

Transcript for RHIhub Webinar: Prevention and Treatment of Substance Abuse in Rural Communities

Kristine Sande: Good afternoon, everyone. I am Kristine Sande, and I'm the program director of the Rural Health Information Hub. I'd like you to welcome you to today's webinar, where we'll be covering a topic that is just critical for rural communities, the prevention and treatment of substance abuse in rural communities. Before we get started, I'll just quickly run through a few housekeeping items. So, we do hope to have time for your questions at the end of the webinar today, if you do have questions for our presenters, we ask that you submit those towards the end of the webinar using the Q&A section that will appear in the lower right hand corner of the screen, following the presentations. We have provided a PDF copy of the presentation slides on the RHIhub website, and that's accessible through the URL that's on your screen right now, or by going to the RHIhub webinar page, which is, "www.ruralhealthinfo.org/webinars," and clicking into today's presentation.

If you do decide to go download those slides though, just don't close the webinar window, or you'd have to log back in to the event. If you have technical issues today, we ask that you call WebEx support at, "866-229-3239." We've got a great slate of speakers for you today. First, we'll hear from Tricia Stauffer, who will tell us about the evidence base for substance abuse treatment and prevention, as well as the types of program models that can be used in rural communities. Tricia is a Principal Research Analyst at the NORC Walsh Center for Rural Health Analysis. Tricia designs and implements evaluations of community outreach and engagement efforts for public health programs. Her research has focused on public health and health policy. She worked on the substance abuse tool kit project, which you'll be hearing about today. She has a Master's degree in public health from Tulane School of Public Health in tropical medicine.

Our next two speakers will share with us their experiences in implementing substance abuse prevention and treatment programs that serve rural areas. Lisa Macon Harrison is the local health director in Granville and Vance counties in North Carolina. She has worked at the intersection of public health and research and practiced in North Carolina since 1995. Ms. Harrison's areas of expertise in public health leadership and training include: working with partners to establish the North Carolina Practice Based Research Network, training the public health workforce in evidence based public health approaches, establishing the quality improvement training program for the North Carolina Division of Public Health, directing the North Carolina Office of Healthy Carolinians and Health Education, leading the North Carolina Public Health Incubator Collaborative Program, and directing the Southeast Public Health Leadership Institute. Lisa has a Bachelor's degree in Public Health, a Bachelor's of Arts in Public Policy, and a Master of Public Health from the Gillings School of Global Public Health at UNC Chapel Hill. She is also a co-author on more than 30 peer reviewed publications in public health.

Next we'll hear from Freddie Jaquez, and he is the Executive Director of the San Luis Valley Area Health Education Center in Alamosa, CO. He began his employment as director on March 1, 2007, and he plans to retire on June 30, 2017. Some of the programs he's currently supervising include: Grow Your Own Youth Pipeline Health Careers Program, The Colorado Heart Healthy Solutions Cardiovascular Assessment Program, The Prescription Drug and Street Drug Abuse Awareness Campaign in the San Luis Valley, and The Anschutz Medical Campus Health Professions Student's Rural

Clinical Rotation Experience. Freddie has experience in community networking with the San Luis Valley Human Services Agencies, and also Healthcare Professional Networks. He is a former Executive Director of the Alamosa County Department of Social Services, and the Field Services Representative of the Workforce Investment Act through Rocky Mountain SER Jobs for Progress in Alamosa, Colorado.

With that I will turn it over to Tricia, to begin her presentation. Thanks.

Tricia Stauffer:

Thank you, Kristine, and thanks to everybody for joining the webinar. Today, I'm happy to be able to introduce the Rural Prevention and Treatment of Substance Abuse Toolkit. This toolkit was developed as part of the Rural Health Outreach Tracking and Evaluation Program, but the project was funded by the Federal Office of Rural Health Policy, within the Health Resources and Services Administration. The project is conducted by the NORC Walsh Center for Rural Health Analysis, in partnership with the University of Minnesota Rural Health Research Center. NORC and the University of Minnesota are also working with the National Organization of State Offices of Rural Health, and with the National Rural Health Association to disseminate findings from the evaluation.

The Rural Health Outreach and Tracking Evaluation Program was designed to monitor and evaluate the effectiveness of programs funded under the Outreach Authority of Section 330A of the Public Health Service Act. Outreach Authority Grantees seek to expand rural healthcare access, coordinate resources, and improve quality. Grantees work as part of a partnership with healthcare providers, schools, travel health programs, and community based organizations. This is just a high level overview of the Outreach Authority Grant Programs that are funded through Section 330A.

A key focus of the evaluation this year, has been to identify evidence based and promising practices for preventing and treating substance abuse in rural communities. Substance abuse is a rapidly growing problem in rural communities. Nationally, there's been a dramatic increase in opioid abuse, especially in states with large rural populations. Other problems in rural communities include binge drinking, and methamphetamine use. Rural communities are implementing a diverse array of programs to prevent and treat substance abuse. These programs aim to prevent substance abuse, to increase access to treatment and support services, increase collaboration among organizations, provide education and training, increase coordination of care, and reduce stigma. The 330A Research Authority Grantees and other rural communities have successfully implemented a range of different program models, and their experiences suggest promising practices that can be adapted in other rural communities.

We developed this toolkit to get evidence based and promising practices and other resources. I want to quickly acknowledge the rest of the team that developed this toolkit. Debra Bachmann, Alicia Baine, Alana Knutson and Molly Powers. Our project goals were to identify models that might benefit grantees, future applicants, and rural communities, document the scope of their use in rural communities, and then to build the toolkit. Our activities included reviewing grantee applications to identify promising practices, conducting literature review, conducting telephone interviews with five SORHP Grantees, four other rural communities, and eleven experts in the field, and

lastly developing the toolkit, that includes resources about how to implement programs to prevent and treat substance abuse in rural communities.

The toolkit is now available on the Rural Health Information Hub Community Health Gateway Website. A link to that toolkit is at the bottom of the slide. This is a snapshot of the main page of the toolkit. The toolkit is organized into different modules, as you can see, on the menu on the left side of the screen. Each module focuses on different considerations for planning and implementing programs. Each module contains information and resources on those topics. Resources might include white papers, websites, or templates, that can be used to help rural communities implement programs.

Module two, describes evidence based and promising program models, implemented in rural communities. For the next few slides, I'll just briefly describe each of the models that discuss in the toolkit. You can find more detailed information on each model in the toolkit itself. The first is, "Medication Assisted Treatment." This is the use of pharmacological medications combined with counseling and/or behavioral therapies to treat substance abuse. Behavioral therapy focuses on changing behaviors related to substance abuse. It also focuses on teaching life skills that can help individuals to better cope with situations that may lead to substance abuse or relapse. In this module, we discuss behavioral therapies that are shown specifically to be effective with substance abuse treatment.

The "Harm Reduction Model" uses a variety of strategies to reduce the harmful consequences associated with substance abuse. Harm reduction strategies seek to reduce morbidity and mortality associated with substance abuse, for those for whom abstinence is not an immediate and/or a feasible goal. Harm reduction models focus on reducing risky behaviors that are often associated with substance abuse. Strategies discussed in the toolkit include the use of screening, brief intervention and referral to treatment, Naloxone expansion, prescription drug monitoring programs, proper drug disposal programs, and the use of drug court.

One strategy that I'd like to discuss in a little bit greater detail is Naloxone expansion in rural communities. The use of emergency medication called Naloxone can reverse the effects of opioid overdoses, and reduce the morbidity and mortality related to opioid overdose. Rural communities are implementing programs to increase the availability and the use of Naloxone. Programs like this focus on delivering technical assistance and education to stakeholders. Naloxone can be administered by anyone who's received training, including providers, pharmacists, emergency responders, and others in the community. These programs focus on providing community wide trainings on how to recognize an overdose, and on coalition building in the community.

Also, in 2015 the US Department of Health and Human Services developed a pilot program called, "The Rural Opioid Overdose Reversal Program." 18 grant recipients in 13 states were awarded \$100,000 over a one year period to reduce opioid overdose in rural communities, through the purchase and placement of Naloxone kits, to reverse the effects of opioid overdoses. We'll hear from two of those grant recipients later in today's webinar.

Care delivery models remove barriers to care for people with substance abuse disorders, increase coordination between healthcare providers, and enhance the potential for treatment and recovery. We discuss strategies related to integrating services, tele-health, continuing care, and case management. Peer based recovery support programs are available throughout the continuum of care. These are non-clinical support services that can be provided by peers who have received training, and also have had a personal experience with substance abuse.

Prevention programs focus on helping individuals to develop knowledge and skills or on changing environmental and community factors that affect a larger population. Interventions like this can be universal and that they reach at entire population, selective interventions that target at-risk subgroups, or indicated interventions, which are aimed at individuals who are exhibiting early signs of substance abuse. Programs can be implemented in a wide variety of settings like schools, workplaces, and the community.

I want to conclude with some of the lessons that we learned through our work on this toolkit. First, that rural communities have fewer treatment facilities, mental health providers, and other services available to residents. People who live in rural communities may experience longer travel distances to available treatment facilities, and other resources. Public transportation is also not available in rural settings, and people who need to seek care might not be able to transport themselves to treatment.

In small rural communities, where there might be little anonymity, stigma is a major barrier to recovery, and impacts whether individuals with substance abuse disorders seek treatment or social support services. Partnerships are critical to success. Community partnerships can be made up of local emergency responders, as well as other local non-profit or for profit entities, involved in the prevention and treatment of substance abuse.

Lastly, the Surgeon General's 2016 Report On Alcohol, Drugs, and Health, is an important resource. It calls for a public health based approach to addressing substance abuse, and discusses the importance of building awareness of substance abuse as a public health problem. Thank you all so much for your time. We hope that you will visit our toolkit, and find it useful. If you have any questions about it, please feel free to reach out to either of our co-directors at the Walsh Center for Rural Health Analysis. Now I'd like to turn the presentation over to Lisa Harrison, who's going to tell us more about Project VIBRANT.

Lisa Harrison:

I'm happy to be with you today, sitting here in Oxford, North Carolina today. I was introduced, I'm a local health director for a two county health district, which means sometimes I'm sitting in Oxford, North Carolina, other times in Henderson, North Carolina, and together these two counties have one local health department but lots of community partners who come together in doing the delivery of services and starting new programs like our Project VIBRANT, that I'm going to talk to you about today.

As you see, and as we like to do often in Public Health, Project VIBRANT is an acronym. It's standing for "Vance Initiating Bringing Resources And Naloxone Training" to the

area. So we have two different versions of VIBRANT. We had from 2016-2017, from a September to October Federal, sort of fiscal year time period, associated with the HRSA Grant that you just heard about, the Rural Opioid Overdose Reversal Program, had one year's worth of funding to get us started on Project VIBRANT, and now we are currently in another funding period by a local legacy foundation called, "The Triangle North Healthcare Foundation." That is helping assistants sustain our coalition work on this effort. So two shout outs, and thanks to those funders, to help keep this work going.

The two different logos you see there on the bottom, one is ours, the other belongs to the North Carolina Harm Reduction Coalition, and without their assistance, we could not have even gotten started with this, so you'll hear a little bit more about them in my presentation. Mike has already alluded to this as a collaboration, it's a partnership across different local agencies, all with the same really solid vision, and heart-forward connection of harm reduction and lifesaving efforts. We have a really nice group that just happens to like to get together despite the fact that we often have lunch when we do get together, which never hurts the group's attendance, I will have to say that is a best practice we feel like we have employed, to make sure that all of our partners are happy to come to the table, we do provide a little bit of snack for them around lunchtime.

The purpose of our group is just to build those relationships, get to know each other, and talk about this issue, in sort of a safe space, which is really important. We are about much more than simply offering the Naloxone kits and the education, but that of course is the focus. So, "Why is the Health Department involved in this, and what's our role?" I asked myself that question from the very beginning, and we continue to ask ourselves that question despite the fact that we know this is an epidemic of huge proportion in the United States, and especially in our area here of North Carolina.

The quick and easy answer as to why the Health Department is involved in this is that, we are used to convening partners. We like helping develop strategy and evidence based practice, and connecting science and practice in this and other areas. So it maps very easily back to our top three health priorities for these two counties. These are the top three health priorities we have in our area, mental health and substance use disorder, is top of the list. So doing this project, starting this project, even though we felt initially we did not have nearly the expertise or the capacity to do it as well as we wanted to, we decided to jump off the high dive, and do it anyway, because the community said they needed it, and wanted it. Then you see our other two priorities listed there.

Here is a picture of one of the key, key, stakeholders and most effective interveners in this particular issue for us. The North Carolina Harm Reduction Coalition is the snapshot of the web page that you see there, "N C H R C." There's a picture of Loftin Wilson, there in the middle, who is our fearless, "boots on the ground", community outreach worker, who has taught us in our group, the most about how to do this work well, what it takes to have the right attitude and the right language, and the right demeanor, and then Loftin himself just goes out and does it all extremely well.

Again, I am going to continue to use the analogy of sort of jumping off a high dive. It's what it felt like. It felt very risky. It felt pretty scary. I felt very unsure about where I was going to land, or why in the world I was doing this in the first place, as a health director without background training in mental health and substance use disorder or treatment. But Loftin really held our hand throughout this process, and said, "Look, we just need some serious support across these different agencies, who do connect mostly with people who need us to be delivering education, intervention, in a caring non-judgmental manner." I think one of the really key tenets of the effectiveness of the North Carolina Harm Reduction Coalition, is that they are made up of a group of volunteers that just know how to make the right connections and build the trust in the communities that we need to be serving for this. I just can't say enough good things about Harm Reduction Coalition, and Loftin Wilson in particular.

You see that there are lots of coalition members who are part of our group. It's certainly important to have the pharmacists at the table in these communities, and I have them onboard knowing what we're doing with distributing Naloxone, being willing to distribute Naloxone with us and for us. We have great relationships with all of our local pharmacies, and now we are lucky enough in North Carolina to have a statewide standing order for Naloxone, so before that happened last year, we were able to provide that standing order locally, through our own medical director at the Health Department. So we ushered that opportunity in, and then the state sort of took it over with the state health director being willing to sign that. So we're lucky in North Carolina we have that.

We also have some really good connections, not just in our local community as you see with our local mental health services and treatment centers, we also have connections with our state and Duke University, with community care of North Carolina, which is our Medicaid managed care option, and others who are helping on the periphery. It's been a really successful group, who once we transitioned from one funding source to the other, we took a brief hiatus, and everyone was sort of disappointed and kept calling us and saying, "When is our next meeting?" "I'm looking forward to this meeting!" So you know you're doing something right when people call you and ask you when the next meeting is, but I've put this other slide in here, I have two slides that sort of give us a visual of complexity, because anytime you have that many people coming around a table, to discuss an issue that is already complex, that is also trying to address so many different core issues for the health of a person or a population, this is sort of what it feels like halfway through.

Once you've taken the dive off the high dive, then you sort of have swim through this for a little while, before you know where you're headed. Thankfully, I tend to as a leader have a low need for control, and a high need for collaboration, so based on this personality characteristic, I think this doesn't make me as crazy as it might make some people. I do know some of my colleagues get a little bit more afraid of the legal risks, for example, you're taking when you send people out into the field, into some of the more dangerous areas of town, where you have active drug dealing happening, or you send people into a shooting gallery, and at first when they said they were sending harm reduction coalition volunteers into shooting galleries, being in the South, and having all

the public health discussion about gun control, I wasn't even sure what they were talking about.

I really thought they were talking about the, "Bang, bang," shooting, not the needle shooting. But there's so much that I've learned about all of this that we've gone through, but the shooting galleries are sort of the places and the hubs where drugs are being taken, usually together with groups, and the harm reduction folks are trained with this, they're well insured, I don't have to take on that risk, they take on the risk of going and saying, "Hey look, here's some snacks, here's some education, here's some naloxone, let me tell you how to use this, we are here to save lives, and we are here to offer treatment options, and we want you to be safe, and we want you to stay alive, and we want you to get your hope back."

That's really powerful stuff, and it's good stuff. Obviously we've already established this and many already know well that we have a critical issue, and we know the numbers around that. These are just two little maps of North Carolina that I included so that you'd see, in the previous map, this one, we have sort of a tiered economic designation of different counties in North Carolina, and then you see here, Granville and Vance County are in the yellow. We have district health departments where we have the most poor, most rural communities in North Carolina, where each of those counties cannot afford their own independent health department, necessarily, and this is also where we see a lot of drug use, because the economy is not so great. I just wanted to give you a sense of, "That's where we live, and that's where we're doing this work."

Here's some accomplishments that we've made so far in this effort. In the first year, we have distributed over 1300 naloxone reversal kits, that doesn't just include handing them out, and making them available, that includes insuring that we are mapping out where they are going, based on the highest risk areas, and that we're also delivering education and treatment options with the distribution of naloxone. We find that really important. We have had 110 reported reversals in Vance County, when we started that, just in that one county. Now that we have extended through our new funding source, to VIBRANT Plus, the progress has been in both Granville and Vance Counties, where we're trying to reach a few more people, and a few more areas, and to date we've distributed a little over 270 kits, and we've had 34 successful overdose reversals in both counties.

The important thing too, is not just the distribution as I mentioned, but also we have these guides that our ROOR Coalition came up with to make sure that both providers and individuals have a knowledge about where they go when they need substance use counseling, or if they have mental health needs that are beyond that alone. We also as part of this work, not only did we do a comprehensive list of where you can find places to go locally for both self-referral and physician referral, but we also made sure that these one pagers and diagrams with phone numbers and access points are available for providers in the area, so that they know where to refer people to.

We found with the transition of going from a publicly run mental health program in North Carolina to a more private public partnership, then a Medicaid managed care situation, there's been some confusion in that transition as other states I'm sure have felt too. Often times, people just don't know who to call and where to go, and it's not

the same as it used to be, they've been here a long time, to try and kind of make an "Easy Button" of sorts for folks, we found was really important.

What we're doing now, is we're trying to build on this harm reduction effort, and continue to go backwards on the scale of prevention, try to hit a lot more educational opportunities among school aged children, for example, continue the education and distribution we have had success in, make sure we're paying attention to anything new and different coming out that has some promising practice or evidence based around it, and continuing to help our colleagues across North Carolina do this work, as they're just getting started, helping hold their hand on the high dive, for example.

We want to expand our coalition and our reach, and make sure that both counties are being involved as much and as well as Vance County started us out. Another picture of complexity, its title is, "Dynamism of a Soccer Player," but I co-titled it, "Dynamism of a Coalition Working on Opioid Overdose Reduction." This is actually a modern art piece, a poster of which hangs in my house, and I've always liked it, and like I said, "I must be attracted to that complexity on some level." This is just a quote that I used to always include at the end of every presentation, and it hangs around because I still think it is very appropriate, and we cannot figure out how to further our happiness and our power as a state, and is a nation, unless we figure out this persistent and very complex problem. So thank you for the work you're doing, and the interest you have in this issue. Now I will pass things over to Freddie, and we'll hear about what's going on in Colorado.

Freddie Jaquez:

All right, well hello everybody, and welcome from beautiful San Luis Valley, in the southernmost part of the state. We ran what was called the, SLV NEED Project. We were one of the 18 pilot projects across the country, and I'll tell you how we got there a little bit later on, but SLV NEED, stands for the Naloxone Education and Empowerment Distribution. I'm gonna include a map here of the United States, these are centers, AHEC centers. I do not want to assume that everyone on the call knows what an Area Health Education Center, is. We're very important to the support of the healthcare system across the country. If you don't know where your AHEC is in your state, you look at this map and just take a look where you have an AHEC Center. Also, you can google NAO, stands for National AHEC Organization, and you'll pull up the website to find out where your closest AHEC Center is.

We're really important with in regard to the work being done around each state regarding the project that that state may have in terms of healthcare education, so please, look at your AHEC. In Colorado, this is what our system looks like. We're divided into six different regions, we are the red San Luis Valley. We are affiliated with what's called a, "Program Office." That program office normally is established and located at a medical institution, a medical school in our case, it's at the University of Colorado Anschutz Medical Campus, in Aurora, Colorado.

I want to show you this other map. This is where we live, in the San Luis Valley, we're in the southernmost part of the state of Colorado, and we are a true mountain valley. As you can see, we have mountain ranges all around us. To the right, we have the Sangre De Cristo Mountains, to the left of to the west, we have the San Juan Mountain Range, and up north we have La Garita Mountain Range. We are enclosed, we are corralled, if

you will. The reason that I'm showing you this slide, is because it's truly important to the way we do business, and to the success of our project.

So, we are a true mountain valley, we have six counties in this small valley, we are only 46,000 plus residents in this valley. When I go to my meetings in Denver, I tell them, "You know, we're only 46,000 people, we're like one of your big neighborhoods here in Denver." But therein lies the success of our work, because we all know each other, so to speak, in this valley. Our elevation is 7500 feet, and little towns in the foothills get close to 8,000 feet, as an elevation.

Two slides to show you the beauty of our area, this is from my hometown in San Luis, Colorado. This is the stations of the cross, and we also are known for our Sand Dunes National Monument. Again, surrounded by this majestic mountain. It's important that I set the stage for you, so that you really do understand why we are so successful in this high mountain hole. So, how did we get here?

Back in October, we were invited to what was called a Narcotics Committee Meeting, and before we went to that meeting, my board chair, Joe Valdez, who is also a pharmacist, already had concerns about things going on in the community, the break-ins that were taking place. People were trying to get whatever they could to make money to buy their drugs and such. Well, in his pharmacy, they broke in twice already by this time. So we attended the Narcotics Committee. Who was the Narcotics Committee? It was representatives of the three hospitals that we have in this valley, which is San Luis Valley Health, Conejos County Hospital, and Rio Grande Hospital. We also have a FQHC called Valleywide Health Systems, and our local mental health center which is SLV Health.

They were meeting, and we joined their meeting. They were working on two documents that became the cornerstone of our work moving forward. Those two documents, one was a provider patient agreement, nothing novel, but what was novel about it, was that the five organizations all agreed on a universal document that they would all use in their organizations with their logos on the document. This document turned out to be a 2 1/2 pager, and it really has made an impact in regard to doctor shopping and such.

The other document they were working on was an update of their prescription guidelines. A for instance might be, If I'm your doc, and I've been giving you pain medicine for three months, we might just change that to just one month, and I may ask for a UA on you, and I should find it in that UA. If it's not in you, where is it? These two documents were as I mentioned, the cornerstones moving forward, because these were all medical people around the table, and they asked, Well, AHEC, who are you, what do you bring to the table? We told them who we are. We are neutral conveners of the community, we work with everyone.

As such, they said, "Well, if that's what you do, what can you do for us?" What I did for them, was we wrote a proposal to the Colorado Trust, one of our private foundations in Colorado, and got a small grant, a convening grant. Convening for Colorado Grant. These were six short convenings, we did one convening each month. The first four convenings were for the benefit of the provider community, the last two convenings were for the

benefit of the provider community and the general community stakeholders. That got to be a very interesting meeting, because there was a lot of finger pointing going on, as one could imagine.

We got through that, but we left a lot of work undone. We uncovered a lot of rocks, and we left a lot of things up in the air. In the meantime then, as I wrote another proposal, a prescription drug task force just formed on its own. These are vested people in the community that saw the need to continue meeting and developing our processes.

In July 2014, I received funding from a corporate grant, here in Colorado, and there was two parts to that grant. One was for the benefit of the provider community to understand better modalities for treating pain, pain management. So we brought in Dr. Josh Blum from Denver Health, a primary care doc. He presented three workshops to the provider community, and we also a second part to that grant, which is to set up neighborhood community meetings. We set those neighborhood meetings up, and they are still going on to this day. We're very proud of that. That just showed the need in those communities.

I wrote a proposal also to the Colorado Access Fund, and I tried to emulate the Project Lazarus from North Carolina, just an outstanding project, it didn't get funded. I called mine, Project Rise. It didn't get funded, that was really unfortunate. A group of people from the state level, from the Anschutz Medical Campus' School Pharmacy, people from Denver Health, others knew of all our work that we were completing in this small valley. We were told about a ROOR Project, and because you guys are in rural America, because you are so active in the work that you are doing to raise the awareness of the opioid issue in your area, you should apply for this.

I utilized ION Business Strategies out of Denver. They helped me write this federal grant. We included Josh Blum again in that project, we sent it out, and we got our funding for this grant, for the ROOR Grant, that we called, SLV NEED, in September 2015. So, we knew that we had a problem in Colorado, and we got a heat map from the CDC that looked like this. As you can see, we are the two bottom red counties there, Costilla County and Huerfano County, which is next to the San Luis Valley, we had a real problem.

The overdose drug death rate by county in 2002 was speeding up. Just a few years later, in 2014, the same map of the state of Colorado looked like this. We have a problem, people. We've been taking that message everywhere that we can, in the state of Colorado. It's not unique to us, because the whole nation is aware of this epidemic that we have. As a matter of fact, a couple of years ago, the United States Health and Human Services Secretary, Burwell, came to Colorado, because she was aware that there was a lot of awareness training going on in our state, and wanted to know what was going on in Colorado.

I was invited to that stakeholder meeting with the governor, and told her what we were doing in our little valley. Well, in our little valley, this shows you, pay attention to the redline. In 2005, the drug poisoning deaths in San Luis Valley were 20, and by 2013 it was 100% increased, and we knew that we had something to do. Now, again I

mentioned to you that we are a small valley, we're 46,000 people, everybody knows each other around here. When someone dies from an overdose, it impacts a lot of people in this valley. Per capita, it's quite the impact. So, we knew had to do something.

So we wrote our proposal for our, "SLV Need." We got our proposal as I mentioned, September 2015, we hired a health educator, we sent out press releases to the community, we began developing MOU's with participating pharmacies and first responders, everyone that we worked with, that we were going to be distributing Naloxone to, was going to have an MOU through us. We ordered the first round of Naloxone, and we got that delivered to our partners, and began our trainings. We hired a gentlemen by the name of Shane Benz, who is a certified alcohol counselor too, to run the program for us, and I will be mentioning this throughout my presentation that our success is due in large part, because of our geography. We are enclosed as a valley with few residents, and the degree of communication will show what your success rate is, or your failure rate.

So, we got to our newspapers and the radio stations, what have you, and we got out there, and we started telling people that we had a new program, a new project that was going to address our prescription drug problem that we have. Our organization looks something like this, that you can see that our participating agencies, which group from this first chart, were extremely important to us. Without the collaborative work that we did and the networking that we did, those collaborations would not be as strong as they were, and quite frankly, it was quite easy to get everybody on board, because everyone knew someone, a family member, a friend, or a friend's friend, they knew someone who was addicted. We knew that going in, and as a result, we needed to develop these partnerships.

This next slide shows the Narcan Nasal unit that we use. Now really important here before we go any further was that, when we started the project, and we started going out to our first responders, they were not on board with us. The reason is that they were not going to put together the injectable unit, and have more needles to deal with, and such. We could not get our first responders on board. About two weeks later, the FDA then approved the nasal units. Immediately after that, we got everyone on board that we needed. We got our County Sheriffs on board, we got our Police Departments on board.

After that, we started running with wildfire in regard to getting our work done with our first responders. Once we had that taken care of, then our priority went in this order: We went with our first responders first, which is law enforcement, we didn't work with our local ambulance services, because they already were trained, and they had their Naloxone in their units, in their ambulances. So, we focused on our law enforcement agencies, and immediately got everyone on board. We got all six County Sheriffs on board, we got all police departments on board, once they knew what kind of unit we were going to be using, and they were going to be carrying it.

The next order was to work with pharmacies. We did not distribute the Naloxone that we purchased, and we purchased 500 units. We did not distribute those to individuals, we took those to the first responders, and we distributed those to the participating

pharmacies. At the end, we had five participating pharmacies. The pharmacies that we really had a challenge with, and never really got underway with, were the chain pharmacies, the chain stores. That's because it took so long for them to get answers from the corporate office, as to whether or not they wanted to participate.

Once we had our first responders and our pharmacies on board, then we did move into the community, and we did community education, we did training, we were hard on the media, and marketing, we did radio interviews, and we were on the newspapers constantly. So, my message is, communicate, communicate, and then communicate. The more you do that, the more people you're gonna get on board with you eventually. The more repetition you have, the more people that you'll reach. We had a collaboration at one time of 43 agencies, and I just have this on here to show you that the entire San Luis Valley, the six counties of this valley came together. It was an amazing show of interest, and vested interest, trying to address our problem.

Overcoming challenges, my goodness we had some challenges, but once we got through those, and the biggest one was going from the injectable to the nasal Narcan, encouraging our pharmacy to participate, and the community stigma, that we dealt with, that's always going to be, to some degree, a challenge for projects like this. We again, communicated, we worked with our media the best we could, and we were there for such meetings so that we could tell them, thank you, for working with us and saving lives.

We did Naloxone trainings at Human Services Agencies of all sorts, we did at warehouses, we did it wherever people wanted us to go. We were there. We developed some material, and took these materials with us to all our trainings. We put together our Naloxone kits ourselves, we bought the Naloxone, we bought little Ziploc bags, our nurse coordinator Charlotte LaDoney, was the supervisor for the project coordinator, they put together this little kit, with the seven step instructions, and this was extremely helpful because if people did not make it to the training, at least they had the steps, the seven steps to follow in the event of an overdose.

Our project ended on September the 15th, at that time we had saved 15 lives. For us, 15 lives in this small county is quite the impact. We had 52 trainings, and trained 560 individuals. Our pharmacy still has some of the Narcan in stock, but it's running out quickly. The lessons that we learned was that outreach to participating partners, with clear understanding was of utmost importance. Inter-agency collaboration is key, but we don't have a problem with doing that kind of stuff in this small valley, but still, our collaboration was key to getting the project successfully done.

Ongoing communication with the community. Always, always, always, communication! Frequent and consistent follow up with the partners to see how they're doing, and what else that we could do for them. Regular monthly media and marketing to the different communities. Recommendations, I gave this to HRSA quite frankly, but I included this slide in here, timeliness of award notice, we got the award in September, but we didn't really get our money until about October. More communication between HRSA and grantee would have been nicer.

Just as we got started, we got our traction, it was time to shut down the program. One year programs go so quickly. Appreciation, I'd like to give my appreciation to HRSA, for being able to allow the San Luis Valley to be recognized for the work that we did here, and the fact that we have a problem here. The ability to allow the San Luis Valley to further state it's case, and to show that we have a need in this small valley, we have per capita, we have huge need. The ability that allows the San Luis Valley Area Health Education Center to assist other Colorado regions.

So with that, I'll just stop my presentation there, and let you know that this was a very exciting project for us, very successful, we learned a lot, we learned that there's more need than we can handle right now, this problem is gonna be going on for quite some time, it's an epidemic in my opinion, it's an epidemic, and with that said, I'll close, and turn it back to Tricia.

Kristine Sande: This is Kristine, and at this time, we have just a couple minutes for questions, so you'll see a Q&A box, if you're on the lower right hand corner of your screen. You can enter questions there, we probably won't have time for very many though. If you do enter a question, please select the option to send it to all panelists, so we don't miss your question.

We do have a couple of questions to start out with. First for Lisa, how did Project VIBRANT track Naloxone, and know their Naloxone was used to reverse overdose, so how did you know it was your Naloxone?

Lisa Harrison: We were able to get Naloxone through the North Carolina Harm Reduction for each of these projects, and distribute them in the pharmacies, with the pharmacies, so we had it locked and the pharmacies had it, but we were responsible for every bit of it in the community. The only exception would be those individuals who would have been able to request from their physician a prescription, and then be able to pay for it. As we all know, the Naloxone has become so expensive over these last few years, that I am doubtful there are many of those, there could be a few however.

Kristine Sande: All right, thank you. Now I have a question for Freddie, what role did the pharmacies play, and what medical director wrote the orders for the Naloxone prescriptions?

Freddie Jaquez: The standing order was done by Dr. Larry Wolf, he's an Executive Director and Chief Medical Officer for the Colorado Department of Public Health, and that was done through Senate Bill 15-053 which allows standing orders at all pharmacies in the state of Colorado. Our pharmacist group played a major role. If people were not able to attend our training, our pharmacists were trained on Naloxone, and so when people needed Naloxone, they went to a participating pharmacist, the pharmacist would give them training, and then go ahead and give them the Naloxone.

So without the pharmacists, we wouldn't have been as successful as we were.

Kristine Sande: All right, next question is, could putting Naloxone with law enforcement, actually deter people from calling in overdoses, so what is the trust level between law enforcement and drug users, and were there community outreach initiative to improve that dynamic?

Freddie Jaquez: This is Freddie. I'll tell you that each of our officers carried it on their body. They usually got there at the request, a call to them, because they were faster normally than the ambulance to the site. But there was some times where people did call the law enforcement because they knew they needed help, and it was a matter of doing it, so law enforcement or not, they called them.

Kristine Sande: Great. So then, the next question is, why did the SLV NEED project stop? Just curious as to why with all the success you were having in Colorado, why the Naloxone kits are no longer being distributed?

Freddie Jaquez: Well, we had 500 units, and all those got distributed. The project ended, the money ended, and we are in midst now of trying to develop a Harm Reduction Program, here in the San Luis Valley, here in Alamosa. If that gets funded, part of the services of that Harm Reduction Program will be the utilization of Naloxone.

Kristine Sande: Okay. So, do the kits have expiration dates on them?

Freddie Jaquez: Yes they do. They have a shelf life, and I think the Naloxone that we ordered has a shelf life that will end sometime in September in this year, I believe.

Kristine Sande: Okay. Another question, related to that is, what is the cost of the kits?

Freddie Jaquez: Boy, you can spend as much money as you want. We went the cheapest route, we found Narcan, Naloxone, and I'm not putting in an ad for them or anything, but we found them at \$37.50 per unit. That was the cheapest that we found, that's what we went with. There are some that are much more expensive out there, in the area to \$400-500 per, and I don't know why that's the case.

Kristine Sande: Okay.

Lisa Harrison: Yeah they've kind of come to be known similar to the EpiPen story that as we've done more community distribution, and as this epidemic has continued and increased, the price of Naloxone skyrocketed. So yeah, it's common to find them at \$400 a pop, especially for the FZO that delivers it in the leg really quickly.

We have the partnership with the North Carolina Harm Reduction Coalition, and they have sort of the power of numbers in being able to bargain very large numbers across the state of North Carolina, and so we go through them to get that lower price, and I feel like ours is similar to Freddie's quote of about \$40.00 or less.

Kristine Sande: Okay. So one last question, and this one, oh it just moved on me. Just a second ... in your opinions, is there maybe a better approach in terms of a preventive strategy? The

question says, saving the lives with Naloxone is critical, but in fact is maybe creating its own addiction, or being a crutch for repeated overdoses? Any thoughts on that?

Freddie Jaquez: If I may, I'll answer by saying that there's two different schools of thought there. We have some people say that, all you're doing is enabling people, if you save their life, they might go back and do it again. That may be the case, but you know what, that's more the exception than the rule. The other school of thought is, with Naloxone, you're saving lives. We went with saving lives.

Kristine Sande: All right, thanks. Lisa, any thoughts on that?

Lisa Harrison: Yeah, I'll echo Freddie there, I think first, we have to do no harm, and make sure that we have people alive to get referred to treatment, and this is a persistent and really difficult, tricky kind of harmful product that people are easily addicted to. These drugs are inherently risky, and ruin people's lives quickly, so we need to preserve life first, and then get into the prevention mode. I see that that question I was sort of answering by typing it, have you seen success in prevention education programs? Yes, it's always difficult to measure those outcomes.

I mean, if we could in public health, prove how many heart attacks we've prevented, how many overdoses we've prevented, and how many pregnancies we've prevented, we would have a much better time valuing the work of public health and prevention with dollars a lot more than we do in the United States, so that is a key question, and one that's really hard to answer. So I think our friends at NORC would better be able to answer that than I.

Kristine Sande: All right. Well thanks for your thoughts on that. At this time, we do need to wrap up. On behalf of the Rural Health Information Hub, I'd just really like to thank our speakers today. Really great information, and interesting projects that you're doing, and great work. I'd also like to thank all our participants for joining us. A survey will be emailed to you following today's webinar, and we hope that you will complete that, to help us improve our webinars in the future. Please note that the survey that appears on your screen after the webinar today is from WebEx, and that is not the RHHub Survey, so watch for that one, that will be emailed to you.

The slides for the webinar today are available at www.ruralhealthinfo.org/webinars. In addition, a recording and a transcript of today's webinar will be made available on the website, and sent to you by email. That gives you an opportunity to listen again, or share the presentation with your colleagues. Thank you again for joining us, and have a great day.