

The Foundation Quarterly

North Carolina Communities Tackle Opioid Abuse and Addiction

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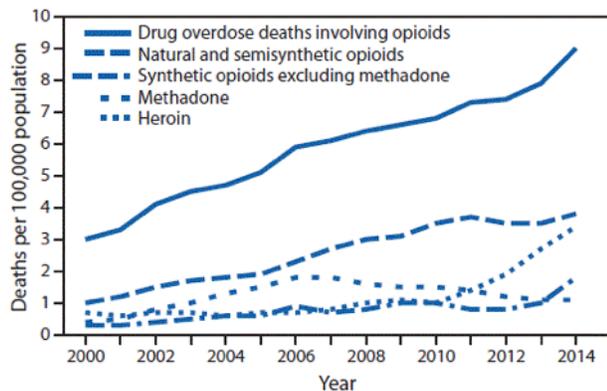
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It's STILL About Whole-Person, Whole-Community... Opioid Abuse and Addiction

The table below from the CDC illustrates what we hear all the time on the news and in our communities: drug overdose deaths are on the rise. It's both heartbreaking and shocking! Since 2000, the rate of deaths from drug overdoses has increased 137%, including a 200% increase in the rate of overdose deaths involving opioids. Escape from chronic pain, caused by a myriad of physical ailments, often initiates the journey to overuse and addiction.



Rather than focusing on the enormous and incredibly complicated routes to opioid addiction, this newsletter will take this opportunity to shine a light on some of the people, communities and projects that are working to make a difference. Once again, our mantra at the Foundation, "it's a whole-person, whole-community thing," holds true. Solving this issue is not possible by a single person or a single agency/institution; it's about how we all can work together.



Rural communities are particularly vulnerable to this issue for a variety of reasons. Access to care, access to pain management, and the number of heavy labor occupations inherent in the economy of these communities have all been linked as reasons for increased opioid use. Research has also shown that prescription drug use in some rural areas is an embedded part of the culture, as they are often prescribed them to maintain a steady workflow in heavy labor occupations.

The Foundation houses The NC Rural Health Leadership Alliance, a group that works closely with the National Rural Health Association (NRHA) on a variety of issues. In February, NRHA provided testimony to the United States Senate Committee on the Judiciary regarding mental health and substance abuse issues in rural America. The following is a summary of the comments and recommendations from NRHA:

- Rural Americans in need of substance abuse treatment services and behavioral health care will find that access to care can be limited.
- Even with rural telemedicine services improving access to mental health care, 60 percent of rural Americans live in a mental health professional shortage area.
- Rural Americans are forced to travel significant distances for care, especially specialty services such as mental health services and pain management.
- With rural hospital closures, rural Americans are farther away from emergency care, as well as options for the ongoing treatment that is essential for successfully treating substance abuse.
- The differences between rural and urban settings, culture and resource availability means the solution for rural America must be uniquely tailored to this population.
- Treatment programs must be available locally and should be tailored to the unique needs and characteristics of rural Americans. Treatment programs must be able to leverage the health care providers in the community while using tele-health and other resources to bring new providers into the community.

- The implementation of models to engage rural communities in addressing opioid issues must be supported. Broad community coalitions, including schools, law enforcement and medical providers need to be a part of the rural solution.
- Evidence-based prevention programs tailored to the needs of rural communities must be identified and developed.
- Implementation of harm reduction strategies must increase. Harm reduction is an essential part of dealing with the existing problem and will require training of both law enforcement and first responders. It will also require administering interventions known to reduce the harm of drug use including needle exchange and naloxone.
- Use of evidence-based prescribing guidelines need to be promoted. Pain management is an important component of health care. However, measurement of hospital and physician quality must balance the need to address patient's legitimate pain with the need to avoid misuse and diversion of pain medications.
- State prescription drug monitoring programs (PDMPs) must be strengthened.
- Use of substance abuse treatment as an alternative to incarceration for opioid users must expand. Those facing substance abuse or mental health crisis may wait years before seeking treatment from a professional, especially in rural America where the stigma discourages people from seeking treatment and views addiction as moral failure.

For the complete testimony from NRHA to the U.S. Senate Committee on the Judiciary, visit:

<http://connect.nrharural.org/blogs/erin-mahn/2016/02/22/nrha-submits-testimony-on>

An enormous thank you to all the people engaged in this work every day. At the end of the day, success comes from the work done by communities, their citizens and the people who need their help.

-Maggie Sauer

CEO & President

Communities Respond to the Rising Opioid Crisis

For years, the country's opioid crisis has quietly escalated. From 1999 to 2012, deaths from common opioid medications increased by 400 percent. Additionally, accidental drug overdose is currently the leading cause of injury-related death in the country for people between the ages of 35 and 54.



North Carolina is no exception. In 2014, more people in North Carolina died from drug overdoses than car accidents.

Some blame decades of overprescribing opioids for the epidemic. Others blame law enforcement for not controlling the influx of cheap heroin. But according to community health advocate Anne Thomas, the "blame game" isn't helpful. "Everyone is part of the problem. And everyone is part of the solution."



Anne Thomas

Consultant for Chronic
Pain Initiative and
Project Lazarus

Anne Thomas is the current Chair of the Foundation's Board of Directors and a consultant for the Chronic Pain Initiative and Project Lazarus. She supports communities in over 30 North Carolina counties who are building capacity to address the opioid epidemic and manage chronic pain effectively.

"Communities are best poised to solve their community health problems because they know their resources, they know their own culture," said Thomas. "They know what things are possible, where there's support, and where there's resistance."

The Chronic Pain Initiative and Project Lazarus is a two-year project funded by the Kate B. Reynolds Charitable Trust. The Foundation partners with the NC Office of Rural Health and Community Care of North Carolina to administer this statewide collaborative around opioid prescription management.

Project Lazarus is based on a successful model developed in Wilkes County aimed at preventing overdoses and meeting the needs of those living with chronic pain. The model includes the use of toolkits for clinical and community training. The toolkits are a range of guidelines for community action, education and for assessing pain and prescribing medication safely.

Thomas's work is with community engagement. She provides technical assistance to help communities create and maintain local coalitions. She assists them with developing locally identified needs and locally tailored drug overdose prevention programs and connects them with state and national resources. This work includes identifying stakeholders who need to be at the table, leveraging resources or providing educational materials to boost awareness. "Many times they have the resources right there in their community, it's just helping them explore and navigate them," said Thomas.

One of the premises of the project is that change is possible with community engagement. Thomas says this means engaging with traditional and nontraditional partners. "We try to bring everyone together and engage the entire community," said Thomas. Many coalitions are made up of parents, school systems, law enforcement, public health, businesses, churches, pharmacists and the medical community.

Thomas said that regional alliances can have a big impact. A cluster of seven counties in the northeastern part of the state have a coalition called the Albemarle Region Project Lazarus Coalition. The coalition includes Currituck, Camden, Pasquotank, Perquimans, Gates, Chowan and Bertie counties. Because of their shared resources, the alliance distributed effective messaging around safe opioid medication use and disposal.



They also organized drop boxes for unused prescription medication and purchased two incinerators for disposing them. They organized training in naloxone—a drug that reverses opioid overdoses—for emergency first responders. The alliance has partnerships with the school system to train school resource officers and school staff in providing prevention education. They work with community colleges to provide addiction education in the health curriculum as well as with law enforcement and the public health department.

“Rural communities have scarce resources,” said Thomas. “So creating economies of scale and scope by sharing resources and getting more people at the table is really effective.”

Thomas says communities can accomplish a lot by setting goals, assigning roles and developing strategy. “People don’t want to come to the table to just talk about something,” she said. “They’d rather be doing something. And when the doing starts to happen, people get involved.”

To learn more about the Chronic Pain Initiative and the Project Lazarus model, visit:
<https://www.communitycarenc.org/population-management/chronic-pain-project/>

For more information on North Carolina’s opioid epidemic, visit:
http://www.ncmedboard.org/images/uploads/other_pdfs/Policy_for_the_Use_of_Opiates_for_the_Treatment_of_Pain_June_4_2014.pdf

Serving Individuals with Addiction: An Integrated Care Perspective

The Center of Excellence for Integrated Care (COE) is a program of the Foundation that works with health providers across the state to integrate primary care and behavioral health services. COE's model of integrated care is well-suited for substance abuse issues, which can harm both the mental and physical well-being of a patient. COE Director Cathy Hudgins says that "integrated care provides those struggling with addiction an opportunity to be treated as a whole person."

The COE helps organizations develop their ability to provide integrated health care. One of their longstanding partners is Family Service of the Piedmont (FSP) in Guilford County.

The primary care provider for FSP is Anthony Steele. Steele is a nurse practitioner with a certificate in family medicine and psychiatry. He has spent 16 years serving individuals with addiction. He says he's a "one-stop-shop" for patients because he has the training to address their physical and mental health in one setting. In the time that the COE has been working with FSP, Steele has assisted in building exemplary integrated care services.



We asked Steele a few questions to understand how he uses the integrated care model to help patients suffering from addiction.

When did you realize that you wanted to work with addiction?

I was done with inpatient healthcare. I needed to do something different. When I came in 16 years ago I knew nothing about addiction. But guess who were the best educators? My patients. They were the ones who taught me about the disease. They even taught me how to change my language when speaking to clients. I had to really adjust. Because when you're looking at a patient and you're calling him or her an addict, it's one of those things that just makes them cringe. 'No, I'm not just an addict. My name is John,' or, 'my name is Suzie.'

I also had to work on my perception and how I addressed individuals. I had to look at them as a patient and as a client. This is someone's son. This is someone's daughter. This is someone's brother. In treatment we always want to keep people alive. Every day you see someone alive is a success. Then you work on developing tools to help them stay alive. You work on helping them build resources and you meet them where they are. Within the first month of working with addiction I became engrossed with learning about the disease process and I thought if not me, then who?

What's encouraging about your work?

When I have a patient come in who's been using 10 bags of heroin a day and then within a week of treatment, they are looking at me in the eye, they are taking a bath, and they are beginning to see changes in their life. When you see a pregnant mother who's been using every drug under the sun get stabilized and she's now able to have a normal labor and delivery. When I see those patients, I know this is where I need to be.

How does integrated care help you serve individuals with addiction?

We look at the whole picture. We do a comprehensive assessment when people come in. We have screening tools that look at depression, anxiety, trauma, addiction history, and physical health issues. When a patient comes in, they have bared their souls to us, and it's a judgment-free zone. It just makes sense for us to treat the mind, the body, and the soul. If a patient is struggling with opioid addiction, but also high blood pressure and diabetes, I'm not going to ignore those physical issues. I'm not going to send them to another primary care doctor that doesn't know them or who may prescribe other medications that could get the patient into trouble. It's important to be mindful of not causing a relapse.

“If we don't begin to address the fragmentation of care, then our opioid addicted individuals will continue to be stigmatized.”

If we don't begin to address the fragmentation of care, then our opioid addicted individuals will continue to be stigmatized. We need providers that know a patient's history, won't judge them, and will meet me where they are. Some of these patients don't have their basic needs being met. When you add addiction on top of that, their addiction takes precedence over food and shelter. That's why we help clients get their cravings under control, and then we work on the other aspects of life. Let's get you gainfully employed. Now let's work on relationships with your family so you can be supported on that road to recovery. Instead of disconnecting the head from the body, my goal is to connect it all together.

How does addiction tie in with other health issues?

People who have addictions have the same chronic medical issues that anyone else has, but they might be highly elevated because they aren't typically treated. If you look at most statistics, more than one in five adults have a co-occurring mental health and substance abuse issue. And so it just makes sense to figure out how to treat them in a collaborative perspective.

One thing I've noticed is that dental care is much needed and sought after. A patient who's addicted to opioids, one of their side effects is dry mouth. If you have dry mouth you aren't producing enough saliva, and then bacteria grows and your teeth decay. But if you're in active addiction, you're not going to be worrying about brushing your teeth. It's a perfect storm for dental problems. If I have dental issues, they effect my self-esteem, and now I have self-doubt, now I'm depressed, now I'm isolated. And it continues that cycle of relapse and recovery, relapse and recovery. Oftentimes our patients are also IV drug users which opens up the risk for Hepatitis C transmission with potentially shared needles. They may not know or have any symptoms, so they keep sharing needles, snorting drugs with dollar bills and having unsafe sex.



Why do you think that integrated care for opioid addiction isn't more widely used?

Sometimes I think it's a comfort level. Most medical programs don't give you a lot of training in substance abuse and mental health. In primary care you maybe get one to two week's rotation in substance abuse, and that's it. You're taking on the responsibility of something you really don't know much about. And sometimes in primary care, if you don't ask about

addiction, you don't have to deal with it. Some primary care providers do want to deal with it, but guess what? They are limited in terms of where they can refer patients. The amount of money that's available for substance abuse treatment compared to all the other diseases is a drop in the bucket. If I'm a primary care provider and I screen for addiction, where can I get this patient into treatment? The hospital is limited and here in Guilford County we only have one in-patient detox facility, which is also limited. I think there might be 15 beds.

In your opinion how do we better address this epidemic?

We've got to do a better job with screening and treatment. You really need to meet the patient where they are. But once we screen for it, we also need funding to cover the cost of these patients who need this service. We have to stop ignoring the issue. Because it's here, and it's prevalent. Until we take a very hard look at this disease, we are going to continue these vicious cycles of chronic relapse and people dying on the streets. Most people look at it as a character flaw. We in the addiction world know that it's not. This is a disease of the brain that needs to be dealt with like any other disease. You don't tell your diabetic, 'you're obese so we aren't going to treat you.' No. You work with that patient where they are. Oftentimes with our addicted individuals, we just don't have that same tolerance.

It is essential that solutions to these problems are rooted in and informed by those individuals who grapple with these realities on a daily basis with evidence-based scientifically sound methods. To that end, the NCOHC is partnering with individuals and organizational representatives who have a vested interest in ensuring all North Carolinians enjoy good oral health.” To learn more about the NCOHC’s work, please visit:

www.oralhealthnc.org



Bernstein Fellow Spotlight: Erin Hultgren



Erin Hultgren, a Bernstein Fellow and Program Manager at Gaston Family Health Services (GFHS) is currently assisting with a behavioral health initiative that will improve and expand the delivery of substance abuse services and Medication-Assisted Treatment (MAT) to underserved populations with opioid use disorders. This initiative is funded by the Health Resources & Services Administration (HRSA) through their recent Substance Abuse Service Expansion, which awarded a total of \$94 million in funding to health centers across the United States. GFHS was one of seven centers in North Carolina and one of 271 centers across 45 states to be awarded.

The additional grant money will enable GFHS to expand behavioral health and substance abuse services to serve its patient panel as well as extending services to both pregnant women and people living with HIV/AIDS and opioid addiction. Through its history of collaborative work with the Gaston County Health Department (GCHD), GFHS will work with GCHD and other community partners to identify pregnant and parenting women and HIV+/AIDS patients who need a more integrated approach to their opioid addiction including primary care, behavioral health, MAT and counseling services. Identification is only the first step. The ultimate goal of GFHS is to not only identify these patients, but also provide them with the integrated care they need to achieve and sustain recovery.

Additionally, GFHS will enhance their existing integrated model by:

- Increasing the number of patients screened.
- Connecting identified patients to treatment.
- Hiring additional behavioral health providers to connect patients with access to MAT treatment.
- Providing training and education for providers on best practices for opiate prescription.
- Working with patients and community members on the availability and use of opioid antagonists.

As the HIV program manager for GFHS, Erin's primary role in this initiative is to increase screening and education regarding the availability of testing and treatment for patients with or at risk of HIV/AIDS and Hepatitis C, both associated with opioid use disorders. Erin will work with behavioral health staff to update risk assessments to include questions regarding sexual health, HIV and Hepatitis C risk. Since integration and coordination of services is key to success, Erin will coordinate services between GFHS and health departments in the area to ensure patient's have access to HIV testing and clinical services regardless of ability to pay. Although she's new to the work of opioid addiction, she believes that an integrated care approach is the best way to provide support for these substance abuse issues.

"As we move forward, I think collaboration and communicating between partners will be our largest challenge and biggest asset," she says. "Education will be critical – educating primary care providers, working with ERs, changing protocols, etc. Opioid addiction has far-reaching consequences and it will take all players at the table to conquer this public health crisis."

For more information about Gaston Family Health services and their unique integrated care approach, visit <http://gfhs.info>.

New Staff Feature: Monica Harrison Joins the Center of Excellence for Integrated Care

Just this month, Monica Harrison joined the team as Technical Assistant for the Center of Excellence for Integrated Care. With years of experience and a great deal of passion, she will provide tools, techniques, training and technical assistance to organizations and healthcare professionals that will help them implement best practices for integrated care. We asked Monica a few questions to get to know her better.



Q. Where are you from and how did you end up in North Carolina?

I was born in New Orleans, LA. However, I'll say I'm from everywhere, as I am what they call a "military brat." Both of my parents were in the army and we moved to Fayetteville (Ft. Bragg), NC in 1991. I decided to attend college at the University of North Carolina at Greensboro for my Bachelor's Degree in Human Development and Family Studies, and then attended NC A&T for my Master's Degree in Social Work.

Q. What drew you to the Foundation?

Talk about the universe smiling down on me. I was eager to learn all I could about integration and making sure my agency participated in continuing our integration efforts in the most concise and evidence-based way possible. I've been on this endeavor since 2010. When I met the Center of Excellence staff in 2011, I thought, "wow it would be great to have had a blueprint to build off of and follow." I've kept pushing forward ever since and have hoped I would have the opportunity to help others in their journey. Now I get to do just that.

Q. What type of organizations have you worked for in the past?

Believe it or not my first career was as an educator/teacher so, I hold a Birth Through Kindergarten Teaching License. Since then, I've held multiple positions with the Guilford County Head Start/Early Head Start program (teacher, education specialist, professional development coordinator, consultant). I've worked for Wake Forest Outpatient Dialysis Centers as a Nephrology Social Worker and Social Worker Manager in which I traveled to facilities in different parts of North Carolina as a part of an interdisciplinary team. I've worked for Win-Win Resolutions where we focused on character education, mentoring, bullying and conflict resolutions for the school system as well as juvenile justice led family programs. I've been the clinical lead for a residential home (group home) conducting clinical groups, and I've also worked at a pediatric primary care office to consult with other pediatric offices to work on integrative efforts. Lastly, I transitioned to working in a Federally Qualified Health Center as a part of and manager of their integrative endeavors.

Q. What are you excited for in this position?

I am excited to get the opportunity to spread my love and joy of integration and to be able to assist others to be successful in their integration efforts.

Q. What do you like to do for fun?

Well if not running around crazy to my children's sporting events (I have five boys who all play a different sport, some of which travel constantly – and yes I am the loudest yelling mom on the team) then you will find me out with my husband trying out a new or favorite restaurant – we are "foodies."

New Staff Feature: Jessica Pikowski Joins the Foundation as Communications Coordinator

In February, Jessica Pikowski joined the Foundation as the new Communications Coordinator. In her role, she brings expertise in strategic communication that she will utilize to assist the Communications Team in setting and implementing strategies that help build the Foundation's brand and visibility. We asked Jessica a few questions to get to know her better.



Q. Where are you from and how did you end up in North Carolina?

I grew up in Connecticut, but ended up in North Carolina when I decided to attend High Point University for my undergraduate degree. I fell in love with the state (and the weather) and ended up staying around to attend UNC Chapel Hill for graduate school. I think it's safe to say I won't be leaving North Carolina any time soon.

Q. What drew you to the Foundation?

I studied strategic communication as an undergraduate, but I've always had an interest in working for health-related nonprofits, which is why I am now pursuing a master's degree in Health Communication. I've found that I enjoy doing work for organizations that make a difference (especially in health), whether it's at the community level or nation-wide, which is one of the main reasons I was initially drawn to the Foundation.

Q. What type of organizations have you worked for in the past?

I went right from undergraduate to graduate school, so I don't have a ton of experience in the work-field, but many of my undergraduate and graduate courses have involved working with clients in the surrounding community, so I've done work for a variety of clients like: the High Point Community Foundation, Kozzy's Grille, Solar Head of State, and the UNC Volunteer Doula Program. I also worked for a small public relations agency called Creative Services, where I worked with mostly university clients, including High Point University and Davidson County Community College.

Q. What are you excited for in this position?

The Foundation's message is an important one, and one that doesn't always get the attention it deserves, so I'm looking forward to helping with the communication of these messages and being able to help get the word out to others about the great work they do.

Q. What do you like to do for fun?

I love to run, go hiking, biking, basically anything that gets me outdoors. I also love to read. With all the academic reading I have to do for school, sometimes it's hard to find time lately to read for pleasure, but I'm trying to fit in at least 2-3 books a semester.

New Staff Feature: Past Bernstein Fellow Tim Smith Joins the Foundation

Tim Smith, a past Bernstein Fellow (2012-2014) and full-time Research Associate for Carolina HealthNet (CHN), will be joining the Foundation part-time to assist them with data collection and evaluation. CHN aims to connect uninsured patients to high-quality, low-cost healthcare while educating them on the merits of a patient centered medical home. The Foundation looks forward to having Tim and his expertise on the team. We asked Tim a few questions to get to know him better.



Q. Where are you from and how did you end up in North Carolina?

I was born and raised in Chapel Hill, so I didn't have much choice about coming to NC. But I have chosen not to leave! My wife, Kelly, was also born and raised in Chapel Hill and we still make our home there with our daughter, Lauren.

Q. What drew you to the Foundation?

When I learned about the Bernstein Fellowship and the work the Foundation does, I decided to apply for the fellowship. I was fortunate enough to be one of 4 chosen that year (2012-2014) and that is where my relationship with the Foundation began. A commitment to rural health and health equity for all are passions I definitely share with FHLI.

Q. What type of organizations have you worked for in the past?

I have worked for several types of organizations ranging from political campaigns, higher education and several different non-profits working with rural areas to improve economic development and health outcomes.

Q. What are you excited for in this position?

To be part of an organization that works every day to bring our communities closer to a place where all North Carolinians (and beyond) have access to high quality, affordable healthcare. Working across the different programs will allow me to learn about the different initiatives occurring to help us get there.

Q. What do you like to do for fun?

My wife, Kelly, and I enjoy playing with our 19-month old daughter, Lauren, and taking family walks with our dog, Basil. I like attending UNC Tar Heel sporting events, playing golf, running and other exercise. Relaxing with family and friends is important, too.

Save the Date for the 2016 Bernstein Dinner!

The date is set! Please reserve **October 6, 2016** from 6:00-9:00pm for the 11th Annual Jim Bernstein Health Leadership Fund Dinner supporting the Jim Bernstein Health Leadership Fellows Program. This premier event convenes health professionals and stakeholders from across North Carolina to network and learn from one another and to celebrate and honor past, present, and future contributions in our state's health sector.



NC Rural Center Releases Rural Advocacy Agenda



Through a series of regional briefings held this month, the NC Rural Economic Development Center (Rural Center), a partner of the Foundation, released its rural advocacy agenda titled “Rural Counts: 10 Strategies for Rural North Carolina’s Future”.

The agenda promotes “stabilizing and transforming rural health” as an essential strategy for providing rural communities with a foundation for success. Regarding this strategy, the Rural Center specifically advocates to “strengthen local, state, and federal efforts to reduce opioid and methamphetamine drug addiction” recognizing addiction and substance abuse as a national crisis and supporting programs from various sectors and government levels designed to address this issue.

Learn more about the Rural Center’s recommendations regarding rural health and its comprehensive strategies for realizing the “economic potential for our rural communities and citizens” from the #RuralCounts download center on the Rural Center's homepage: <http://www.ncruralcenter.org/>