Implementing Project Lazarus in North Carolina: Lessons Learned From the Project Lazarus Model

A Two-Part Webinar on Lessons Learned from Implementing Project Lazarus in North Carolina - A Clinical and Community Based Intervention to Prevent Prescription Drug Overdose

Dates: May 11 and June 29, 2015
Time: 2:00-3:30 PM Eastern Time

THE UNIVERSITY of NORTH CAROLINA at CHAPEL HILL
Injury Prevention Research Center
savir Society for Advancement of Violence and Injury Research
SOUTH TO SOUTHWEST
CSN Children's Safety Network at Education Development Center

Meeting Orientation Slide

- If you are having any technical problems with the webinar please contact the Adobe Connect hotline at 1-800-416-7640 or type it into the Q&A box.
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PROJECT LAZARUS

Part 2: THE INTERVENTION-BASED ("TOP-DOWN") COMPONENTS OF THE PROJECT LAZARUS MODEL

June 29, 2015

Lessons Learned from Project Lazarus

HOSTS

- UNC Injury Prevention Research Center (IPRC)
- Children's Safety Network (CSN)
- SOUTH TO SOUTHWEST, S2SW Injury Prevention Network
- Society for Advancement of Violence and Injury Research (SAVIR)

SPONSORS

- Centers for Disease Control and Prevention (CDC)
- Kate B. Reynolds Charitable Trust
- NC Office of Rural Health and Community Care
- Community Care of North Carolina (CCNC)

Centers for Disease Control and Prevention

Karin Mack, PhD

- **Science Advisor**

Part 2 Webinar Goals

1. Rationale for presenting a **"lessons learned"** webinar
2. Review of the **Lessons Learned Webinar, Part 1**
3. Examples of lessons learned from the public health (top-down) components of Project Lazarus
   1. **What worked**
   2. **What didn't work**
   3. **Solutions or alternative approaches**
4. Discussion among webinar participants as to how to implement components of Project Lazarus elsewhere

UNC Injury Prevention Research Center

Christopher L. Ringwalt, DrPH
- **Senior Scientist**

Recap of Part 1

Lessons Learned from Community-Based Approaches
- Community Coalitions are critical in:
  - Using data to drive all substance use disorder strategy implementation decisions
  - Raising community awareness of the problem and strategies that exist to address the problem
  - Enhancing the capacity of stakeholders to address the problem through training and technical assistance
  - Engaging local health departments to share resources related to policies and protocols

Recap of Part 1

Lessons Learned from Community-Based Approaches
- Ways to Support Community Coalitions include:
  - Providing professional development opportunities for coalition members
  - Providing technical assistance regarding coalition recruitment and sustainability, data collection and reporting, and the selection of implementation strategies
  - Providing and maintaining funding

Community Education and Pain Patient Support Parts of the Project Lazarus Model

Fred Wells Brason, II

- Co-founder and CEO of Project Lazarus, based in Wilkes County, NC

Epidemic Crisis

Prevention – Intervention - Treatment

- ***Preventing opioid poisonings***
- ***Presenting responsible pain management***
- ***Promoting Substance Use Treatment and Support services***

Prescription Medication Misuse

Overdose Defined: Accidental Poisoning –> Unintentional Overdose

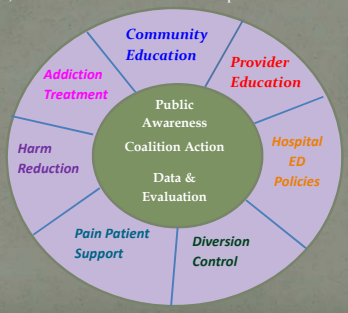
An overdose occurs when the body consumes more of a drug than can be tolerated.

Overdose – Who, What, When, Where, Why, How?

- Patient misuse – *respiratory depression*
- Family/Friends sharing to self medicate
- Accidental ingestion
- Recreational User
- Substance Use Disorder/Treatment/Recovery

Project Lazarus Model – The Wheel

The Project Lazarus model can be conceptualized as a wheel, with three core components (The Hub) that must always be present, and seven components (The Wheel) which can be initiated based on specific needs of a community.



The SPOKE – Community Education

Community Education – Public Health

Efforts are those offered to the general public and are aimed at changing the perception and behaviors around sharing prescription medications, and improving safety behaviors around their use, storage, and disposal.

"Prescription medication: take correctly, store securely, dispose properly and never share."

Why Am I needed
What Do I Need To Know
What Needs To Be Done

Varying Sources and Levels of Data

Obtaining, interpreting, understanding

Translate, communicate

Drive change and practice – policy and guidelines

Public Health – Community Sectors

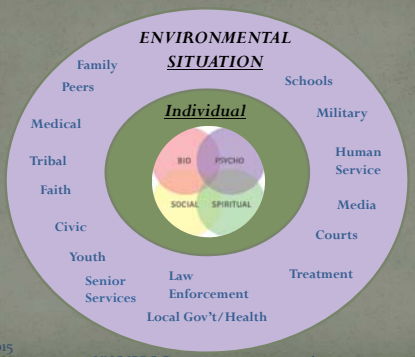
COLLECTIVE IMPACT

Stanford SOCIAL INNOVATION Review

Large-scale social change requires broad cross-sector coordination, yet the social sector remains focused on the isolated intervention of individual organizations.

http://www.ssireview.org/articles/entry/collective_impact

Community



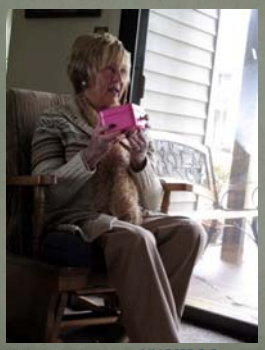
Community Education – Lessons Learned

1. Lack of community sector knowledge and understanding
   a. Allows for prejudice and stigma to rule (addiction)
   b. Personal issue rather than a public health concern
   c. Lack of organizational development and collaboration to address
   d. Lack of personnel resources
2. Tangible, community active components easiest to begin
   a. Medication Take Backs/Permanent Drop Boxes
3. Lack of integrated, comprehensive mobilization; single sector focused, mainly prevention – not intervention and treatment.
4. Leading organization, agency or coalition base not same for each county.

Solutions for Community Education: Lessons Learned

1. Focus on where the energy is to begin – community champion? Invest in leadership.
2. Community and Sector education pertaining to science of addiction/Substance Use Disorder
3. Map out action plans and strategies, individualized per sector as developed by that sector.
   a. Prevention – Intervention – Treatment
4. Seek community resources and support – collaborating and combining initiatives

Supporting Pain Patients



Supporting pain patients goes beyond access to opioids.

"Meeting patients where they are at" means that small changes at home can lead to less pain.

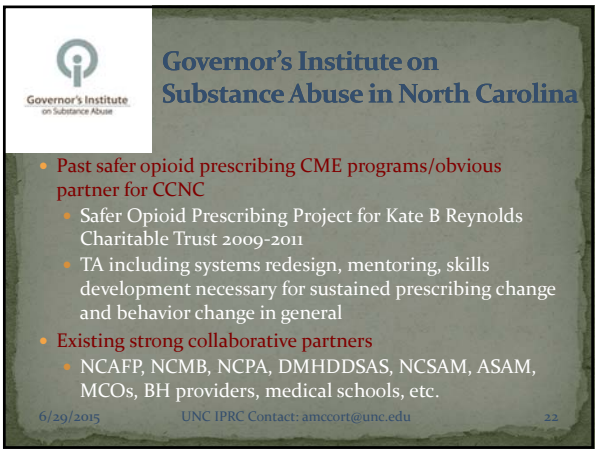
Support for People with Pain: Lessons Learned

1. Support extremely lacking within communities
2. Little or no understanding of support and alternatives surrounding pain, especially in rural communities
   (Physical, Music, Breathing Therapy's, Wellness and Nutrition, Exercise, Prayer and Medication, Yoga and Acupuncture)
   a. No potential for prescriber referrals
   b. Little or no time to address factors and alternatives in office visit
   c. No payment coverage
3. No external support evaluating and addressing any negatives pertaining to psycho/social/spiritual and cultural and environmental factors.
   a. Pertaining to medication safety, risk and lifestyle.
4. Sustainability

Provider Education and Emergency Department Opioid Prescribing Policies as part of the Project Lazarus Model

Sara McEwen, MD, MPH

- Executive Director, Governor's Institute on Substance Abuse


Governor's Institute
on Substance Abuse
Governor's Institute on Substance Abuse in North Carolina
Past safer opioid prescribing CME programs/obvious partner for CCNC
Safer Opioid Prescribing Project for Kate B Reynolds Charitable Trust 2009-2011
TA including systems redesign, mentoring, skills development necessary for sustained prescribing change and behavior change in general
Existing strong collaborative partners
NCAFP, NCMB, NCPA, DMHDDSAS, NCSAM, ASAM, MCOs, BH providers, medical schools, etc.
6/29/2015
UNC IPRC Contact: amccort@unc.edu
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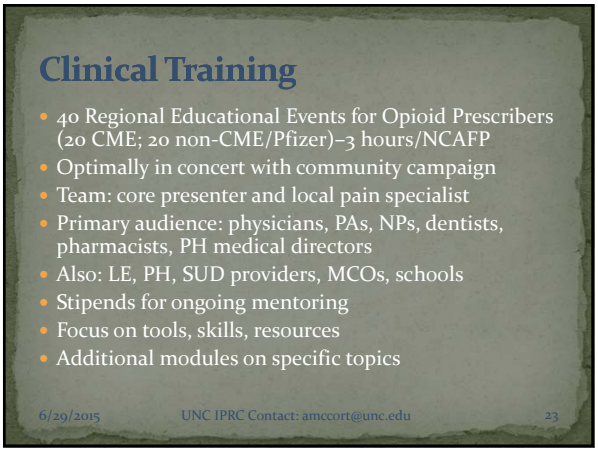
Clinical Training
40 Regional Educational Events for Opioid Prescribers (20 CME; 20 non-CME/Pfizer)–3 hours/NCAFP
Optimally in concert with community campaign
Team: core presenter and local pain specialist
Primary audience: physicians, PAs, NPs, dentists, pharmacists, PH medical directors
Also: LE, PH, SUD providers, MCOs, schools
Stipends for ongoing mentoring
Focus on tools, skills, resources
Additional modules on specific topics
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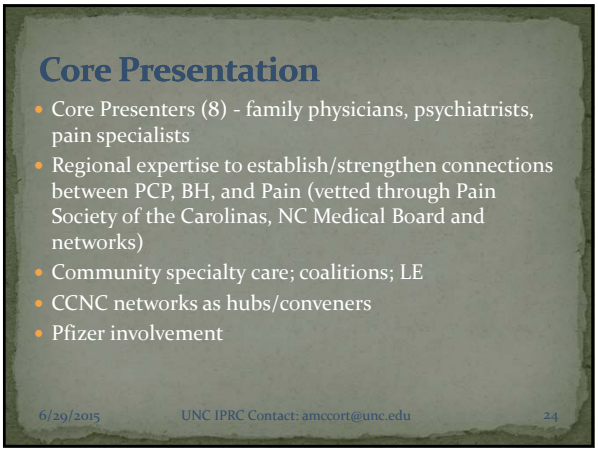
Core Presentation
Core Presenters (8) - family physicians, psychiatrists, pain specialists
Regional expertise to establish/strengthen connections between PCP, BH, and Pain (vetted through Pain Society of the Carolinas, NC Medical Board and networks)
Community specialty care; coalitions; LE
CCNC networks as hubs/conveners
Pfizer involvement
6/29/2015
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Core Content

- Nature of chronic pain and the role of opioids in its management
- Adequate assessment and risk stratification: indications and contraindications for safe use
- Informed consent, treatment agreements, and establishing realistic goals for an opioid trial
- Time efficient monitoring to maintain safety and effectiveness
- Adapting treatment, intervening and when and how to stop prescribing opioids

Application of concepts practiced through ongoing case discussion.

Focus on Tools and Resources

- Toolkits
- Controlled Substances Reporting System (CSRS)
- NCMB, NC Board of Pharmacy modifications
- Treatment agreements
- Provider Portal (CCNC/Medicaid patient database)
- ED policies
- SBIRT forms; Opioid Risk tools
- Naloxone specifics
- Buprenorphine waiver information

Toolkits for Primary Care, Emergency Departments, and Care Managers

Primary Care Content includes:

- Chronic Pain Overview/Universal Precautions
- Algorithms for assessment and management
- Pain management agreement
- Chronic pain management progress note
- Patient education brochures
- SBIRT (AUDIT, DAST, CRAFT)
- DIRE
- UDS guidance
- CSRS guidance
- DMA Lock-in referral form

Additional Resources:

- Naloxone guidance
- Good Samaritan Law guidance

Emergency Department Content includes:

- Clinical management algorithm
- Sample ED Policy
- Sample patient education handout
- Controlled Substance Reporting System (CSRS) guidance
- DMA Lock in information and referral form
- SUD screening tools (AUDIT-C, CAGE-AID)
- Discharge Instructions
- Outpatient Resources for patients with chronic pain and/or needing SUD care

Additional Resources:

- Naloxone guidance
- Good Samaritan Law guidance
- Info on referral for care coordination

CCNC's Project Lazarus Advisory Workgroup

- Primary care, behavioral health, and pain management providers
- Professional Societies (medical, dental)
- Professional Boards (medical, dental, pharmacy)
- State agencies (DMA, DMH, DPH)
- NC Community Health Center Assn (FQHCs)
- CSRS
- NC AHEC
- NC Hospital Association
- Law Enforcement
- Pfizer

Modifications/Lessons Learned

- Local Involvement
- Continuous Content Modifications
- Tools/Ancillary Materials
- Technical Assistance
- Partnering with Pfizer
- Engaging EDs
- Geographic challenges

Local Involvement Critical

- Coordinating clinical training/TA with community coalition work optimal, but not necessary
- Best trainings had strong local recruitment, marketing, and introduction of local problem/epidemiology by PH or CCNC staff
- Best trainings had active participation of pain expertise, community BH providers, MCO representation
- TA needs to be tailored to specific network/locale

Content Refinements

- Standardized presentation important given the nature of this project
- Key points for recurrent emphasis
- Needs to be succinct, thorough, and clinically relevant
- Co-presentation with ongoing case discussion most effective
- Ancillary materials as handouts/links

Tools/Ancillary Materials Need Continual Updating

- FSMB/NC Medical Board Position Statement
- CSRS guidance and upgrades (registration, usage, how to access other states, etc.)
- Naloxone
- Good Samaritan Law
- Pregnancy and Opioid Dependence Guidelines
- Specific recommendations for pharmacists and dentists
- Mini modules on video (UDS X 2; CSRS planned)

Partnering with Pfizer

- Enabled us to double the number of trainings (from 20 to 40)
- Provided content for the pain overview portion of the training (*Pain Narrative for Primary Care*)
- Pfizer trainings non-CME so less desirable than trainings with CME (despite same content)
- Pfizer trainings usually 2 hours tops
- Burdensome regulations
- Corporate reorganization
- Limited speakers bureau among presenters

Emergency Departments

- Needed to be engaged separately/separate toolkit
- Urgency, but schedule and time constraints impact training
- Usual barriers – time, workflow, "system"
- Additional barriers
  - ED physicians working in multiple hospitals
  - Press Gainey a major disincentive especially for hospitals that contract out ED services
  - CSRS usage difficult initially (delegate accounts partial fix)

Emergency Departments (cont.)

- CSRS Modifications (delegate accounts)
- Engage systems (Vidant, Novant, First Health) and imbed in workflow
- Increased "comfort" with initially negative patient satisfaction scores
- CCNC Care Managers for Medicaid patients with chronic pain

ED Barriers Remain

- Time
- System not designed for complicated chronic pain/SUD assessment
- Other CSRS barriers – e.g. interoperability
- Perceived and real lack of access to community BH and pain expertise
- CP managers available only for Medicaid
- Hospital policies

Catalysts

- Federation State Med Boards/NCMB policy
- MAHEC CMS Innovations Grant
- Legislation: Good Samaritan Law/CSRS upgrade.
- Partnership with Pain Society of the Carolinas and Boards
- Harm Reduction Coalition
- REMS efforts nationally and in NC
  - NCAFP, NC SAM, NCMB/NCMS
  - NCAFP/NCMB – 700 family physicians 12/14

Next Steps

- Finish 3 module online CME training and apply for "risk reduction" points
- Continue to facilitate and promote prescriber education/TA on pain management, SBIRT, medication assisted SUD treatment, etc.
- Develop additional disease specific protocols (fibromyalgia, headache, back pain, etc.)
- Continue to improve functionality of CSRS
- Recruit additional buprenorphine prescribers
- Facilitate linkages between PCPs, EDs, and BH providers

Harm Reduction as Part of the Project Lazarus Model

Tessie Castillo

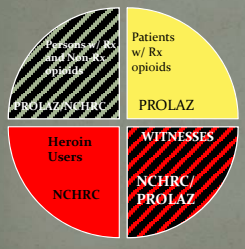
- Advocacy and Communications Coordinator, North Carolina Harm Reduction Coalition (NCHRC)

North Carolina Harm Reduction Coalition

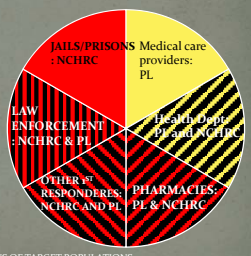
- NCHRC is a statewide nonprofit dedicated to reducing the negative consequences of drug use, including drug overdose, through harm reduction strategies.
- Though a completely separate entity, NCHRC has collaborated with Project Lazarus to reduce opioid overdose.
- NCHRC distributes naloxone directly to people at risk for opioid overdose on the street level through a standing order.
- NCHRC runs the South's largest needlestick prevention and naloxone training program for law enforcement.

Populations* Targeted for Naloxone by NCHRC and Project Lazarus

Target Populations for Naloxone by ProLaz and NCHRC



Target prescribers/dispensers of NX by ProLaz and NCHRC



*SCHEMATICS DO NOT REFLEXT ACTUAL PORPORTIONS OF TARGET POPULATIONS

North Carolina Harm Reduction Coalition

Lesson 1: Naloxone distribution needs a legal framework
Lesson 2: Legislation can be passed in any political climate

-- 2013 NC: SB 20 (Good Sam/Naloxone)
- 2013 NC HB 850 (Partial Syringe Decrim)
- 2014 GA: HB965 (Good Sam/Naloxone)- *NCHRC was TA leader*
- 2015 SC: HB3083 (Naloxone)- *NCHRC was TA leader*
- 2015 NC: SB154 (Good Sam Improvements, Pharmacy naloxone)- *Signed by Governor 06-19-2015*
- 2015 NC: HB712 (Biohazard Collection/Decrim Syringes with Residue)- Just Passed House with Unanimous Vote

SB20: 911 Good Samaritan Law

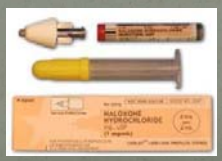
- Effective April 9, 2013
- Provides limited criminal immunity for possession of small amounts of drugs, drug paraphernalia, or underage drinking to any person who experiences an overdose or seeks medical assistance in good faith for person experiencing a drug overdose
- Provides civil and criminal immunity to anyone who administers naloxone in good faith and to medical providers who prescribe it
- Allows prescribers to prescribe naloxone via standing order

NCHRC's Naloxone Distribution Program

- August 1, 2013-June 12, 2015
- Distributed naloxone kits: 11,000
- Reported Rescues: **596**

Differences in Types of Naloxone Delivery Systems are Not a Deal Breaker

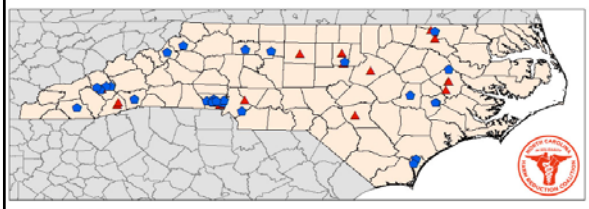
- NCHRC has distributed intramuscular and auto-injector forms of naloxone, as well as facilitated the distribution of some Project Lazarus intranasal kits to law enforcement, treatment programs, and first responders



Largest Rescue Sites

- **Asheville** - *160 Rescues*
  - Primary Distribution: Asheville's 6 area methadone/ bupe clinics (best for documentation of reversals)
  - Secondary: Transient populations, active drug user networks and recovery houses
- **Greensboro** - *126 Rescues*
  - Primary Distribution: Active drug user networks
  - Secondary Distribution: 2 Methadone/Buprenorphine Clinics
- **High Point** - *69 Rescues*
  - Primary Distribution: Active drug user networks
  - Secondary Distribution: Referrals from ADS

North Carolina Law Enforcement Narcan Distribution Locations



▲ Current Narcan Programs ⬟ Upcoming Narcan Programs

Programs That Started in 2014

1. Alcohol Law Enforcement
2. Ayden Police, NC
3. Carrboro Police, NC *(2 rescues)*
4. Greenville Police, NC *(4 rescues)*
5. Orange County Sheriff's Office
6. Pitt County Sheriff, NC *(1 rescue)*
7. NC State Bureau of Investigation

Programs That Started in Between 1/1/2015 and 6/30/2015

1. Brevard PD, NC
2. Cramerton PD, NC
3. Fayetteville PD *(1 rescues)*
4. Guilford County Sheriff, NC *(1 rescue)*
5. Halifax County Sheriff's Office
6. Roanoke Rapids PD
7. Transylvania Sheriff, NC
8. Waynesville Police, NC

NC Law Enforcement Attitudes Towards Naloxone

Are you willing to carry naloxone on the job?

carrynj	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	213	90.25	213	90.25
No	22	9.32	235	99.58
Did not answer	1	0.42	236	100

NCHRC Preliminary Study Results On Law Enforcement Attitudes Towards Syringe Criminalization and Drug Overdose, 2015

Best Practices

- Standing Orders
- Mobility
- Distribution Through Peer Network and Methadone/Buprenorphine Clinics

Challenges and Solutions

- Funding
  - Utilize the most cost effective route possible (intramuscular with stripped down kits)
  - Seek small city or county level grants
  - Take advantage of free or reduced pricing from pharmaceutical companies like Kaleo
- Overcoming Myths About Naloxone
  - Naloxone distribution does not encourage or enable drug use
  - Education
  - Community members fully embrace IM naloxone
- Reaching Across the State
  - NCHRC: 3 staff members, but diverse network of over 100 volunteer distributors

Diversion Control Part of the Project Lazarus Model

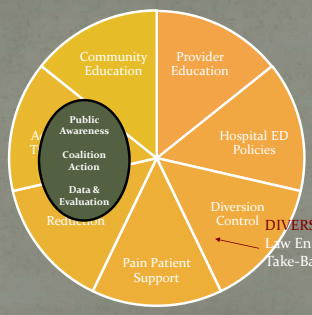
Donnie Varnell

- Special Agent in Charge, North Carolina State Bureau of Investigation, Diversion and Environmental Crimes

NC State Bureau of Investigation

Diversion and Environmental Crimes Unit

The Project Lazarus Model

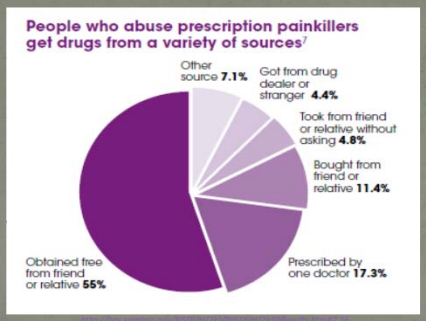


DIVERSION CONTROL: Law Enforcement and Pill Take-Back Activities

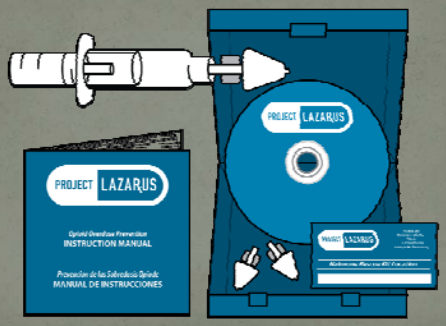
Diversion Control

Continuing education on diversion control

Sources of Pain Medications



Project Lazarus Naloxone Reversal Kit

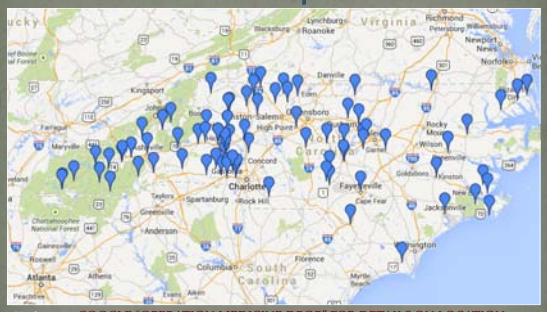


Operation Medicine Drop

Diversion Control

- Operation Medicine Drop

Location of Permanent Pill Drop Boxes at Police Stations in NC – March 2014



March 26, 2014 GOOGLE "OPERATION MEDICINE DROP" FOR DETAILS ON LOCATION

Diversion Control

Pills obtained from one Operation Medicine Drop dropbox in NC

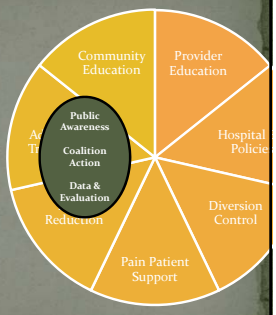
Substance Use Disorder Part of the Project Lazarus Model

Ashwin Patkar, MD

- **Professor of Psychiatry & Community and Family Medicine and Medical Director, Duke Addictions Programs, Duke University Medical Center**

The Project Lazarus Model

The second safety net in the seven Project Lazarus Model spokes: The provision of, or referral to, ADDICTION TREATMENT (now called SUBSTANCE USE DISORDER Treatment) for individuals with opioid addiction.



Role in Project Lazarus

- Community practitioner: substance use disorder practice
- Technical Expert for Project Lazarus Chronic Pain Initiative (CPI) course for medical care providers
- Presenter for Project Lazarus CPI training programs
- Local mentor for pain management/SUD for CCNC network medical care providers
- Regional mentor for buprenorphine treatment under PCSS

Accepting and Implementing SUD Treatment

OBJECTIVE: Enhance evidence-based practicing behaviors of medical care providers of patients with chronic pain who are high risk due to history of SUD or misuse and/or abuse of prescription pain medications.

1. RISK ASSESSMENT AND BRIEF INTERVENTION
2. REGISTRATION WITH NC'S PDMP (Controlled Substance Reporting System)
3. MAT in conjunction with psychosocial treatments, using:
   - buprenorphine/naloxone combination
   - methadone
   - naltrexone/vivitrol
4. CO-PRESCRIBING OF NALOXONE TO PATIENTS AND/OR FAMILY
5. MANAGEMENT OF CO-OCCURING PSYCHAITRIC DISORDERS
6. REFERRAL of HIGH RISK PATIENTS TO ADDICTION/PAIN SPECIALISTS

Creating and Teaching CPI Course Material

- Response to outreach to seminar recruitment often did not include the optimal target audience we intended to enroll.
  - Example, over 60% of attendees at the local Project Lazarus seminar were practitioners at Duke and not providers from more rural communities.
- Resistance by attendees to new elements of contents: e.g., S.B.I.R.T. and co-prescribing of Naloxone
- AUDIENCE FATIGUE: Attendance at seminars diminished over two year period.
- SOLUTION: Practice-specific outreach by CPI coordinator, case-based learning, telephone case conferences for complicated patients, and provision of CME credits. Role playing of S.B.I.R.T. to demonstrate its use.

Promoting MAT

- 30 or 100 patient limit per buprenorphine prescriber - restricted access for publically funded patients.
- Reluctance by some primary care providers due to lack of psychosocial treatment resources.
- Perceived limited time to acquire special DEA certification for buprenorphine.
- Resistance to including patients with SUD in clinical practice.
- Stigma of methadone clinic.
- SOLUTION: Working with existing practitioners/programs that accept publicly funded patients to get trained for buprenorphine prescribing.
- Working with MCOs (local managed care organizations) to develop centralized referral system for publicly funded patients seeking buprenorphine treatment.
- Developing integrated models of care where primary care offices that prescribe buprenorphine will have on-site behavioral counselor.

Promoting Co-Prescribing Naloxone

- National and local resistance to co-prescribing (e.g., FSMB)
- Counter acted (to some degree) by NC Medical Board, 911 Good Samaritan Law and Project Lazarus tool kits. However,
- Variability in supply of Project Lazarus kits in clinics
- Variability in supply of Project Lazarus kits in pharmacies
- Variability in supply of intra-nasal naloxone in pharmacies

SOLUTION: Each network should buy individual kits and naloxone, and make the kit available at local pharmacies and practices

Focusing on Individual Practitioners Insufficient: Need to Involve Health Systems

- LESSON LEARNED: involvement of health systems to make system wide changes more effective than ONLY working at the individual practitioner level
- EXAMPLES: At Duke, an Opioid Safety Task Force that included key members of the Project Lazarus Chronic Pain Initiative recommended
  - the new EMR EPIC to include a framework for new elements of safe opioid prescribing
  - encouraged use of CSRS.

Challenges of Working in Communities with Limited Resources

- REALITY: Many rural counties/communities do not have adequate resources to treat patients with complex chronic pain, with or without SUD.
- REALITY: NC does not have Medicaid expansion and indigent patients are disproportionately represented in high-risk chronic pain patients.
- WORK-AROUNDS: Working with community partners.
  Examples:
  - FHQC'S : face-to-face meetings between members of CPI team at Duke with local CMO to address treatment strategies for complicated chronic pain patients.
  - COUNTIES WITHIN NORTHERN PIEDMONT CCNC NETWORK: pilot study for a monthly phone call with Duke CPI and pain management specialists and at least one practitioner from each network to discuss up to 3 challenging cases.

Conclusions

- Provision of treatment for SUD is a key component of Project Lazarus
- Easier to implement in locations with existing Chronic Pain and addiction specialists
- Having CCNC resources was important
- Resource and coverage limitations are major challenges to fully implement the model in certain populations

DISCUSSION

Evaluation

- https://www.surveymonkey.com/r/YNRSNYC