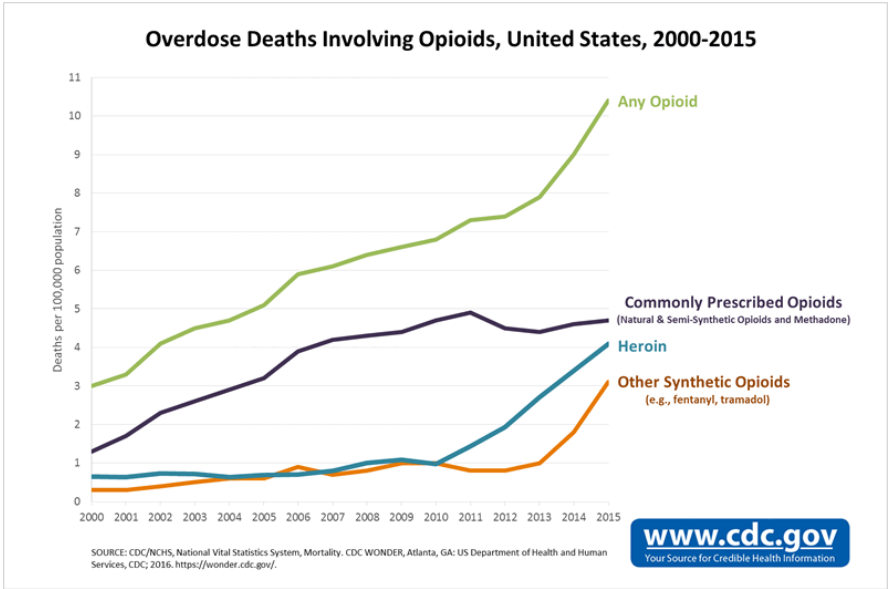
Why: Provider Opinion



Provider Survey

- Anonymous, web-based survey of providers in the Richard Fine People's Clinic at ZSFG
  - Urban, academic teaching clinic, Internal Medicine
- Respondents (n=76)
  - 55% residents, 37% attendings, 6% NPs
  - Majority with <5 patients taking chronic opioids

Why: Cultural Changes & Safety



Remember the Guidelines

- CDC Opioid Guidelines*
  - Opioids not 1st line
  - Non-pharm. and non-opioid tx are preferred
  - Chronic opioids often start with acute rxs. Use lowest dose, <3d
  - Limit MME to <50mg daily
  - Monitor closely: urine drug screen, PDMP, risk/benefit

https://www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-a.pdf

Peer Review

- Peer review
  - Process whereby provider(s) evaluate the quality of their colleagues' work in order to ensure that prevailing standards of care are being met
  - Origins in the 19th century when standardization of care was needed to protect the public
  - Required by joint commission (peer credentialing)

Why: Evidence Base

- Opioid Peer Review
  - Chart review tool in a family medicine clinic (n=99 charts, 14 FCM MDs):
    - Patients: >60% of patients with "agreement violation" before intervention, 28% with multiple violations, mean dose 76mg/day MME
    - Intervention:
      - chart review by anonymous peer (MD or pharmacist, 3/mo)
      - form filled out (based on prior 6 months),
      - optional in chart

Penti B et al. J Opioid Manag 2016;12(4):269)

CONTROLLED SUBSTANCE REVIEW FORM
Please:

- **Limit chart review to last 6 months.**
- Please document how time to complete form.

Medical record #

PCP being reviewed (initials):

What controlled substance? (Please circle, & write dose & amount of pills)

	Dose/amt of tabs per month:		Dose/amt tabs per mon
Oxycodone/Percocet		Fentanyl	
Morphine/MS contin		Suboxone	
Ativan/Lorazepam		Methadone	
Klonopin (Clonazepam)		Codeine/Tylenol 3	
Dilaudid (hydromorphone)		Vicodin (hydrocodone)	
Tramadol (ultram)		Flexeril	
Valium (Diazepam)			

- Other:_____

Indication for controlled substance (ie back pain, fibromylgia, etc):

Number of PCP Clinic visits in past 6 months. Does not include phone contact or visits to other providers in ACC clinic.

Is there evidence of narcotic contract in the chart? (either narcotic contract printed at somepoint, or other evidence of discussion done?)

Is the patient in violation of controlled-substance policy by any of the below items:

	YES	NO
Failing to arrived at scheduled follow-up appointments (either PCP or referred specialist)		
Failure to submit to requested urine testing or pill counts (or abnormal results on urine tox or pill count)		
Increasing dose of meds without discussing w. PCP		
Seeking early refills		
Calling after hours for refills		
Getting controlled substances from other healthcare providers without discussing with PCP		
Not treating staff respectfully		
Misrepresenting facts or failing to discuss info to providers		

OTHER:

If patient has violated narcotic contract, how many documented violations exist?

Table 4. Provider practices per charts reviewed (n = 99)

Percentage of patients with documented controlled substance treatment agreement in chart	50.1
Percentage of patients with urine drug screens in past 6 months	
None	35.0
1	20.5
2	18.0
3 or more	26.5
Percentage of patients with UDT, with abnormal results (n = 26)	41
Among patients with abnormal UDT, patient with	
Prescribed drug missing (n = 20)	77
Abnormal drug present (n = 7)	27
Percentage of patients with a random pill count in past 6 months	1
Percentage of charts with provider documentation of decreased pain or improved quality of life	29
Percentage of charts with provider documentation of symptoms that can be explained by possible side effects from controlled substance	23

- Opioid Peer Review
  - Outcome:
    - mean decrease 2.6mg MED/day (v. 7mg/d increase before intervention)
    - 16% taken off meds
    - "I have greatly benefited from it and would certainly support a standardized approach."

Why: Case 1

- 62yo M with hx of COPD, CAD, DM (poorly controlled), HTN, HCV, HL, R knee trauma s/p surgery with ongoing chronic pain on opioids, and seizure disorder coming for follow-up with PCP.
- Primary complaint is poorly controlled pain. Pain is excruciating (10/10); he's newly in wheelchair, and quite depressed "all I do is lay in bed and sleep"
  - Requesting early refill and dose increase of opioids
  - Reports taking friend's methadone to control his pain because current meds not sufficient
- Current meds:
  - Oxycodone 20mg 1-2 tabs po TID
  - Morphine sulfate CR 60mg po tid
  - Clonazepam 2mg PO tid
  - MEQ = 300mg/day

Case 1

- Patient perspective
  - My pain is out of control. I need more of my medicine. I know what helps me. Why can't you increase my dose.
- Provider perspective
  - You are already on extremely high dose, but you are clearly suffering.
  - You are clearly depressed, but haven't engaged with behavioral health. You missed the ortho appointment to discuss your total knee replacement, but I started these meds.

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How Could We Do It?

- RFPC Controlled Substance Issues (CSI) Committee
  - Who: 1 RN, 1 behavioral health clinician (LCSW), 1 pharmacist, 1 medical assisstant, 1 MD
  - When: monthly meetings, 1 hour long, over lunch hour
  - Number of Cases Reviewed: 1-4
  - Means of Referral:
    - providers (preference)
    - external referral (RNs, front-line staff)
    - registry data

How Could We Do It?

- RFPC Controlled Substance Issues Committee
  - Process:
    - Provider fills out intake form* →
    - Committee* discusses case and reviews additional information
      - Alternative pain treatments being used,
      - PAR,
      - urine drug screen data,
      - attendance at appointments,
      - behavioral health involvement →
    - Recommendations sent to provider by email
      - *optional in/out of official medical record

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Sometimes just an email

Provider usually not there

Move towards IN the record given size of clinic

How Could We Do It?

- If done well
  - Reviews are supportive, not punitive
  - Pools knowledge and resources
  - Provides "external" perspective
  - Assist with patient communication (if possible)
  - Institutional support
    - Clinical FTE, blocked patient(s) slots
    - Public acknowledgment

Intake Form

GMC Controlled Substances Issues (CSI) Committee: Intake Form

Patient Name:_____ MRN:_____ DOB:_____ PCP: _____

Morphine Equivalent Dose (MED): _____ Patient Provider Agreement signed:_____ *Date*

What is your reason for referral? What are you hoping to obtain from the committee?

_____

_____

_____

Aberrant medication related behaviors

Any history of concerning behaviors? ☐Yes ☐No ☐Unknown **If Yes or Unknown, please see check list on back of this form.

Urine Toxicology Testing

Latest urine drug screening: _____ *date* Were results congruent with prescribed medication? ☐Yes ☐No

History of prior incongruous urine drug screens? ☐Yes ☐No

Risk Factors for Opioid Abuse/Diversion/Overdose

	Yes	No	Unknown
History of substance use disorder, including nicotine, alcohol, and marijuana			
Family history of substance abuse/addiction			
History of trauma or specific mental health d/o (depression, ADHD, PTSD, BPD, OCD, schiz)			
History of oversedation with medication			
History of overdose			
History of physical or sexual abuse			
On methadone maintenance			

Pain Management History

Diagnosis/cause of pain: _____

(Required) Current medication list, including controlled substances, up to date in ECW? ☐Yes ☐No

Has pain improved with opioid therapy? ☐Yes ☐No ☐Unknown
If unknown, please explain: _____

Intake Form

Yellow Flags

These are behaviors that might suggest opioid abuse or diversion, but might also be rational and normal responses to undertreated pain or to fear of pain. They have a **low specificity** for abuse and diversion.

- ☐ Anger or irritability when questioned closely about pain
- ☐ More concern about controlled substance than about the underlying medical problem that persists beyond the first few visits
  - may indicate inadequate treatment of pain
- ☐ Report of multiple medication sensitivities
  - may be true, or may be the patients' way of making sure to get the medications that they know work best for their pain
- ☐ Request for specific drugs or refusal to take generic medications
  - may be a truly significant observation by the patient that his/her genes/receptor population can utilize specific opioid more effectively than other opioids
- ☐ Unsanctioned dose escalation one or two times
  - may indicate inadequate treatment of pain
- ☐ Aggressive complaints about the need for more drug
  - may be a true need for increased dose
- ☐ Open acquisition of similar drugs from other medical sources one or two times, e.g. in the ER
  - may indicate inadequate treatment of pain or inadequate coverage of flares
- ☐ Drug hoarding during periods of reduced symptoms
  - may indicate unsatisfactory dosing during flares pain and is also a rational response to difficulty scheduling timely appointments and concerns about emergency preparedness.
- ☐ Resistance to a change in therapy associated with "tolerable" adverse effects, with expressions of anxiety related to the return of severe symptoms
  - reasonable reaction when patient has experienced increased pain as part of withdrawal

Red Flags

- ☐ Manipulative or abusive behavior directed at caregivers, including intimidation or coercion, and aimed at acquisition and continuance of the substance abuse
- ☐ Urine drug screen negative for the prescribed medication
- ☐ Urine drug screen positive for other controlled substances
- ☐ Refusal of diagnostic workup or consultation
- ☐ Multiple no-shows to PCP visits and other appointments that are part of treatment plan (i.e. behavioral health, PT, healthy spine, pain referral clinic)
- ☐ Frequent dose escalations after being told this is inappropriate
- ☐ Multiple (>2) episodes of lost or stolen prescriptions or medications
- ☐ Prescription forgery
- ☐ Stealing drugs from others
- ☐ Selling prescription drugs
- ☐ Obtaining prescription drugs from non-medical sources

Example of recommendations

GMC Controlled Substances Issues (CSI) Committee: Recommendations

Patient Name:_____ MRN:_____ Date of Review: 6/5/14

PCP:_____ Reason for Review: _____High Dosage_____

Opioid Dose: oxycodone 30mg IR - 3 pills qid (540mg MED per day)

Summary: 64yo F with a history of obesity and chronic back and knee pain on chronic opioids. Her case was evaluated because of her high dosage as an SFHP patient. Generally speaking, this patient has attempted several treatments: knee pain (seen by ortho, trialed on knee injections, referred for pool therapy, tried diet), and back pain (seen previously in ortho clinic). She was seen in Pain Clinic with and started on adjunct agents for pain. She attends PCP apts and is up to date on pain agreement (9/7/13) and Utox (4/10/14). Her PCP reports that her pain has diminished with opioids and function has improved. Her only concerning behavior has been a strong resistance to a change in therapy.

The committee recommends the following:

1) Patient should have repeat urine toxicology screen at next visit

2) The patient needs a follow-up appointment scheduled with PCP (no F/U seen in LCR and last apt was >6 months ago (12/23/13)

3) Given that her dose will have to be decreased in accordance with the new SFHP payment guidelines (NOTE: Starting 1/1/15, she will have to taper), the non-opioid agents recently added should be titrated up. A taper schedule is provided below (in 4 week increments). WE would recommend discussing this with the patient at the next visit and starting as soon as possible given the difficulty of tapering.

Oxycodone 30mg IR 3 pills in AM, 3 pills at noon, 2 pills at 6pm, 3 pills at bedtime x4 weeks

Oxycodone 30mg IR 3 pills in AM, 2 pills at noon, 2 pills at 6pm, and 3 pills at bedtime x4 weeks

Oxycodone 30mg IR 3 pills in AM, 2 pills at noon, 2 pills at 6pm, and 2 pills at bedtime x4 weeks

Oxycodone 30mg IR 2 pills QID x 4 weeks

Other Recommendation Templates

Total morphine equivalents of current regimen:_____

Opiate Oversight Committee Recommendations

Pain	
Recommended Medication Changes	
	Recommended change to opioids or other controlled medications:
	Add anti-epileptic med for neuropathic pain (e.g._____)
	Add antidepressant
	Add NSAID/Tylenol
	Add topical (lidocaine gel, capsacin)
	Add immune modulators (e.g._____)
	Withdrawal symptom pack: Clonidine 0.1mg BID PRN malaise, anxiety. Loperamide PRN diarrhea. Ondansetron 4mg q8 PRN nausea. Trazadone 50mg nightly PRN insomnia.
	Naloxone prescription
Recommended procedures or referrals	
	Joint injection
	Trigger point injection
	Rheum referral
	Orthopedics referral
	Neurosurgery referral
	Epidural steroid injection (only indicated with radiculopathy)
	Mt. Zion pain clinic for local block or pump
	Ice and/or heat
Movement based	
	Physical therapy
	Supervised/graded physical activity
Behavioral and Psychological	
	Individual therapy
	Spine health group
	Chronic pain group
	Pelvic pain group
	Depression/anxiety group
	Social engagement plan
	Pacing

Case Continued

- 62yo M with hx of COPD, CAD, DM (poorly controlled), HTN, HCV, HL, R knee trauma s/p surgery with ongoing chronic pain on opioids, and seizure disorder coming for follow-up with PCP.
- Primary complaint is poorly controlled pain (10/10); he's newly in wheelchair, depressed "all I do is lay in bed and sleep"
  - Requesting early refill and dose increase of opioids
  - Reports taking friend's methadone to control his pain because current meds not sufficient
- MED = 300mg/day

Case

- Over the past 6 months patient has struggled with outpatient follow-up & chronic disease management:
  - No-shows to appointments (DM clinic, orthopedics to discuss knee replacement, neuro to discuss seizure regimen)
  - Does not bring meds for med reconciliation
  - Seen in ED for seizure – etoh level neg
  - Reports to PCP that he passed out a week ago and fell down stairs w/LOC – HCT neg. Sleepy at apt.
- Urine drug screens are frequently abnormal:
  - neg oxycodone,
  - pos methadone,
  - neg BZD
- Pain is terrible – only ancillary agent is gabapentin for pain

Case

- Patient was referred to clinic controlled substance review committee. Committee recommended:
  - Utox at next visits and if abnormal, taper meds
  - Review controlled substance agreement
  - Discuss methadone
  - Rx naloxone
- Patient had repeat utox that was abnormal (pos methadone, neg oxy). PCP did not elect to taper meds given complaints of uncontrolled pain.
- Patient found dead 3 months later.
  - Cause of death: opioid overdose

Controlled Substance Committees: Pain v. Addiction

- Distinguishing between pain and an opioid use disorder?
  - Opioid use disorder
    - 4 Rs
      - Risk of bodily harm
      - Relationship trouble
      - Role failure
      - Repeated attempts to cut back
    - 4 Cs
      - Loss of Control
      - Continued use despite harm
      - Compulsion (time & activities)
      - Craving
    - Withdrawal and tolerance

Recent episode of passing out;

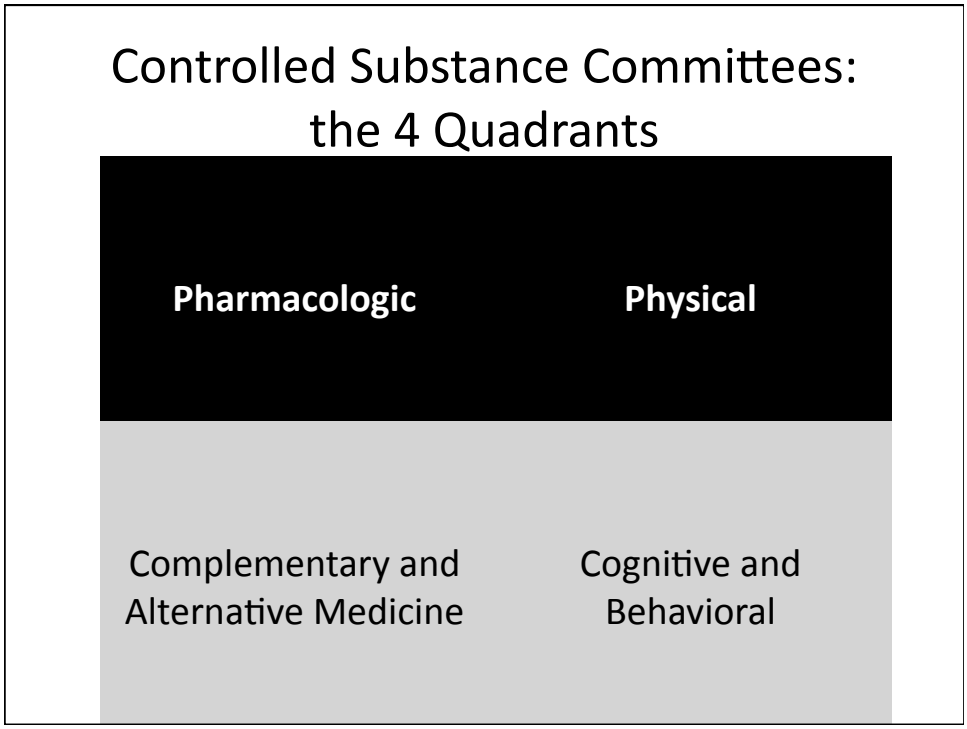
Laying in bed all day, doing nothing

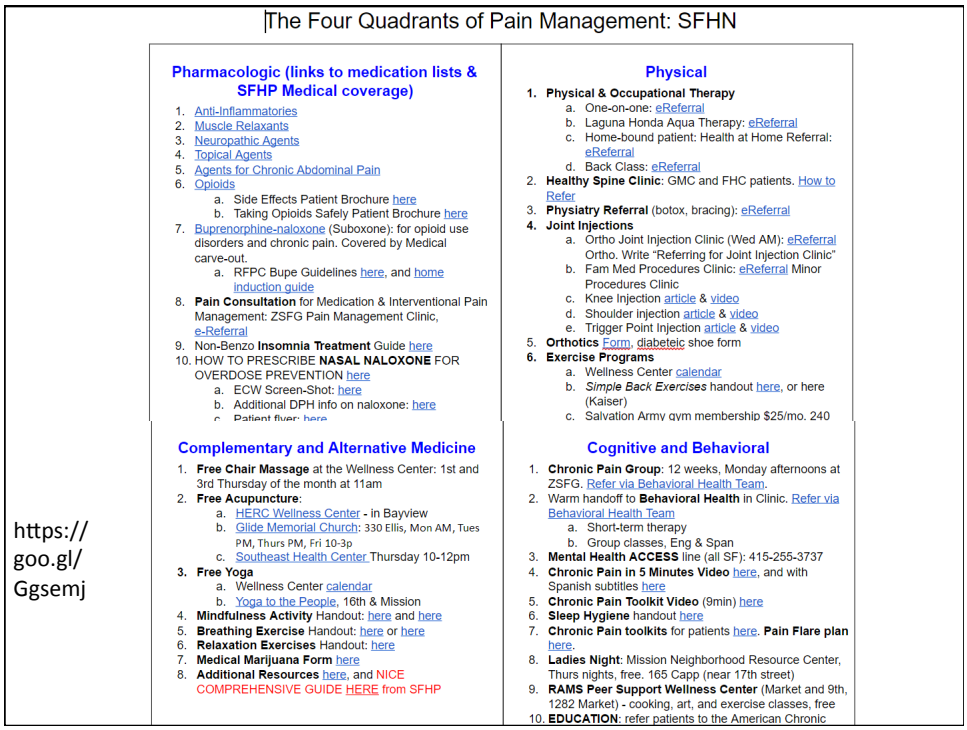
Sleepy at visits

Time/$ for methadone

need more pills, early refill requests

Mild: 2-3 criteria
Moderate: 4-5
Severe: 6+





The Four Quadrants of Pain Management: SFHN

Pharmacologic (links to medication lists & SFHP Medical coverage)

1. Anti-Inflammatories
2. Muscle Relaxants
3. Neuropathic Agents
4. Topical Agents
5. Agents for Chronic Abdominal Pain
6. Opioids
   a. Side Effects Patient Brochure here
   b. Taking Opioids Safely Patient Brochure here
7. Buprenorphine-naloxone (Suboxone): for opioid use disorders and chronic pain. Covered by Medical carve-out.
   a. RFPC Bupe Guidelines here, and home induction guide
8. **Pain Consultation** for Medication & Interventional Pain Management: ZSFG Pain Management Clinic, e-Referral
9. Non-Benzo **Insomnia Treatment** Guide here
10. HOW TO PRESCRIBE **NASAL NALOXONE** FOR OVERDOSE PREVENTION here
    a. ECW Screen-Shot: here
    b. Additional DPH info on naloxone: here
    c. Patient flyer: here

Physical

1. **Physical & Occupational Therapy**
   a. One-on-one: eReferral
   b. Laguna Honda Aqua Therapy: eReferral
   c. Home-bound patient: Health at Home Referral: eReferral
   d. Back Class: eReferral
2. **Healthy Spine Clinic**: GMC and FHC patients. How to Refer
3. **Physiatry Referral** (botox, bracing): eReferral
4. **Joint Injections**
   a. Ortho Joint Injection Clinic (Wed AM): eReferral Ortho. Write "Referring for Joint Injection Clinic"
   b. Fam Med Procedures Clinic: eReferral Minor Procedures Clinic
   c. Knee Injection article & video
   d. Shoulder injection article & video
   e. Trigger Point Injection article & video
5. **Orthotics** Form, diabeteic shoe form
6. **Exercise Programs**
   a. Wellness Center calendar
   b. *Simple Back Exercises* handout here, or here (Kaiser)
   c. Salvation Army gym membership $25/mo. 240

Complementary and Alternative Medicine

1. **Free Chair Massage** at the Wellness Center: 1st and 3rd Thursday of the month at 11am
2. **Free Acupuncture**:
   a. HERC Wellness Center - in Bayview
   b. Glide Memorial Church: 330 Ellis, Mon AM, Tues PM, Thurs PM, Fri 10-3p
   c. Southeast Health Center Thursday 10-12pm
3. **Free Yoga**
   a. Wellness Center calendar
   b. Yoga to the People, 16th & Mission
4. **Mindfulness Activity** Handout: here and here
5. **Breathing Exercise** Handout: here or here
6. **Relaxation Exercises** Handout: here
7. **Medical Marijuana Form** here
8. **Additional Resources** here, and NICE COMPREHENSIVE GUIDE HERE from SFHP

Cognitive and Behavioral

1. **Chronic Pain Group**: 12 weeks, Monday afternoons at ZSFG. Refer via Behavioral Health Team.
2. Warm handoff to **Behavioral Health** in Clinic. Refer via Behavioral Health Team
   a. Short-term therapy
   b. Group classes, Eng & Span
3. **Mental Health ACCESS** line (all SF): 415-255-3737
4. **Chronic Pain in 5 Minutes Video** here, and with Spanish subtitles here
5. **Chronic Pain Toolkit Video** (9min) here
6. **Sleep Hygiene** handout here
7. **Chronic Pain toolkits** for patients here. **Pain Flare plan** here.
8. **Ladies Night**: Mission Neighborhood Resource Center, Thurs nights, free. 165 Capp (near 17th street)
9. **RAMS Peer Support Wellness Center** (Market and 9th, 1282 Market) - cooking, art, and exercise classes, free
10. **EDUCATION**: refer patients to the American Chronic

https://goo.gl/Ggsemj

Another Referral

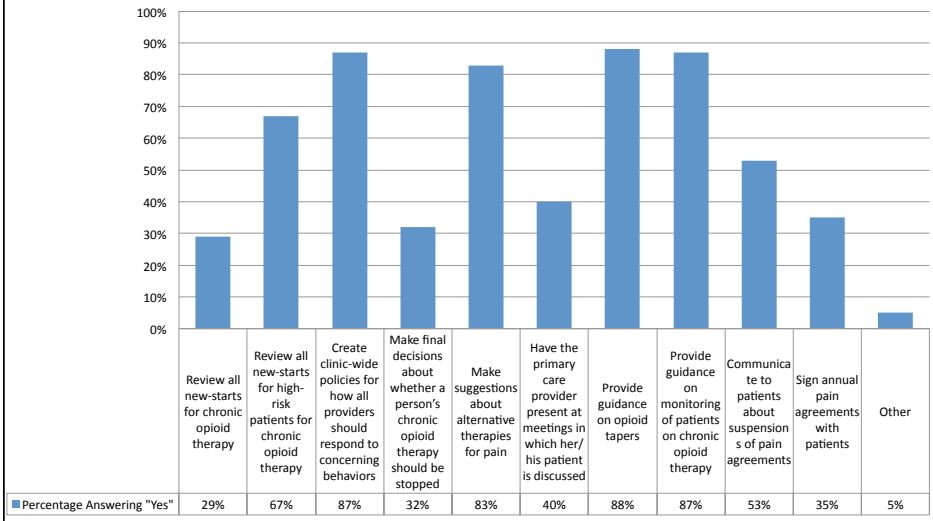
- LE is a 65yo M with a hx of DJD, remote "substance abuse," HTN, HCV, and depression presenting for follow-up. He has been on long-standing chronic opioid therapy for DJD pain with the following:
  - Oxycontin 180mg po tid
  - Methadone 20mg po tid
  - MEQ = 1400mg

- Has repeatedly abnormal urine drug screens, including:
  - Absence of oxycodone
  - Presence of opiates (morphine)
  - Presence of benzodiazepines (not prescribed)
- Oxycodone not high enough to control his pain. He is also prescribed ibuprofen. He declines knee injection and has not attended physical therapy (despite re-schedules and reminders from PCP).
- Given repeated concerning behaviors despite warnings, provider initiated taper.
- Next urine drug screen positive for heroin and patient referred to CSI.

- CSI Recommendations
  - Given history and recurrent concerning behaviors with poor pain control, recommendations made to change patient to buprenorphine-naloxone
- Epilogue
  - Patient has been stable on bupe-nal >6 months
  - "I'm so glad I'm off Oxycontin"

What do Providers Actually Want?

Provider Opinion on the Role(s) of the Controlled Substance Review Committee in GMC

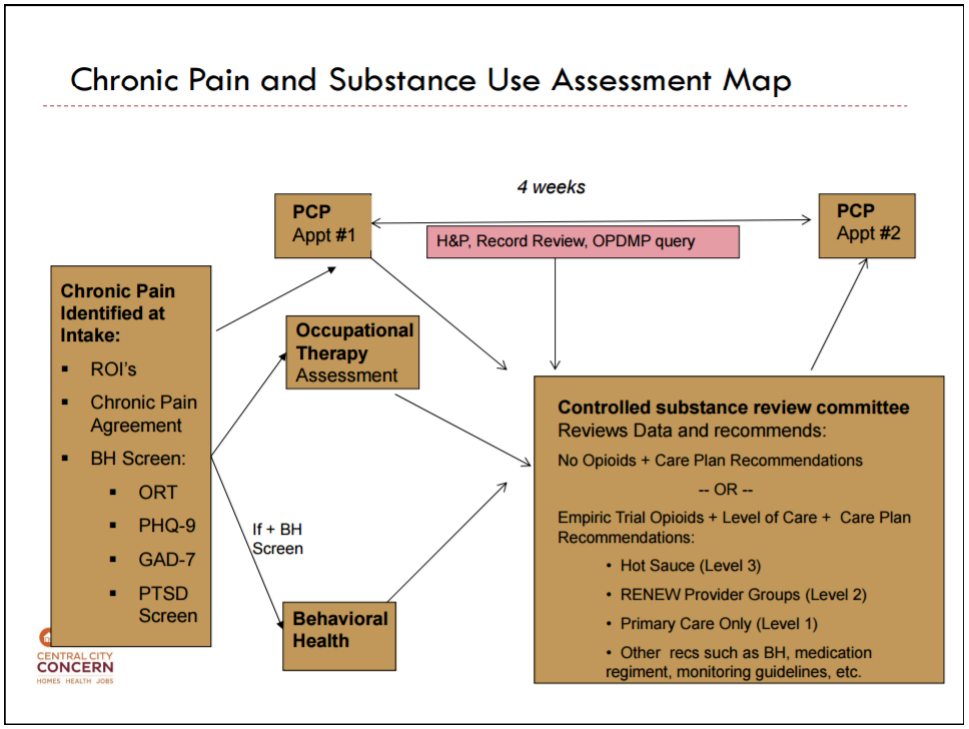


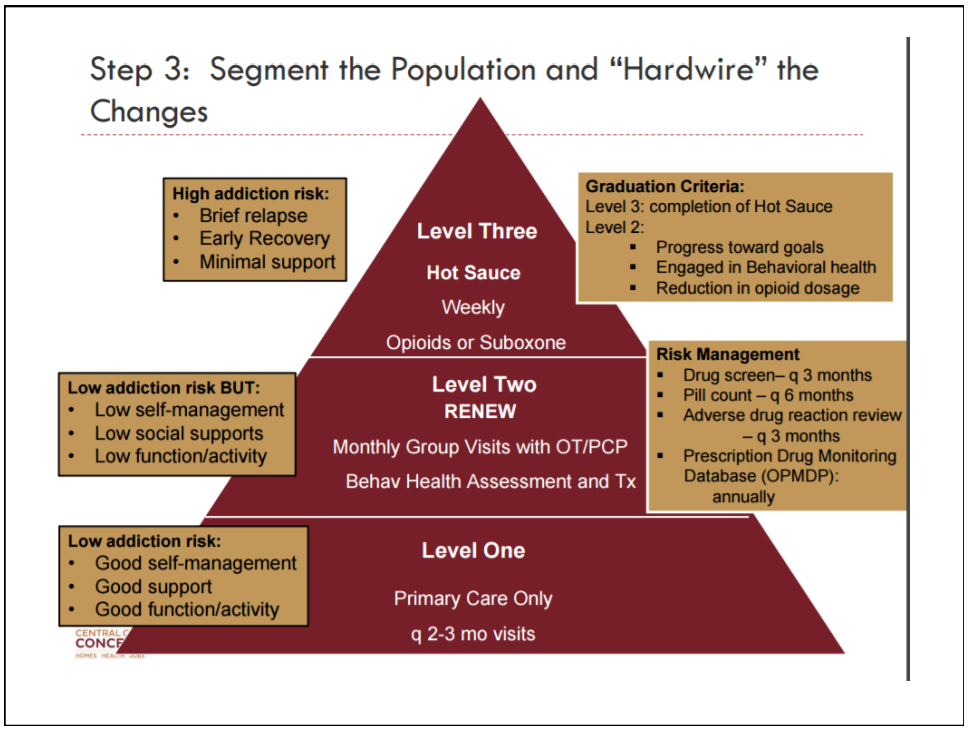
Other Clinics (aka, my colleagues and friends)

- Family Health Center: Pain Squad
  - Once monthly peer review
    - Used to be twice monthly to discuss clinic policies/ panel management
    - Bulk of work in policies & population management
  - *Start*: RN, clerk, MA, MD, PA, NP, psychologist → *Now*: data manager, QI lead, MD, PA, NP, psychologist (lunch provided)
  - Email recommendations, optional to put in medical record

Other Clinics

- Tom Waddell Urban Health Center "Yellow Flag Committee"
  - Twice monthly peer review, facilitated discussion
  - Referrals by providers, often from team meetings
  - Meetings in AM (during clinic closure)
  - Recommendations emailed to provider
- Central City Concern, Portland
  - Reviews all new starts, all episodes of misuse or misconduct, and provides guidance on complex cases


Chronic Pain and Substance Use Assessment Map
4 weeks
PCP Appt #1
H&P, Record Review, OPDMP query
PCP Appt #2
Chronic Pain Identified at Intake:
ROI's
Chronic Pain Agreement
BH Screen:
ORT
PHQ-9
GAD-7
PTSD Screen
Occupational Therapy Assessment
If + BH Screen
Behavioral Health
Controlled substance review committee
Reviews Data and recommends:
No Opioids + Care Plan Recommendations
-- OR --
Empiric Trial Opioids + Level of Care + Care Plan Recommendations:
Hot Sauce (Level 3)
RENEW Provider Groups (Level 2)
Primary Care Only (Level 1)
Other recs such as BH, medication regiment, monitoring guidelines, etc.
CENTRAL CITY CONCERN


Step 3: Segment the Population and "Hardwire" the Changes
High addiction risk:
Brief relapse
Early Recovery
Minimal support
Level Three
Hot Sauce
Weekly
Opioids or Suboxone
Graduation Criteria:
Level 3: completion of Hot Sauce
Level 2:
Progress toward goals
Engaged in Behavioral health
Reduction in opioid dosage
Low addiction risk BUT:
Low self-management
Low social supports
Low function/activity
Level Two
RENEW
Monthly Group Visits with OT/PCP
Behav Health Assessment and Tx
Risk Management
Drug screen– q 3 months
Pill count – q 6 months
Adverse drug reaction review – q 3 months
Prescription Drug Monitoring Database (OPMDP): annually
Low addiction risk:
Good self-management
Good support
Good function/activity
Level One
Primary Care Only
q 2-3 mo visits

Who Will This Benefit?

- Patients
  - More eyes, more ideas, greater perspective
  - Maintain relationship with PCP
- Providers
  - "I don't have to be the 'bad guy.''
- Staff
  - Changed the culture of opioid prescribing in our clinic
  - We know who to ask for help

Cautious Optimism: Downsides

- Time
  - Wrangling schedules is difficult and participant time
- Buy-In
  - Providers need enough time to respond and/or take action on the recommendations
  - Providers may (often) disagree with recs (what if in medical record?)
- Needs a Champion
- Down-Stream Effects
  - PCP change requests (leadership support)
  - Opioid refugees

Take-Home Points

- Controlled substance review committees are perceived by providers to be helpful in provider support & enhancing patient safety.
- Review committees have many possible designs:
  - In-person meetings with facilitated discussion
  - Individual, anonymous chart review
  - Provider panel review
- Opioid peer review is associated with a decrease in amount of opioids received by patients.
- Success of a review committee will depend on interest by providers, support by leadership, and a willingness to engage on this topic by colleagues.

Resources

- Intake Form
- Reviewer Form
- Chart Review Tool (BU)

Questions?


CSAM WEBINAR SERIES
Treating Addiction in the Primary Care Safety Net (TAPC)
4th Friday of every month | 12:00 -1:00 pm PST
(unless otherwise indicated)
CSAM
California Society of Addiction Medicine
California Health Care Foundation
NEXT WEBINAR:
Friday, 09/22/2017
Transitioning High-Dose Opioid Chronic Pain Patients to Buprenorphine
Friday, 10/27/2017
Medication Assisted Treatment for Alcohol Use Disorder: A Guide for Primary Care Providers


CSAM WEBINAR SERIES
Treating Addiction in the Primary Care Safety Net (TAPC)
4th Friday of every month | 12:00 -1:00 pm PST
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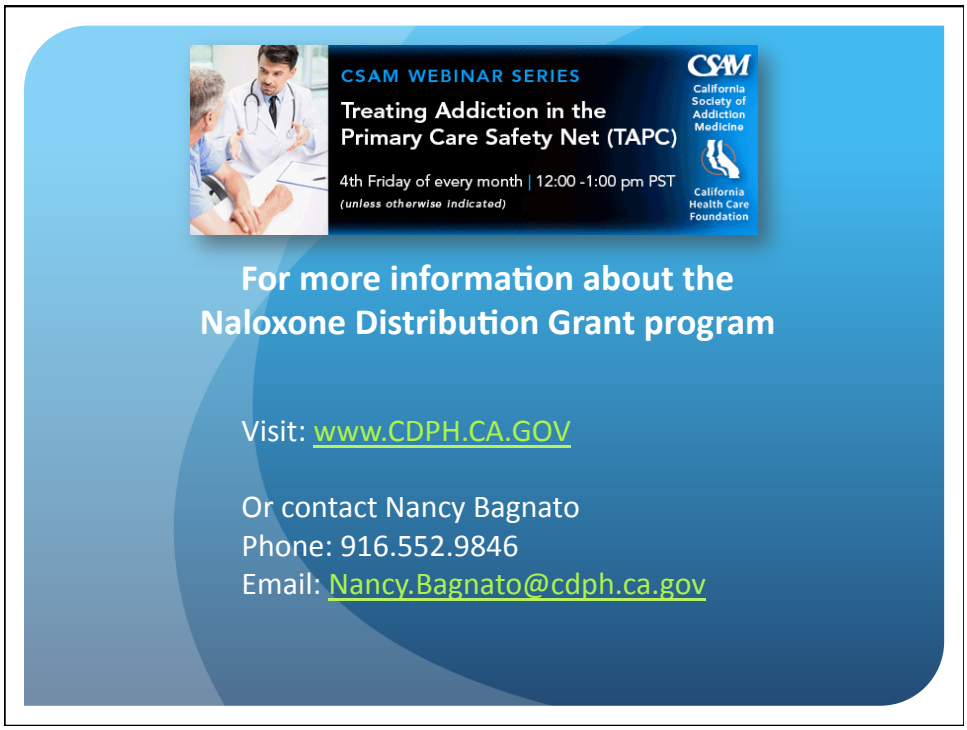
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For more information about the Naloxone Distribution Grant program
Visit: www.CDPH.CA.GOV
Or contact Nancy Bagnato
Phone: 916.552.9846
Email: Nancy.Bagnato@cdph.ca.gov

Thank you for participating in today's webinar.

Stay online after the webinar ends
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