PROJECT LAZARUS

Community Toolkit

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PROJECT LAZARUS

A Project of Community Care of North Carolina

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Introduction

The Project Lazarus Community Toolkit was designed from real experience and results with local communities everywhere in mind. The components included in this toolkit will provide the basis and guidance for communities everywhere to start their own coalition to fight the epidemic surrounding prescription drug misuse, abuse, diversion, and overdose. The toolkit is divided into four sections and may be read as a whole or sections may be read separately depending on the needs of the reader. The sections are as follows:

- **Section I: Project Lazarus Community Coalition Leader Manual**
  The Project Lazarus Community Coalition Leader Manual explains in detail the various parts of the Project Lazarus Model, while also providing illustrations and testimonies to further understanding of the Model.

- **Section II: Project Lazarus Sustainability Series**
  The Project Lazarus Sustainability Series delivers the necessary training materials for sustaining efficiency once a coalition is established. Topics covered include Capacity Building, Community Assessment, Data, Reporting and Evaluation, Leadership, Strategic Planning, and Structure.

- **Section III: Project Lazarus Sector Factsheets**
  The Project Lazarus Sector Factsheets provide sectors with information relative to their specific area of work, knowledge, and/or interest.

- **Section IV: Project Lazarus Appendix**
  The Project Lazarus Appendix contains the essentials for keeping coalitions and communities engaged. The appendix is broken into four sub-sections:

    - **Section IV.I: Naloxone**
      The Naloxone sub-section contains informational pages about how to order naloxone for prescribers and individuals, health center naloxone programs, and prescribing naloxone. A naloxone rescue kit order form is also included.

    - **Section IV.II: Resources & Samples**
      The Resources & Samples sub-section provides a sample action plan, budget, community readiness survey, job description, logic model, request for application, and satisfaction survey. Articles on coalition sustainability and the North Carolina Good Samaritan Law are also included.

    - **Section IV.III: Templates**
      The Templates sub-section offers user-friendly documents that allow for easy input by coalitions. A county invitation, meeting agenda, minutes, membership form, organizational chart, sign-in sheet, and simple strategic plan are all included in this sub-section.

    - **Section IV.IV: Handouts**
      The Handouts sub-section is ever-growing and will continue to provide promotional materials to coalitions as developed. Currently available documents include a Project Lazarus factsheet, pharmacy stickers, medication disposal infocards (Project Pill Drop),

NC Good Samaritan Law infocards, with more to come. While some of these materials are generic for any Project Lazarus coalition, most can have individual coalition information input for local distribution.

With the use of this toolkit coalitions can make a difference in their communities. It is vital for success to remember that all communities have a specific make-up that is unique and coalition activities must be tailored to fit this uniqueness. Project Lazarus has taken great strides to produce a toolkit that can be applicable in any community, while also maintaining room for coalitions to add in their own individuality. With that in mind, coalitions should also reach out to local, state, and even national resources for help in their community; the larger the amount of support and resources available, the more positive the results will be. Project Lazarus can help communities in their initial search for support and resources locally, statewide, and nationally.

Acknowledgements

Project Lazarus would like to give special thanks to *Purdue Pharma*, *L.P. Healthcare* (Grant No.:NED103476) for their support in the creation of the Project Lazarus Community Toolkit.

We acknowledge our gratitude for the North Carolina Project Lazarus Initiative sponsors: *Kate B. Reynolds Charitable Trust*, NC *Office of Rural Health*, *Community Care of North Carolina, Mountain Area Health Education Center* (MAHEC), *Cherokee Preservation Foundation*, *Northwest Community Care Network, UNC Injury Prevention Research Center*, *Covidien*, *Governor's Institute for Substance Abuse*, *Open Society Institute, NC Division of Public Health and the many community, state, and federal partners throughout the United States.*

The Beginning of Project Lazarus

In 2007, Wilkes County, a large land mass county in the western mountains of North Carolina (NC), had an unintentional drug poisoning mortality rate of 28.3 deaths per 100,000 people, making it the third highest county death rate *in the country*. The problem had worsened by 2009. In 2009, the Wilkes County unintentional drug poisoning mortality rate was quadruple that of NC's (46.6 vs. 11.0 state mortality rate per 100,000 population), and was due almost exclusively to misuse of prescription opioid pain relievers. The average age of death was in the late 30s and the people who died often had other health problems such as respiratory, circulatory, and metabolic disorders. The victims of overdose in Wilkes used opioids for both medical and nonmedical reasons and exceeded their physiologic tolerance, either directly or in combination with other licit or illicit substances.

At the time, Fred Wells Brason II was serving as the Director and Chaplain of Wilkes Hospice and began to notice increased issues with prescription drugs in the homes of patients in 2004. The level of sharing, stealing, and selling escalated to such a point that prescribers would no longer write prescriptions to certain households, creating a barrier between the patient and critical medical care. Further investigation led Brason to local law enforcement personnel and the local hospital emergency department, who both readily testified to the magnitude of the problem among Wilkes County residents. Upon connecting with the Wilkes Health Department, Brason was referred to the Substance Abuse Task Force and quickly learned that they were not fully aware of the prescription drug problem. Neither NC State nor Federal authorities were able to give specific guidance on effective ways to address the issue. Brason then turned inward to his community, who designed their own responses and solutions to the problem. By obtaining real time data on unintentional drug poisoning mortality rates, emergency departments and hospitalization admissions involving overdose and withdrawal information, and data on prescribing patterns, the process of finding solutions to the monumental problem improved dramatically. The data proved to be one of the key drivers in building awareness and response in the community, leading to coalition engagement. Ultimately, these three key factors determined the project's objective and specific action plans.

The combination of compelling data and Brason's energy, hard work, and desire to make change attracted community groups, particularly practitioners, to join together in addressing the epidemic in Wilkes County. The project began with a community coalition in which there was representation from key county stakeholders, such as the health department, hospital, mental health centers, drug treatment facilities, law enforcement, and schools.

The venture was dubbed Project Lazarus and soon after a small non-profit organization with the same name was formed. The Project Lazarus mission was and is still clear:

> *"Project Lazarus believes that communities are ultimately responsible for their own health and that every drug overdose is preventable. We are a non-profit organization that provides training and technical assistance to community groups and clinicians. Using experience, data, and compassion we empower communities and individuals to prevent drug overdoses, provide effective substance use treatment, and meet the needs of those living with chronic pain."*

Once the coalition was underway and began addressing the problem, the results were increasingly notable. For more information on the start of Project Lazarus, see the North Carolina Medical Journal Vol. 74, No. 3, Spotlight on the Safety Net article: Project Lazarus: An Innovative Community Response to Prescription Drug Overdose.

Community Care of North Carolina & Project Lazarus

A community-wide response to managing chronic pain

Problem:

Utilization of highly addictive opioid medications has risen 160% in the last 10 years. In North Carolina the death rate for unintentional poisonings is 11.4 per 100,000 citizens (22nd in the country), with 1140 such deaths occurring in 2011. In North Carolina, deaths by motor vehicle accidents and unintentional poisonings are almost equal. North Carolina Division of Public Health describes unintentional poisoning deaths as of "epidemic proportions"

Solution:

The model of intervention in the chronic pain cycle is based on a successful integrated care pilot in Wilkes County called Project Lazarus (PL). Begun in 2007, PL decreased unintentional overdose deaths in the county by 69% from 2009-2011.

Community Care of North Carolina (CCNC), supported by a $2.6 million grant from The Trust (KBR) and matching funds from the ORH, is expanding the Project Lazarus approach statewide through three interrelated initiatives:

1. **Community-based Coalitions** aim to broaden awareness of the extent and seriousness of unintentional poisonings and chronic pain issues, and to support community involvement in prevention and early intervention. Attendees include a broad range of community partners including law enforcement, public health, schools, hospitals and faith based organizations.

2. **The Clinical Process** focuses on the medical assessment and treatment of chronic pain. Toolkits have been developed to guide decisions by treating providers in Emergency Room, primary care and care management settings. The kits provide decision support and other tools for providers identifying and addressing each patient's specific care needs. Additional training will be rolled out in 40 sites across the state for all opioid prescribers including primary care physicians, emergency room doctors, hospitalists, dentists, and local pharmacists. The focus of the education is on assessment criteria for pain, safe opioid prescribing, use of CCNC's Provider Portal, and registration and use of the Controlled Substance Reporting System (CSRS). Information tailored to specific clinicians includes:
    - **Care managers.** Data tools have been developed to help care managers identify patients most at-risk of developing issues with opioids, (>12 narcotic scripts and >=10 ED admissions in a 12 month period of time). Tools tailored to the needs of these high-risk patients such as pain agreements are available through the CCNC Provider Portal and the CCNC website.
    - **Primary care physicians**. The PCP tool kit provides information on assessing and managing chronic pain in the primary care setting, encourages the use of pain treatment agreements and offers guidance for accessing and using the Provider Portal and the CSRS.
    - **Emergency Department physicians**. The ED toolkit describes policy issues that must be addressed at the administrative level; provides clinical tools for the assessment of acute vs. chronic pain; discusses the value of the Provider Portal and CSRS in the ED setting; shares strategies to decrease unnecessary imaging; and lists appropriate pain treatment pathways.
3. **Program outcome goals** (as measured through the Injury Prevention research Center): Decrease mortality due to unintentional poisonings; decrease inappropriate utilization of ED for pain management; decrease inappropriate ED utilization of imaging with diagnosis of chronic pain; and increase use of Provider Portal and CSRS.

Project Lazarus Resources: Infrastructure of Community Care of North Carolina (14 CCNC Networks, 14 local Chronic Pain Coordinators, 600 care coordinators statewide, 5,000 primary care physicians participating with CCNC).

Section I:

Project Lazarus Community Coalition Leader Manual

The Project Lazarus Community Coalition Leader Manual elaborates on all components of the Project Lazarus Model necessary for community leaders to establish their own working coalition. Graphs, charts, and info-boxes provide detailed statistics, as well as testimonies and samples from various Project Lazarus Community Coalitions.

Wilkes County, NC: The Beginning

In 2009, the Wilkes County unintentional drug poisoning mortality rate was quadruple that of NC's (46.6 vs. 11.0 state mortality rate per 100,000 population) and was due almost exclusively to the misuse of prescription opioid pain relievers. The average age of death was in the late 30s and the people who died often had other health problems, such as respiratory, circulatory, and metabolic disorders. The victims of overdose in Wilkes used opioids for both medical and nonmedical reasons and exceeded their physiologic tolerance, either directly or in combination with other licit or illicit substances.

Figure 1.1 Unintentional Drug Poisoning Mortality Rate in the US, NC, and Wilkes County from 2004-2011

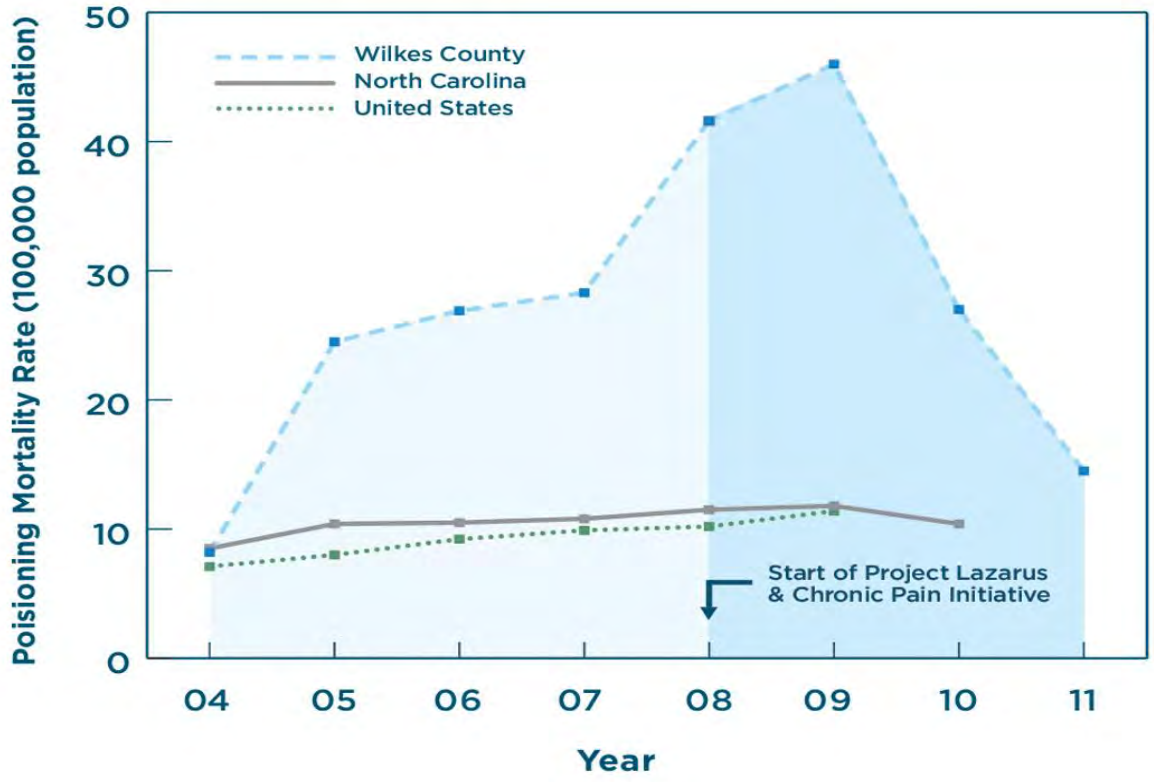


Figure 1.1 shows the steep decline in Wilkes County's unintentional drug poisoning mortality rate that occurred in the three years after Project Lazarus began. This decline occurred as the death rates in the rest of the state and country continued to climb.

The Project Lazarus Model

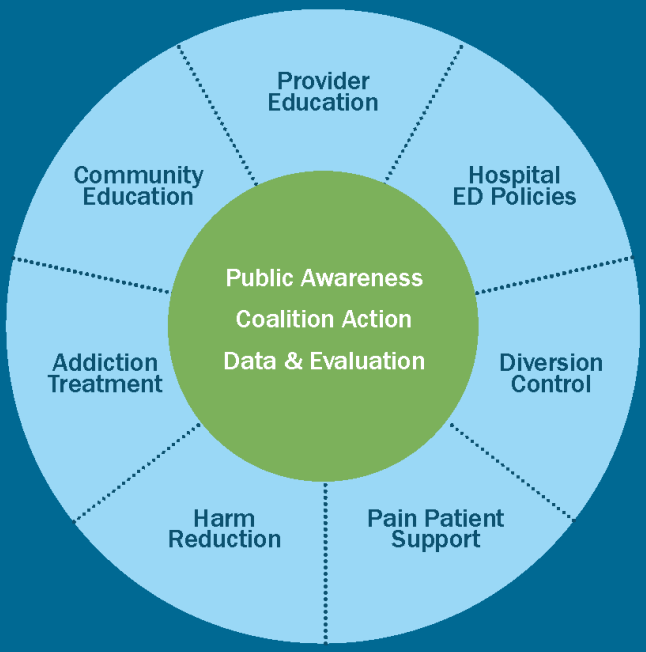
The Project Lazarus Model is a public health model based on the twin premises that drug overdose deaths are preventable and that all communities are ultimately responsible for their own health. The Model can be conceptualized as a wheel, with three core components in the "Hub," and seven components that make up the "Spokes." The three foundational components of the Hub are: 1) ***Public Awareness***, 2) ***Coalition Action***, and 3) ***Data and Evaluation***. **Public Awareness** is defined by shining the light on the issue and providing accurate information about prescription drug overdoses. **Coalition Action** is concerned with coordinating the community's response to the issue and how it impacts their specific area. **Data and Evaluation** relates a community's response to their unique and local issues, and helps to focus on where help is needed most. Each one of the seven components of the Spokes has a menu of different activities that can fall within. The seven Spokes are: 1) ***Community Education***, 2) ***Prescriber Education***, 3) ***Hospital ED Policies***, 4) ***Diversion Control***, 5) ***Pain Patient Support***, 6) ***Harm Reduction***, and 7) ***Addiction Treatment***. This wheel is always in motion since coalitions and communities are always evolving. A coalition may start with a focus in one or two areas and then expand to other areas as the availability of resources changes, community sector engagement increases, or the nature of the problem shifts.

The flexibility of the Model should not be confused for a model which can only be partially implemented. The Project Lazarus Model was developed in response to some of the highest drug overdose death rates in the country. There are ten components of the Model altogether and communities should implement components from all ten to have an appreciable impact on overdose deaths. Focusing on only a few of these areas has been proven ineffective in reducing overdose deaths. The dramatic effects seen in Wilkes County, NC occurred after the core Hub activities were in place and at least some aspects of all seven Spoke components had been addressed in the community. The Model is shown in figure 1.2.

Figure 1.2 The Project Lazarus Model

PROJECT LAZARUS

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 Spokes) which can be initiated based on the specific needs of a community.



THE HUB

Public Awareness of the problem of overdose from prescription opioid analgesics.

Coalition Action to coordinate all sectors of the community response.

Data and Evaluation to ground a community's unique approach in their locally identified needs and improve interventions.

THE SPOKES

Community Education to improve the public's capacity to recognize and avoid the dangers of misuse/abuse of prescription opioids.

Provider Education to support screening and appropriate treatment for mental illness, addiction, and pain.

Hospital ED Policies to encourage safe prescribing of controlled substances and provide meaningful referrals for chronic pain and addiction.

Diversion Control to reduce the presence of unused medicines in society.

Pain Patient Support to help patients and caregivers manage chronic pain.

Harm Reduction to help prevent opioid overdose deaths with the antidote naloxone.

Addiction Treatment to help find effective treatment for those ready to enter recovery.

The Hub

The Hub is the foundation and center of the wheel. This is the part of the Model that defines the issue through Data and Evaluation, gets the community to identify the problem as their own through Public Awareness, and builds capacity to act through Coalition Action.

Public Awareness

Public Awareness is particularly important because there are widespread misconceptions about the risks of prescription drug abuse/misuse/diversion/overdose. It is crucial to build public identification of prescription drug overdose as a community issue. Project Lazarus's message is that prescription drugs must be "taken correctly, stored securely, disposed of properly, and never shared." Project Lazarus explains to communities that while overdose is common, it is preventable. If these messages are not spread widely, the efforts developed by the coalition will have difficulty taking hold and being sustainable. Communities can develop new and creative ways to share messages and enhance awareness, as well as rely on what has been tried with success in other places. The following is a list of some of the activities and venues that can be used to improve Public Awareness:

- Town hall meetings
- Specialized task forces
- Youth prevention teams
- Inclusion of community-based leadership
- Billboards, posters, and flyers containing messages about prescription drugs and the risks of sharing medications
- Presentations at colleges, community forums, civic organizations, churches, schools, and military bases.
- Radio and newspaper advertisements
- Coalition building

Coalition Action

Building the Coalition: Counties that have adopted the Project Lazarus Model of a community approach to prescription drug overdose have largely followed the same general steps in establishing a community coalition, which is the driving force behind most of the other work that occurs. This section describes the chronological steps that the majority of coalitions have taken. Naturally, every community is different and if there is an already existing coalition that will be adopting the model, the process will look slightly different. However, each of the following steps has a specific function that should occur in order to maintain the integrity and usefulness of the Project Lazarus Model.

***Getting High Level Stakeholders On Board*:** The stakeholders may be the individuals who identified the issue in the first place. The fundamental point is to get the decision makers from the key sectors involved at the lead table from the initial onset. These are not the "worker bees," but rather the ones who can assign resources, such as human resources, financial support, influence, and intellectual or

informational resources to the issue. Examples of the kinds of high level stakeholders who have been involved in other communities have included health directors, superintendents of schools, sheriffs and/or chiefs of police, directors of local substance abuse treatment facilities, mental health services administrators, hospital executives, and leaders in the medical field. Project Lazarus can help identify people in communities that should be involved at this stage. These stakeholders should come together and initiate action to guarantee support from county leaders in order for the efforts to be sustainable. If an already established coalition exists, but the support of the high level stakeholder does not, it is crucial to go back and engage with these key participants.

Initial Stakeholders Presentation Example
Surry Co. Participant List
Blue Ridge Medical Group
City Commissioners of Mount Airy
Cross Roads Behavioral
Department of Social Services
Dobson, Mt Airy, Pilot Mtn, and Elkin Police Depts.
Elkin City, Surry Co, and Mt Airy School Systems
Foothills Primary Care
Kerr Drug
Medical Associates of Surry
Mount Airy Ministerial Association
North Carolina State Senator
North West Medical Partners
Northern Hospital of Surry County
Pain Center of Mount Airy
Right Care Doctors Office
Surry County Health and Nutrition Center
Surry County Sheriff Office
Unlimited Success
Wal-Mart Pharmacy

***Bring Together the Larger Community*:** Once the stakeholders have committed to engage the support from each of the key sectors in the community, along with a preliminary base of public awareness on the issue, the first task is to plan and hold a community forum. The community forum is designed to share information with the broader community about the issue of prescription drug abuse/misuse/diversion/overdose specific to their county. Based on Project Lazarus experience, the community forums are held approximately 45 days after the initial stakeholders' presentation has taken place in order to build on initial community energy surrounding the issue. The forum serves two purposes: to raise awareness in the community that there is a problem, so community members are ready to engage as efforts are developed to address it, and to draw the attention of other dedicated people who want to become part of an on-going coalition that drives those efforts.

Diagram of Project Lazarus Coalition Capacity Building Process

The Community Forum: Haywood County, NC

The stakeholders promoted and recruited were among the organizations, colleagues, peers, families, and friends in the community. Local space was donated and a buffet lunch paid for with donations. The forum was advertised through public service announcements on the radio, notices in newspapers, email lists, church bulletins, flyers, and other material provided at diverse venues. The speaker agenda was created to include a full presentation by Project Lazarus, local law enforcement, and an addiction medicine specialist. Other programs addressing the issue within the community were invited as exhibitors to further build a strong network. The entire forum was set for 2 hours.

In this small community, 133 individuals attended. Those present included media, various law enforcement agencies, the medical community, schools, faith groups, youth, substance abuse treatment centers, those in recovery, family members who had lost loved ones to overdose, and others.

Contacts made at the forum were informed of the first meeting date for a community sector coalition workshop, where over 70 people attended and led to the formation of the Haywood Co. Coalition.

The Steering Committee: The Steering Committee is a group of liaisons delegated from each sector along with the most active community representatives. This committee works closely with Project Lazarus in the establishment of the coalition and then propels and sustains the ongoing work of the coalition after Project Lazarus's role diminishes. The role of the Steering Committee cannot be emphasized enough. The high level stakeholders should designate one person from each sector to be involved and to ensure that the coalition has the organizational support to really engage members. The Steering Committee is absolutely necessary. At some point in this process, it is important that a **Community Coalition Coordinator** steps forward to work within the Steering Committee. It is important to have a designated person available for Project Lazarus to contact, as well as someone who will keep the process on track and gauge the effectiveness of their efforts.

***Establish a Working Coalition*:** This is the group of people that will accomplish tasks. The forum will have hopefully identified community members such as parents, teens, people in recovery, pain patients, or patient advocates who would like to be involved, yet were not otherwise designated by the high level stakeholders. Together with the Steering Committee and Community Coalition Coordinator, these interested parties form the coalition.

Establish a Community Plan for Addressing Prescription Drug Overdose: Establishing a community plan generally happens through a series of workshops, often facilitated by Project Lazarus for the coalition. However, with the guidance of this manual, coalitions should be able to make progress without the presence of a Project Lazarus staff member at every meeting. Workshops begin by having coalition members divide into groups by sector such as clinical care, health department, public health, law enforcement, schools, faith community, general public, and local government, with at least one member of the Steering Committee in each group. Each group then works through the primary goals and objectives for their sector. Overviews for each sector are available in the Community Toolkit Sector Factsheets. The groups then report back to the coalition for discussion, alignment, and collaboration with other sectors. Next, each sector group identifies specific activities that would move them towards their revised goals and objectives. Again, input from the whole coalition allows for

Creating a Community Plan: Surry County, NC.
At the first coalition workshop in Surry County, placards were set on each table indicating the different community sectors to be represented. Participants were directed to sit at their respective tables. After a brief synopsis of the agenda, plans, and strategy of coalition building, each sector was given a worksheet to guide discussion and planning around how to address prescription drug misuse, abuse, diversion and overdose within their sphere of influence. Upon completion of the worksheet, one person from each sector reported back to the entire coalition, inviting input by all other sectors. As is common in the early meetings, participants identified already on-going activities about which other sectors were unaware. Over time, the different sectors developed different action plans. Within 2 months of the initial meeting, the schools sector convened a student working group who created their own initiative utilizing flyers, posters, and t-shirts addressing awareness and dangers of prescription medications in the schools. They also chose a curriculum for the classroom and had it approved by the local school board. The awareness plan and curriculum were disseminated to the administration, teachers, school counselors, nurses and social workers, as well as parents. The law enforcement sector decided to seek out additional diversion training for officers, increase pill take back days (with more promotional activities) and establish permanent pill take-back locations. They worked with law enforcement, local pharmacies, the emergency department, and prescribers to direct patients to proper disposal. Within the medical sector was an emergency department physician who learned of the Project Lazarus ED policies through the coalition presentations and workshops. He set an action plan to request his hospital administration to formally adopt and implement these policies.

feedback and coordination of activities between sectors since many of them will overlap. At this point, the members of the Steering Committee work with the list of goals, objectives, and activities to figure out resources, responsible parties, and deadlines by which activities should occur. *Remember*, this is a multi-stage process that will initially occur in a series of meetings over 6-9 months.
This short video describes a Project Lazarus Workshop in Surry County:
http://www.youtube.com/watch?v=a2FQQutz02g

Coalition leaders: Coalition leaders should have a strong understanding of what the nature of the issue is in the community and what the priorities should be to address the problem. There will be relatively high levels of energy and enthusiasm in each group. The key will be to figure out how to maintain and sustain the engagement and activity as the issue is addressed. A coalition and Steering Committee are needed for the long haul. While change varies from community to community, it can be anticipated that the first fruits of the coalition's efforts will be seen in 1-2 years, although some changes such as ED policies may occur much more quickly. Finally, it is important to keep in mind the needs of coalition members who are not only professionally engaged with this topic, but who also may have personal connections. In building a community coalition, be prepared to support the members who are personally adversely affected, such as loved ones of people who are currently struggling or have overdosed. Specifically, resources about addiction treatment support for families of people who are currently using and grief support should be made available to coalition members. If there are no resources for these issues locally, direct individuals to internet-based resources, but know that development of local resources for support will need to be part of the action of the coalition.

A Well-Functioning Coalition:
Every coalition looks different; however, there are some common features in those that work well. There is consistent participation in community sectors, ranging from simply identifying the problem to actively implementing the strategies and action plans, as well as reporting to the coalition on a regular basis. Interaction between the various sectors is occurring outside of coalition meetings and more networking is taking place. Those sectors who may not have engaged at the onset are now beginning to or have become part of the coalition as word of the group's efforts and successes has filtered throughout the community, and coalition members are taking it upon themselves to reach out to the missing sector groups.

An active coalition should see the development of a change in behaviors, practices, and policies among the community sectors without accusation or blame focused on any one particular group for the issue.

Relational Diagram Among All Components of the Coalition

Venues Provided by Project Lazarus for Coalition Building

Data and Evaluation

Several pieces of this work will help with ongoing coalition maintenance. First, collecting strong Data and Evaluation will give coalition members feedback to ensure that they have a sense of the impact and results from their work. The data also lays the groundwork for making subsequent decisions on how to move forward after an initial round of efforts. Data and Evaluation are collected and used by each community to establish priorities and identify progress, which helps sustain coalition momentum. All Project Lazarus coalitions have certain Data and Evaluation requirements, which take the form of surveys and reports. This requirement comes as part of a larger effort to measure the effectiveness of the Model on a statewide level.

Second, coalition self-evaluation should constantly be assessing who is NOT at the table. Bringing in new energy is always helpful. Even more important is making sure that all the key players in the community are engaged to make certain that there is widespread ownership of the activities and the outcomes. This also helps ensure that no single sector dominants planning or implementing strategies.

The early data that is needed includes specific health related information, such as the number of emergency department visits and hospitalizations due to overdose, the number of overdose deaths, the number of prescriptions and recipients for opioid pain medication and other controlled substances dispensed, and the number of providers in the county who actively use the state's prescription drug monitoring program (PDMP). In NC, the PDMP is called the Controlled Substances Reporting System, or CSRS. The data can be obtained by working with your local health department as well as with the state's Injury and Violence Prevention Branch. Project Lazarus will provide training for data querying and will help connect communities with the state resources needed. Service oriented data and information such as numbers, types, and locations of drug treatment facilities, and numbers and locations of physicians who can prescribe buprenorphine for opioid addiction is also needed. Access to this data is available through each state department of Health and Human Services, as well as at www.SAMHSA.gov for buprenorphine prescribers and opioid treatment programs.

How Will the Data Change Early On?

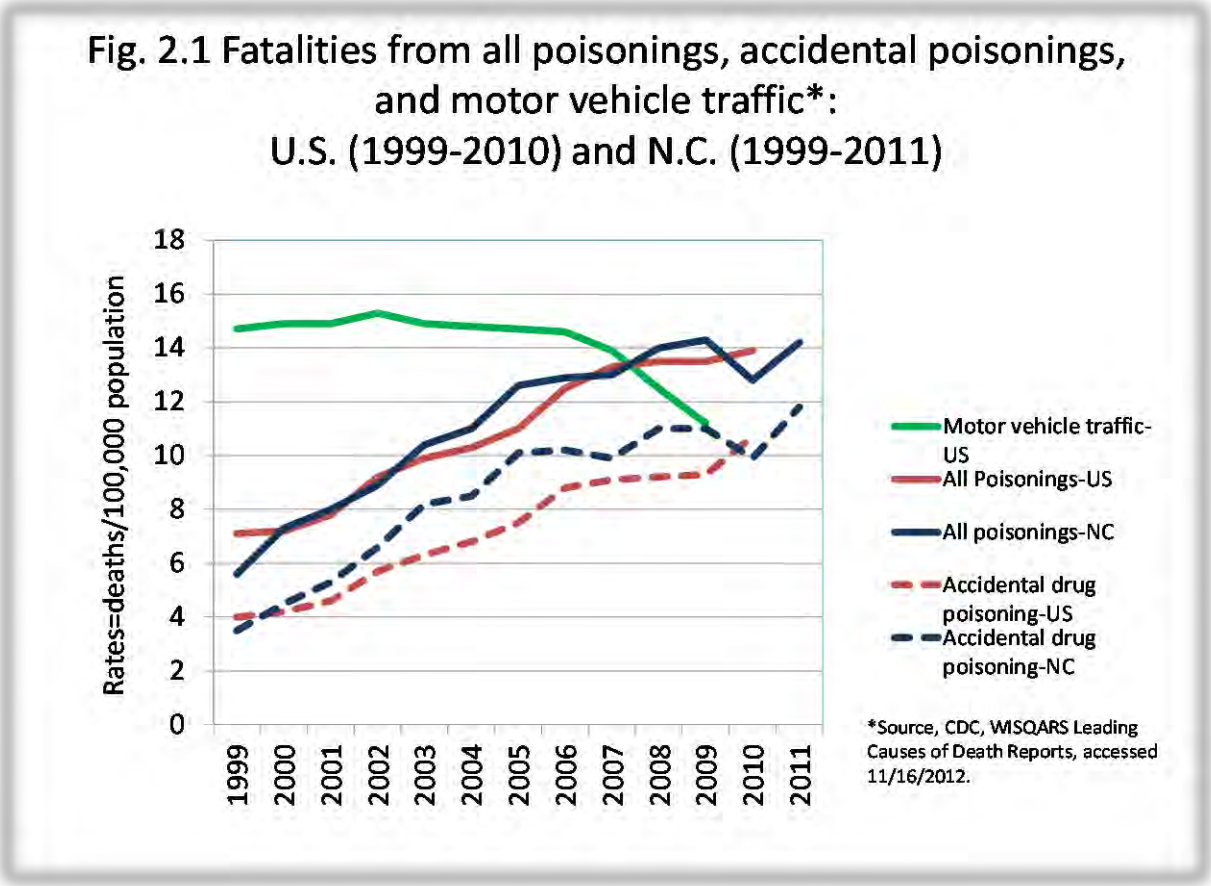
Data may begin to show a decline in overdoses while treatment numbers increase and emergency department drug seeking behavior issues decrease. Most communities expect to see an early decrease in prescribing and increase in arrests; however, do not anticipate this occurring. Do expect more *appropriate* prescribing, less sharing of medications, and more people with addiction who are identified by the medical community and law enforcement finding their way into treatment. This will apply pressure and possibly overtax current treatment options within a community, but with concerted effort an increased capacity of effective substance abuse treatment should become evident.

Project Lazarus will be collecting a biannual report from each coalition. These reports will serve multiple functions and be used by multiple parties. First, they will serve the coalition directly as a reminder to stay focused on the specific activities and outcomes that are unique to the Project Lazarus Model. The reports also help the coalition keep track of progress, which is crucial in being able to tell the story of the work being done as new partners and sectors are invited to participate. Second, the reports will serve Project Lazarus. The lessons learned from how the work progresses differentially in each county will help enrich and improve the training and technical assistance that Project Lazarus can offer to all counties. Third, they will serve the needs of researchers at the University of North Carolina Injury and Prevention Research Center at Chapel Hill who are conducting a formal evaluation of the

statewide Community Care of NC collaborative Project Lazarus. Being able to measure the extent to which different activities are in place in different counties is crucial to their ability to connect the work Project Lazarus is doing to health outcomes, like changes in ED admissions for overdose rates across the state. The information provided in these reports will capture the process of the work, which could then be connected to the outcomes this work is aiming to affect.

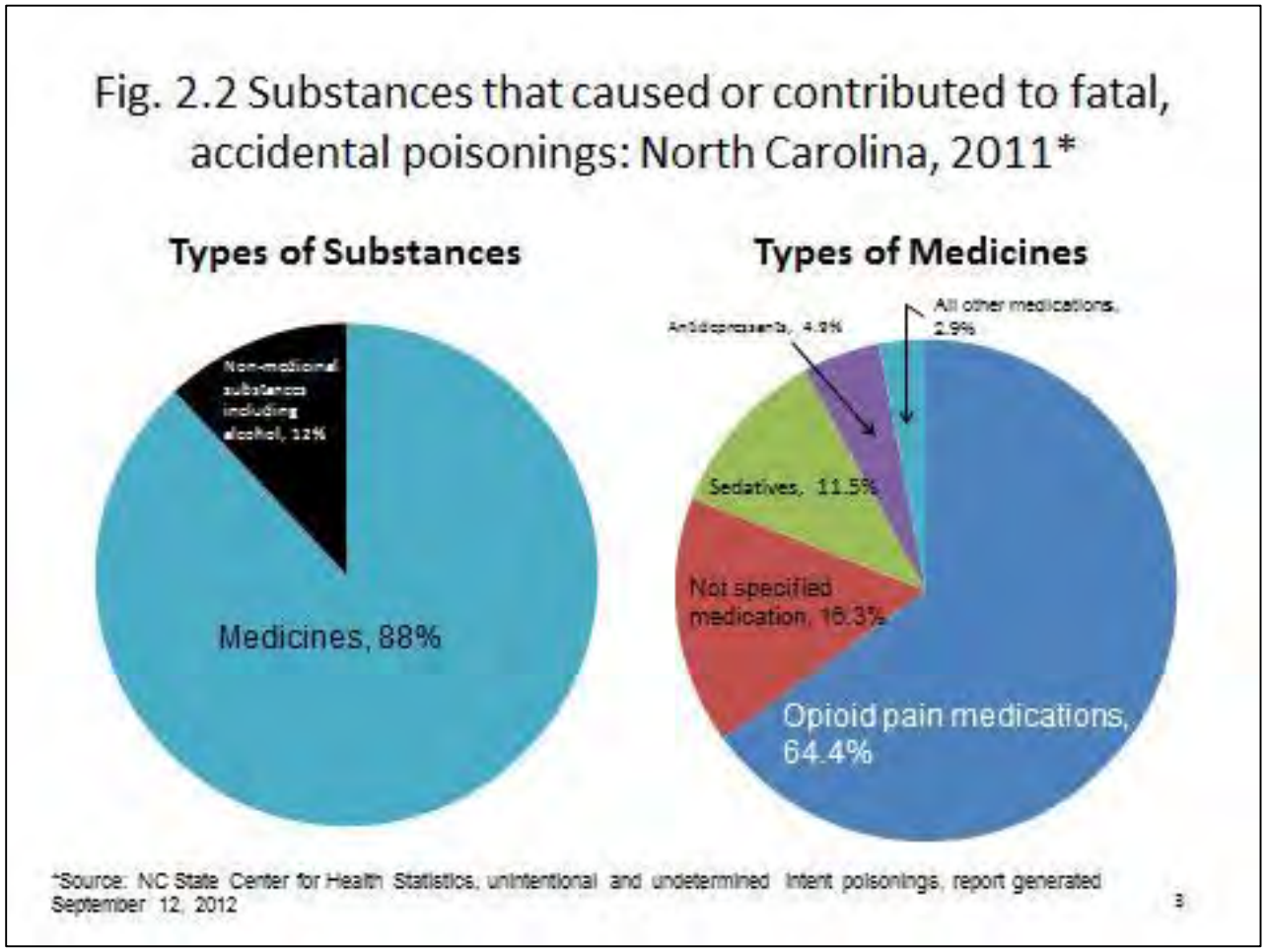
It is very important to understand that these reports are not "graded" reports on the coalition leader or the work of the coalition. There is not a standard that coalitions are being measured against. Rather, the information provided in the reports will help everyone better understand what the Model looks like when implemented in varied settings. These reports help describe the program in the real world rather than being used to measure coalitions against some theoretically perfect program. The following are some examples of how data and evaluation has been used in Wilkes County, NC to enhance coalition efforts.

Poisoning deaths are on the rise nationally and in NC (solid red and blue lines), as seen in Figure 2.1. These death rates have even surpassed the national mortality rate from motor vehicle crashes (solid green line). Accidental drug poisonings are the main cause of this increase (dashed red and blue lines); this is evident from the similar trajectories of each dashed line when compared with its same-colored solid line. By comparing both blue lines (NC) with both red lines (USA), it is apparent that NC has consistently had a higher death rate from poisonings than the nation as a whole. Over a five year span (2007-2011), over 5,000 people died from accidental drug poisonings in NC. Nearly all of these deaths (88%) involved medicine, as opposed to illicit drugs like cocaine or heroin (Figure 2.2).

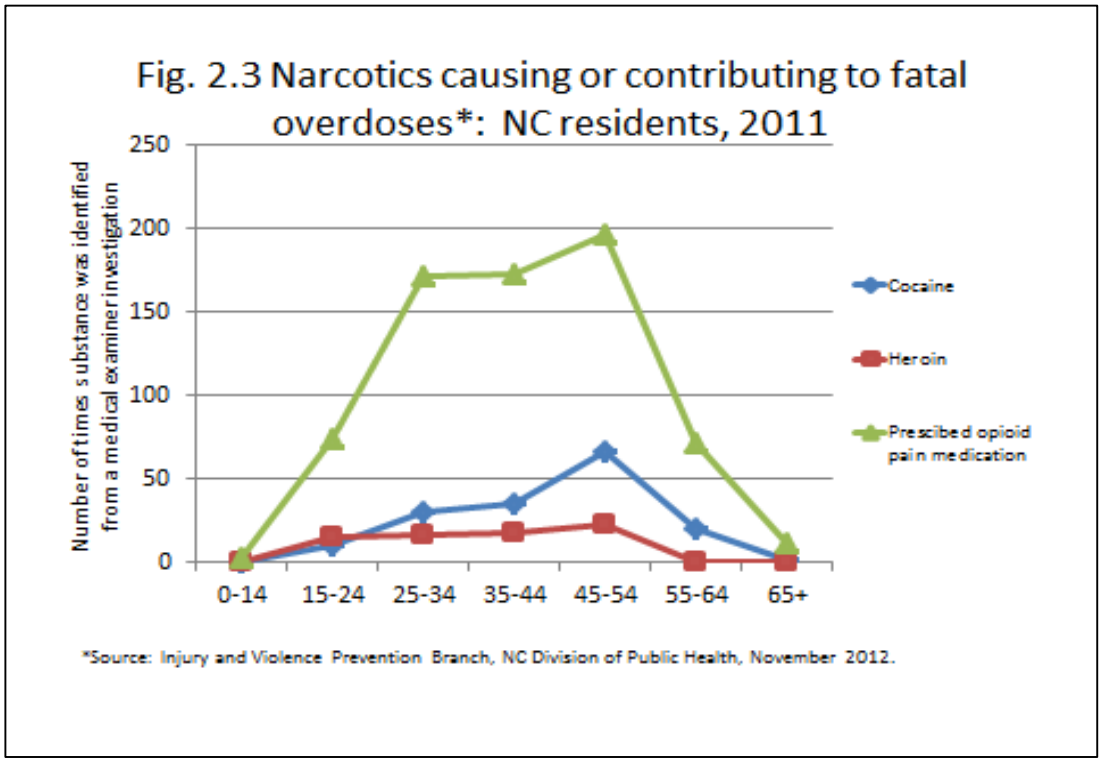


Of the deaths from medicine, over half (64%) are from one class of medication: prescription opioid pain relievers (e.g. methadone, oxycodone, fentanyl, morphine, hydrocodone).

In fact, deaths from prescription opioids *alone* outnumbered those from cocaine and heroin *combined* (Figure 2.2).



Who is dying must also be considered in order to understand this epidemic further. Figure 2.3 below shows that this is not an epidemic of the young or the old, but that the majority of these deaths are adults between the ages of 25 and 54. Moreover, men are dying from prescription drug overdose at a much higher rate than women. The information shared in this section can be used for brief conversations to describe the problem to those unaware of the accidental poisoning epidemic.



Main talking points can include:

- Poisoning deaths are on the rise nationally and in NC. Poisoning death rates have surpassed the national mortality rate from motor vehicle crashes.
- Most of the rise in deaths are due to accidental drug overdose.
- NC has a higher death rate from accidental poisonings than the nation as a whole. Over 5,000 people died from accidental poisonings in NC between 2007 and 2011.
- Nearly all of these deaths (88%) involved medications. Of the deaths from medicine, over half (64%) are from prescription opioid pain relievers.
- Prescription opioid pain relievers are involved in more deaths in NC than cocaine and heroin combined.
- Most deaths are among men between the ages of 25 and 55.

For discussions that move beyond these talking points or for community presentations on the topic, see the NC Injury and Violence Prevention Branch. (http://www.injuryfreenc.ncdhhs.gov/About/poisoning.htm)

The Seven Spokes

Transitioning from the Hub to the Spokes is moving from building the community's ability to define and identify the problem, along with gathering the resources to address it, to actually providing solutions to the problem and reversing the epidemic.

Spoke #1 - **Community Education**

Education is almost always the first response in addressing public health problems. It is indeed an important strategy, but its goals and objectives need to be carefully defined. The line between Public Awareness building and Community Education is not strict, but there are differences. Whereas the Public Awareness activities can be thought of as sharing information, the Community Education activities are about changing skills, behaviors, and norms to actually address the issue. These educational activities can be understood as two broad categories: *General Community Education* and *Specific Community Education*.

General Community Education: These efforts are those offered to the general public and are aimed at changing the perception and behaviors around sharing prescription medications, as well as improving safety behaviors around their use, storage, and disposal. The main message in these general efforts is the same as the awareness message: **"***Prescription Medication: Take Correctly, Store Securely, Dispose Properly, and Never Share."*

Many of the same venues that are used in Public Awareness may be used in this type of Community Education, but the emphasis is different: Public Awareness teaches that "this is a problem," while Community Education teaches "this is what you should do about it." There are many activities that might serve dual purposes of Public Awareness *and* General Community Education. For example, a billboard might let people know that this is a problem (awareness) and have a list of actions to take around safe storage practices (education). A Red Ribbon campaign (warnings not to share medications attached to dispensed prescription packaging) may primarily work on changing behaviors around sharing of medications (education), but will also reinforce the basic message that prescription drugs can be dangerous (awareness). This is fine, as long as coalitions make sure that efforts don't confuse the two kinds of messages. It is important to ensure that while teaching awareness, coalitions do not forget to educate on how to resolve problems.

Specific Community Education: This refers to the specially tailored educational messages that must be put into place by each sector. Because communities are made of various individuals with their own biological, psychological, social, and spiritual make-up, each community also has a unique make-up; therefore, the medical and substance abuse treatment options must be

The sharing of these basic educational messages must be ongoing. Based on the University of North Carolina Injury Prevention Research Center's Health Department survey, in 2012, Wilkes Co. had received more concerted overdose prevention education than any county in the state of NC and had indeed shown dramatic reductions in overdose deaths. Still, there continued to be cases of overdoses caused by abuse of pain medications obtained illegally from outside the community and through misuse from sharing legally obtained pain medications. There are two lessons here:

1. Never stop providing the basic messages about prescription medications, and
2. General education *alone* is not enough to change behaviors.
3. Continue to evaluate to implement interventions to specific population groups that may remain adversely affected.

crafted to fit this specific make-up. Core messages for each sector include:

- School Children: Teach Wisdom, i.e. the dangers of taking medication not prescribed to them.
- Senior Citizens: Teach Safety, i.e. taking medication correctly and storing securely.
- Inmates and Jail/Prison Staff: Teach Tolerance, i.e. awareness of body tolerance changes when not using often and the danger of overdose.
- Faith Community: Teach Public Education, i.e. "Prescription Medications: take correctly, store securely, dispose properly and never share," and perceptions about drug use and addiction.
- People Who Use Drugs or Misuse Prescription Medications: Teach Harm Reduction, i.e. overdose, tolerance, diseases from sharing drug paraphernalia, and avenues for treatment while always reducing stigma.
- Law Enforcement: Teach the properties of addiction, naloxone rescue, and provide community resources.
- Parents: Teach wisdom and safety surrounding prescription medications for themselves and children.
- Workplace/Employers: Teach properties of addiction, medication effects, workplace use, and diversion.
- Medical Community: Teach Chronic Pain Management & Appropriate Prescribing, i.e. use of PDMP, patient assessment, universal precautions, treatment referral, and expansion for access to care.

In addition to reaching out to the above groups, which are universally present in communities, each community must evaluate their various population groups that may require specific collaboration. These groups may include military families, tribal groups, particular linguistic or cultural groups, and others who may need individually customized messages. Project Lazarus has detailed information to assist with the crafting and modifying of messages for different groups.

Spoke #2 - **Prescriber Education**

Chronic pain is recognized as a complicated medical condition requiring a substantial amount of knowledge and skill for appropriate evaluation, assessment, and management. Pain is sometimes treated in an emergency department with opioid-based medicine and often is not recognized as requiring pain-specific clinical expertise. Prescriber Education is most effective when provided by professional peers as opposed to concerned citizens. Members of the Prescriber Education sector group should include clinicians and work with other organizations offering continuing medical education (CME) to prescribers in the community to optimize their efforts. The local

Project Lazarus, working in collaboration with Community Care of North Carolina (CCNC), developed prescriber and care manager toolkits as part of the statewide Project Lazarus (www.communitycarenc.com/population-management/chronic-pain-project/)[0] Each of the 14 CCNC regions in the state has a Chronic Pain Initiative (CPI) regional coordinator whose role is to focus specifically on the medical/clinical aspects of the Project Lazarus model. The Prescriber Education sector should absolutely collaborate with their regional CPI coordinator to support his or her efforts. Additional prescriber education will be accomplished by Project Lazarus, Governors Institute on Substance Abuse, NC Hospital Association, Medical Society and other educational organizations offering CMEs specific to pain prescriptions. Naloxone prescribing is also encouraged.

hospitals, statewide chronic pain organizations, local addiction treatment specialists, and local pain specialists are all examples of the kinds of resources that can support these efforts.

While much of the emphasis in these efforts is on those writing the actual prescriptions, it is important to also engage with nurses and pharmacists. Nurse practitioners should be receiving the same Prescriber Education as all other prescribers. The nurses being discussed here are those without prescriptive authority. Nurses have a vital role in caring for patients with chronic pain and/or addiction and should understand the signs of patients' risk behavior and be able to care for them effectively. Pharmacists also have an incredibly important role in this effort. Pharmacists should understand the problem and what their role is in identifying diversion, forgery, and promoting patient safety.

Communities and professional organizations are continually developing new and creative ways to optimize education for prescribers and other clinicians. The following is a list of some of the activities that have been successfully implemented:

- Promoting adoption of the CPI toolkits for primary care providers, emergency departments, and care managers.
- One-on-one Prescriber Education or "academic detailing" on pain management.
- Continuing medical education sessions on pain management, appropriate prescribing, and diversion control.
- Pharmacist continuing education on diversion, forgery and the use of the PDMP.
- Promoting prescriber and dispenser use of the PDMP.
- Information concerning the Good Samaritan Law and prescribing naloxone.

Spoke #3 - **Hospital Emergency Department Policies**

The emergency department (ED) is a source of many prescriptions for opioid pain medications. There are several factors that could increase the risk of adverse events in patients receiving controlled substances through the ED. Since there is no ongoing physician-to-patient relationship in most cases, the ED provider may not have readily available information regarding co-morbid medical conditions, other prescription medicines the patient is taking and possible drug-to-drug adverse interactions, or other patient factors that could increase the risk for overdose. There are also patients who exhibit "drug seeking behavior" and come through the ED, sometimes even multiple EDs, to get controlled medications for a variety of reasons, including trying to address unrelieved pain and issues related to medication dependency. For these reasons, it is recommended that hospital EDs develop a system-wide standard protocol with respect to prescribing narcotic analgesics. Considerations in developing an opioid prescribing policy might include the following points:

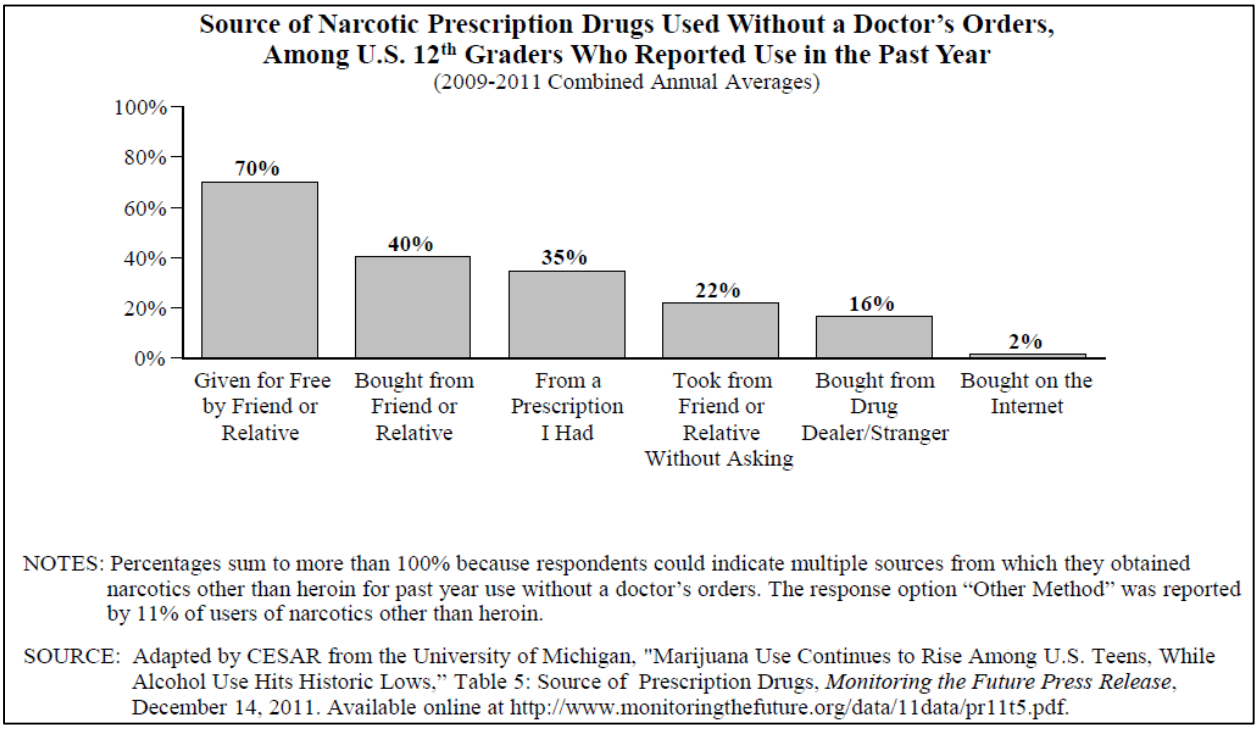
a. ED will avoid prescribing controlled substances for pain that is chronic and, instead, prescribe a non-narcotic medication and refer to the patient's primary care provider, pain specialist, or dentist.
b. ED will avoid providing refills for chronic pain medications due to lost prescriptions, need for after hours, or weekend refills.
c. ED provider should check the PDMP (CSRS) before prescribing a controlled medication for pain.

d. ED will limit the number of doses of controlled medications dispensed or prescribed. For instance, the default number for computerized prescriptions for opiates will be set at #10 or less for chronic pain.
e. For patients who are frequently seen in the ED for pain complaints and who have no established primary care provider, the ED or other hospital staff will work to help get that patient established with a regular provider.
f. ED will create a case manager position to work specifically with patients dealing with chronic pain and substance abuse issues, as well as coordinate appropriate care and work with patients who are under-or uninsured.

Again, in NC, the CPI regional coordinator uses the ED CPI Toolkit in reaching out to every hospital in the region and promoting the above points as part of a model ED policy. Make sure that any efforts initiated are coordinated with the broader Chronic Pain Initiative.

Spoke #4 - **Diversion Control**

Supporting patients who have pain, particularly those who treat pain with opioid pain medications, is an important form of Diversion Control. However, there are additional ways to prevent diversion in communities. As seen in Figure 4.1, the majority of prescription pain medication used by teenagers without a doctor's prescription come from legitimate prescriptions written for someone known to them. Pills being imported from other countries, obtained from dealers, or over the internet are considerably less common among young people.



Because the way people get prescription drugs is different than illicit drugs, i.e. from a friend or family member vs. from a drug dealer or on the black market, the strategies for preventing access to prescription drugs must also be different. There are several main strategies, most of which require the

involvement of law enforcement. One strategy is to reduce the overall supply of unused prescription medications available in communities for potential abuse/misuse/diversion/overdose. The ED policy points described above help in this effort. In addition, many people have medicine cabinets full of expired or unused prescriptions. Helping people to dispose of these medications in ways that are not harmful to the environment, such as flushing them down the toilet and into public water supply, is a crucial piece of Diversion Control. For those controlled substances that need to remain in the home, locked storage containers can be made available and promoted. Another main strategy is to support capacity building among state and local law enforcement to identify, investigate, and prosecute illegal diversion activities. Promoting networking between law enforcement and local behavioral health and/or substance abuse treatment services is also an important strategy. The Crisis Intervention Team (CIT) model has been very well received in many communities. For more information on this, visit http://www.nami.org/template.cfm?section=cit2.

Communities, law enforcement agencies, and health care professionals are constantly developing new and creative ways to ensure that prescription medications are used only by the person they are prescribed for and to minimize diversion. The following is a list of some of the activities that have been successfully implemented:

- Hospital ED opioid dispensing policy modified as described above.
- Unused medication take-back events by sheriff and police departments, with support from DEA and State Bureau of Investigation.
- In NC, Operation Medicine Drop is an excellent resource for supporting local communities in sponsoring these events. For more information visit: http://www.ncdoi.com/osfm/SafeKids/sk_OperationMedicineDrop.asp
- Fixed medicine disposal sites at law enforcement offices.
- Project Lazarus has initiated Project Pill Drop, supplying county law enforcement agencies with permanent pill take back “kiosks,” see www.projectpilldrop.org for more information.
- Hiring and training drug diversion specialized law enforcement officers.
- Encouraging the use of locked storage for controlled substances in the home.

Spoke #5 - **Pain Patient Support**

In the same way that prescribers benefit from additional education on managing chronic pain, the complexity of living with chronic pain makes supporting community members with pain vitally important.

A factor that contributes to the complexity of the overdose situation is the overlap of pain patients who have previously developed or have substance use disorders. If people who have pain and people who have substance use disorders were separate non-overlapping groups, then an effective intervention might be simpler. However, whether the use of prescription drugs is legitimate or not is irrelevant when unintentional overdose deaths can be prevented. No one deserves to die of an overdose no matter where the substance came from or why it was being used. Table 4.1 summarizes the research to date on these two groups and the overlap between substance use and chronic pain.

Table 4.1 Statistics on Substance Use and Chronic Pain in the United States

Category	Statistic	Source
Chronic pain patients who may have addictive disorders	32%	Chelminski et al., 2005
People ages 20 and older who report pain that lasted more than 3 months	56%	National Center for Health Statistics, 2006
People experiencing disabling pain in the previous year	36%	Portenoy, Ugarte, Fuller, & Haas, 2004
People ages 65 and older who experience pain that has lasted more than 12 months	57%	National Center for Health Statistics, 2006
Civilian, non-institutionalized U.S. residents ages 12 and older who report nonmedical use of pain relievers in past year	5%	Substance Abuse and Mental Health Services Administration [SAMHSA], 2007
People ages 12 and older who report that they initiated illegal drug use with pain relievers	19%	SAMHSA, 2008
People with opioid addiction who report chronic pain	29–60%	Pele et al., 2005; Potter, Shiffman, & Weiss, 2008; Sheu et al., 2008

These factors contribute to the complex relationship between pain and substance abuse. Project Lazarus and Community Care of North Carolina have developed the Chronic Pain Initiative toolkits for the needs of NC health care providers who treat pain: https://www.communitycarenc.org/population-management/chronic-pain-project/. There are also national resources like the American Chronic Pain Association, http://www.theacpa.org, which can provide useful information for provider and patient alike.

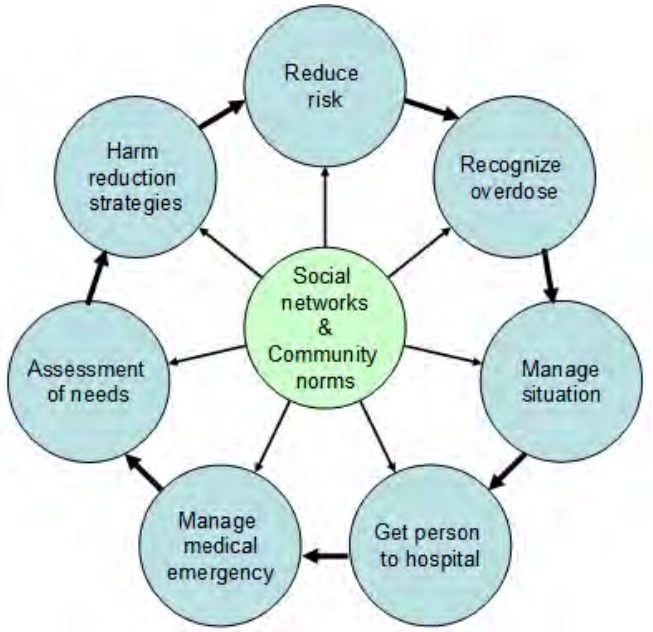
Communities and health care professionals can work in many ways to optimize pain management and support patients with pain. The following is a list of some of the activities that have been successfully implemented.

- Promoting adoption of the CPI toolkits for primary care providers, EDs, and care managers.
- Medicaid policy change: Mandatory use of patient–prescriber agreements, medical home, and pharmacy home for high risk patients which could also be adopted by private insurance companies.
- Support groups for pain patients and their families.
- ED case manager for patients with chronic pain.
- Medical practice vetting of local pain clinics and facilitation of specialized pain clinic referrals.

Many of these activities around pain patient treatment and support fall directly under the purview of the regional CPI coordinators. Be sure to align these activities with their efforts.

Spoke #6 - **Harm Reduction**

For individuals who are at risk of overdose, prevention can be conceptualized as a cycle including a series of stages where different actions are appropriate or effective at different times. At each stage there are opportunities to act and save a person's life. The actions that are appropriate and available are also influenced by community norms and by social networks. An important Harm Reduction intervention is to equip people in the community with training and the medicine naloxone to reverse overdoses.



<u>Elements of Overdose Harm Reduction Education</u>

Often, during an overdose another person is present. *Recognizing that an overdose is occurring* is the first step in ensuring that someone survives. While this might seem obvious, there have been many reports of someone who thought an overdose victim was sleepy or snoring when the person was actually beginning to have the respiratory distress that comes with an overdose that leads to death. If the overdose is recognized, a bystander who has been taught how to manage the situation can save a life. Through simple training, family and friends learn that by calling 911, beginning rescue breathing, administering naloxone, and placing the victim in the rescue position, they can prevent the death of a family member or friend and save a life. Having naloxone available and knowing what to do is a key component that may not be accessible in various communities. Even if the overdose victim has had naloxone administered, he or she should still receive medical attention. *Getting the victim to the hospital* is important, but is also influenced by other factors. These factors include variables, such as if they expect to be treated with respect, if going to the hospital initiates arrest, investigation, probation violation, or a housing investigation, and if the cost is perceived to be a barrier. Once at the hospital, the medical emergency is managed. After the immediate danger has passed, this can be an excellent time to do an *assessment of needs*, including the evaluation of whether drug treatment is appropriate and desirable for the overdose victim. The overdose victim's experience, whether positive or negative at this moment, may influence the person's willingness to utilize services. Particularly for people who do not have or want access to drug treatment, *Harm Reduction strategies*, including conversations about overdose prevention, naloxone, and making an overdose plan, are very appropriate. Discussing Harm Reduction strategies like naloxone, practicing safer drug use strategies such as minimizing drug mixing, and being aware of the community norm for tolerance of drug overdose can *reduce the risk* of overdose among people who continue to use drugs.

There are many efforts all over the country to improve the availability and accessibility of Harm Reduction strategies in communities; some function at the state level. For example, changing the Good Samaritan laws to reduce fear of arrest by a witness to an overdose who might call 911 can make a huge impact. The following is a list of some of the activities that have been successfully implemented in communities in NC:

- Overdose prevention education in prisons.
- Take-home naloxone prescribing. For more supporting information about this, visit http://prescribetoprevent.org/.
- Overdose recognition, prevention, and response education. See the Harm Reduction & Prescription Drugs factsheets included in this Community Toolkit that can be used in educational efforts.

The NC Harm Reduction Coalition, http://www.nchrc.org, is North Carolina's only comprehensive Harm Reduction program that addresses many issues, including prescription drug overdose.

The North Carolina Medical Board has issued a statement supporting the use of naloxone to prevent overdoses:

> ***Drug Overdose Prevention*** *Created: Sep 1, 2008 Modified: March 2013*
> *"The Board is concerned about the rise in overdose deaths over the past decade in the State of North Carolina as a result of both prescription and non-prescription drugs. The Board is encouraged by programs that are attempting to reduce the number of drug overdoses by making available or prescribing an opioid antagonist such as naloxone to someone in a position to assist a person at risk of an opiate-related overdose.*
> *The prevention of drug overdoses is consistent with the Board's statutory mission to protect the people of North Carolina. The Board therefore encourages its licensees to cooperate with programs in their efforts to make opioid antagonists available to persons at risk of suffering an opiate-related overdose."*
> ** Naloxone is the antidote used in emergency medical settings to reverse respiratory depression due to opioid toxicity.*
> http://www.ncmedboard.org/position_statements/detail/drug_overdose_prevention

Additionally, the American Medical Association has issued a positive position statement, as has the National Association of Drug Diversion Investigators, www.naddi.org.

Moreover, the White House Director of the Office of National Drug Control Policy, R. Gil Kerlikowske, often referred to as the "Drug Czar," is also supportive of efforts to promote the use of naloxone. At a symposium in Wilkes County, NC on prescription drug overdose prevention hosted by Project Lazarus in August 2012, for the first time, he voiced support for naloxone and encouraged making it widely available. He also broadly praised Project Lazarus:

> *"Project Lazarus is an exceptional organization—not only because it saves lives in Wilkes County, but also because it sets a pioneering example in community-based public health for the rest of the country… This Administration understands that substance dependence is a health issue—not necessarily a criminal justice issue—and we support innovative ways to bring treatment to people who need it most… Project Lazarus is a striking example of this kind of innovation."-R. Gil Kerlikowske*

The latter statement is especially important in thinking about naloxone. Reaching out to those who are still misusing and abusing prescription drugs to help them avoid dying of overdose will never be

effectively done if the issue is framed as a criminal justice matter. For more information, download the opioid overdose toolkit recently released by SAMHSA at http://store.samhsa.gov/product/SMA13-4742.

The use of naloxone is the most innovative part of the Project Lazarus Model. This is because Project Lazarus was among the first communities in the country to dispense naloxone to people receiving prescription opioids. Previously, naloxone had only been provided for heroin users. This use of naloxone is very cutting edge, and, therefore, when new naloxone programs begin in a community, the coalition should be prepared for additional surveys and requests for data above and beyond the basic Project Lazarus reporting requirements discussed previously.

Spoke #7 - **Expanding Access to Drug Treatment**

Drug treatment, especially Medication-Assisted Treatment like methadone maintenance treatment or office-based buprenorphine treatment, has been shown to dramatically reduce overdose risk; see http://www.ncbi.nlm.nih.gov/pubmed/?term=Emmanuelli+and+Desenclos+reduction+in+overdoses for more information. Unfortunately, access to treatment is limited by three main factors: availability, accessibility of treatment options, and negative attitudes or stigma associated with addiction and drug treatment in general.

Drug treatment options are underfunded in the US and North Carolina is not an exception. Many people who seek help for their problematic drug use are unable to access treatment, encounter insurance barriers, month-long wait lists, programs that don't meet their needs, or programs they cannot afford. Regrettably, many people are only able to access drug treatment as a result of an arrest or criminal conviction. Advocating for increased funding of drug treatment and more qualified health care providers who are willing and able to provide these services can improve drug treatment access.

In addition to the possible logistical difficulties in accessing services, people with substance use disorders may not want to access drug treatment because of shame or fear of stigma. There is an increasing trend in people becoming addicted to prescription drugs; however, the community or individual perception may be that drug treatment is only for substances like alcohol, heroin, or cocaine, but not for prescription drugs. Community members and people struggling with addiction specifically need to be aware that there is a broad range of treatment options, including treatment for people addicted to prescription drugs which can be tailored to suit the needs of each individual. Additional advocacy work can be done to broaden the definition of drug treatment to include models of care that incorporate Harm Reduction principles and prioritize health, safety, and improving quality of life over strict abstinence. Drug treatment, like other health care decisions, should be consensual and self-directed.

Expanding support services for those that have been affected by prescription drug misuse/abuse/diversion/overdose is a needed adjunct to treatment centers and community self-help groups. Providing peer-led non-abstinence based support groups for those who have experienced an overdose and for their family members can make a genuine difference in getting individuals and families back on track. The same goes for youth, for those who have lost a loved one to an overdose, or for opioid dependent individuals who are not benefitting from traditional treatment options. Peer support specialists who are trained in crisis intervention, available during an emergency such as an overdose, who advocate for the overdose victim and their families, and who are well-versed in

navigating addiction recovery services provide the glue that holds all of the Recovery-Oriented Systems of Care together. Peer support service workers help to remove the barriers of stigma that come with drug abuse and dependence because they've been there. They know the recovery ropes, they act as a partner for wellness, and they give hope to those suffering from drug abuse.

The following is a list of some of the ways that access to drug treatment has been expanded as a part of prescription drug overdose prevention efforts:

- Negotiation and support for the opening of a satellite office-based drug treatment clinic using buprenorphine.
- Encouraging doctors to get trained by SAMHSA to prescribe buprenorphine. Project Lazarus can assist in linking resources for this training.
- Advocating for drug treatment services that have been proven to work.
- Fighting misinformation on ineffective strategies of dealing with substance abuse.
- Initiating peer support specialist services
- Getting eligible people enrolled in Medicaid to access drug treatment services for free or reduced cost.
- Treatment awareness campaigns, including real life success stories from relatable community members.
- Opening a drug detox program.

Section II:

Project Lazarus Sustainability Series

The Project Lazarus Sustainability Series empowers communities with the training documents needed to effectively sustain their coalition once established.

Leadership

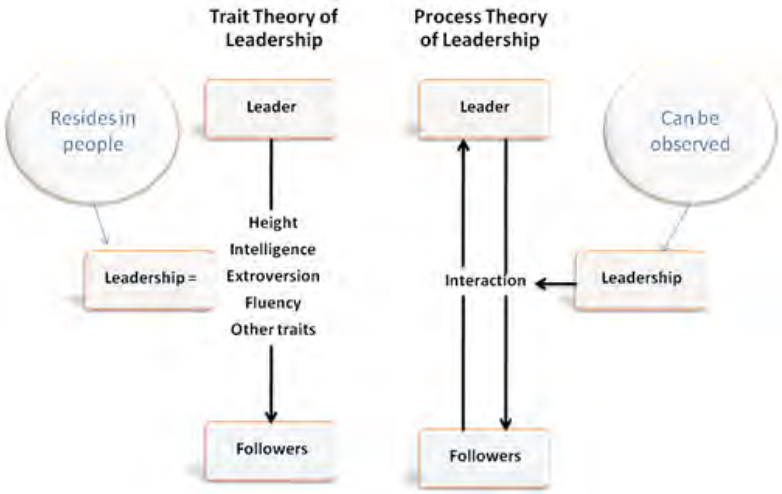
Warren Bennis, who is widely regarded as the pioneer of the contemporary field of leadership, a Distinguished Professor of Business Administration, and a Founding Chairman of The Leadership Institute at USC wrote this in regards to leadership:

> *"I used to think that running an organization was equivalent to conducting a symphony orchestra. But I don't think that's quite it; it's more like jazz. There is more improvisation*."

Given the important nature of leadership, much research and many theories exist in an attempt to analyze and explain what makes for the best leader. Some theories would suggest that leadership skill is not something you are "born" with, but rather something you learn. Others point to inherent traits that lean toward natural built-in leadership qualities. Researchers at the Harvard Medical School studied six characteristics of project directors: "status with community (insider vs. outsider); shared leadership; bridge building skills; substance abuse expertise; vision; and management style. Shared leadership, bridge building skills, and insider status were consistently related to leadership effectiveness. Less support was found for substance abuse expertise or vision. When hiring project directors, coalition leaders may consider assessing whether candidates are "insiders" within the community and demonstrate shared leadership and bridge building skills."[1]

While a plethora of explanations can be found in the literature, leadership consultant and trainer Donald Clark directs us to two theories of leadership in general which are compared in the models below. Process Theory has to do with applying the leader's knowledge and skill effectively to inspire others to reach a common goal. Trait Theory pertains to unique attributes that influence the leader's actions. Good leaders will use knowledge, skill, and their personal attributes to motivate others toward achieving objectives.

In essence, good leaders will possess self-awareness, expertise, decisiveness, and loyalty. They also have the ability to bring out the best in others, give clear and concise directions, create a team atmosphere, set the example for others, take responsibility, and make full use of all their resources. For more information on leadership, please visit Clark, D. (2004). *Concepts of leadership*. Retrieved from http://nwlink.com/~donclark/leader/leadcon.html.



Motivating Volunteers

Coalitions fluctuate depending on the motivational strength of its volunteers. Keeping those volunteers engaged and productive necessitates applying knowledge about what drives people to volunteer. It is mainly the job of the coalition coordinator, but coalition members also play an important role in modeling the motivational character of their leader. If a coalition adopts a culture that switches motivation on and keeps volunteers active, the division of labor can be distributed equitably and satisfactorily.

Tom McKee, president and owner of www.volunteerpower.com, a leadership development firm specializing in volunteerism, researches "what is the motivation for people to take their time, money, and talent to become involved in coalition work?" McKee reports that motivation comes from within. People do things for personal reasons. Leaders must therefore create a culture that stimulates the personal motivations of each volunteer. McKee states that most people respond to one of three basic levels of motivational drives: a personal interest drive, a social drive, or a cause drive. In coalitions we find recruits at all three levels and can use each kind of motivation to enlist volunteers.

Personal Interest Motivation

People often join an organization because it meets their needs. That need may be for business, for friendship, or for belonging. Networking and belonging are both incredible benefits for people to gain from volunteering. Recruitment efforts should include these kinds of volunteers because it benefits both the volunteer and the coalition. When recruiting at the basic level, stress the personal benefits volunteers will receive when they work for your coalition.

Social Motivation

People also volunteer because of friendship. When a friend personally asks someone to volunteer, it is often hard to say, "no." Many people join an organization and work as volunteers because they were recruited by a friend. Relational marketing is one of the most effective marketing tools. Investing in relationships is one of the strongest stimulators of motivation. The advantage of having a recruiting team is that the synergy of brainstorming increases the sphere of influence.

Cause Motivation

The cause level is the *strongest* level of commitment. When people volunteer because of their passion for a cause, even if that cause will cost them a great deal of personal sacrifice and pain, the volunteer will stay highly motivated. Although people often join an organization at level one for a personal interest drive or at level two for a social drive, in time they become passionately committed and believe in the cause. This is our hope for each member who joins.

For more information about motivating volunteers visit: http://www.volunteerpower.com/articles/Why.asp

Simple Reminders to Sustain Motivation

1. Remind members of the magnitude of the project but never resort to threats.
2. Provide rewards for extra hard work.
3. Be specific when giving instructions.
4. Set short and long term goals.
5. Be kind and patient, but decisive and firm.
6. Schedule mini-deadlines leading up to a major deadline.
7. Create team camaraderie.
8. Give credit and acknowledgment for accomplishments, especially to those who shine.
9. Know your volunteers personal stake in the project.
10. Do not micro-manage, instead give volunteers freedom to achieve outcomes.
11. Give volunteers trust and respect.

12. Create new challenges to keep it fresh.
13. Allow for creativity.
14. Use constructive feedback.
15. Make group functions and activities fun.
16. Keep the lines of communication open and easy.
17. Make projects stimulating by mixing things up.

Visit: http://motivation-srisupan.blogspot.com/2012/07/how-to-get-motivated-motivation-is.html.

Managing Volunteers

Leadership skill is never more tested than while working with large numbers of volunteers. Despite the volume, it is fitting to get to know your volunteers well. Invest time to understand their motivation and what they find satisfying about volunteering. Provide a vehicle for them to air their concerns and obtain clarification about their role and about the coalition as a whole. Volunteers have different life circumstances and pressures. Managing volunteers may mean coordinating 100 of those lives at various stages. Time constraints may pose a difficult task in reaching all of them. However, you may still want to provide opportunities for giving and receiving feedback on their work. There are different ways of getting feedback from your volunteers. Traditional methods include questionnaires, interviews and focus groups. A sample satisfaction survey is included in this toolkit. Exit interviews are particularly helpful in this respect, as well.

Understanding the feedback given by your volunteers will help you to:

- Revamp roles for relevancy.
- Suggest possibilities for keeping volunteers engaged.
- Improve organizational methods.

Volunteer Conflict Management

Coalitions are people-oriented organizations. People within a coalition have to collaborate to accomplish goals; therefore, interaction with others is inevitable. Conflicts arise from misunderstandings or differences of opinions on an approach used to execute tasks. If mishandled, conflicts can affect the culture of the coalition and thus, the productivity of its members. Investigating the cause of conflict and making a fair final decision without favoring parties is another very important role of the coalition coordinator. To better equip yourself for this leadership role, it may be helpful to review conflict management literature before an issue presents itself and identify your conflict management style preference. The suggestions below are only a small sample of all that has been written about conflict; however, some general guidelines may be found helpful in all instances.

Skills for Conflict Management*

Active Listening- A lack of listening skills leads to misinterpretation of information. Patience, respect, and the desire to come to an understanding aids in conflict resolution.

*Regulating Emotion*s- Getting overly excited, behaving inappropriately, or becoming verbally combative escalates volatile emotions. Learning self-control and modeling the behavior of leaders is conducive to cooperative partnerships. Apologize quickly when an error is made and practice consistent corrective behaviors.

Positive Mindset- This comes from a confident “can-do” and “things usually work out for the best” attitude. Think of conflict management as an exciting opportunity that leads to positive rewards and even better

outcomes.

Wisdom- Wisdom is gained through various life lessons. Learning to take an objective step back, not internalizing, and improving in some way is an advanced view of conflict.

*By Charlie S. Last Updated: 10/7/2011: http://www.buzzle.com/articles/conflict-management-skills.html.

Assertive Communication

The skill of being assertive is an effective communication technique that usually creates a "win-win" scenario between people to resolve conflict. Assertive communication is neither aggressive nor passive. It is centered and balanced on helping all parties receive the best results possible. It requires honesty and awareness of self and others. An article on stress management and being assertive by the Mayo Clinic points out that assertiveness can help you control stress and anger, and improve coping skills. Excerpts from the article are contained below.

"Being assertive is a core communication skill. Being assertive means that you express yourself effectively and stand up for your point of view, while also respecting the rights and beliefs of others. Being assertive can also help boost your self-esteem and earn others' respect. This can help with stress management, especially if you tend to take on too many responsibilities because you have a hard time saying no."

"Of course, it's not just what you say but how you say it that's important. Assertive communication is direct and respectful. Being assertive gives you the best chance of successfully delivering your message. If you communicate in a way that's too passive or too aggressive, your message may get lost because people are too busy reacting to your delivery."

"People develop different styles of communication based on their life experiences. Your style may be so ingrained that you're not even aware of what it is. People tend to stick to the same communication style over time. But if you want to change your communication style, you can learn to communicate in healthier and more effective ways."

"Using "I" statements lets others know what you're thinking without sounding accusatory. For instance, say, "I disagree," rather than, "You're wrong."

"If you have a hard time turning down requests, try saying, "No, I can't do that now." Don't beat around the bush — be direct. If an explanation is appropriate, keep it brief."

"Communication isn't just verbal. Act confident even if you aren't feeling it. Keep an upright posture, but lean forward a bit. Make regular eye contact. Maintain a neutral or positive facial expression. Don't wring your hands or use dramatic gestures. Practice assertive body language in front of a mirror or with a friend or colleague."

"Conflict is hard for most people. Maybe you get angry or frustrated, or maybe you feel like crying. Although these feelings are normal, they can get in the way of resolving conflict. If you feel too emotional going into a situation, wait a bit if possible. Then work on remaining calm. Breathe slowly. Keep your voice even and firm."

"At first, practice your new skills in situations that are low risk. For instance, try out your assertiveness on a partner or friend before tackling a difficult situation at work. Evaluate yourself afterward and tweak your approach as necessary."

For more tips and help on assertiveness, visit http://www.mayoclinic.com/health/assertive/SR00042 to read the full article.

Preventing Burnout

Assertive communication reduces stress, improves coping skills, and prevents burnout. However, burnout can still occur if it is not addressed properly. Early detection of fatigue can avert harm to the physical, emotional, and mental well-being of all members of your coalition, particularly those in leadership.

Burnout can be defined as a condition of physical, emotional, and mental exhaustion caused by exposure to chronic stress. Chronic stress drains your energy supplies and can produce an emotional state of helplessness, hopelessness, and resentment. Feelings of overwhelm from the constant demand of your leadership role may leave you discouraged and wanting to escape. Overtime, you may come to believe that you have no more to give.

Burnout happens over time so it is a process that can be identified and corrected. If you pay attention, you can recognize the warning signs and exercise protective measures.

***Physical Signs and Symptoms of Burnout**

• Always feeling tired and drained. • Lowered immunity and feeling sick, a lot.	• Frequent headaches, back pain, muscle aches. • Change in appetite or sleep habits.

Emotional signs and symptoms of burnout

• Sense of failure and self-doubt. • Feeling helpless, trapped, and defeated. • Detachment, feeling alone in the world.	• Loss of motivation. • Increasingly cynical and negative outlook. • Decreased satisfaction and sense of accomplishment.

Behavioral signs and symptoms of burnout

• Withdrawing from responsibilities. • Isolating yourself from others. • Procrastinating, taking longer to get things finished.	• Using food, drugs, or alcohol to cope. • Taking out your frustrations on others. • Skipping work or coming in late and leaving early.

Dealing with Burnout: The "Three R" Approach

- **Recognize** – Watch for the warning signs of burnout
- **Reverse** – Undo the damage by managing stress and seeking support
- **Resilience** – Build your resilience to stress by taking care of your physical and emotional health

Visit: http://www.helpguide.org/mental/burnout_signs_symptoms.html.

Delegating Responsibility

Proper and effective delegation of responsibility is how the coalition's strategic plan becomes activated. Delegation is an art form. It brings all of your people and communication skills to bare on apportioning the right group for the right task at the right time. Although the task may be daunting, some initial planning and forethought can smooth the process of transitioning from the theory of your strategic plan into a reality. In effect, proper delegation means helping others succeed which ultimately means your overall plan succeeds.

Keep in mind these simple procedures for delegation. First, the big picture or successful outcome desired must be clearly described and communicated to each workgroup, while delineating each workgroup's smaller area of responsibility and how it fits into the big picture. Secondly, all workgroups should be given contact information and access to the overall project leader should questions, problems, or needs for collaboration arise. Additionally, each workgroup should have specific instructions and know exactly what to do. Each will need to know how to give you feedback along the way. Without micromanaging, leaders will still want to influence the direction in which the project is moving at each benchmark. Therefore, descriptions of key project benchmarks, what their deadlines are, and what reporting method will be used for feedback should be clearly outlined.

An understanding of the approximate amount of time each task will require should be considered in advance. An eye on the seasonal calendar for when the tasks should be completed or launched is also crucial to your success. Timing really is everything. Keeping your finger on the pulse of your community for timing signals can save you time and effort in the long run.

References and Additional Resources:

1.http://www.ncbi.nlm.nih.gov/pubmed/16479236

2.http://www.volunteering.org.uk

3.http://www.volunteermatters.com

4.http://www.ehow.com/how_6377250_manage-conflict-volunteers.html

5.https://www.nationalserviceresources.org/volunteer-member-staff-management/conflict-resolution

6.http://humanresources.about.com/bio/Susan-M-Heathfield-6016.htm

Structure

What is Structure?

Structure is the foundation upon which your coalition's blueprint can be built. Your coalition must have an organized platform to start the process of building with clear, apparent, and appropriate boundaries that are solid and dependable. A robust structure will enhance the functionality of your coalition on its way to achieving its mission and goals.

Generate specific job or role descriptions for all coalition members, including, but not limited to coalition coordinator, treasurer (if necessary), and steering committee members. This saves members unnecessary mistakes, confusion, and disappointments. To a large extent, your coalition's work will occur between coalition meetings. Set up workgroup formations and select components of your overall comprehensive strategic plan that members can tackle together. Each workgroup or committee should be aware of what each is given to accomplish, what resources are available, and what authority each has to make decisions. A reasonable expectation is for each member to participate in at least one subcommittee that hopefully pertains to their expertise, work, sphere, and interest. Joining more than two subcommittees should be discouraged as progress may be slowed down when people are spread too thin.

Efficient meetings and effective communication requires that meetings are held regularly, consistently at the same time, and adjourned at a reasonable hour. Well thought-out agendas are communication tools that improve productivity. Agendas should be distributed well in advance. A sample agenda can be found in Section IV.III Templates. Effective agendas include the following items:

(1) A brief description of the agenda item.
(2) The person who is presenting or presiding over the discussion of that item.
(3) The time appropriated on the agenda for that item.
(4) The required actions desired from the information.

Like people, meetings may drift and derail from agendas. Establish early on that meetings are targeted and productive. If an emergent issue should arise, the facilitator can choose several options: schedule time for discussion at the next meeting, designate a workgroup to tackle the issue independently and bring a summary of their ideas to the next meeting, or choose to defer a scheduled agenda item for another time. Whichever occurs, it should be explicitly stated and recorded in the meeting minutes.

A coalition's meeting minutes embody the most elementary and essential form of precise communication. Chronicling and dispensing minutes ***quickly*** is a sound mechanism that gives all members a record of decisions that have been made and a reminder of follow-up actions. A sample minutes template is included in Section IV.III Templates.

In the age of information we now live in, many new ways to communicate can increase access to coalition activities and events. Email lists, online calendars and spreadsheets, or other electronic tools to keep information flowing can be used to your advantage. Text reminders and announcements have become a new norm for sharing information quickly. Sharing updated progress between meetings by establishing a coalition blog keeps everyone in the loop and on the same page much faster. Try engaging your teens to help with catching the latest trends in communication methods. Agendas and minutes can be posted on your website. Newsletters are great ways to highlight special events, member achievements, and network your members. Personally contact a newspaper reporter who may have a special interest in your efforts to prevent prescription drug misuse/abuse/diversion/overdose. Ask how your media friends would like to be contacted when something is newsworthy.

Relational Diagram Among All Components of the Coalition

References and Additional Resources

CADCA National Coalition Institute 625 Slaters Lane, Suite 300, Alexandria, VA 22314 www.cadca.org; E-mail: training@cadca.org

Coalition Organizational Chart Template

Coalition Meeting Sign-In Sheet

Capacity Building

What is Capacity Building?

"Nonprofits have an obligation to seek new and even more effective ways of making tangible progress towards their missions, and this requires building organizational capacity. All too many nonprofits, however, focus on creating new programs and keeping administrative costs low instead of building the organizational capacity necessary to achieve their aspirations effectively and efficiently…This must change: both nonprofit managers and those that fund them must recognize that excellence in programmatic innovation and implementation are insufficient for nonprofits to achieve lasting results. Great programs need great organizations behind them."[1]

"Capacity building is not just about the capacity of a nonprofit today -- it's about the future. Distinct capacity building projects such as identifying a communications strategy, improving volunteer recruitment, developing a leadership succession plan, identifying more efficient uses of technology, and engaging in collaborations with community partners -- all build the capacity of a charitable nonprofit to effectively deliver its mission in the future. When capacity building is successful, **it strengthens a nonprofit's ability to fulfill its mission over time, and enhances the nonprofit's ability to have a positive impact on lives and communities.**"[1]

Building the aptitude, faculty, and ability required to develop and implement a comprehensive community plan to reduce prescription drug misuse/abuse/diversion/overdose requires the capability to involve community partners, key stakeholders, and residents, retain and preserve high levels of commitment and engagement, and strategically organize community interventions efficiently.

Three areas that coalitions focus on concerning capacity building are: 1.) Membership Recruitment and Retention 2.) Organizational structure and 3.) Leadership.

Capacity touches all aspects of your coalition as it governs the level of functionality that expedites the work in which you've chosen to endeavor. First, use broad-based, expansive, and comprehensive thought processes that will provide a "big picture" mentality for bringing about populace change. Then, match your leadership, organization structure, and membership to fit into the big picture for administration, containment, and maintenance of it.

Membership

Coalitions spread their resources and activities across multiple stakeholder groups—each with its own agendas, limitations and modes of operation. The coalition represents an intersection at which all these different stakeholders converge on a particular problem. Bonds and partnerships formed at this intersection produce avenues to greater impact in your community. Coalitions exist because people and organizations contribute their knowledge and resources to joint undertakings. The coalition is the conduit that sparks joint efforts across stakeholder groups in a more synchronized way.

Coalitions need to continually draw fresh knowledge, interest, and resources locally for effective implementation of their strategies. Your membership should be considered a bridge of understanding to the needs and preferences of different groups in your community. Membership recruitment is essential in energizing and connecting stakeholder groups with your coalition.

Members can be organizations, civic groups, or individuals that have agreed to affiliate themselves with the mission of your coalition, to send delegates to coalition meetings on a regular basis, and to take part in your comprehensive action planning and evaluations.

Members serve two primary functions. One function is to provide perspective and direction on the problem you are addressing and to safeguard that the inner processes of the coalition are running smoothly. The second function of members is to serve as an external barometer and compass while carrying out the coalition mission within their sphere of work, life and influence and locating undiscovered resources.

Food for Thought in Selecting and Recruiting Members

Since membership is an important part of developing your coalition's capacity, it is important to remember that quantity does not rank above quality. Here are some things to keep in mind when formulating your recruitment efforts.

Consider your coalitions place in the community overall and what has been identified as the priority needs of the community through your assessments. Find out what other organizations and groups are already collectively working on and how it fits in with what you are working on. What approaches are being used and are they effective? How do non-coalition residents think about prescription drug misuse/abuse/diversion/overdose in your community? What outlooks could identify top notch strategies? Brainstorm ideas together detailing lists of specific community sectors with which to make contact.

Ascertain the necessary resources, skills, and information needed to perform your mission. Overall, you will most likely need members with solid communication skills, collaboration know-how, problem-solving methods, and proven decision-making practices. Members who have experience with coalition work already will probably have technical expertise in intervention strategies or evaluation, grant writing and/or resource gathering techniques, useful knowledge of local policy and politics, and project management skills. Some members will offer a place to meet and additional volunteers. A variety and volume of these resources is excellent if you do not want to over-burden any one of your members. Recruit entities within premium stakeholder organizations who would be an asset toward running regular operations as part of the steering committee.

Gauge interest and engagement levels. Using a brainstorming list, match the scope and intensity of your potential partners to their interest. Some sectors of your community will be central to the mission of preventing prescription drug misuse/abuse/diversion/overdose, such as health departments, law enforcement, prescribers, pharmacists, and treatment providers. Others will assume a more peripheral place at the table like media, businesses, and faith groups, for example. The structure of your coalition should include a way for all levels of interest to have a way of contributing to your efforts.

Engage in the recruiting membership process. The best way found to recruit members is by personal invitation. The leadership of your coalition should meet separately with potential recruits. When meeting your prospects, it is important to share a concise and compelling description of your coalition's mission. Convey how you see the prospect contributing to your vision. Ask what they would like to contribute and how much time they can invest. Know your audience and tailor-fit your message to your listener.
This toolkit contains many sector factsheets that specifically touch on points geared for each sector.

You may want to have for display an array of opportunities at various commitment levels for your recruit to get involved. Mention previous work done by your coalition that has been effective and successful. Conversely, if there have been mistakes in the past which raise concerns in the present, be armed and ready

to remedy and allay those apprehensions. Match leadership to their best targeted audience where their influence could be maximized. Reiterate if necessary what your coalition wants to accomplish and why your potential partnership is important to your success. Leave your prospective member or newly committed member with a membership application to cement your efforts. Through ongoing recruitment efforts by way of newsletters, blogs, and local media, your coalition will project a sense of momentum that will help keep existing members energized and make recruitment easier.

Sustain membership engagement by identifying and reducing barriers to participation. Logistical barriers include poorly timed meetings, inconvenient locations, and difficulties with transportation or parking. Work to bring consensus on logistics that encourage the most involvement.

Develop support for participation in your coalition. When employers value the time members spend on coalition work they may be willing to balance workloads and schedules to accommodate full participation. Outline how it is a win-win partnership for employers to encourage the efforts of your coalition. Memorandums of Understanding with participating organizations can ensure more active participation and unfettered commitments.

Make sure that each participant has a clear understanding of expectations. Allow room for negotiations of what they are able and willing to give. Get agreement from members on what the general requirements should be including meeting attendance each year and volunteering for at least one committee. Support for final group decision is also expected. Provide written job descriptions and delineate the authority exercised by each subcommittee. Establish work group meetings and provide structure of resources that are available to each.

Make a big deal of small successes. When progress on goals is reported frequently, members are more likely to remain active. Setting short- and long-term goals will help members experience enjoyment and pride from achieving tangible goals.

Celebrate, honor, and respect your members' contributions to bolster morale. Most people do not look for accolades through coalition work. Coalitions, therefore, neglect to publicly acknowledge the contribution made by their members. Consider a variety of ways to highlight the work of your members. One approach is to spotlight them in your newsletters, blogs, or other outreach vehicles. Many coalitions have annual celebrations in which multiple contributions of numerous members receive attention.

Take time to discuss differences in language, communication style, attitudes, and traditions of stakeholders. Expressions sometimes hold very different meanings for members of diverse cultural groups. Health and human service professionals use jargon and acronyms that are confusing for certain groups such as youth, faith community, and grassroots leaders. Make sure each member understands why every other member is involved and what each hopes to accomplish. It is essential that your coalition members perceive each other as having a legitimate role to play. Communication gaps do not have to create opportunity for confusion.

Continually evaluate and keep the vision in front of all members to sustain focus and purpose by asking:

- What is the impact of the prescription drug epidemic on your community?
- What are the major factors leading to prescription drug abuse within community/populations you serve?
- What effective prevention strategies are needed to address those factors to diminish the misuse of prescription drugs?
- Who in the community should be educated about naloxone?

- How could the community work to expand access to naloxone?
- What are the roles, activities, and plans your agency currently takes to address prescription drug abuse?
- What are the needs of your agency when working with individuals who have difficulties with prescription drug abuse?
- What are the resources, education, and/or support your agency could use to address the problem?
- What positive outcomes could arise from the sharing of resources and expertise with other local agencies? Which agencies? What resources?
- List other agencies who need to know about your services.
- Who can possibly contribute to a local speakers' bureau within your agency?
- Who have been suggested as agencies, organizations, and individuals for coalition membership?
- Who is not at the table for your mission, but is still necessary for great impact and change?

Disengagement

When you notice members of a coalition reduce their attendance or participation, a personal phone call could be what is needed to help assess the situation and reengage the member. Sometimes members stop participating because they feel that they are not useful, they don't have anything to offer, the coalition isn't working well, or maybe have just over committed themselves. The goal of the phone call is to speak with them and find out what is contributing to the decline in involvement. The person may have some constructive feedback. For example, they may state that the meetings were unorganized and nothing seemed to get accomplished. Invite their suggestions or ideas for solving the problem. It's important to hear them out and not become defensive or offer excuses. Thank them for their feedback and let them know that you'll look into the issues further.

When someone expresses that they cannot continue with the coalition, an exit interview is the best process for getting vital feedback to help develop capacity and sustainability within your coalition. This can be completed with two options depending on the member's choice. One option is to complete a written exit survey which can be mailed to the coalition leader anonymously if desired. Another option is to set an appointment to conduct a personal interview wherein the coalition leader has a set of questions to complete during the appointment. From this process, patterns will be revealed that will require leadership's attention. Examples of exit interviews are found with the links below. Ongoing evaluation processes can be a major ally in building and sustaining coalition capacity.

References and Additional Resources

1. Effective Capacity Building in Nonprofit Organizations, Report for Venture Philanthropy Partners by McKinsey & Company (2001) - See more at: http://www.councilofnonprofits.org/capacity-building/what-capacity-building#sthash.bLu6Umj8.dpuf

CADCA National Coalition Institute 625 Slaters Lane, Suite 300, Alexandria, VA 22314 www.cadca.org; E-mail: training@cadca.orgg

CADCA Article: Study Highlights Key Factors for Improving Coalition Collaboration and Unification

Links to Surveys:

http://coalitionswork.com/wp-content/uploads/coalition_meeting_checkup.pdf

http://coalitionswork.com/wp-content/uploads/coalition_member_survey.pdf

Diagram of Project Lazarus Capacity Building Process

Strategic Planning

What is Strategic Planning?

Strategic Planning is a process for making plans. The driving force is utilizing information and data that guides how you take action in your community. When beginning the strategic planning process, it is helpful to consider where you are along the spectrum of prevention. Knowing where you are provides the target for your strategic planning process. The spectrum includes the follow levels of intervention:

1. Strengthening the individual's knowledge and skills, i.e. curriculums in schools addressing the issue.
2. Promoting Public Awareness, i.e. community presentations, health fairs, and media campaigns.
3. Fostering coalitions and networks, i.e. Project Lazarus coalition, Prescription for Safety.
4. Environmental changes, i.e. organizational practices influencing policy and legislation
5. Educating prescribers

Regardless of the approach taken, many coalition members will come to the table with different levels of understanding of prescription drug abuse/misuse/diversion/overdose and the basic planning process. For example, many may not be familiar with the inner workings of effective logic models. It is important to conduct some learning sessions to get everyone to the same baseline in their understanding of the planning process.

In order to create an effective strategic plan, a coalition should employ one or more of the well-established planning methods:

- Outcome-based Planning and Evaluation (OBPE)
- Strengths, Weaknesses, Opportunities, Threats (SWOT)
  For a free Word template visit www.wordtemplatesonline.com/2011/08/swot-analysis-template/.
- Plan, Investigate, Execute (PIE)
- Proceed/Precede

Although an excellent strategic plan does not assure effective actions and outcomes, it has been associated with some type of positive outcome. Strategic Planning is an ongoing process that allows the coalition to know current status, where they are headed, how they will get to where they are going, and how they will know when they have arrived. A strategic planning template can be found in Section IV Appendix: IV.III Templates. An action plan example may also be found in Section IV Appendix: IV.II Resources & Samples.

In Drug Strategies, 2001, and the National Institute on Drug Abuse, 2003, a number of critical steps were found helpful in planning and are listed below.

1. Develop a clear coalition mission statement with consensus from the members.

2. Conduct an initial community needs and asset assessment which is essential for understanding the community issues and concerns (Kegler et al., 2000).

3. Conduct periodic needs and assets assessments grounding the strategic plan to the most current community needs and issues (Drug Strategies, 1996).

4. Prioritize and clearly state goals and objectives based on the needs/assets assessment.

5. Incorporate and deliver evidence-based programs and strategies logically linked to the goals and objectives.

6. Utilize comprehensive programs and strategies that target multiple levels of prescription drug misuse/abuse/diversion/overdose, along with related risk and protective factors targeting several sector domains.

7. Engage people, ideas, and resources to create a synergy of efforts (Lasker & Weiss, 2003).

8. Diversify sector representation as the higher the levels of collaboration you engage, the more comprehensive the plan will be (Hays et al., 2000).

9. Use programs with high outcome measures that are appropriate for the community setting (Florin & Chavis, 1990).

10. Have some paid staff and recruit members continually as this has been proven in studies to lead to more highly rated strategic plans (Florin et al., 2000).

Programming and Implementation

The coalition's strategic plan serves as its roadmap for coalition objectives and actions. After the plan has been developed, accepted, and disseminated to the community, the coalition along with affiliated individuals and organizations become the impetus to implement the plan or to ensure that strategies are effectively implemented by other community organizations (Bracht, 1999; Butterfoss et al., 1993).

Quality implementation requires an array of intervention strategies and requires engaging key organizations, networks, and citizens in implementation (Florin et al., 2000; Hays et al., 2000). Programmatic capacity is important. If you are using programs with impact, getting others to implement them, and obtaining community support, you have demonstrated programmatic capacity (Foster-Fishman et al., 2001). Programming should fit the community context because it is driven by community needs and builds on community strengths and resources (Foster-Fishman et al., 2001). Programs must be culturally competent (Foster-Fishman et al., 2001). Greater member participation correlates with greater impact (Hays et al., 2000). Social climate, member knowledge and skills, and inter-organizational linkages lead to higher levels of prevention program implementation skills (Florin et al., 2000).

Effective implementation is associated with better outcomes (Durlak & Dupre, 2008; Greenhalgh et al., 2005; Fixsen et al, 2005; Stith et al., 2006) Access to resources, social capital, communication channels, and existing networks provide reciprocal links, supportive interactions, new associations, and cooperative decision making when implementing programs (Goodman, 1998).

Cultural Competency

Cultural competence starts with cultural awareness and moves toward the principles that enable coalitions to have positive interactions in culturally diverse environments. It is essential to continually think about cultural competence on different levels, such as within your community, coalition, and host organization.

Some key principles fostering cultural competence include:

- Recognition of unique cultural needs.
- Realize that diversity exists within cultures. Cultural groups are complex and should not be viewed as a single entity.
- Acknowledge the difference between a group and a personal identity. See people as individuals, but honor their group affiliations.
- Recognize that dominant cultural norms may not be accepted by other cultural groups.
- Understand that culture shapes values, beliefs, behaviors, and institutions.

- Cultural competence should be exercised for diversity of age, gender, religion, and sexual identity; not just ethnicity.

Cultural competence cuts across all aspects of Strategic Planning and effects all phases of building the capacity of your coalition.

It is important to consider whether an intervention you would like to initiate is suited to important cultural, social, psychological, environmental, and historical factors that can influence risk and protective factors in the target population. Cultural competency also includes understanding the culture of an agency or organization and deciding if a program matches an agency's worldview and principles (Guerra & Knox, 2008). Additionally, the agency's culture must be in harmony with that of the site where the program will be implemented (Guerra & Knox, 2008).

Strategic Prevention Framework

Substance Abuse and Mental Health Services Administration (SAMHSA) developed the Strategic Prevention Framework (SPF) to facilitate implementation of programming. The infrastructure needed for a comprehensive community-based public-health approach for sustainable results is described in the SPF model. The elements of the framework are:

Assessment- Collect data to define problems, resources, and readiness within a community to address needs.

Capacity- Build and mobilize a community to address needs.

Planning- Develop a comprehensive strategic approach which can effect policies, programs, and practices. Create a rational plan from data sets to address areas of need discovered in the assessment phase.

Implementation– utilize evidence-based action plans, programs, policies, and practices.

Evaluation- Measure to see if the actions carried out made a significant difference in reaching your objectives.

The SPF places cultural competence and sustainability at its center as these key concepts must be incorporated in every step.

Sustainability means that you have systems in place that will continually support the work you are doing.[1] Long-term sustainability includes a focus on funding and maintaining fiscal resources. Sustainability also requires non-financial resources.

Internal resources:

- Management and Board Member Leadership
- Technical Expertise
- Administrative and Financial Management

External resources:

- Support from Policy Makers, Key Stakeholders, and the Community
- Outside Technical Expertise
- Community Engagement

References and Additional Resources

1. *"Sustaining Comprehensive Community Initiatives: Key Elements for Success." Financing Strategy Brief. The Finance Project. (Apr2002).*
2. http://www.samhsa.gov/prevention/spf.aspx

3. Center for Prevention Research and Development. (2009). Background Research: The Strategic Prevention Framework. Champaign, IL: Center for Prevention Research and Development, Institute of Government and Public Affairs, University of Illinois.
4. http://ezinearticles.com/?PIE:-The-Simple-3-Step-Process-for-Creating-Your-Strategic-Business-Plan&id=7929350
5. http://www.enotes.com/topics/precede-proceed-model
6. http://www.uvu.edu/sponsoredprograms/pdfs/IMLS-3%20Plan%20the%20Project%20-%20Evaluation.pdf
7. http://prevention.sph.sc.edu/tools/CoalitionEvalInvent.pdf
8. CADCA National Coalition Institute 625 Slaters Lane, Suite 300, Alexandria, VA 22314 www.cadca.org;
9. E-mail: training@cadca.org
10. https://protect.omni.org/sites/rpsco/Pages/CmCb.aspx
11. http://www.wordtemplatesonline.com/2011/08/swot-analysis-template/

Community Assessment, Data, and Evaluation

Community Assessment and Data

Communities may have an idea that they have a problem with prescription drug overdose, but may not know where to start addressing the problem. One important step in understanding a good place to start is by looking at the data about your community. Project Lazarus will be providing regional data regarding overdose-related emergency department visits, school-based drug-related events, and substance use treatment.

Our community data profiles consist of:

- Prescription drug overdose mortality rates
- Emergency department utilization for substance use issues
- Hospitalizations due to adverse effect of substance use
- County ranking in overdose deaths
- Age distribution of overdose deaths
- NC overdose death time trends
- Percent of recipients receiving controlled substance prescriptions
- Opioid prescription medication for pain
- County ranking for prescription rates

You may also have data that is specific to your community that may guide you in a particular direction or you may decide to collect your own local data. Either of these is a great option.

In the figure above, the baseline is the recent data regarding a particular issue, the intervention is what you plan to do about the issue, and the outcome is the results of your intervention. You can then compare the outcome to the baseline to assess if your intervention was successful or if it needs some adjustments.

Setting Goals

When thinking about setting goals for a community health problem, the SMART objectives formula is a process by which goals are made clear and simple. SMART is an acronym for Specific, Measurable, Achievable, Relevant, and Time-bound. Fundamentally filtering the goals through a series of questions will aid your goal setting experience.

Ask - Is this goal:

- Specific – Be precise about what improvement will be made. For example: “We want to reduce the number of overdose deaths in our community from 14 per 100,000 people to 10 per 100,000 people in the next 2 years.”

- Measurable – Can data be collected and reviewed to show if the goal was achieved?
- Achievable - Is the goal attainable? Thinking about improving, rather than solving or eliminating the problem, is a good place to start.
- Relevant – Does the goal pertain to the community given people power, time, money, and cooperation from local partners?
- Time-bound - Create goals that include a timeframe, such as "within the next 18 months." If you achieve your goal prior to the 18 months, you can revisit and update the goal.

Reporting and Evaluation

An important part of having a community coalition is to make sure you are conducting self-evaluations. These self-evaluations can help you find out from coalition members how they think the coalition is working together to achieve the goals. In addition to addressing current community members, it's important to identify who is not a part of the community coalition and how members might go about engaging them. Please see the links below for survey examples that you can use or adapt for your coalition evaluation. We recommend that evaluations occur every six months.

It's important to share your work so the community is aware of what you are doing, your goals, and results. When we talk about reporting, we are referring to the process of sharing your results with members of your community and other organizations. Sharing your results can happen in a number of creative ways, such as sharing outcomes on social media, a short press release to local papers, an interview with a local TV station, or a blog post about your work.

Sometimes an evaluation will show that the intervention didn't help meet the goal. That's okay! Knowing what doesn't work can certainly be a helpful piece of the puzzle to rule out ineffective activities and further identify effective interventions.

In addition to evaluating the coalition as a whole, evaluating individual events will be important as well. We have provided an example of an event feedback survey in Section IV Appendix: IV.III Templates. One survey targets attendees of an event and another focusses on volunteer involvement throughout an event.

Links to Survey Templates

http://mihealthtools.org/ccat/pdfs/CCATSurvey_PrintVersion.pdf

http://coalitionswork.com/wp-content/uploads/coalition_member_survey.pdf

http://coalitionswork.com/wp-content/uploads/coalition_meeting_checkup.pdf

http://coalitionswork.com/wp-content/uploads/Prioritizing-Your-Strategies.pdf

http://coalitionswork.com/ (see Tools & Resources Section)

Section III:

Project Lazarus Sector Factsheets

Project Lazarus Sector Factsheets provide individual sectors with information regarding why they are needed and how they can help address the issues relating to prescription drug misuse/abuse/diversion/ overdose.

Business & Industry

Why Am I Needed?

Seventy percent (70%) of the individuals who admit utilizing a controlled substance medication that was not prescribed to them obtained the medication from family or friends; bought, stolen, or freely shared.*

This perception and behavior, with potential addiction issues, regarding prescription drugs carries over into the workplace causing safety issues, loss of productivity, and an increase in healthcare costs.

What Do I Need to Know?

Drug abuse costs the United States economy hundreds of billions of dollars in increased health care costs, crime, and lost productivity.

The total costs of drug abuse and addiction due to use of tobacco, alcohol, and illegal drugs are estimated at $524 billion a year. Illicit drug use alone accounts for $181 billion in health care, productivity loss, crime, incarceration, and drug enforcement. *Surgeon General's Report 2004; Harwood 2000 NIDA.*

"Five Ways to Curb Workplace Drug Risks" *CFO.com August 8, 2013*

The Executive Director of the Workers Compensation Research Institute discusses the Institute's study, Longer-Term Use of Opioids (2012), as well as appropriate employer responses. The study analyzed almost 300,000 workers' compensation injury claims and 1,100,000 associated opioid prescriptions from 21 states. The injuries occurred between October 1, 2006, and September 30, 2009, with data on prescriptions collected filled up to March 31, 2011. Nearly 80 percent of claimants received at least one opioid prescription. The study defined longer-term use as patients receiving opioids for at least 3 months, while having three or more prescriptions for opioids. Long-term users included 16 percent of injury claimants in Louisiana and New York; around 10 percent in California, Massachusetts, North Carolina, Pennsylvania, and South Carolina (and some other unnamed states); 4 percent in Wisconsin; and 3 percent in Arizona. One-fourth of longer-term users received opioid drug testing to help prevent misuse. Evidence-based treatment guidelines recommend random drug testing for this purpose, periodic psychological evaluations, and treatment to help manage the addictive effects of these powerful drugs. In most states studied, few injured workers received these evaluation and treatment services (only 4-7 percent of injured workers with longer-term use of opioids). The highest usage was one in four with psychological evaluations in Texas and one in six with psychological treatment in Wisconsin.*

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What Needs To Be Done?

- [x] Employee education on appropriate behavior pertaining to prescribed controlled substances, as well as signs and symptoms of impaired functioning.
- [x] Employee Assistance programs addressing substance use disorder treatment.
- [x] Health insurance polices that carry substance use disorder treatment.
- [x] Promote smoke free and drug free environment in the workplace.
- [x] Sign up for the SAMHSA Prevention of Prescription Drug Abuse in the work place.
    - Listen (The Pow Ta Center) paw@asgonline.com
- [x] Know and understand the signs and symptoms of prescription drug abuse.
- [x] Have Naloxone antidote available in the work place.
- [x] ***Take Correctly, Store Securely, Dispose Properly, Never Share.™***

Resources

Preventing Prescription Abuse in the Workplace Webinar:
http://captus.samhsa.gov/sites/default/files/capt_resource/paw-prescriptiondrug.pdf

An Employer's Guide to Workplace Substance Abuse: Strategies and Treatment Recommendations:
http://www.businessgrouphealth.org/pub/f3151957-2354-d714-5191-c11a80a07294

For more information visit
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or call
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* Retrieved from http://www3.cfo.com/article/2013/8/risk-management_opioids-prescription-workers-compensation-drug-testing-

Courts

Why Am I Needed?

Historically, in the US, the approach to treating substance use disorders has been a strict abstinence-based protocol. Medication-Assisted Treatment (MAT) involves the use of medications to treat substance use disorders (SUD). Methadone and Suboxone (buprenorphine) are two medications that have been proven effective in treating opioid dependence. Typically, treatment centers have been hesitant to use pharmacotherapies for opioid dependence. And while it may seem inappropriate to treat SUD with medication, the MAT practice has been found to have better treatment outcomes than abstinence-based programs.

In the criminal justice system, pharmacotherapy is not always understood and MAT programs present challenges to parole and probation officers attempts to monitor newly released inmates. The Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) is a National Network for the Study of Drug Abuse Treatment for Offenders. This network has initiated research called Medication-Assisted Treatment Implementation in Community Correctional Environments (MATICCE). MATICCE has piloted programs in several states attempting to implement medication-assisted treatment within correctional facilities.* In the MATICCE study, criminal justice personnel participate in training about addiction pharmacotherapies. Additionally, the leadership of the correctional agencies and substance use disorder treatment facilities complete a joint strategic planning process together in order to identify and resolve barriers to collaboration on behalf of clients across the two systems.

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The Centre for Research Excellence into Injecting Drug Use (CREIDU) reports that in Australia half the prison population consists of intravenous drug users. Although the intravenous drug use may cease somewhat while incarcerated, many return to injecting when they are released. This places the released inmate at high risk of a fatal overdose, committing repeat offenses, and numerous health concerns that impact public health. CREIDU advocates for the initiation of Medication-Assisted Treatment for prisoners while incarcerated and extend through release and parole.

The World Health Organization (WHO) of Europe recently reported that many released prisoners die within weeks after leaving jail. The reason for this is reduced tolerance to drugs after a period of abstinence and combining multiple substances which can double the overdose risk. WHO suggested pre-release counseling specific to substance use problems, post-release follow-up and a greater ability to identify those at risk when leaving correctional facilities.

Approximately 1.2 million people involved with the justice system have an addiction to drugs or alcohol.* The National Association of Drug Court Professionals reports that this year, "2,734 Drug Courts will serve over 136,000 people". Drug Courts offer a diversion option from lengthy jail and prison sentences for those with substance use problems. Clients will attend a year-long intensive group therapy program which also closely monitors behavior and abstinence from substances ensuring strict adherence to probation stipulations.

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Why Am I Needed? Cont.

Many programs also insist that clients attend support groups in addition to counseling sessions. A judge oversees all participants and meets with clients regularly in a court room setting. Substance use counselors attend with their clients to report what progress has been made. Random drug screens are performed frequently. The drug court structure rewards compliant behavior and consistent progress by lessening sessions and court time requirements. However, sanctions are given if clients fail a drug screen or do not attend counseling sessions. Drug Court programs recognize that addiction is a chronic brain disease which requires lengthy treatment regiments to sustain long-term remission. Through Drug Court, the external motivation to achieve recovery begins what is hoped to become overtime an internalized abstinent life-style.*

What Needs To Be Done?

- ☑ Implement education and training programs about addiction and Medication-Assisted Treatment for all working in the criminal justice system.
- ☑ Distribute Naloxone Rescue Kits to corrections officers, parole and probation officers, and released inmates who have a history of SUD and their loved ones.
- ☑ Recognize the warning signs and high risk situations of overdose for inmates and ex-inmates.
- ☑ Include harm reduction training in pre-release preparation programs.
- ☑ Consider Drug Court as an option to be explored.
- ☑ Collaborate with MAT programs that will assist with monitoring of released inmates through monthly reports and urinalysis.
- ☑ Gain factual information to effect influence in changing the "criminal justice system to break the cycle of drug use, crime, and incarceration".
- ☑ ***Take Correctly, Store Securely, Dispose Properly, Never Share.™***

What Do I Need to Know?

SUD is a major issue for the criminal justice system. Providing and supporting evidence-based treatment may help someone to enter and stay in recovery and avoid relapsing to drug use and the criminal activities associated with drug use.

If a person is already involved in a MAT program, disrupting their treatment could cause significant negative life changes.

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*Retrieved from:
http://www.nadcp.org/learn/what-are-drug-courts
http://www.drugabuse.gov/justice-system-research-initiatives
www.wh.gov/DrugPolicyReform
http://www.nadcp.org/learn/what-are-drug-courts
http://www.bop.gov/inmate_programs/release_emp.jsp

Emergency Departments

Executive Overview Emergency Departments

The North Carolina College of Emergency Physicians has partnered with Community Care of North Carolina (CCNC) and Project Lazarus in the development and implementation of a chronic pain initiative. This initiative addresses the epidemic and exponential increase of accidental narcotic overdose deaths not only in North Carolina, but also across the United States. While the Project Lazarus is initially targeting Medicaid Access II patients, the recommended tools and strategies are useful for any patient with chronic pain issues. Its goals are to:

- Reduce opioid-related overdoses
- Optimize treatment of chronic pain
- Manage substance abuse issues associated with opioids

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Full Access is Available at:

https://www.communitycarenc.org/media/related-downloads/pl-toolkit-eds.pdf

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Faith Communities

Why Am I Needed?

Project Lazarus understands that the faith community is vital in the prevention and healing of opioid addiction and needs pastors and faith leaders as partners to help develop, organize, and/or offer spiritual guidance and support to not only those struggling with opioid addiction, but also to the friends, families, and loved ones suffering from the emotional and spiritual effects.

While Project Lazarus has made great gains in answering the questions of how this happens and how it can be prevented, there is still a need for faith communities to offer love, support, and guidance to those who are asking the questions of "why?" Although different faiths and denominations may answer these questions differently, Project Lazarus believes that what is most important is not necessarily the right answers, but the presence of those offering love and support, which can make all the difference in the world.

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What Do I Need to Know?

"Addiction is a chronic brain disease that causes people to lose their ability to resist a craving, despite negative physical, personal, or social consequences."* Before the onset of addiction or dependence, using drugs and alcohol produce a pleasurable feeling by activating the brain's reward center. With repeated use, the structure of the brain gets altered to require substances to feel normal. Some will be more likely to control their drug use or stop using altogether if they receive treatment, although multiple rounds may be needed. Many will recover from addiction on their own, but may cause harm or heartache to themselves and those around them before they do. Neuroscience conducts research to identify key factors like emotional, mental, environmental, cultural, and physical vulnerabilities which may lead to drug and alcohol dependence.

There are some who believe that opioid addiction and overdose is as much a spiritual problem as a physical one. There has been great success in recent years by bringing together local educators, professionals, government leaders, and community organizers to help fight the most immediate and pressing causes of physical opioid addiction and accidental overdose. However, it is important to see the same success by bringing together different faith communities to address the underlying spiritual and emotional causes that are directly related to addiction and overdose. Anyone who has suffered from any form of addiction knows that it can be a frightening, dark, and lonely experience.

Addiction almost always alienates a person from their friends, family, and loved ones; cutting themselves off from the very people they need the most and, thus, causing their addiction and likelihood of overdose to increase. The feelings of grief, anger, regret, and guilt can weigh heavily on the hearts and minds of family, friends, co-workers, and anyone else who is in a relationship with those suffering from the side effects or death due to misuse/abuse of prescription medications. The emotional and spiritual effects of addictions, overdose, and death are far reaching, traumatizing experiences for families and communities.

What Needs To Be Done?

- [x] Social and religious stigmas are often times placed on those struggling with opioid addiction, and addictions in general. It is important to remove all stigmas from opioid addictions and other addictions, in order to move forward.

- [x] Hold support meetings and anonymous groups for those suffering from the emotional pains of addiction.

    1. Overdose Survivors
    2. Families/Friends Affected by Overdose Death
    3. Addiction
    4. Life Skills
    5. Adolescents
    6. Parent/Family Empowerment

- [x] Share important safety messages regarding the importance of storing medications securely in a lock box, as well as disposing of medications properly.

- [x] Network with other members of faith community for outreach and education regarding prescription drug misuse/abuse/diversion/overdose.

- [x] Network with local behavioral health and addiction treatment providers as studies have shown pastors to be first line of referral by those seeking assistance.

- [x] ***Take Correctly, Store Securely, Dispose Properly, Never Share.™***

Resources

American Society of Addiction Medicine: http://www.asam.org/docs/publicy-policy-statements/1definition_of_addiction_long_4-11.

For more information visit
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or call
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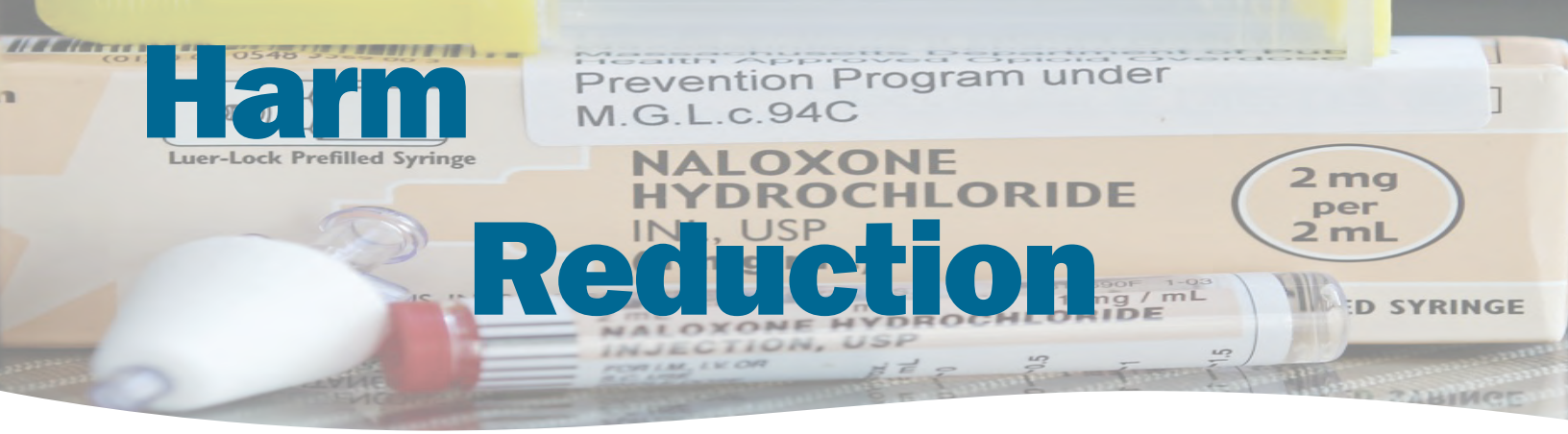
* Retrieved from http://www.brainfacts.org/diseases-disorders/addiction/



Reduction

Why Am I Needed?

Health Care Centers & Providers: Health centers can play a role in reducing overdose deaths by educating people and giving them access to the opioid antidote naloxone. Naloxone programs could be useful in any medical clinic, especially community clinics, federally qualified health centers, (FQHC), opioid treatment programs, (OTP), and pain clinics. Clinic naloxone programs can take a variety of shapes ranging in size, scope, and cost. A program could be as simple as writing prescriptions to patients who ask for naloxone or as complex as handing out complete naloxone kits and holding training classes. The type of program will depend on feasibility and patients' needs.

Prescribing naloxone to patients at risk of an opioid overdose is legal (1). Some states, including North Carolina, have passed laws that protect providers who write prescriptions for friends and family members in contact with people at risk of an opioid overdose (2). The bill absolves civil liability for providers who write naloxone prescriptions.

The steps to prescribing naloxone are as follows:

1. Educate patients on how to recognize an overdose, how to respond with naloxone, and how changes in tolerance can increase the risk of opioid overdose. Overdose prevention education could be a part of a Screening, Brief Intervention, or Referral to Treatment (SBIRT), which can be billed as CPT 99408, G0396, or H0050.

2. Write a prescription for either nasal or intramuscular naloxone hydrochloride.

Nasal Naloxone: 2x 2mg/2ml pre-filled Luer-Lock ready needleless syringes (NDC 76329-3369-1). The atomization devices (MAD 300) can be purchased by patients through a pharmacy or obtained in a Project Lazarus Rescue Kit. (See below.)

Intramuscular Naloxone: 2x 0.4mg/ml single dose 1 ml vials (NDC 0409-1215-01) and 2x intramuscular syringes (23 gauge, 3cc, 1 inch).

3. Gauge patient's interest in behavioral change. As appropriate, present support services and treatment options.

Households: Anyone using or in contact with a user of opioids, such as heroin or prescription pain relievers like oxycodone, methadone, or hydrocodone, should have naloxone available. Since naloxone is a prescription medication, speak with a health care provider about getting a naloxone prescription or look for a community public health program that distributes naloxone kits. An overdose program locator can be found at: http://www.overdosepreventionalliance.org/p/od-prevention-program-locator.html.

What Do I Need to Know?

Naloxone is an effective, non-addictive opioid antagonist that can reliably reverse an overdose and is not a controlled substance. Community-based organizations have been successfully training bystanders to use naloxone for over 15 years (3). The risks lie in the rapid onset of withdrawal symptoms and naloxone's short half-life. When someone is revived by naloxone they can vomit, be agitated, and have diarrhea, body aches, rapid heart rate, and increased blood pressure. Naloxone wears off faster than some extended-release opioids and there is the potential for someone to overdose again, although this is rarely observed in community-based programs. Patients should be encouraged to call 911.

Rescue kits are available through Project Lazarus that can help simplify bystander naloxone use. Individuals can order kits for themselves or
clinics and prescribers can order in bulk for distribution. The kit provides everything necessary for a nasal rescue except the naloxone vials, including two nasal atomizers, a step-by-step naloxone use guide (English & Spanish), and an overdose prevention DVD and comes in a small durable hard plastic container for $12.

There are three ways to order rescue kits:
Project Lazarus website at this link:
www.projectlazarus.org/naloxone-od-antidote/naloxone-kit-order-form
By email at:
rescuekit@projectlazarus.org.
Complete form, scan,
and email back or fax to
866-400-9915.
Call 336-667-8100
and request by phone.

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What Needs To Be Done?

- Prepare Pharmacies: Most outpatient chain pharmacies do not carry naloxone. Before sending off prescriptions, alert local pharmacies so they can start stocking naloxone and the atomization devices, unless purchasing a Project Lazarus Rescue Kit which contains the nasal atomizers. There might also be some pharmacies that are interested in partnering with the clinic on overdose prevention. Reach out to pharmacies to see if a pharmacy wants to be involved in your effort. The clinic could also order naloxone directly from the manufacturer: nasal at Amphastar and intramuscular at Hospira, or through distributors.

- Cost Considerations: The type of naloxone administration needs to be considered whether it is being paid for by the clinic or patient. Nasal administration is more expensive, about $25 per dose with atomizer, compared to $5 per dose for intramuscular. The intramuscular administration requires drawing naloxone from a vial into a syringe and using a needle. Atomizers, which are needed for nasal delivery of naloxone, are not covered by insurance and increases the cost of kits. Educational materials and people's time are also not free. Overdose prevention education could be a part of a Screening, Brief Intervention and Referral to Treatment (SBIRT), which can be billed as CPT 99408, G0396, or H0050.

- Develop a Naloxone Policy: A policy should outline how naloxone will be offered to patients, when patient education will take place, what information will be given, how the program will be paid for, and who is responsible for documenting kit distribution and restocking supplies. Here are some options to consider when developing a program.

- Initiate Conversation or Respond to Patients: How will conversations about naloxone begin? The approach can be passive, using signs to let patients know that naloxone is available, or more proactive, where prescriptions could be offered to any patient getting an opioid analgesic prescription. The tactic might vary by physician, but there needs to be some indication that the clinic is willing to talk to patients about naloxone.

- Patient Education Handouts or Conversations: Information about overdose prevention and naloxone use could be conveyed through a conversation, video or handout. The conversation could be with a medical provider or a different health center staff member. The discussion could occur as part of a patient visit, or if there were enough interest, classes could be organized to train people to recognize and respond to an overdose.

- Educate Patients about what are the risk factors of an overdose: Changes in tolerance after a period of abstinence, such as incarceration, hospitalization or outpatient/inpatient treatment, increase the risk of an overdose. Taking other substances such as alcohol, benzodiazepines, anti-depressants and illicit drugs with an opioid may cause overdose. Other risk factors may depend on co-morbid physiological and biological factors such as emphysema, asthma, sleep apnea, COPD, heavy smoking, renal issues and metabolism rate. An overdose occurs when the body consumes more opioids than can be tolerated and the aforementioned factors increase the likelihood of an overdose.

- Educate Patients about what are the signs of an opioid overdose:
  -Unresponsiveness to stimulation, such as a sternal rub
  -Shallow or absent breathing
  -Blue or ashen lips

- Prescriptions or Distribution: Naloxone can be offered to patients as a prescription that they fill at a pharmacy or distributed directly from the clinic. Naloxone is covered by most insurance, including North Carolina Medicaid. To make sure that patients get naloxone, the clinic could order naloxone to distribute on its own or as part of a rescue kit.

- Individual Prescription or Standing Order: If a clinic is going to distribute naloxone from the office, a standing order could be used to separate naloxone education from the medical visit. A standing order would enable clinic staff to evaluate a patient's need for naloxone and train them, rather than making it part of the medical provider's visit.

- ***Take Correctly, Store Securely, Dispose Properly, Store Securely.*** ™

Resources

Prescribe to Prevent:
www.prescribetoprevent.org/

Naloxone Info:
www.naloxoneinfo.org/get-started/about-naloxone

Up-to-date:
www.uptodate.com/contents/naloxone-drug-information

Project Lazarus:
www.projectlazarus.org/naloxone-od-antidote

Project Lazarus Pain Patient Video:
http://www.projectlazarus.org/patients-families/videos

Treatment Options:
www.findtreatment.samhsa.emt

For more information visit
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or call
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1. Davis C, Webb D, Burris S. Changing law from barrier to facilitator of opioid overdose prevention. The Journal of Law, Medicine and Ethics. 2013; 41 (s1)33-36.
2. Good Samaritan Law/Naloxone Access, NC [statue on the internet]. c2013 [cited 2013 July 6]. Available from: ncleg.net/Sessions/2013/Bills/Senate/HTML/S20v7.html
3. Wheeler E, Davidson PJ, Jones TS, Irwin KS. Community-based opioid overdose prevention programs providing naloxone-United States, 2010. Morbidity and Mortality Weekly Report 2012; 61(06)101-105.

Health Departments

What Do I Need to Know?

Prescription misuse/abuse/diversion/overdose is a costly problem, creating significant morbidity and mortality in your community.

Prescription drug use is the fastest growing cause of accidental death in North Carolina and the United States, now surpassing automobile accidents.

Individuals and the general public may feel that if a drug is prescribed by a trained medical professional that it is safe.

There is general unawareness about the potential dangers of prescription opioids related to dosage of opioid, underlying medical conditions, and other prescribed or over the counter medications.

There is also a general unawareness of the proper storage and disposal of opioid medications.

Why Am I Needed?

Prescription drug misuse/abuse is an important issue affecting the health of clients seen in Health Departments for primary care and other public health programs.

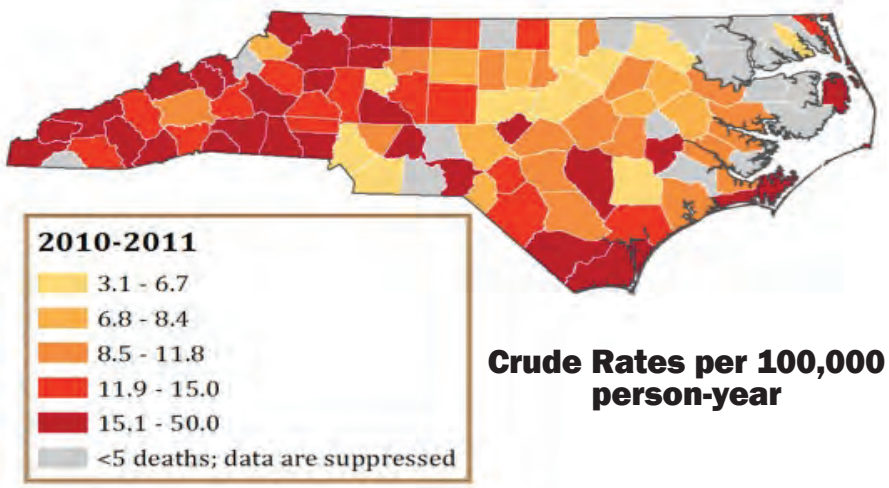
Prescription drug overdose has met definition criteria of an epidemic and, as such, is an important public health and safety issue.

Health Departments are poised (through already established partnerships with local hospitals, medical community, government, social services, schools, etc.) to bring together a collaborative effort between multiple sectors to address this issue that affects individual and community health.

Health Departments are responsible for collecting and dispersing information on issues affecting the health of their communities.

Health Departments are charged with improving health of their communities by addressing and developing plans to alleviate causes of significant morbidity and mortality.

Unintentional Poisoning Mortality Rates: North Carolina, 2010-2011



Crude Rates per 100,000 person-year

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What Needs To Be Done?

It will take a community effort to address this problem by raising public awareness, decreasing demand for and supply of opioid medications, and providing harm reduction for those who experience symptoms of an overdose.

- ☑ Recognize prescription drug overdose as a public health concern.
- ☑ Organize interested parties from as many sectors as possible to create a community response to the issue of prescription drug overdose.
- ☑ Promote education among the medical community with respect to safe opioid prescribing practices.
- ☑ Promote education among the public regarding potential danger and proper use, storage, and disposal of prescription opioids.
- ☑ Promote and support programs that supply naloxone, the antidote to opioid medications.
- ☑ Be part of or facilitate a community-wide task force/coalition that addresses substance abuse.
- ☑ Support increases in addicted treatment services availability.
- ☑ Collect real time data pertaining to prescription drug overdose mortality, emergency department and hospitalizations pertaining to substance use, school based incidences, and local crime dates surrounding diversion and addiction.
- ☑ ***Take Correctly, Store Securely, Dispose Properly, Never Share.™***

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Law Enforcement

Why Am I Needed?

In the last several years there has been an increase in opioid overdose deaths. Today, the leading cause of accidental death is overdose, surpassing automobile accidents. The overdose death rates will continue to climb unless communities come together with law enforcement to share the burden of stopping this trend.

Currently, the criminal activity associated with prescription drug misuse/abuse/diversion/overdose absorbs a great deal of law enforcement manpower. Communities that have increased education and awareness about the signs and symptoms of prescription medication problems can assist police through tip lines and 911 calls when citizens are informed. Criminal efforts to divert and sell narcotics can be stifled by storing medications correctly and disposing of them properly. Communities following the Project Lazarus motto of "Take Correctly, Store Securely, Dispose Properly, and Never Share" can have a significant impact on crime rates.

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What Do I Need to Know?

As first responders, law enforcement may potentially be called to overdose situations. Therefore, it is important to know the key signs of an opioid overdose. Look for very slow and shallow breathing, blue or black fingernails or lips, clammy or pale skin, limp body, unconscious, unresponsive to being stimulated (calling out their name or rubbing knuckles on their breastbone). The quick recognition of an opioid overdose with the administration of naloxone will save lives.

Naloxone is a medication that can be administered to reverse opioid overdoses. In April 2013, the Good Samaritan Law & Naloxone Access Law, SB20, was passed in North Carolina. This bill provides immunity from criminal or civil liability for the individual administering naloxone to reverse an overdose. Furthermore, SB20 provides limited immunity for the individual seeking medical assistance by calling 911, even if there are small amounts of drugs or paraphernalia at the scene of the overdose. Similar laws have also been passed in multiple other states.

The President's drug policy includes reform to the criminal justice system to "break the cycle of drug use, crime, and incarceration, while protecting public safety." This is a tall order that will require anecdotal information from the law enforcement community on effective interventions and naloxone use. By broadening the perspective of law enforcement to view prescription drug misuse/abuse/diversion/overdose as a public health epidemic as stipulated in the President's Drug Control Reformation, law enforcement can recognize the need to join forces with community coalitions working to bring a comprehensive and holistic approach to the issue.

Youth parties now include pharmaceuticals. When responding to a probable overdose emergency, you may not have information regarding what the victim has taken. Trainings about pharmaceuticals, pill recognition, and potentially hazardous combinations of substances are vital for all First Responders. There are phone apps that can assist with this.*

What Needs To Be Done?

- [x] Understand that naloxone saves lives. Develop a naloxone program for law enforcement departments, which includes training in the administration of naloxone, rescue kits that contain naloxone, laws pertaining to overdose prevention like the Good Samaritan Law (NC SB20), standing orders for naloxone, and quick recognition of overdose symptoms.

- [x] Educate citizens to be vital partners in crime prevention; crimes can be prevented by securing medications in lockable containers.

- [x] Implement pill take back events coinciding with the DEA twice per year and establish permanent pill disposal sites. Visit www.projectpilldrop.org for disposal sites and more information.

- [x] Know the signs and symptoms of prescription medications misuse/abuse/diversion/overdose.

- [x] Train community police officers on how student populations transport prescription drugs through school gateways. Students who share personal or family prescription medication with friends and family should be educated about the legal and health risks of this practice.

- [x] Learn pill recognition and lethal combinations, for example benzodiazepines taken with opiates can cause respiratory arrest and death. A phone application is available for assistance. Philip Thornton, CEO of Drugs.com, stated, "The app will be especially useful for law enforcement agencies and emergency workers requiring quick access to Pill Identification tool without being reliant on an Internet connection."*

- [x] Collaborate with local emergency departments, as well as behavioral health and substance use disorder treatment organizations within communities to further assist those individuals with substance use disorders and mental illness that incarceration, on average, will not address.

- [x] Create tip lines for citizens who want to report criminal activity anonymously.

- [x] Use billboards, television, and radio media to increase public awareness.

- [x] ***Take Correctly, Store Securely, Dispose Properly, Never Share.™***

Resources

Information on additional training, grants, pill boxes, and other material is available at www.naddi.org

Information pertaining to average street prices for prescription medications may be found at http://streetrx.com

Operation Medicine Drop:
www.ncdoi.com/OSFM/SafeKids/sk_OperationMedicineDrop.asp

NC Good Samaritan and Naloxone Legislation:
http://www.networkforphl.org/_asset/qcyvh5/NC-overdose-prevention-naloxone.pdf

http://openstates.org/nc/bills/2013/SB20/documents/NCD00022391/

US Naloxone Legislation:
http://www.networkforphl.org/_asset/qz5pvn/network-naloxone-10-4.pdf

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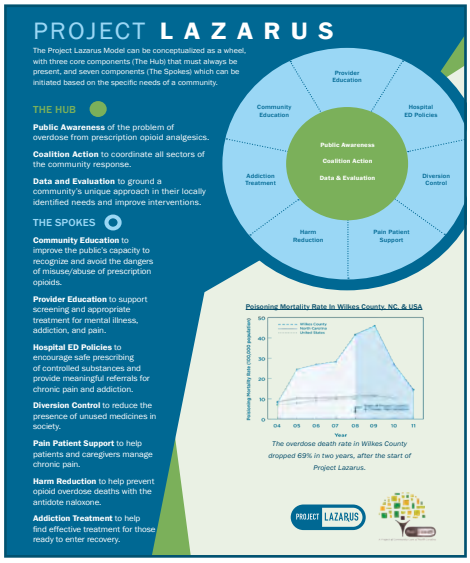
*Retrieved from http://blog.drugs.com/2010/09/new-pill-identifier-app-for-the-ipad-iphone-and-ipod-touch/
App: Drugs.com Medication Guide is available for download with Android and iPhone.

Media

Project Lazarus has a variety of media items available to coalitions for use and distribution, such as formatted fill-in-the-blank community forum invitations, trifold brochures, informational handouts, public service announcements, PowerPoint presentation slides, school flyers, and Project Pill Drop placards, just to name a few. These items will soon be available for download at www.projectlazarus.org. Find us on Facebook & Twitter.

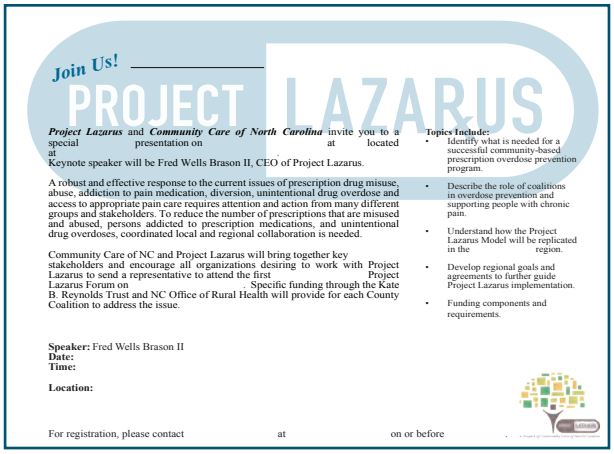
Informational Handouts



Advertisements

Pharmacy Labels

Community Forum Invitations



Information Cards

BE A "GOOD SAMARITAN"

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CALL 9-1-1

If someone is experiencing an opioid poisoning, you can administer the antidote naloxone to reverse the overdose. Call 9-1-1, begin rescue breathing, administer naloxone, and stay with the person until help arrives.

Under The North Carolina Good Samaritan Law, Senate Bill 20, those who seek medical attention for someone experiencing an overdose by calling 9-1-1 cannot get charged for possession of small amounts of drugs or drug paraphernalia that may be present at the scene of the overdose.

Furthermore, an individual who is acting in good faith and administers naloxone to someone experiencing an overdose is immune from any civil or criminal charges as a result of administering naloxone.

Project Pill Drop Event Announcements & Placards

EAST WILKES CARDINALS

PROJECT LAZARUS

CARDINAL FEST 2013
Saturday, October 19, 2013
2pm-6pm

East Wilkes High & East Wilkes Middle
Welcome ALL Community Members to Join the FUN as We Present the First Annual
CARDINAL FEST
Project Pill Drop

"Take Correctly, Store Securely, Dispose Properly, Never Share"

Help avoid drug abuse by bringing your unused and expired medications to a disposal container at Cardinal Fest 2013. Once a prescription has expired or no longer used, obscure any personal information on your prescription label with a black felt-tip marker. By taking appropriate measures to ensure that medications are stored securely and disposed of properly, we can be certain that prescription drugs and medications are not misused, abused, or diverted.

What is Accepted?	What is Not Accepted?
Prescriptions	Needles
OTC Meds	Syringes
Cold & Flu Meds	
Pain Relievers	
Cough Syrups	
Topical Ointments	
Vitamins	
Pet Meds	

+1.336.667.8100 projectpilldrop.org

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Project Pill Drop

Take Correctly, Store Securely, Dispose Properly, Never Share™

Always keep medications stored securely and out of sight from children and guests.

Once a prescription has expired or no longer used, obscure any personal information on your prescription label with a black felt tip marker.

Dispose of the medication at the nearest "Project Pill Drop" container near you.

Project Lazarus Disposal Containers Near You:

+1.336.667.8100 projectpilldrop.org

For more information visit
projectlazarus.org
or call
+1.336.667.8100

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Military Personnel

What Do I Need to Know?

"Prescription drug abuse doubled among U.S. military personnel from 2002 to 2005 and almost tripled between 2005 and 2008" –National Institute of Drug Abuse*

Military administration and health care policy has created barriers to effective identification and treatment for opioid use disorder.

Why Am I Needed?

Active duty military personnel sustain physical injuries and emotional trauma in the line of duty and service to their country.

Prescribers typically use opioids for pain management and benzodiazepines for anxiety disorders, such as Post-Traumatic Stress Disorder (PTSD). Administered together, these two medications make for a dangerous combination as both slow respiration. Since coordinated communication among military, veterans affairs, and civilian healthcare systems is lacking, our military is put at high risk for developing a substance use disorder and may even suffer an overdose from prescription medications.

To complicate matters, a military lifestyle requires frequent transitions, including multiple health care sites due to transferring to a new base, moving back and forth from duty station to home in the case of reservists and National Guard, as well as when being discharged from active duty altogether. This makes it difficult to keep track of military personnel and their families' health care needs.

Hospital transitions are high risk events and entire programs, such as Team STEPPS (Strategies and Tools to Enhance Performance and Patient Safety) have been developed to attempt to decrease risk.** Completion of an outpatient program is hazardous for patients with significant medical conditions who take high risk medications.

Establishing lines of communication by building relationships through civilian-military coalition work will increase awareness of the misuse/abuse/diversion/overdose threat to military forces and their families who are falling through the cracks of these types of frequent transitions.

Operation OpioidSafe is a pilot overdose prevention education and rescue naloxone program based in Ft. Bragg, Fayetteville, North Carolina. Prescription drug overdose fatalities among active duty soldiers is an increasingly prominent problem that requires a comprehensive response. Operated from the Pain Management Clinic at Womack Army Medical Center for the Warrior Transition Brigade, this first in the nation program incorporates prevention and treatment elements of national guidelines on: proper opioid prescribing (including use of pain contracts and patient monitoring), patient and peer education (including training barracks officers and families of enlisted soldiers), substance abuse treatment referral (including buprenorphine detoxification as needed for patients completing opioid therapy for pain), and naloxone provision (intranasal kits dispensed from hospital pharmacy at Ft. Bragg with DVD-based education). The pilot program has been approved by the Institutional Review Board at Ft. Bragg.

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What Needs To Be Done?

- Establish comprehensive lines of communication between military and civilian medical providers.
- As military personnel are at risk of misusing prescription medications due to Traumatic Brain Injury (TBI), Post-Traumatic Stress Disorder (PTSD), and other emotional health issues, routine universal screening for prescription medication, alcohol, and illicit drug misuse by a physician is strongly recommended.
- Invest in developing alternative and holistic approaches to treatment for trauma and pain.
- Keep a list of local treatment providers as referral sources of additional support and specialized treatment for military personnel.
- Improve the health of our military forces and decrease adverse events through early detection, prevention, and intervention, which will improve patient satisfaction and save on overall healthcare costs.
- Avoid practitioners who prescribe without proper supervision and training for the treatment of pain.
- Know the signs and symptoms of misuse/abuse/diversion/overdose from prescription medications.
- Understand harm reduction, in the form of naloxone rescue kits, for those who have been struggling with an opioid addiction and include loved ones in education and training programs.
- Have military police adopt the use of permanent pill drop containers on base to send the message of the importance of safe medications practices.
- ***Take Correctly, Store Securely, Dispose Properly, Never Share.™***

Resources

If you feel that you have a problem with prescription medication, alcohol, or illicit drugs you can call the military Employee Assistance Program at 1-800-342-9647 and speak with a counselor who can direct you toward resources specific to your branch of the military.

www.prnewswire.com/news-releases/operation-opioidsafe-rescues-wounded-soldiers-from-prescription-drug-addiction-179131531.html

www.youtube.com/watch?v=zeMZ511yDFY&feature=player_embedded

For more information visit
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* Retrieved from http://www.drugabuse.gov/publications/topics-in-brief/substance-abuse-among-military-veterans-their-families
** Retrieved from http://teamstepps.ahrq.gov/

Neonatal Abstinence Syndrome

Why Am I Needed?

When an infant has been exposed to opioids in utero, there is a risk they may have physical withdrawal symptoms when they are born.

If an infant has withdrawal symptoms, this does not necessarily mean that the mother has an active substance use disorder.

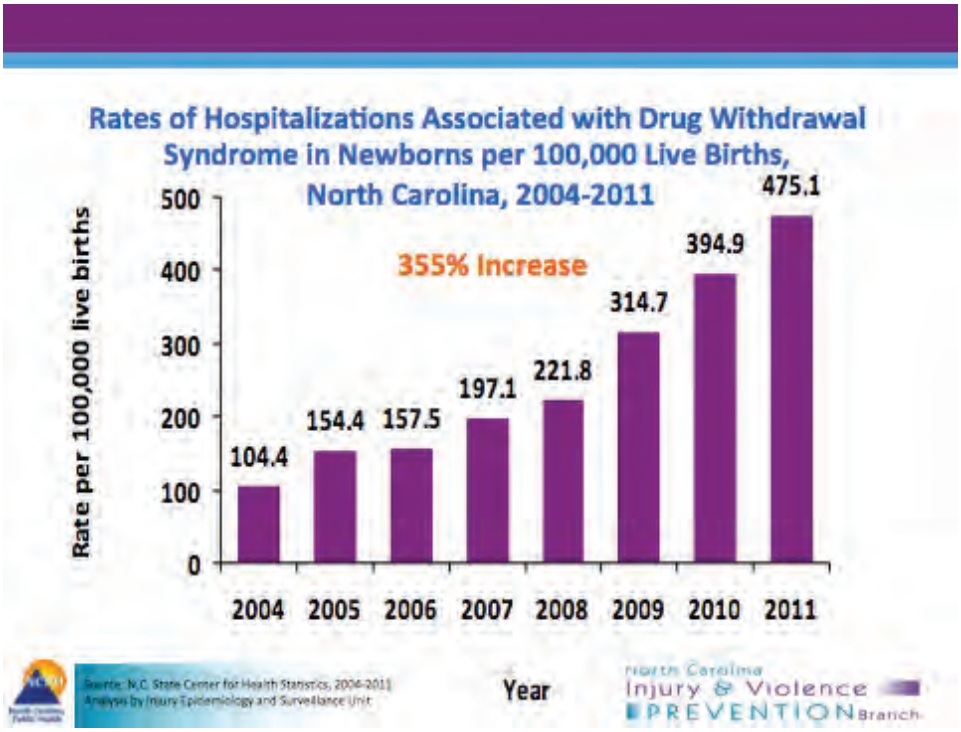
The physical withdrawal symptoms are treatable through non-pharmacological and pharmacological interventions.

For women in MAT with methadone or buprenorphine, the severity of NAS is not dependent on the material dose of medication.

What Do I Need to Know?

Neonatal Abstinence Syndrome (NAS) can occur when a women takes a prescription opioid medication as directed, misuses prescription opioid medication, or uses illicit drugs, such as heroin. These medications include those prescribed to treat chronic pain, as well as medication-assisted treatment (MAT) for opioid use disorder. NAS is a treatable condition that occurs when an infant has withdrawal symptoms due to exposure to opioids in utero.

NAS can be caused by opioid medications that are legally prescribed and taken as directed, opioid medications that are misused, opioid medications that are obtained illegally, and illegal opiates such as heroin.



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What Needs To Be Done?

- [x] If not pregnant, yet sexually active with males, consider using a variety of family planning measures to avoid complications due to use of opioids during pregnancy.

- [x] Know the potential risks of interaction between opiates and other medications, including SSRIs like Celexa, Lexapro, Luvox, Paxil, Prozac, Zoloft, and seizure medications, especially if you have multiple providers.

- [x] For most women in MAT with methadone or buprenorphine, who become pregnant, the best option is to remain in treatment and not taper off or stop your medications.

- [x] If pregnant, find out the things to do to reduce the risk of NAS, including sharing a room with your baby, swaddling your baby, and reducing stimulus such as bright lights and loud noises.

- [x] If taking opioid medications, regardless if they are prescribed or not, consider talking with a medical professional to assess the situation and provide recommendations.

- [x] If pregnant or parenting, and think a problem may exist, call 1-800-688-4232 for information and referrals.

- [x] Most women and infants will benefit from remaining in MAT with methadone or buprenorphine.

- [x] ***Take Correctly, Store Securely, Dispose Properly, Never Share.™***

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Parents & Families

Why Am I Needed?

Many parents do not realize that they play a crucial role in their teen's decision not to use drugs.

Two-thirds of youth ages 13-17 say losing their parents' respect and pride is one of the main reasons they do not use drugs.

Many teens report that their parents have the greatest influence on their drug use attitudes and decisions.

Kids who continue to learn about the risks of drugs at home are up to 50% less likely to use drugs than those who are not taught about these dangers. *

Inform other parents and family members the dangers of sharing prescription drugs.

Monitor all medications in the home, prescription and OTC medicines.

Safely store medicines out of children's reach and sight, by locking them up.

Get rid of old or unused medicines.

What Do I Need to Know?

The misuse of Rx drugs is a growing, under-recognized problem that puts young lives at risk.

Rx drugs serve an important purpose when used under a doctor's care.

Misuse can lead to overdose, addiction, and even death.

1 in 5 teens has abused Rx drugs.

1 in 3 teens reports there is "nothing wrong" when using Rx drugs "every once and a while."

1 in 3 teens report knowing someone who abuses Rx drugs.

Every day, almost 2,500 teens abuse a prescription drug for the first time.*

Prescription drugs are abused more than cocaine, heroin, ecstasy and methamphetamine combined.

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What Needs To Be Done?

Parents and other family members are in the best position to reduce access to prescription drugs by locking up medicines and properly disposing of expired or unused medicines.

- Brief screening/intervention. A conversation in the car ride home can make a difference.
- Empathize with teens. Validate common stressors facing teens and the pressure to excel academically/get into college, fit in with peers, and find their place in the world.
- Provide healthy alternatives for coping like exercise, playing a sport, and finding drug-free social activities.
- "Denormalize" the behavior: While 1 in 5 teens are abusing Rx drugs, 4 in 5 are not.*
- Debunk common myths. Educate teens on prescription drugs being just as dangerous as other substances and just as addictive.
- Set limits and let teens know of your disappointment if they use.
- Limit use of medicines in front of teens.
- Teach teens how to get out of a bad situation. Suggest a response they can use so they don't feel "uncool," such as "I don't want to ruin my season or get in trouble with the coach," "I have to do something with my parents really early tomorrow morning," "I'm the designated driver," "I'm not interested," or "No, thanks."
- Be aware of behavioral changes, as well as signs and symptoms of possible substance abuse and overdose.
- ***Take Correctly, Store Securely, Dispose Properly, Never Share.™***

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* Retrieved from http://www.talkaboutrx.org/documents/TAP2009_EducatorsMaxRole.pdf

People with Pain

Why Am I Needed?

Pain sufferer voices must be heard as best estimates reveal that 100 million people suffer from chronic pain in the USA. Collectively, individual voices detailing personal experiences, issues, and obstacles to care need to be made known as the national spotlight focuses on chronic pain management, appropriate prescribing, the epidemic of addiction, dependence, and overdose surrounding the medications to treat.

Rural America has seen the largest issues surrounding prescription drug misuse, abuse, diversion and overdose, with the constant questioning of prescribing levels frequently above the individual state average. Contributing factors can include higher levels of manual labor, increasing need for treatment for injury and chronic pain; additionally, increased levels of poverty, unemployment, depression, and lack of alternative treatments with medication therapy are lacking. Collective voices will draw attention to bring about systematic change in care meeting the individual need.

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What Do I Need to Know?

A comprehensive approach that addresses the physical, mental, and emotional aspects surrounding pain is necessary in establishing a functional supportive lifestyle. As medication has been the primary first course of therapy to relieve pain, it still remains a treatment option, but for many requires integration of other supportive therapies or perhaps more invasive intervention.

Many alternatives or additional modalities are available and should become more obtainable. For someone with pain, a continued seeking of relief may be constant, which has led many to attempt to self-treat and medicate. It is important to know and share all measures with one's health care team to avoid adverse affects. This would include vitamin and herbal therapy, over the counter products, or medication prescribed by another provider.

A comprehensive list of therapies and interventions is available from PartnersAgainstPain.com, with additional resources listed on reverse.

Overall patient health is one of the largest contributing factors adversely affecting chronic pain management. Lack of exercise, poor nutrition, cigarette smoking, obesity, and poor stress management are contributing factors for some while inability to adequately function in daily activities may result in a lifestyle counter indicative to wellness and managing pain. Though not true for all, it is important to evaluate one's own regimen for managing chronic pain and learning how best to address daily living to thrive.

Furthermore, communication with one's own healthcare team is vital for the understanding of individual pain and the dynamics surrounding the peaks and valleys of both the physical and emotional elements of chronic pain. It is important to document personal experiences, known adverse affects, as well as what brings comfort and relief while functioning at the level desired.

This takes individuals beyond the "pain scale of 1-10" and assists in the multi-faceted approach to treatment. Additionally, this communication further assists family and friends in understanding the elements of one's pain, providing better appropriated care and support that is less stigmatized.

What Needs To Be Done?

- [x] Improve coverage for nutrition, counseling, and lifestyle management.
- [x] Increase access to pain and palliative care treatment.
- [x] Remove the stigma surrounding individuals with pain.
- [x] Increase medical provider education for chronic pain management in medical school and subsequent continuing medical education.
- [x] Remove obstacles that hinder the medical provider from individualizing the patients treatment for chronic pain.
- [x] Implementation of screening and assessment modalities to lessen risk of adverse affects and addiction.
- [x] ***Take Correctly, Store Securely, Dispose Properly, Never Share.*** ™

Resources

American Academy of Pain Management:
www.aapainmanage.org

American Academy of Pain Medicine:
www.painmed.org

American Osteopathic Association:
http://www.osteopathic.org

American Pain Society:
www.americanpainsociety.org

Carolinas Pain Society:
www.carolinapain.org

Consortium of Academic Health Centers for Integrative Medicine:
http://www.imconsortium.org

Foundation for Alternative and Integrative Medicine:
http://www.faim.org

National Center for Complementary and Alternative Medicine:
http://nccam.nih.gov

Power of Pain: www.PowerofPain.org

PubMed Central (PMC) is the U.S. National Institutes of Health (NIH) free digital archive of biomedical and life sciences journal literature, and another excellent resource for information on integrative therapies.
http://www.ncbi.nlm.nih.gov/pmc/

U.S. Pain Foundation:
http://www.uspainfoundation.org

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Albert, S., Brason II, F. W., Sanford, C. K., Dasgupta, N., Graham, J. and Lovette, B. (2011), Project Lazarus: Community-Based Overdose Prevention in Rural North Carolina. Pain Medicine, 12: S77–S85. doi: 10.1111/j.1526-4637.2011.01128.x

Pharmacy

Why Am I Needed?

Prescription drug misuse, abuse, and accidental overdose are on the rise.

Pharmacists are in a position to educate the public about potential dangers of opioid medications.

Pharmacists are in a position to educate their clients about proper use, storage, and disposal of controlled medications.

Pharmacists are in a position to alert prescribers about drug interactions that could put individuals at risk for accidental opioid overdose.

Pharmacists area in a position to notify prescribers about possible aberrant behaviors like "doctor shopping" or consistently early refills based on refill history or a Controlled Substance Reporting System (CSRS) and Prescription Drug Monitoring Program (PDMP).

Pharmacists are liaisons between medical providers and the public. They can provide education and information in both directions to help maintain safety for individuals that require opioid therapy to maintain quality of life.

What Do I Need to Know?

Opioids are analgesics that can improve pain and function in individuals with chronic pain from many conditions. However, prescription drug overdose is the fastest growing cause of accidental death in North Carolina and the United States, surpassing automobile accidents. The combination of opioids and benzodiazepines (and many other drugs that may alter the clearance of opioids) significantly increases the risk of accidental overdose.

Many patients see more than one provider and these providers are often unaware of all medications that are being prescribed. Naloxone, the antidote for opioid overdose, can be dispensed on a provider's prescription to patients who are at increased risk for opioid overdose because of age, opioid dosage, drug-drug interactions, or specific disease states.

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What Needs To Be Done?

It will take involvement of the entire medical community and the public working together to impact the devastating results of accidental opioid overdose that is being witnessed nationwide.

- ☑ Build awareness of the growing problem of prescription drug overdose.
- ☑ Educate patients on the potential for adverse effects of opioids including respiratory depression and death.
- ☑ Educate patients on signs and symptoms of overdose and appropriate actions to take.
- ☑ Educate patients on safe storage and disposal of controlled medications. Make lock boxes available for purchase.
- ☑ Display information on pill take back days and locations of take back boxes.
- ☑ Check for drug-drug interactions that could increase the risk of accidental overdose and report those interactions to the prescriber.
- ☑ Be aware of current diversion and forgery techniques.
- ☑ Be aware of and use the CSRS or PDMP to identify patients who may be filling controlled medications at multiple pharmacies, which would raise the concern for misuse or diversion.
- ☑ Have naloxone available for dispensing upon written prescription.
- ☑ ***Take Correctly, Store Securely, Dispose Properly, Never Share.™***

Resources

Read more about the NC Good Samaritan Law & Naloxone Legislation here :

http://openstates.org/nc/bills/2013/SB20/documents/NCD00022391

http://www.ncdhhs.gov/mhddsas/controlledsubstance/

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Prescribers

Community Care of North Carolina (CCNC), in conjunction with non-profit organization Project Lazarus, is responding to some of the highest drug overdose death rates in the country. In the past decade, there are increasing indicators that the misuse and abuse of prescription opioid analgesics by patients contributes to this epidemic. This Primary Care Physician Toolkit is one of three resource documents created through this collaboration to assist medical care providers throughout North Carolina in managing patients with chronic pain. Similar Toolkits have been created for CCNC Care Managers and hospital Emergency Departments.

While Project Lazarus is initially targeting Medicaid patients, the recommended tools and strategies are useful for any patient struggling with pain issues. Medical care providers are encouraged to adopt the practices and policies in this Toolkit for all patients, regardless of payment source.

While doctors and nurses play a major role in treating chronic pain and preventing overdose deaths, the responsibility for action goes beyond the clinic. Project Lazarus is working to engage the entire community in preventing overdoses. This public health model is centered on community coalitions tailored to each locality. The model uses data from state health surveillance systems to get a clearer understanding of the nature of the overdose problem and engages doctors and nurses in both prevention of opioid abuse and optimal treatment of chronic pain. This public health model has been proven to produce results in North Carolina, including both dramatic and sustained decreases in prescription opioid overdose, and improved access to appropriate opioid pain treatment.

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The goals of Project Lazarus are to reduce opioid-related overdoses, optimize treatment of chronic pain and manage substance abuse issues associated with opioid misuse. Many people who have problems with opioid use also have legitimate needs for adequate pain control. Education around safe prescribing and appropriate use of opioids in our health care system and communities will enhance pain control and prevent unnecessary injury and death for our citizens in North Carolina. Some notes on specific sections of this Toolkit:

• Opioids in the Management of Chronic Pain: This five-page overview provides a concise review of chronic pain issues and regulations and outlines key tools for managing the care of patients with chronic pain patients.

• Assessment and Management Algorithms: These flowcharts summarize the optimal processes for assessing and managing chronic pain.

• Pain (opioid) Management Agreement: This agreement is helpful in clarifying patient guidelines and protecting the provider from prescribing to drug-seeking patients. CCNC recommends its use with patients for whom opioids are prescribed.

• Chronic Pain Progress Note: This form provides a convenient record of the pain visits and a helpful reminder of questions to ask regarding risk factors for opioid misuse. © Community Care of North Carolina October 2012 Pg. 4

• Medication Flowsheet: This flowsheet is intended to serve as a comprehensive record of a patient's opioid medication history. By briefly checking this form, providers can quickly determine how many chronic pain medicines the patient has been prescribed, as well as trends in dosage.

Table of Contents

Full Access is Available at:
https://www.communitycarenc.org/media/related-downloads/cpi-toolkit-pcps.pdf

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Prescription Drugs

Why Am I Needed?

Pain medication (opioid analgesics) are involved in the majority of unintentional overdoses.* While these medications can be used appropriately in the management of acute and chronic pain, they may be misused because they can make a person feel euphoric and create a state of intense pleasure; some people refer to this as feeling "high."

Misuse of prescription medication, especially pain medication, occurs among all ages and socioeconomic groups.

Medication diversion is a term used when a medication is taken by someone that was not prescribed the medication. Taking someone else's medication or selling and/or giving someone else medication that is not prescribed to them is illegal.

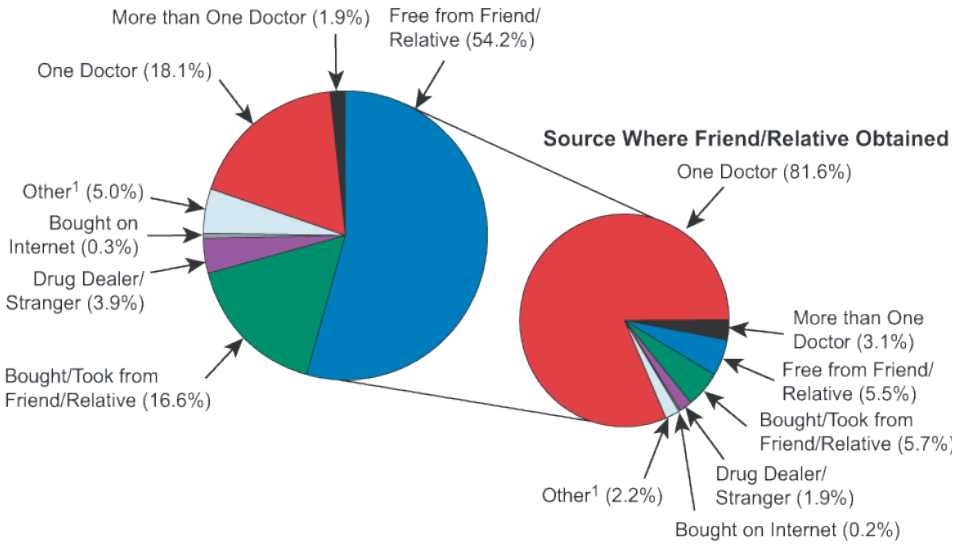
What Do I Need to Know?

Naloxone is a medication that can reverse overdose caused by pain medication or heroin. Recent NC legislation provides immunity to people administering naloxone and to medical staff who prescribe the naloxone.

Know the signs of an opioid (pain medication/heroin) overdose: shallow breathing, unresponsive to stimuli (calling their name or rubbing knuckles on their breastbone), and blue/black fingernails or lips. Respond by calling 911 and administering naloxone.

Taking pain medication and benzodiazepines at the same time can increase your risk of overdose because both medications decrease your heart and breathing rates; this decrease can be drastic enough to stop your heart and breathing entirely. Mixing these medications with alcohol can also have a similar effect.

Source Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older: 2010-2011**



Note: The percentages do not add to 100 percent due to rounding. The Other category includes the sources "Wrote Fake Prescription," "Stolen from Doctor's Office/Clinic/Hospital/Pharmacy," and "Some Other Way."

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What Needs To Be Done?

Follow these steps when you are prescribed a medication:

- [x] To dispose of medications correctly, follow these suggestions:
  - http://www.fda.gov/forconsumers/consumerupdates/ucm101653.htm
  - www.projectpilldrop.org
  - https://apps.ncdoi.net/f?p=102:4:14019262828324::NO:::
- [x] Ask your medical provider to write you a prescription for naloxone if you or someone you know is at risk of an opioid overdose.
- [x] Get involved in community action. Explore opportunities to collaborate with other members of your community to distribute information about this important topic.
- [x] ***Take Correctly, Store Securely, Dispose Properly, Never Share.*** ™

Resources

Help is available. If you have a problem with prescription medications or know someone who does, you can call 1-800-662-HELP or visit: http://findtreatment.samhsa.gov/.

For additional information about avoiding unintentional overdose, visit: http://www.cdc.gov/HomeandRecreationalSafety/Poisoning/preventiontips.htmj.

Read more about the Good Samaritan Law & Naloxone Legislation here: http://openstates.org/nc/bills/2013/SB20/documents/NCD00022391/

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*Retrieved from http://www.cdc.gov/homeandrecreationalsafety/pdf/poison-issue-brief.pdf
**Retrieved from http://www.samhsa.gov/data/nsduh/2k11results/nsduhresults2011.htm#2.2

School Administration

Why Am I Needed?

When thinking about consequences of illicit prescription drug use, worry of addiction and overdose come to mind. However, the widespread and unauthorized use of illicit prescription drugs is affecting the academic performance of children, today.

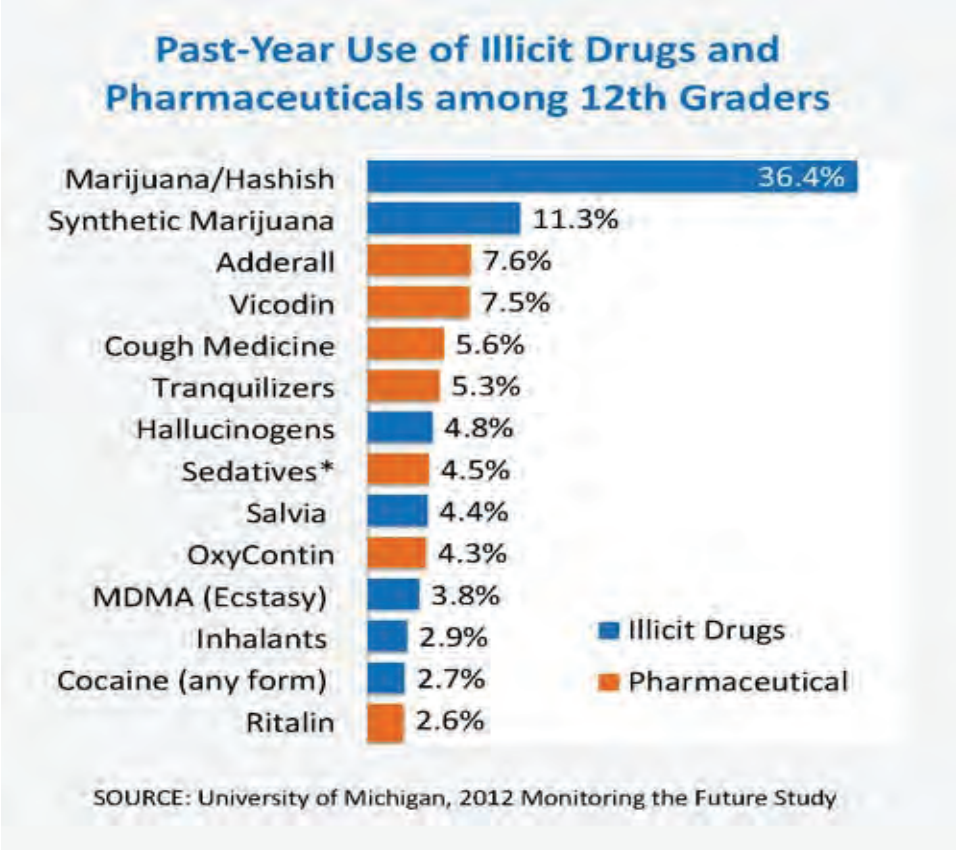
The 2009 National Risk Behavior Survey conducted by the Centers for Disease Control showed a strong correlation between illicit prescription drug use and a decline in academic performance in high school. The use of prescription drug use was correlated to 26% of students achieving a C average and 41% of students who were barely passing or not passing their classes at all.*

What Do I Need to Know?

"Every day in the United States, an average of 2,000 teenagers use prescription drugs without a doctor's guidance for the first time. Among youth who are 12 to 17 years old, 2.8% reported past-month nonmedical use of prescription medications."*

In a recent study, 3% of youth aged 12-17 reported current nonmedical use of prescription medications. ** Teens believe the myth that "if it is prescribed by a doctor, it won't hurt me," leaving them to think they can take anyone's medication and remain safe.

In a 2008 survey conducted by the White House Office of National Drug Control Policy, using prescription drugs illegally ranked second only to marijuana use among teens. 70% of teens get prescription drugs from their own home, other family members or from a friend's home.



Nonmedical use of prescription and over-the-counter medicines remains a significant part of the teen drug problem. In 2012, 14.8 percent of high-school seniors used a prescription drug nonmedically in the past year. Data for specific drugs show that the most commonly abused prescription drugs by teens are the stimulant Adderall and the pain reliever Vicodin.***

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What Needs To Be Done?

- [x] Provide a safe and open environment in the schools with staff development.
- [x] Invite drug abuse prevention speakers, local law enforcement, treatment providers to update staff on community information on a regular basis.
- [x] Partner with agencies for Red Ribbon week in the schools and community which usually occurs on the last full week of October.
- [x] Support drug abuse prevention education and consider using a school wide drug abuse curriculum. The Substance Abuse and Mental Health Services Administration (www.Samhsa.gov) and The National Institute on Drug Abuse (www.drugabuse.gov) provide many resources for school prevention, intervention, and drug abuse curriculum.
- [x] Develop, encourage and support youth-led drug abuse prevention teams in the high schools and middle schools. Involve the student body in positive activities that support abstinence.
- [x] Partner with a local drug abuse prevention agency to start parent drug abuse advocacy groups in the middle and high schools. Collaborate with behavioral health and substance use disorder treatment agencies, juvenile crime prevention councils, and the medical community to keep children out of danger.
- [x] Inform parents of pharmaceutical parties and/or diversion and how to properly monitor and dispose of prescription medications. Develop email lists and other ways to stay connected to parents and staff about prescription drop off events and permanent pill drop boxes. Educate families on the value of proper use and storage of prescription medications.
- [x] Advocate for deferment programs that offer help, treatment and special curriculums targeting intervention, not just punishment or expulsion for drug use.
- [x] Consider parenting classes to empower single, blended, or disengaged families using a structured curriculum.
- [x] Focus on the enhancement of protective factors that reduce substance use. Effective prevention programs involve students, families and the community at large.
- [x] Know what the signs and symptoms of an overdose are: chest pain, difficulty staying awake, shallow or absent breathing, blue or ashen lips , unresponsiveness to stimulation, such as a sternal rub, dizziness, faintness, nausea, vomiting, cold and clammy skin, slowed heart rate, and/or convulsions.
- [x] Check with the school health department to discuss policy and having naloxone, the antidote to an opioid overdose, on site.
- [x] Learn pill recognition and lethal combinations.
- [x] ***Take Correctly, Store Securely, Dispose Properly, Never Share.™***

*Retrieved from http://teens.drugabuse.gov/drug-facts/prescription-drugs
**Retrieved from http://oas.samhsa.gov/
***Retrieved from http://www.drugabuse.gov/publications/drugfacts/high-school-youth-trends

Resources

For more information about the scope of the problem, visit:

http://www.hhs.gov/ash/oah/adolescent-health-topics/substance-abuse

http://www.imdrugfree.com/

http://blog.drugs.com/2010/09/new-pill-identifier-app-for-the-ipad-iphone-and-ipod-touch/

https://www.positiveaction.net/

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School Services Personnel

Why Am I Needed?

In a recent study, 3% of youth aged 12-17 reported current nonmedical use of prescription medications.*

Historically, the favored substances used by teens has been alcohol and marijuana. Now prescription pills have entered the teen realm through easy access to medicine cabinets or by way of a friend sharing a personal prescription of "Vicodin, Xanax, or Adderall," to name a few by brand. Although the media has sensationalized teen Pharmaceutical parties or Pharm parties, the threat of being exposed to prescription medication at the school-aged level during a party or in an educational institution is still very real.** The collateral damage during these parties can result in teens having to deal with STDS, unwanted pregnancy, mental health disorders like depression and anxiety, guilt, low self-esteem, and poor school performance.

Interventions on the middle school level may reduce risk of prescription drug use later in young adulthood. "Young adults who had participated in a community-based prevention program in middle school reduced their prescription drug misuse up to 65 percent...researchers studied the effectiveness of the Iowa Strengthening Families Program, designed for parents and children ages 10 to 14. It aims to prevent teen substance abuse and other behavior problems, strengthen parenting skills and build family strengths. It consists of seven sessions for parents, youth and families, and includes videos, role-playing, discussions, learning games and family projects."***

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What Do I Need to Know?

The signs and symptoms of an opioid overdose are chest pain, difficulty staying awake, shallow or absent breathing, blue or ashen lips, unresponsiveness to stimulation, such as a sternal rub, dizziness, faintness, nausea, vomiting, cold and clammy skin, slowed heart rate, and/or convulsions.

Recognize the signs and symptoms of various intoxication:

Opiates: slurred speech, very tired, falling in and out of sleep (nodding off), difficulty standing or sitting straight, unbalanced and uncoordinated, pupils constricted to pin points in the eye.

Benzodiazepines: lapses in memory, poor judgment/confusion, unsteady walking, violent or out of control behavior, passing out, slurred speech, dizziness, rapid eye movements, unusually revved up or sedated.

Stimulants: suspiciously too alert, seeming to appear nervous, sweating, often thinking and moving with abnormally high energy, high body temperature, dilated pupils.

What Needs To Be Done?

- ☑ Advocate for deferment programs that offer help, treatment, and special curriculums targeting intervention, not just punishment or expulsion for drug use.
- ☑ Implement Prevention curriculums and positive student leadership groups.
- ☑ Involve the student body in positive activities that support abstinence.
- ☑ Warn parents of "pharm parties" and the importance of properly monitoring, storing, and disposing of prescription medications.
- ☑ Know the indications of drug use: changes in physical appearance, behavioral issues, habit and action changes, multiple health issues, school work performance changes.
- ☑ Consider parenting classes to empower single, blended, or disengaged families using a structured curriculum.
- ☑ Focus on the enhancement of protective factors that reduce substance use. Effective prevention programs involve students, families and the community at large. Protective factors include extra-curricular activities, positive communication skills, social skills, and access to adult support systems.
- ☑ Indirectly communicate through posters, informational pamphlets, announcements, online quizzes, and questionnaires.
- ☑ Directly communicate by talking to a student about drug use if you suspect he or she is in danger.
- ☑ Parent involvement is considered a protective factor. Consider working through barriers that prevent parent involvement.
- ☑ Naloxone is a medication that can be administered to reverse an opioid overdose. Check with the school health department to discuss policy and having naloxone on site. Teach students the benefits of calling 911, saving lives with Naloxone, and the laws protecting them from prosecution during an overdose emergency.
- ☑ ***Take Correctly, Store Securely, Dispose Properly, Never Share.™***

Resources

Family Check-up:
http://www.drugabuse.gov/sites/default/files/files/Famliycheckupall.pdf

Student Quizzes:
http://www.drugabuse.gov/publications/national-drug-iq-challenge

Radio Game:
http://www.drugabuse.gov/news-events/nida-notes/podcasts/2013/05/jack-jill-keep-your-body-healthy-radio-spot-female-announcer

Interaction:
http://timetoact.drugfree.org/think-first-step-ask.html

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*Retrieved from http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm#2.16
**Retrieved from http://www.youtube.com/watch?v=bHIF54fajh4
***Retrieved from http://www.drugfree.org/join-together/community-related/middle-school-prevention-program-helps-cut-later-prescription-drug-abuse-study

Seniors

Why Am I Needed?

Senior citizens are at risk for accidental poisoning caused by prescription medication.

Changes to body processes as you age can affect the way medicines are absorbed and used. Digestion effects the rate at which medicine enters the bloodstream. Body weight effects the amount of medication prescribed and how long it stays in the system. Circulatory systems effect the speed at which medication reaches the liver and kidneys. Liver and kidney function effects how medication is broken down and removed from the body. Any one of these changes will have an impact on prescription interactions, dosage tolerance, and effectiveness.

Having multiple prescribers, interactions between prescription medication and OTC medications such as aspirin, and doubling amounts of medications because of missed or forgotten doses put seniors at risk.

What Do I Need to Know?

Medications can help to support health, but can also have unintended consequences when not taken as prescribed, combined with other medications, or taken with alcohol or other illicit drugs.

Particular health conditions can affect memory, such as dementia and Alzheimer's. Memory issues can create a barrier to taking medications as directed.

Health conditions like high blood pressure and asthma may cause a harmful reaction to decongestants.

Some foods should be avoided when taking certain medications as they interfere with absorption.

Alcohol should be avoided with some medications as it slows reaction time.

Alcohol may cause different unwanted effects because of the changes in body processes.

Expired medications can cause problems if accidentally or unintentionally taken due to improper storage or disposal. Family members or friends may target seniors in an attempt to divert prescription medications for improper use.

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"Approximately 70% of those who abuse prescription medications get them from family and friends."*

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What Needs To Be Done?

- [x] Understand as much as possible about your prescribed medications to avoid potential problems by talking with all prescribers about all your medications, including over-the-counter medications. Do not forget to mention vitamin, herbal, or mineral supplements, dietary restrictions, topical ointments, and daily caffeine, water, and sugar intake.
- [x] Ask the pharmacist or prescriber to write medications out, so a comprehensive list of everything being taken is available for family, friends, or medical responders to have as a reference.
- [x] Use daily pillboxes to help track medications.
- [x] Ask for help when packing pillboxes.
- [x] Safely dispose of medications once they are no longer needed or when they expire.
- [x] Consider designating a responsible person for accompaniment to the doctor's office or pharmacist to read label warnings and help identify any harmful medication interactions.
- [x] To prevent the diversion of prescription medication, use lock boxes or find a lockable storage area for prescriptions.
- [x] ***Take Correctly, Store Securely, Dispose Properly, Never Share.™***

Resources

Safe Medication:
http://www.ahrq.gov/legacy/consumer/safemeds/yourmeds.pdf

http://assets.aarp.org/www.aarp.org_/articles/health/images/meds/meds_made_easy.pdf

Medication Disposal Information:
https://apps.ncdoi.net/

"The prescribing of medications is the most common type of medical treatment in the United States, and pharmacists dispense approximately 4 billion prescriptions each year."*

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*Retrieved from http://seminolepreventioncoalition.org/pitchyourpills/prescription-drug-abuse-prevention.html#comunleaders

Teachers & Staff

Why Am I Needed?

Students spend at least 7 hours at school each day; for some students this is actually more time than they spend with their parents.

For students who don't have a strong support at home, school may be the only place they can talk to a supportive adult.

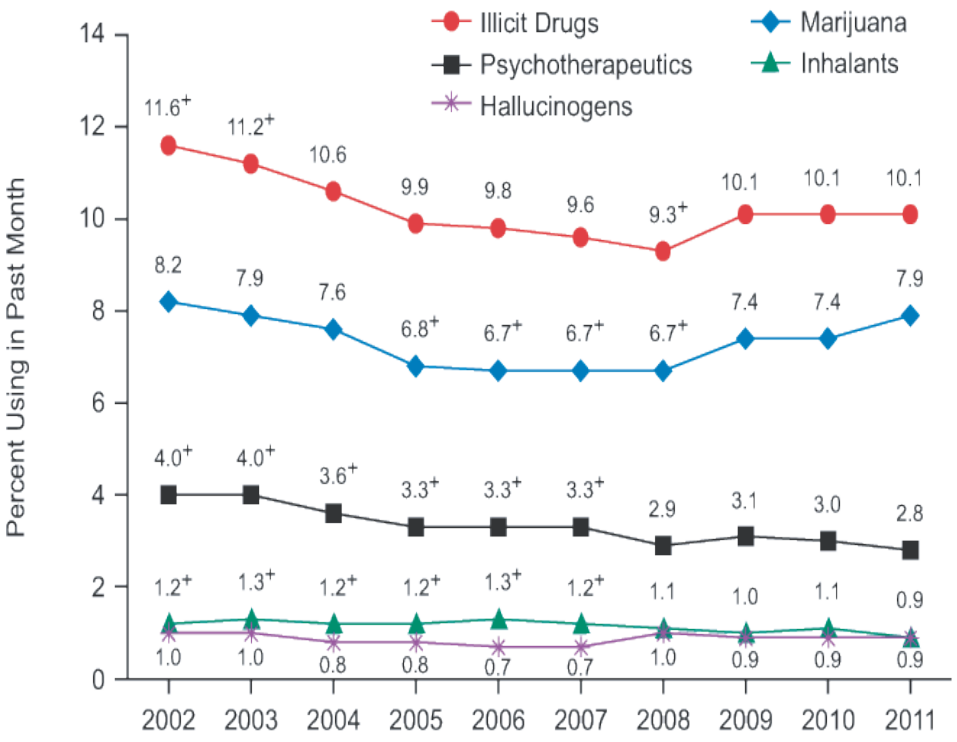
Teachers, coaches, and support staff are often the ones who overhear Monday morning conversations about the weekend's activities.

School staff may see behavior changes before parents do, such as academic or athletic performance decline, acting out in class, or unexplained absences.*

What Do I Need to Know?

While the rates of tobacco, alcohol, and illicit drug abuse are down overall, more teens are abusing prescription drugs. One in five teens (4.5 million) report using prescription medication recreationally either to get high or because they believe these medications might help lower stress or depression. It's surprisingly easy for teens to get their hands on prescription drugs from the families' medicine cabinets, someone's purse, or even a schoolmates' locker. Schools are uniquely positioned to identify and help prevent prescription and over-the-counter drug abuse among teens.*

Past Month Use of Selected Illicit Drugs among Youths Aged 12 to 17: 2002-2011



For each of the five drug categories, there is a line showing use over the years 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, and 2011. Tests of statistical significance at the .05 level were performed between 2011 and each of the previous years listed; significant results are indicated where appropriate.**

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What Needs To Be Done?

- [x] If serving as an advisor to students as part of homeroom or another mentoring program, a rapport has probably already been established, as well as trust with the students. Try to talk about the issue of prescription drug abuse one-on-one as a small group.

- [x] Team up with student clubs that promote healthy decisions and behaviors.

- [x] Coaches are a strong role model for impressionable teens and coaches can be aware of the trend toward misusing or abusing prescription drugs with their players.

- [x] Be a resource to parents and teens.

- [x] Take action locally. Stay current about the prescription drug abuse problems, as well as any local efforts to promote drug-free safe schools.

- [x] The best lesson to give is helping teens know how to make healthy life choices and avoid prescription drug abuse and other high-risk behaviors.

- [x] Set examples for students by never sharing medications with anyone and not taking another person's medications.

- [x] Respect the power of medicine and use it properly.

- [x] Recognize that all medicines have risks along with benefits.

- [x] Take responsibility for learning how to take prescription drugs safely and appropriately. Seek help at the first sign of one's own or a friend's problem.*

- [x] ***Take Correctly, Store Securely, Dispose Properly, Never Share.™***

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*Retrieved from http://www.talkaboutrx.org/documents/TAP2009_EducatorsMaxRole.pdf
**Retrieved from Substance Abuse and Mental Health Services Administration, Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

Treatment Providers

Why Am I Needed?

Prescription drug overdose is now the leading cause of accidental death in the United States (US) – surpassing motor vehicle accidents in 2012. One in six US teens has taken medicines prescribed for someone else and most have obtained the medicines from a family member or friend who is unaware of the dangers they pose. In the last two decades, the misuse and abuse of prescription opioids grew at exponential rates partly due to aggressive pain treatment with prescription opioid analgesics.

Expanding the ability to reach those who are at high-risk for opioid poisoning with preventative measures, while increasing the availability of comprehensive treatment for addicted patients has proven to be an effective approach to this tragic epidemic.

Specifically, the National Take-Back Initiative launched in 2010 to reduce the volume of unused or expired prescription drugs in local communities. Prescription Drug Monitoring Programs (PDMP) offer a way to track patient compliance to opioid therapy protocols. In North Carolina, Senate Bill 222 now mandates pharmacies who prescribe controlled medications to report to the Controlled Substance Reporting System (CSRS) within three days starting in January 1, 2014. The Bill also allows prescribers one delegate who is designated to receive information on their behalf. Using the CSRS is vital in reducing the potential for harmful drug interactions and grants access to dosage levels from all prescribers.

Naloxone is an opioid antagonist which reverses the fatal effects of an opioid poisoning. Naloxone is a non-addictive medication and has been used to save lives due to prescription opioid overdoses. In April 2013, the Naloxone Access Law was signed in North Carolina. This law allows medical providers to prescribe naloxone to those at risk, as well as friends and family. The prescriber is immune from any civil or criminal liability regarding the prescribing of naloxone. In April 2013, in the state of NC, SB20- the 911 Good Samaritan Law & Naloxone Access Law was signed. This bill provides the following: Immunity from criminal or civil liability to a person who administers naloxone and protection from prosecution for the 911 caller and the victim if there are small amounts of drugs or paraphernalia at the scene of the overdose.

While it may seem illogical to treat substance use disorders (SUD) with substances or medications, this practice has been found to have better treatment outcomes and greater sustained periods where illicit drug use was absent as compared to those in an abstinence only based program. Medication-Assisted Treatment (MAT) involves the use of medications to treat substance use disorder (SUD). Methadone, Suboxone (buprenorphine), and Naltrexone medications that are commonly used to treat opioid dependence.

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What Do I Need to Know?

Opioid Treatment Programs exist to help those struggling with opioid dependence. The National Survey of Substance Abuse Treatment Services (N-SSATS) conducted a study looking at the similarities and differences in Opioid Treatment Programs (OTP) which can help those in need and those making referrals arrive at an informed decision regarding treatment.

"In the case of OTPs, it appears that the greatest difference between these two types of facilities is that OTP Mixed facilities more often offer a richer array of services and more payment options than OTP only facilities. Clients with multiple needs for support services, including opioid addiction, might be better served by those facilities with a wider selection of support and recovery services."*

Also, new evidence suggest that OTPs should develop best practice policies surrounding a relapse event. In the same way a physician would not stop treating a person with diabetes for eating food that is not on the prescribed diet, a relapse should not warrant automatic discharge. Discuss with treatment providers what their policy is on relapse.

The Three Types of Opioid Drug Interactions

Full agonists bind to endorphin receptors in the brain, producing pain relief, euphoria, and possible dependence. Full agonists include: Methadone, heroin, oxycodone, and morphine.

Antagonists block receptors in the brain causing no activation and no opioid effects. The antagonists obstructs other molecules from binding to the receptors. Opioid Antagonist are naloxone and naltrexone.

Partial agonists bind to opioid receptors in the brain activating them somewhat but much less than full agonists. Buprenorphine is a partial agonist.

Buprenorphine has lower abuse potential, lower level of physical dependence, less withdrawal discomfort, and greater safety in overdose. Caution should be taken with prescribing buprenorphine in combination with benzodiazepines or to patients who abuse or are addicted to benzodiazepines and other central nervous system depressants including alcohol and barbiturates.**

Conversely, the Centers for Disease Control CDC) reports that in 2009, Methadone accounted for more than 15,500 deaths. Methadone captures only 2% of all pain relief prescriptions written, yet it was involved in 30% of overdose deaths, up six times the death rate as the previous decade. "More than 4 million methadone prescriptions were written for pain in 2009, despite US Food and Drug Administration warnings about the risks associated with methadone." Methadone is cheaper than buprenorphine and preferred by insurance companies. Since 2006, methadone related overdoses have dropped in NC, according to the NC State Center for Health Statistics.

What Needs To Be Done?

- ☑ Implement Naloxone kits with training programs wherever they can be effectively used.
- ☑ Ask OTPs if they use the CSRS.
- ☑ Know local referral sources and how to make a referral including funding and waiting list time.
- ☑ Implement peer specialists and all support systems along the recovery oriented systems of care.
- ☑ Introduce non-abstinence-directed initiatives into publicly funded treatment and research.
- ☑ ***Take Correctly, Store Securely, Dispose Properly, Never Share.™***

*Retrieved from http://www.oas.samhsa.gov/2k10/225/225OpioidTx2k10.htm
**Retrieved from http://store.samhsa.gov/shin/content//SMA05-4003/SMA05-4003.pdf

Resources

National Treatment Referral Helpline 1-800-662-HELP (4357) or 1-800-487-4889 (TDD — for hearing impaired)

National Substance Abuse Treatment Facility Locator: www.findtreatment.samhsa.gov/TreatmentLocator to search by state, city, county, and zip code

Buprenorphine Physician & Treatment Program Locator: www.buprenorphine.samhsa.gov/bwns_locator

State Substance Abuse Agencies: http://findtreatment.samhsa.gov/TreatmentLocator/faces/abuseAgencies.jspx

For full law detail, please go to this link: http://openstates.org/nc/bills/2013/SB20/documents/NCD00022391/

http://www.samhsa.gov/data/2k3/OutpatientTX/outpatientTX.htm

http://www.novusdetox.com/suboxone-information-4-agonist.php

http://www.dovepress.com/preventing-deaths-from-rising-opioid-overdose-in-the-us-ndash-the-prom-peer-reviewed-article-SAR

http://www.ncdhhs.gov/mhddsas/controlledsubstance/

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Tribal

Why Am I Needed?

Native Americans are losing Tribal members rapidly due to prescription drug overdoses. Tribal poverty increases the severity of the prescription drug epidemic and impacts generations of Native American. Many more families and outside agencies are raising children who have lost parents to opioid poisoning.

Despite knowledge of prescription drug use, many family members are not intervening where opportunity exists. Tribal communities are uniquely positioned to have a significant impact on overdose death rates by educating community members about the prescription drug epidemic and equipping them with naloxone rescue kits. Naloxone is the antidote for an opioid poisoning and reverses the overdose effects. By being equipped with naloxone at the scene of an overdose, community and family members can drastically reduce the death toll.

What Do I Need to Know?

The HIS Primary Care Provider is a journal for health professionals working with American Indians and Alaska Natives. In an article published in February 2013, Lee Hyde, MD, Staff Family Physician for Cherokee Indian Hospital in Cherokee, NC, stated, "In 2007, we were experiencing nearly one death a month from drug overdoses, many in young people, usually involving opioids, on a Reservation with approximately 13,400 enrolled members at this time. We were admitting an average of 168 patients a year to our 20-bed hospital for drug treatment services." With others, Hyde began a Substance Abuse Task Force and implemented several strategies to address the epidemic. Project Lazarus Rescue Kits are being prescribed at the Cherokee Indian Hospital.

A Buprenorphine Clinic was opened in 2008 to provide Medication-Assisted Treatment (MAT) to those with an opioid dependence. Hyde found that Buprenorphine is available through a VA contract for a discounted price. The average age of patients in treatment at the clinic is 18-25. Hyde reported that when appropriate, the Tribe pays for residential treatment for younger patients who would not use MAT services where it is available outside the community, but there is usually a long waiting list. The program has treated 352 since inception and currently treats approximately 85 patients. Cherokee saw a success in reducing narcotic prescribing to 6-7% which is below the national average (Hyde).*

Preventing prescription drug abuse strengthens tribal communities. Using other people's medication increases the risk of overdose fatality. Combining prescription medications with other prescriptions, alcohol, and even over-the-counter drugs can lead to a fatal overdose.

There are alternative treatments that work for pain relief including yoga, physical therapy, and routine stretching and exercise, MAT treatment modalities for opioid addictions are effective.

Opioids and benzodiazepines in combination may be harmful and even fatal.

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What Needs To Be Done?

- [x] Implement permanent pill disposal sites.
- [x] Disperse Naloxone rescue kits to family members and train on use.
- [x] Naloxone saves lives and cannot be diverted for illicit use.
- [x] Know the signs and symptoms of misuse/abuse/diversion/overdose from prescription medications.
- [x] Prevention begins in the home through education: ***Take Correctly, Store Securely, Dispose Properly, Never Share.*** ™
- [x] Encourage harm reduction and MAT programs.
- [x] Locate additional treatment centers for substance use disorders and specialized trauma clinics.
- [x] Media campaigns can increase public awareness about the potential for harm when prescription medications are not used properly and how easily they can be diverted. Educated citizens can prevent crime that starts in the home medicine cabinet.

Resources

http://www.cdc.gov/VitalSigns/PainkillerOverdoses/

The Centers for Disease Control reported:
"About 1 in 10 American Indian or Alaska Natives aged 12 or older used prescription painkillers for nonmedical reasons in the past year, compared to 1 in 20 whites and 1 in 30 blacks."

"Whites and American Indian or Alaska Natives are more likely to overdose on prescription painkillers."

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*Retrieved from Hyde, L. (2013). The cherokee indian hospital. The IHS Primary Care Provider, 38(2), Retrieved from http://www.ihs.gov/Provider/documents/2010_2019/PROV0213.pdf

Youth

Why Am I Needed?

Abusing certain pain relievers is similar to abusing heroin because the ingredients affect the brain in the same way.

Sleeping pills can slow breathing and the heart, which can be fatal, especially if combined with certain prescription pain medicines, alcohol,or OTC cold remedies.

Abusing medicines intended to treat ADHD can cause irregular heartbeats or deadly seizures. Mixing them with cold medicines could make these dangerous effects worse.

Abusing prescription drugs can negatively affect your health, academics, athleticism, activities, and relationships.

What Do I Need to Know?

Prescription drugs are safest when used correctly under a doctor's supervision.

Taking prescription drugs that are not intended for one's self and/or mixing them with alcohol or illicit drugs can result in potentially deadly consequences.

Drug-induced deaths have now passed motor vehicle crash deaths.

There are serious health consequences to any type of drug abuse.

While 1 in 5 teens are abusing Rx drugs, 4 in 5 are not. No, not "everyone" is abusing prescriptions.*

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What Needs To Be Done?

- [x] Rehearse ahead of time how to refuse drugs, if offered.
- [x] Avoid threatening situations. If someone's parents are out of town and students are talking about a wild party planned for the weekend, it is fairly certain drugs or alcohol will be involved.
- [x] Choose friends wisely. Be prepared to say goodbye to friends who decide to drink or do drugs.
- [x] Find healthy ways to deal with stress and have fun: sports, music, drama, clubs, etc.
- [x] Share messages with others like: "Do not share prescription drugs, It is illegal to share and teens can end up at juvenile court, Prescription medicines can be dangerous when it is not one's prescription and can result in serious health consequences."
- [x] Never mix prescriptions with other medicines, drugs, or alcohol. It is never certain how these substances will interact with one another or with any health condition one might have.
- [x] Help friends stay drug free. Talk to them about the dangers of drug abuse.
- [x] If there is a friend who has had severe mood changes, is hanging out with a different crowd, or has less interest in school and hobbies, he or she may be exhibiting signs of drug abuse. Help is available and recovery is possible.
- [x] Join the school drug abuse prevention team. If there is not one, start one! Find out what is going on in school and how a team of teens can make a difference.
- [x] It is illegal to share any prescription. Pharmaceuticals are nothing to play with.
- [x] Get involved with the local substance abuse task force. This would be a bonus to put on a college application.
- [x] Talk to someone you trust if you or someone you know is dealing with a substance use problem.
- [x] ***Take Correctly, Store Securely, Dispose Properly, Never Share.™***

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*Retrieved from http://www.talkaboutrx.org/documents/TAP2009_EducatorsMaxRole.pdf

Section IV:

Project Lazarus Appendix

The Project Lazarus Appendix is divided into four sections: Naloxone Information, Resources & Samples, Templates, and Handouts. Each section of the appendix is designed to provide the necessary materials to help actively engage coalitions and communities.

Section IV:

Project Lazarus Appendix

IV.I Naloxone

Details on how to order and prescribe naloxone are given in this section of the appendix.

How to Order Project Lazarus Rescue Kits For a Household

Naloxone can reverse an overdose caused by opioids. With a naloxone kit the steps to responding to an overdose become simplified by providing step-by-step picture instructions and keeping necessary materials organized in one location.

Who Should Have a Project Lazarus Rescue Kit?

Anyone using or in contact with a user of opioids, such as heroin or prescription pain relievers like oxycodone, methadone, or hydrocodone, should have naloxone available.

What Is In a Project Lazarus Rescue Kit?

Rescue kits are available through Project Lazarus that can help simplify bystander naloxone use. Individuals can order kits for themselves or clinics can order in bulk for distribution. The kit provides everything necessary for a nasal rescue except the naloxone vials.

Kit Contents

Two nasal atomizers, a step-by-step naloxone use guide (English & Spanish), and an overdose prevention DVD are all included in a small durable hard plastic container for just $12.

How Do I Order a Rescue Kit?

There are three ways to order rescue kits:

- Through the Project Lazarus website at this link: http://www.projectlazarus.org/naloxone-od-antidote/naloxone-kit-order-form
- By email at: rescuekit@projectlazarus.org. Complete form, scan, and email back or fax to 866-400-9915.
- Call 336-667-8100 and request by phone.

How Do I Get Naloxone?

Since naloxone is a prescription medication, speak with a health care provider about getting a naloxone prescription or look for a community public health program that distributes naloxone kits. An overdose program locator can be found at: http://www.overdosepreventionalliance.org/p/od-prevention-program-locator.html.

What are the risk factors of an overdose?

Changes in tolerance after a period of abstinence, such as incarceration, hospitalization or outpatient/inpatient treatment, increase the risk of an overdose. Taking other substances such as alcohol, benzodiazepines, anti-depressants and illicit drugs with an opioid may cause overdose. Other risk factors may depend on co-morbid physiological and biological factors such as emphysema, asthma, sleep apnea, COPD, heavy smoking, renal issues and metabolism rate. An overdose occurs when the body consumes more opioids than can be tolerated and the aforementioned factors increase the likelihood of an overdose.

Where Can I Learn More?

Prescribe to Prevent: prescribetoprevent.org/
Naloxone Info: naloxoneinfo.org/get-started/about-naloxone
UptoDate: uptodate.com/contents/naloxone-drug-information
Project Lazarus: projectlazarus.org/naloxone-od-antidote
Treatment Options: findtreatment.samhsa.gov/

Health Center Naloxone Program

Prescription drug overdose is an increasing problem in North Carolina. Health centers can play a role in reducing overdose deaths by educating people and giving them access to the opioid antidote naloxone. With naloxone in hand, bystanders can reverse overdoses and save lives.

Naloxone programs could be useful in any medical clinic, especially community clinics, federally qualified health centers, (FQHC), opioid treatment programs, (OTP), and pain clinics. Clinic naloxone programs can take a variety of shapes: ranging in size, scope, and cost. A program could be as simple as writing prescriptions to patients who ask for naloxone, or as complex as handing out complete naloxone kits and holding training classes. The type of program will depend on feasibility and patients' needs. Here is information to get a program started and ideas to consider when expanding a program further. Please contact Project Lazarus if you would like more information and guidance.

Start Prescribing
The simplest and fastest approach is to encourage providers to prescribe naloxone. Here are the steps to prescribing naloxone:

1. Educate patients on how to recognize an overdose, how to respond with naloxone, and how changes in tolerance can increase the risk of opioid overdose. (See risk factors and signs of an overdose, page 2.)
2. Write a prescription for either nasal or intramuscular naloxone hydrochloride.
   Nasal Naloxone: 2x 2mg/2ml pre-filled Luer-Lock ready needleless syringes (NDC 76329-3369-1). The atomization devices (MAD 300) can be purchased by patients through a pharmacy or obtained in a Project Lazarus Rescue Kit. (See below.)
   Intramuscular Naloxone: 2x 0.4mg/ml single dose 1 ml vials (NDC 0409-1215-01) and 2x intramuscular syringes (23 gauge, 3cc, 1 inch).
3. Gauge patient's interest in behavioral change. As appropriate, present support services and treatment options.

Liability
Prescribing naloxone to patients at risk of an opioid overdose is legal.[1] Some states, including North Carolina, have passed laws that protect providers who write prescriptions for friends and family members in contact with people at risk of an opioid overdose.[2] The bill absolves civil liability for providers who write naloxone prescriptions.

Prepare Pharmacies
Most outpatient chain pharmacies do not carry naloxone. Before sending off prescriptions, alert local pharmacies so they can start stocking naloxone and the atomization devices, unless purchasing a Project Lazarus Rescue Kit which contains the nasal atomizers. There might also be some pharmacies that are interested in partnering with the clinic on overdose prevention. Reach out to pharmacies to see if a pharmacy wants to be involved in your effort. The clinic could also order naloxone directly from the manufacturer: nasal at Amphastar and intramuscular at Hospira, or through distributors.

Cost Considerations
The type of naloxone administration needs to be considered whether it is being paid for by the clinic or patient. Nasal administration is more expensive, about $25 per dose with atomizer, compared to $5 per dose for intramuscular. The intramuscular administration requires drawing naloxone from a vial into a syringe and using a needle. Atomizers, which are needed for nasal delivery of naloxone, are not covered by insurance and increases the cost of kits. Educational materials and people's time are also not free. Overdose prevention education could be a part of a Screening, Brief Intervention and Referral to Treatment (SBIRT), which can be billed as CPT 99408, G0396, or H0050.

Develop a Naloxone Policy
A policy should outline how naloxone will be offered to patients, when patient education will take place, what information will be given, how the program will be paid for, and who is responsible for documenting kit distribution and restocking supplies. Here are some options to consider when developing a program.

- *Initiate Conversation or Respond to Patients?*
  How will conversations about naloxone begin? The approach can be passive, using signs to let patients know that

naloxone is available, or more proactive, where prescriptions could be offered to any patient getting an opioid analgesic prescription. The tactic might vary by physician, but there needs to be some indication that the clinic is willing to talk to patients about naloxone.

- *Patient Education Handouts or Conversations?*
  Information about overdose prevention and naloxone use could be conveyed through a conversation, video or handout. The conversation could be with a medical provider or a different health center staff member. The discussion could occur as part of a patient visit, or if there were enough interest, classes could be organized to train people to recognize and respond to an overdose.

- *Educate Patients about what are the risk factors of an overdose?*
  Changes in tolerance after a period of abstinence, such as incarceration, hospitalization or outpatient/inpatient treatment, increase the risk of an overdose. Taking other substances such as alcohol, benzodiazepines, anti-depressants and illicit drugs with an opioid may cause overdose. Other risk factors may depend on co-morbid physiological and biological factors such as emphysema, asthma, sleep apnea, COPD, heavy smoking, renal issues and metabolism rate. An overdose occurs when the body consumes more opioids than can be tolerated and the aforementioned factors increase the likelihood of an overdose.

- *Educate Patients about what are the signs of an opioid overdose?*
  -Unresponsiveness to stimulation, such as a sternal rub
  -Shallow or absent breathing
  -Blue or ashen lips

- *Prescriptions or Distribution?*
  Naloxone can be offered to patients as a prescription that they fill at a pharmacy or distributed directly from the clinic. Naloxone is covered by most insurance, including North Carolina Medicaid. To make sure that patients get naloxone, the clinic could order naloxone to distribute on its own or as part of a rescue kit.

- *Individual Prescription or Standing Order?*
  If a clinic is going to distribute naloxone from the office, a standing order could be used to separate naloxone education from the medical visit. A standing order would enable clinic staff to evaluate a patient's need for naloxone and train them, rather than making it part of the medical provider's visit.

- *How does a Health Center Naloxone Program order Project Lazarus Rescue Kits?*
  Kits are available through Project Lazarus and can help simplify bystander naloxone use. The rescue kit keeps all materials together, includes step-by-step instructions for responding to an overdose, and contains 2 nasal atomizers. Patients can order kits for themselves for $12 or a clinic can order in bulk for distribution. There are three ways to order rescue kits:

    1. Orders can be placed through the Project Lazarus website at this link: http://www.projectlazarus.org/naloxone-od-antidote/naloxone-kit-order-form
    2. Order forms can be requested by email at rescuekit@projectlazarus.org. Complete form, scan, and email back or fax to 866-400-9915.
    3. Call 336-667-8100 and request by phone.

More information

Prescribe to Prevent: prescribetoprevent.org
Naloxone Program Development Guide: harmreduction.org/issues/overdose-prevention/tools-best-practices/manuals-best-practice/od-manual/
Naloxone Info: naloxoneinfo.org
Project Lazarus: projectlazarus.org
UptoDate: uptodate.com/contents/naloxone-drug-information

1. Davis C, Webb D, Burris S. Changing law from barrier to facilitator of opioid overdose prevention. The Journal of Law, Medicine and Ethics. 2013; 41 (s1)33-36.
2. Good Samaritan Law/Naloxone Access, NC [statue on the internet]. c2013 [cited 2013 July 6]. Available from: ncleg.net/Sessions/2013/Bills/Senate/HTML/S20v7.html

How to Order Project Lazarus Rescue Kits As a Provider

Naloxone can reverse an overdose caused by opioids. With a naloxone kit the steps to responding to an overdose become simplified by providing step-by-step picture instructions and keeping necessary materials organized in one location. Educate patients on how to recognize an overdose, how to respond with naloxone, and how changes in tolerance can increase the risk of opioid overdose. Educational materials and people's time are not free. Overdose prevention education could be a part of a Screening, Brief Intervention and Referral to Treatment (SBIRT), which can be billed as CPT 99408, G0396, or H0050.

The Project Lazarus Rescue Kit

Rescue kits are available through Project Lazarus that can help simplify bystander naloxone use. Individuals can order kits for themselves or clinics can order in bulk for distribution. The kit provides everything necessary for a nasal rescue except the naloxone vials.

Kit Contents

Two nasal atomizers, a step-by-step naloxone use guide (English & Spanish), and an overdose prevention DVD are all included in a small durable hard plastic container for just $12.

How Do I Order a Rescue Kit?

There are three ways to order rescue kits:

- Through the Project Lazarus website at this link: http://www.projectlazarus.org/naloxone-od-antidote/naloxone-kit-order-form
- By email at: rescuekit@projectlazarus.org. Complete form, scan, and email back or fax to 866-400-9915.
- Call 336-667-8100 and request by phone.

Who Should Have a Project Lazarus Rescue Kit?

Anyone using or in contact with a user of opioids, such as heroin or prescription pain relievers like oxycodone, methadone, or hydrocodone, should have naloxone available.

What are the risk factors of an overdose?

Changes in tolerance after a period of abstinence, such as incarceration, hospitalization or outpatient/inpatient treatment, increase the risk of an overdose. Taking other substances such as alcohol, benzodiazepines, anti-depressants and illicit drugs with an opioid may cause overdose. Other risk factors may depend on co-morbid physiological and biological factors such as emphysema, asthma, sleep apnea, COPD, heavy smoking, renal issues and metabolism rate. An overdose occurs when the body consumes more opioids than can be tolerated and the aforementioned factors increase the likelihood of an overdose.

How Do I Prescribe Naloxone?

Naloxone can be legally prescribed to those at risk of an opioid overdose or the family/friends of someone at risk. To complete a Project Lazarus rescue kit, a prescription should be written for 2x 2mg/2ml pre-filled Luer-Lock ready needleless syringes (NDC 76329-3369-01). Refer to the Prescribe Naloxone Today information sheet to learn more.

Where Can I Learn More About Naloxone?

Prescribe to Prevent: prescribetoprevent.org/
Naloxone Info: naloxoneinfo.org/get-started/about-naloxone
UptoDate: uptodate.com/contents/naloxone-drug-information
Project Lazarus: projectlazarus.org/naloxone-od-antidote
Treatment Options: findtreatment.samhsa.gov/

Prescribe Naloxone Today

Steps to Prescribing Nasal Naloxone

1. Educate patients on how to recognize an overdose, how to respond with naloxone, and how changes in tolerance can increase the risk of opioid overdose. (See risk factors and signs of an overdose on right.)Educational materials and people's time are not free. Overdose prevention education could be a part of a Screening, Brief Intervention and Referral to Treatment (SBIRT), which can be billed as CPT 99408, G0396, or H0050.
2. Write a prescription for either nasal or intramuscular naloxone hydrochloride.
   - Nasal Naloxone: 2x 2mg/2ml pre-filled Luer-Lock ready needleless syringes (NDC 76329-3369-1). The atomization devices (MAD 300) can be purchased by patients through a pharmacy or obtained in a Project Lazarus Rescue Kit. (See below.)
   - Intramuscular Naloxone: 2x 0.4mg/ml single dose 1 ml vials (NDC 0409-1215-01) and 2x intramuscular syringes (23 gauge, 3cc, 1 inch).
3. Gauge patient's interest in behavioral change. As appropriate, present support services and treatment options.

The Project Lazarus Rescue Kit

Rescue kits are available through Project Lazarus that can help simplify bystander naloxone use. Individuals can order kits for themselves or clinics can order in bulk for distribution. The kit provides everything necessary for a nasal rescue except the naloxone vials.

Kit Contents

Two nasal atomizers, a step-by-step naloxone use guide (English & Spanish), and an overdose prevention DVD are all included in a small durable hard plastic container for just $12.

There are three ways to order rescue kits:

- Through the Project Lazarus website at this link: http://www.projectlazarus.org/naloxone-odantidote/naloxone-kit-order-form
- By email at: rescuekit@projectlazarus.org. Complete form, scan, and email back or fax to 866-400-9915.
- Call 336-667-8100 and request by phone.

Frequently Asked Questions About Naloxone

Is prescribing naloxone legal?

Prescribing naloxone to patients at risk for an opioid overdose is legal.1 Some states, including North Carolina, have passed laws that protect providers who write prescriptions for friends and family members in contact with people at risk of an opioid overdose.2

What are the benefits and risks in using naloxone?

Naloxone is an effective, non-addictive opioid antagonist that can reliably reverse an overdose and is not a controlled substance. Community-based organizations have been successfully training bystanders to use naloxone for over 15 years.3 The risks lie in the rapid onset of withdrawal symptoms and naloxone's short half-life. When someone is revived by naloxone they can vomit, be agitated, and have diarrhea, body aches, rapid heart rate, and increased blood pressure. Naloxone wears off faster than some extended-release opioids and there is the potential for someone to overdose again, although this is rarely observed in community-based programs. Patients should be encouraged to call 911.

What are the risk factors of an overdose?

Changes in tolerance after a period of abstinence, such as incarceration, hospitalization or outpatient/inpatient treatment, increase the risk of an overdose. Taking other substances such as alcohol, benzodiazepines, anti-depressants and illicit drugs with an opioid may cause overdose. Other risk factors may depend on co-morbid physiological and biological factors such as emphysema, asthma, sleep apnea, COPD, heavy smoking, renal issues and metabolism rate.

An overdose occurs when the body consumes more opioids than can be tolerated and the aforementioned factors increase the likelihood of an overdose.

What are the signs of an opioid overdose?

- Unresponsiveness to stimulation, such as a sternal rub
- Shallow or absent breathing
- Blue or ashen lips

How to respond to an overdose?

- Call 911
- Start rescue breathing
- Administer naloxone
- Put the person in recovery position
- Stay with the person until help arrives

How is nasal naloxone used?

Assemble the vial, syringe, and atomizer. Spray half of the naloxone into each nostril. If the person does not wake up in five minutes, use the second vial of naloxone. There are instructional videos in the links below.

Where to learn more?

Prescribe to Prevent: prescribetoprevent.org/
Naloxone Info: naloxoneinfo.org/get-started/about-naloxone
Up-to-date: uptodate.com/contents/naloxone-drug-information
Project Lazarus: projectlazarus.org/naloxone-od-antidote
Treatment Options: findtreatment.samhsa.gov/

1.Davis C, Webb D, Burris S. Changing law from barrier to facilitator of opioid overdose prevention. The Journal of Law, Medicine and Ethics. 2013; 41 (s1)33-36.
2. Good Samaritan Law/Naloxone Access, NC. c2013 [cited 2013 July 6]. Available from: http://www.ncleg.net/Sessions/2013/Bills/Senate/HTML/S20v7.html.
3. Wheeler E, Davidson PJ, Jones TS, Irwin KS. Community-based opioid overdose prevention programs providing naloxone-United States, 2010. Morbidity and Mortality Weekly Report 2012; 61(06)101-105.

PROJECT LAZARUS Naloxone Rescue Kit Order Form

Contact Name:_____

Date:_____

Phone:_____

Email:_____

Shipping Address:_____

_____

Organization Name:_____

Type of Organization:

- ☐ Pharmacy
- ☐ Health Center
- ☐ Household
- ☐ Treatment Facility
- ☐ Law Enforcement
- ☐ Other:_____

Number of Kits:_____

Cost:_____(number of kits x $12)

Would you like to make a donation?

Amount:_____

Total Included:_____

Payment Type:

- ☐ Check (pay to the order of Project Lazarus)
- ☐ Invoice Later

Thank you for your efforts to stop overdose deaths.

Please allow two weeks for shipping.

PROJECT LAZARUS
A Project of Community Care of North Carolina

P.O. Box 261, Moravian Falls, NC 28654 USA +1.336.667.8100 projectlazarus.org info@projectlazarus.org

Section IV:

Project Lazarus Appendix

IV.II Resources & Samples

Several documents are requested by Project Lazarus when beginning a coalition. This section of the appendix provides resources and samples that can be of assistance during the process of starting and maintaining a coalition.

CADCA® Research *into* Action

July/August 2013

Study Highlights Key Factors for Improving Coalition Collaboration and Unification

As with any group formation involving multiple parties, backgrounds and opinions, coalition unification can be a challenging feat. Though members of coalitions join for the shared goal of creating safe and drug-free communities, contrasting personalities and experiences sometimes result in conflict, inhibiting coalition progress. In this instance, members view differences with other members as incompatible for successful collective efforts. A recent study conducted by researchers from the University of Calgary identified four crucial factors for helping organizations facilitate effective community collaboration.

What did they do?

Drawing upon previous work for their foundation, researchers Ellen Perrault, Robert McClelland, Carol Austin, and Jackie Sieppert first examined the Wilder Collaboration Factors Inventory (WCFI). A resource often used in team building and assessment, the WCFI highlights forty items identified as significant for constructive collaboration. Based on the findings of the WCFI, Perrault et al. took collaboration research a step further by implementing a case study to determine the most valid factors of the WCFI for successful collaboration, as well as other factors not highlighted through previous research.

Over the course of a two year and four month period, the researchers studied the Elder Friendly Communities Program (EFCP). This program, founded in 2000 to empower seniors to engage in community development, was specifically chosen due to its high level of collaborative success. The EFCP's indicators of success, including public appreciation from outside sources, recognition among members about the group's success, and member organizations' involvement, resulted in positive and beneficial outcomes. Furthermore, the EFCP created sustainability through their collaboration, as the program continues to thrive today.

To identify patterns of the EFCP's collaboration success, the researchers collected a broad spectrum of data including WCFI results completed by EFCP members, interview transcripts with EFCP members, meeting transcripts, six years of archived material, and member discussions to receive feedback for the accuracy of data outcomes.

What did they find?

Based on their extensive data collection, the researchers identified four key factors contributing to the EFCP's successful collaboration, including two WCFI factors and two newly discovered elements.

As originally highlighted through the WCFI, Perrault et al. noted the combination of informal and formal communication links enhanced group collaboration as members felt their personal familiarity with others created a more cohesive and effective professional environment. The EFCP's establishment of informal relationships also facilitated effective conflict prevention and resolution, with EFCP members citing mutual care between members as important for maintenance of positive relationships.

EFCP members identified the combination of mutual respect, understanding, and trust as the second WCFI element crucial to successful collaboration conflict resolution. As issues arose, a heightened sensitivity for collective group satisfaction motivated the EFCP to look beyond hasty resolution methods, ensuring the the group reached widespread consensus.

Beyond the WCFI, researchers discovered shared leadership led to greater collaboration. As highlighted by the researchers, "leadership in the EFCP collaboration was fluid...appeared to honor the importance and contribution of all members, flexibly creating clear roles for members, depending on the task at hand" (Perrault, et al. 2011, p. 291). This form of leadership created greater inclusion within the EFCP, not only allowing multiple members to assume a leading role but also function congruently under the group's conflict-preventative consensus structure. As a result, their maximized capacity for collective group direction established a collaborative and minimized conflict structure within the EFCP.

Researchers identified a shared learning purpose as the final component of the group's collaborative success. This factor, directly tied to the EFCP's shared leadership, encourages the idea that a shared pursuit of learning among the group members creates a more unified and collaborative process. The group implemented a learning initiative, setting joint goals and purpose definitions. As a result, shared learning was noted as having contributed to greater commitment, attentiveness, empathy for others, and receptiveness to different approaches.

What Coalitions Can Do

- ✓ **Encourage informal communication links and relationships.** While positive professional relationships are a crucial component of collective capacity, these relationships may be strengthened by establishing informal connections and communication links. Coalition members should not hesitate to get to know their fellow members on a level providing insight into their daily lives. Without engaging in informal communication, one might never know if his or her fellow member has children, enjoys sports, or shares similar interests. As a result, deeper understanding and empathy among members will likely solidify bonds and allow potential conflicts to transform into progressive and positive outcomes.
- ✓ **Build processes to promote consensus.** Coalitions should emphasize consensus reaching within their internal structure. As they develop their decision-making processes, coalitions must identify consensus as a major goal, carefully shaping their procedures to involve widespread member agreement before action. In contrast, hasty decision-making fails to seek unified approval resulting in intergroup bitterness and disconnect. Coalition accord will minimize tensions and ensure members remain engaged and satisfied.
- ✓ **Establish distributive power.** Shared leadership reduces the potential conflict risk of having some coalition members feel underrepresented or "left out." Coalitions may distribute power by allowing some leadership roles to be rotated amongst members, or by creating multiple leadership positions so "specialists" of a specific subset within the coalition can assume a leadership role for their given area. As a result, diversified leading may increase the likelihood that all members experience inclusion and satisfaction of representation.

To review the original source, please refer to:

Perrault, E., McClelland, R., Austin, C., & Sieppert, J. (2011). Working together in collaborations: Successful process factors for community collaboration. *Administration in Social Work*, 35(3): 282-298.

Mattessich, P. Murray-Close, M., & Monsey, B. (2001). *Collaboration: What makes it work* (2nd ed.). Saint Paul, MN: Amherst H. Wilder Foundation.

CADCA's National Coalition Institute, 625 Slaters Lane, #300, Alexandria, VA 22314, 1-800-54-CADCA , www.cadca.org

CADCA's National Coalition Institute mission is to increase the effectiveness of community anti-drug coalitions throughout the nation.

The Network for Public Health Law

Ideas. Experience. Practical answers.




LEGAL INTERVENTIONS TO REDUCE OVERDOSE MORTALITY IN NORTH CAROLINA

Fact Sheet

Background

Fatal drug overdose is a nationwide epidemic that claims the lives of over 36,000 Americans every year.[1] The situation is particularly acute in North Carolina, where overdose deaths have increased more than 300 percent in just over a decade, from 297 in 1999 to 1,140 in 2011.[2] This increase is mostly driven by prescription opioids such as oxycontin and hydrocodone, which now account for more overdose deaths than heroin and cocaine combined.[3] Opioid overdose is typically reversible through the timely administration of naloxone, a drug that reverses the effects of opioids, and the provision of other emergency care.[4] However, access to naloxone and other emergency treatment is often limited by laws that a) make it difficult for those likely to be in a position to reverse an overdose to access the drug and b) discourage overdose witnesses from calling for help.[5] In an attempt to reverse this unprecedented increase in preventable overdose deaths, a number of states have recently amended those laws to increase access to emergency care and treatment for opiate overdose.[6]

In 2013, North Carolina joined their ranks. Senate Bill 20, "Good Samaritan Law/Naloxone Access," was passed by overwhelming majorities in the state House and Senate and was signed by the Governor on April 9, 2013. The law went into effect immediately.[7] As explained in more detail below, the law provides limited immunity from prosecution for possession of certain drugs and drug paraphernalia for individuals who experience a drug overdose and are in need of medical care and for those who seek medical care in good faith for a person experiencing an overdose. The bill also provides limited immunity from certain underage drinking offenses for minors who seek help in the event of an alcohol overdose. Finally, the bill establishes limited civil and criminal immunity for medical professionals who prescribe naloxone, and laypeople who administer it to a person suspected of suffering from an opioid overdose.

Limited Immunity for Possession of Certain Drugs

In many cases, overdose bystanders may fail to summon medical assistance because they are afraid that doing so may put them at risk of arrest and prosecution for drug-related crimes.[8] SB20 attempts to address this problem by providing limited immunity from prosecution for possession of certain drugs for both a person acting in good faith who seeks medical assistance for an individual experiencing a drug-related overdose and the person suffering from the overdose where the evidence for prosecution was obtained as a result of the seeking of medical assistance. The law provides immunity from possession charges only; it provides no protection for other crimes such as the sale of illegal drugs.

Mainly because of how the state Controlled Substances Act is written, the drugs and quantities covered by SB20 are slightly complicated.[9] We provide below a complete list of the drugs and quantities for which a person may not be prosecuted if the requirements described above are met, and an incomplete list of drugs and quantities for which the bill does not grant immunity.

Complete List of Drugs and Quantities Covered by SB20

- Less than one gram of cocaine
- Less than one gram of heroin
- Less than one gram of Methylenedioxypyrovalerone (MDPV)
  - *This is one of the drugs commonly known as "bath salts"*
- Less than 100 tablets, patches or other dosage units of most, but not all, Schedule II, III, or IV drugs10
  - *This includes most common prescription drugs including Vicodin, Percocet, OxyContin, Opana, Suboxone, methadone and other opioid pain relievers except hydromorphone drugs such as Dilaudid and Exalgo (see below); Ritalin, Adderall, and some other stimulants (see below); Xanax, Klonopin, Valium and other benzodiazepines; Ambien, Lunesta, Sonata and other sleep aids; and testosterone steroids.*
- Four or fewer "tablets, capsules, or other dosage units or equivalent quantity" of hydromorphone
  - *Brand names Dilaudid and Exalgo*
- Any quantity of a Schedule V drug
  - *These are generally non-prescription drugs that can only be sold by a pharmacist, such as cough syrup with codeine*
- One and one-half ounces or less of marijuana
- 21 grams or less of a synthetic cannabinoid or any mixture containing a synthetic cannabinoid
  - *These are synthetic marijuana products, such as those sold as "Spice" or "K-2"*
- Three-twentieths of an ounce or less of hashish

If a drug and quantity is not in the above list, the new law does not provide immunity for its possession. A non-exclusive list of the drugs and quantities for which immunity is not granted follows.

Incomplete List of Drugs and Quantities Not Covered by SB20

- One gram or more of cocaine
- One gram or more of heroin
- One gram or more of methylenedioxypyrovalerone (MDPV)
- Any quantity of any Schedule I drug *except* heroin or MDPV, for which immunity is granted for quantities less than one gram (see above)
  - *Schedule I drugs are those that cannot be prescribed for any purpose. They include LSD, MDMA/Ecstasy, and ibogaine, among others*
- Any quantity of methamphetamine
- Any quantity of amphetamine[11]
- Any quantity of phencyclidine (PCP)
- Any salt, isomer, salts of isomers, compound, derivative, or preparation of methamphetamine, amphetamine, phencyclidine, or cocaine
- Any quantity of coca leaves and any salt, isomer, salts of isomers, compound, derivative, or preparation of coca leaves
- Any quantity of synthetic tetrahydrocannabinols or tetrahydrocannabinols isolated from the resin of marijuana

Limited Immunity for Possession of Drug Paraphernalia

The law also provides immunity from prosecution for possession of drug paraphernalia for both the person who seeks medical assistance in good faith for a person experiencing an overdose and the person in need of help, if the evidence for the charge was obtained as a result of the call for medical assistance. Drug paraphernalia includes syringes, baggies, cookers and similar instruments used or intended to be used with activities that violate the Controlled Substances Act.[12]

Limited Immunity for Possession and Consumption of Alcohol

Under the terms of the law, a person under the age of 21 who seeks medical assistance for another "shall not be prosecuted" for unlawful possession or consumption of alcohol if he or she acts in good faith and upon a reasonable belief that he or she was the first to call for assistance. The person must provide his or her own name when contacting

authorities and remain with the person needing medical assistance until help arrives. This alcohol-related immunity applies only to the person who seeks help, not the person needing medical assistance.

Additionally, Both Duke and Elon universities have written policies that encourage alcohol overdose bystanders to seek medical assistance by providing limited immunity from sanction under university alcohol rules for underage students who seek medical help for a person experiencing an alcohol overdose.[13] As the Elon policy notes, "[t]he university's main concern is getting the proper care for the student in need."[14]

Increased Access to Naloxone

The law also takes several steps to make it easier for those likely to be in the position to save a life to do so by administering naloxone, the standard treatment for opioid overdose. First, the bill authorizes a medical professional otherwise permitted to prescribe naloxone to prescribe the drug to a person at risk of experiencing an overdose as well as a family member, friend, or other person "in a position to assist a person at risk of experiencing an opiate-related overdose." These changes should help increase access to the drug, since in general prescriptions are not permitted to be written for persons the practitioner has not personally examined, even though the friends and family members of a person at high risk for overdose are often the ones to seek help from a trusted practitioner.

Further, the bill permits physicians to prescribe the drug via standing order, so that persons operating under the direction of a prescriber can offer the drug where clinically indicated even where the recipient was not examined by the prescriber. Since it can often be difficult to access a professional with prescribing privileges, this change can be expected to increase access as well. Finally, the bill authorizes a person who receives naloxone under the terms of the bill to administer it to another person in the event of an overdose, so long as they exercise reasonable care in doing so.[15]

Both practitioners who prescribe the drug as authorized in the law and laypeople who administer it are immune from any civil or criminal liability for those actions.

In March, 2013 the North Carolina Medical Board modified its Position Statement on drug overdose prevention to note that it is "encouraged by programs that are attempting to reduce the number of drug overdoses by making available or prescribing an opioid antagonist such as naloxone to someone in a position to assist a person at risk of an opiate-related overdose." In the Statement, the Board encourages "its licensees to cooperate with programs in their efforts to make opioid antagonists available to persons at risk of suffering an opiate-related overdose."[16] That same month the Board modified its position statement on third party prescription to note that prescribing to a patient that the practitioner has not personally examined is permitted in certain instances, including "prescribing an opiate antagonist to someone in a position to assist a person at risk of an opiate-related overdose."[17]

SUPPORTERS

Robert Wood Johnson Foundation

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This document was developed by Corey Davis, J.D., M.S.P.H., at the Network for Public Health Law -- Southeastern Region (cdavis@networkforphl.org) with assistance from Nabarun Dasgupta, Ph.D. at the University of North Carolina at Chapel Hill.

[1] MARGARET WARNER, ET AL., NAT'L CTR. FOR HEALTH STATISTICS, DRUG POISONING DEATHS IN THE UNITED STATES, 1980–2008 (2011).
[2] INJURY AND VIOLENCE PREVENTION BRANCH, NORTH CAROLINA DIVISION OF PUBLIC HEALTH, PRESCRIPTION & DRUG OVERDOSES (2013), *available at* http://injuryfreenc.ncdhhs.gov/About/PoisoningOverdoseFactSheet2013.pdf
[3] *Id.*
[4] *See* C. Baca, et al., *Take-home Naloxone to Reduce Heroin Death*, 100 ADDICTION 1823 (2005); Centers for Disease Control and Prevention, *Community-Based Opioid Overdose Prevention Programs Providing Naloxone – United States,* 2010, 61 MORBIDITY AND MORTALITY WEEKLY REPORT 101 (2012).
[5] *See* Davis CS, Webb D, Burris S. *Changing Law from Barrier to Facilitator of Opioid Overdose Prevention,* 41 JOURNAL OF LAW, MEDICINE AND ETHICS 33 (2013).
[6] For a comprehensive list of other state efforts, *see* NETWORK FOR PUBLIC HEALTH LAW, LEGAL INTERVENTIONS TO REDUCE OVERDOSE MORTALITY: NALOXONE ACCESS AND GOOD SAMARITAN LAWS (2013), *available at* http://www.networkforphl.org/_asset/qz5pvn/network-naloxone-10-4.pdf.
[7] The bill, Session Law 2012-23, will be codified at N.C.G.S. § 90-96.2 (Good Samaritan provisions), § 90-106.2 (naloxone access provisions), and § 18B-302.2 (alcohol provisions).
[8] Karin Tobin, et al., *Calling emergency medical services during drug overdose: an examination of individual, social and setting correlates*, 100 ADDICTION 397 (2005); Robin A. Pollini, et al., *Response to Overdose Among Injection Drug Users*, 31 AMERICAN JOURNAL OF PREVENTIVE MEDICINE 261 (2006).
[9] Immunity is provided for "a misdemeanor violation of G.S. 90-95(a)(3), (ii) a felony violation of G.S. 90-95(a)(3) for possession of less than one gram of cocaine, (iii) [and] a felony violation of G.S. 90-95(a)(3) for possession of less than one gram of heroin.."
[10] The 100-dosage unit limit is for all drugs combined.
[11] The relevant section of the state Controlled Substances Act places the following amphetamine and amphetamine-like drugs in Schedule 2: Amphetamine, its salts, optical isomers, and salts of its optical isomers, Phenmetrazine [Preludin, no longer manufactured] and its salts, Methamphetamine, including its salts, isomers, and salts of isomers, Methylphenidate [Ritalin], Phenylacetone [an amphetamine precursor],and Lisdexamfetamine [Vyvanse, and a component of Adderall], including its salts, isomers, and salts of isomers. N.C.G.S. § 90-90(3)(a)-(f). The section of the act prohibiting possession of certain drugs makes it a felony to possess any amount of "amphetamine." N.C.G.S. § 90-95(d)(2). We assume that the legislature intended to refer to only "amphetamine" as listed in N.C.G.S. § 90-90(3)(a) and not the other amphetamine-type drugs listed above; since if it intended to capture all amphetamine-type drugs it could have referred to the entirety of N.C.G.S. § 90-90(3).
[12] *See* N.C.G.S. § 90-113.21.
[13] See ELON UNIVERSITY, ALCOHOLIC BEVERAGES AND POLICIES, *available at* http://www.elon.edu/e-web/students/handbook/violations/alcohol.xhtml, DUKE UNIVERSITY, ALCOHOL POLICY, *available at* http://studentaffairs.duke.edu/conduct/z-policies/alcohol-policy.
[14] ELON, supra note 13.
[15] Under the terms of the bill, "Evidence of reasonable care shall include the receipt of basic instruction and information on how to administer the opioid antagonist," but such instruction is not required to be delivered and its receipt is not required to gain the law's protection.
[16] NORTH CAROLINA MEDICAL BOARD, DRUG OVERDOSE PREVENTION (2013), *available at* http://www.ncmedboard.org/position_statements/detail/drug_overdose_prevention.
[17] *See* NORTH CAROLINA MEDICAL BOARD, CONTACT WITH PATIENTS BEFORE PRESCRIBING (2013), *available at* http://www.ncmedboard.org/position_statements/detail/contact_with_patients_before_prescribing

Budget & Budget Justification

Provide a detailed itemized budget and written justification consistent with planned activities of the project. Budget items should be realistic and clearly linked to project activities and expected outcomes.

Use the following categories for your itemized budget:

Name of Agency: _____

Budget Category:	**Amount:**
A. Coalition Coordinator Stipend	$ _____
B. Subcontracts	$ _____
C. Training	$ _____
D. Educational Materials	$ _____
E. Travel Expense Mileage: **X** miles @ **X** ¢ per mile	$ _____
F. Supplies	$ _____
G. Incentives	$ _____
H. Other	$ _____

Total Amount Requested $ _____

Budget Justification

A. Coalition Coordinator Stipend **Amount: $_____**

Provide job description including duties, responsibilities, and hours required.

B. Subcontracts **Amount: $ _____**

Provide justification for all subcontracted services. The justification should include the name of the contractor if known, the scope of work, the period of performance and expected outcomes or products. Explain how cost is deemed reasonable and necessary.

C. Training **Amount: $ _____**

List all expenses anticipated for training that will be provided as part of the intervention. Include rental space for training, training materials, speaker fees, and any other applicable expenses related to the training.

D. Educational Materials **Amount: $ _____**

List the type and approximate quantity of educational materials purchased to support the intervention and a brief description of how they will be used.

E. Travel **Amount: $_____**

Travel must be within the county only ***unless*** funds are used for Project Lazarus regional trainings or events. Identify titles of staff whose travel is supported, briefly explain the purpose of the travel and how it relates to the action plan, and provide an estimate of mileage and per diem costs showing how those expenses were calculated. (note: travel must be computed at rates up to but not exceeding the current State regulations).

F. Supplies **Amount: $ _____**

Provide a reasonable dollar amount for general office supplies like pens, paper, etc. Provide justification for supply items other than general office supplies. Show calculation of cost.

G. Incentives **Amount: $ _____**

List the type and approximate quantity of items that will be used to increase or motivate participation of volunteers in the project and data collection activities.

H. Other **Amount: $ _____**

Enter any other budgeted items here and explain how they are essential to the implementation of your proposed interventions.

Total Funds Requested: **Amount $ _____**

Job Description

Job Description: Community Coalition Coordinator **Year**:

JOB SUMMARY:

The Community Coalition Coordinator communicates and promotes the objectives, action plans, and initiatives of Project Lazarus. Coordinator will serve as a vital link of communication among the strategic stakeholders in the community that effect health practices and policies; specifically, physicians and medical office managers, local government entities such as the county board of health, the hospital board, county commissioners, town councils, as well as community groups such as faith based volunteer fire departments, law enforcement and civic clubs, schools, etc.

The core of this job is to develop and support the infrastructure within the community in ways that lift the organization/projects to the standards set for successful community sector partnerships; namely, enhanced membership, leadership, and communication. The importance of effecting community practice and policy that influences the health and wellness of the community surrounding prescription medications, and recruiting stakeholders from influential leaders in the community are vital for this position. In completing these tasks, Project Lazarus' commitment to caring for communities, by promotion and education on the misuse, abuse, diversion and risks/harm from prescription medications and building trusted relationships, will be accomplished.

The specific program to be developed is Project Lazarus in collaboration with the Community Care Networks of NC, Governors Institute for Substance Abuse and UNC Injury Prevention and Research Center. Time and resources will be given to the task of providing leadership and direction to the Project Lazarus coalition unless otherwise instructed.

ESSENTIAL FUNCTIONS:

A. Essential Functions of Job:
    1. Works directly with members of the community and specific community groups on projects that enhance health practices and services involving prescription medications.
    2. Recruits elected officials, civic organization representatives, prescribers, pharmacists, law enforcement, schools, faith based groups, etc. for membership in the Project Lazarus community coalition.
    3. Manages coalition efforts by setting goals, objectives, strategies and action plans with individual community sectors documenting processes and outcomes utilizing collaborative relationships in the county, region, and state.
    4. Identify and seek additional resources necessary for the successful functioning of community response to the issue.
    5. Effectively balances business considerations, while remaining oriented on tasks, projects and coalition capacity building.
    6. Accountable for overall completion of project objectives.
    7. Performs additional related duties as assigned by the Project Lazarus coalition steering committee.

EDUCATION, TRAINING, AND EXPERIENCE:

Education/Formal Training:

- Degree in Business, Public Health, Public Administration or related field preferred, or equivalent work and/or training experience considered.

Work Experience:

- Minimum of 3 years experience in community program development, military collaborative, or experience with health care issues preferred.

Knowledge, Skills and Abilities Required:

- Requires knowledge of local healthcare and human service organizations.

- Experience in human services field, with at least three years experience at public speaking.

- Excellent organizational skills, administrative ability, public speaking, and leading/facilitating focus and coalition groups.

- Excellent written and oral communication skills to relay prescription medication education initiatives to the public through general media (newspaper, radio, and presentations to community groups).

- Ability to work as part of a comprehensive community coalition team and represent Project Lazarus in the community.

- Ability to establish and maintain credibility.

- Ability to be decisive, but able to recognize Project Lazarus preferences and priorities.

- Responsible for making programmatic, as well as administrative recommendations in order to obtain project goals and objectives.

The above statements are intended to describe the general nature and level of work being performed by people assigned to this job classification. They are not to be construed as an all-inclusive list of all duties, skills, and responsibilities of people so assigned.

Community Health Action Plan Sample

Office of Healthy Carolinians / Health Education
Community Health Action Plan Instructions 2010
The Community Health Action Plan is designed to address Community Health Assessment (CHA) priorities and to meet Healthy Carolinians Re/Certification requirements.

County: Wilkes County

Partnership: Wilkes County Healthy Carolinians

Period Covered: 2005-2020

LOCAL PRIORITY ISSUE

- **Priority issue: Substance Abuse**
- **Was this issue identified as a priority in your county's most recent Community Health Assessment? XYes _ No**
- **Listing of other sources of information about this priority issue:**
  - **State Center for Health Statistics;**
  - **NC resident unintentional poisoning death rates 2009;**
  - **Review of NC's response to an Epidemic of Fatal Unintentional Drug Overdoses 1997-2006;**
  - **The NC Injury and Violence Prevention Branch;**
  - **NC Division of Public Health;**
  - **NC Detect;**
  - **NC Controlled Substance Reporting System.**
  - **Wilkes County Health Department and Medical Examiners**
  - **SBI, local Law Enforcement**

LOCAL COMMUNITY OBJECTIVE - Please check one: __ New X Ongoing (was addressed in previous Action Plan)

- **By (date): Projected date of completion of Objective 12/2010**

- **Objective: Wilkes County will see a reduction in total number of deaths as a result of unintentional poisoning by 20 % for the year of 2010 as compared to data from 2009.**

- **Original Baseline: Unintentional deaths due to poisoning have risen from 3.5 individuals per 100,000 from 1999 to 11.5 in 2008 in NC; Wilkes County is averaging 46 deaths per 100,000 population, nearly four times the NC State average of eleven and one half per 100,000; In 2009, Wilkes County had a total of 31 Deaths as a result of intentional poisoning.**
- **Date and source of original baseline data: Review of NC's Response to an Epidemic of Fatal Unintentional Drug Overdoses 1997-2006, The Injury and Violence Prevention Branch, NC Division of Public Health, Catherine Sanford, Head, Injury Epidemiology Unit, Kay.Sanford@ncmail.net.**
- **Updated information (For continuing objective only):**
  - **Greater public awareness through education regarding substance abuse,**
  - **Greater adult community participation in training and prevention of substance abuse among general population,**
  - **Development of a resource guide for treatment that will be published for distribution in 2010**
  - **A Decrease in the number of substance abuse drug overdose cases in the latter portion of 2009 and early in 2010**
  - **Increased awareness in the identification of abuse by the public as well as, the medical providers**
  - **Increased counseling (especially to adolescent's) and active program participation to school age children, their teachers, counselors and nurses to more quickly identify at risk youth and provide early intervention measures.**
  - **Identification of barriers to prevention and treatment programs**
  - **Continue to identify gaps in treatment available to Wilkes County residents and the promotion of different organizations and programs to be initiated.**
  - **Coordination of community efforts in response to problems of domestic violence, child abuse, automobile accidents, illness, and death from substance abuse of alcohol, tobacco, and drugs.**
  - **Date and source of updated information:**

INTERVENTIONS, SETTING, & TIMEFRAME	COMMUNITY PARTNERS Roles and Responsibilities	EVALUATION MEASURES

POPULATION(S) – *(Healthy Carolinians Partnerships: Review Standard 2.)*

- **Describe the local population(s) experiencing disparities related to this local objective: Deaths are primarily ages 30 to 45 with the majority being male. Many may have other extenuating factors such as income level and level of education, which may attribute to misuse and abuse. Others fall into addiction due to chronic pain resulting from an injury or disability.**
- **Describe the population(s) in your county that will be targeted by this Action Plan: Adolescent's, young and middle aged adults, as well as those who are identified as having potential risk factors for unintentional poisoning by their medical providers.**
- **Total number of persons in the local disparity population(s): Approximately 12% of entire population based upon information from local ED visit, Substance Abuse Treatment Centers and other local data. This equates to approximately 8,050 persons from a total population of approximately 67,000.**
- **Numbers you plan to reach with the interventions in this Action Plan: We are anticipating to reach 80% (6,440 persons) of those included the estimated 12% of people within our county affected by these issues. We also intend to education and mentor approximately 7,000 students within the local school system as well as their parents.**

NC 2010 FOCUS AREA AND NC 2010 HEALTH OBJECTIVE ADDRESSED: Increase the proportion of adults in need of comprehensive substance abuse treatment who receive treatment.

- **NC 2010 Health Objective: Injury Prevention**

  - **Check one NC 2010 focus area:**

__ Access to Health Care	__ Environmental Health	__ Injury
__ Chronic Disease	X Health Promotion	__ Mental Health
__ Community Health	__ Infant Mortality	__ Older Adult Health
__ Disability	__ Infectious Diseases	__ Oral Health

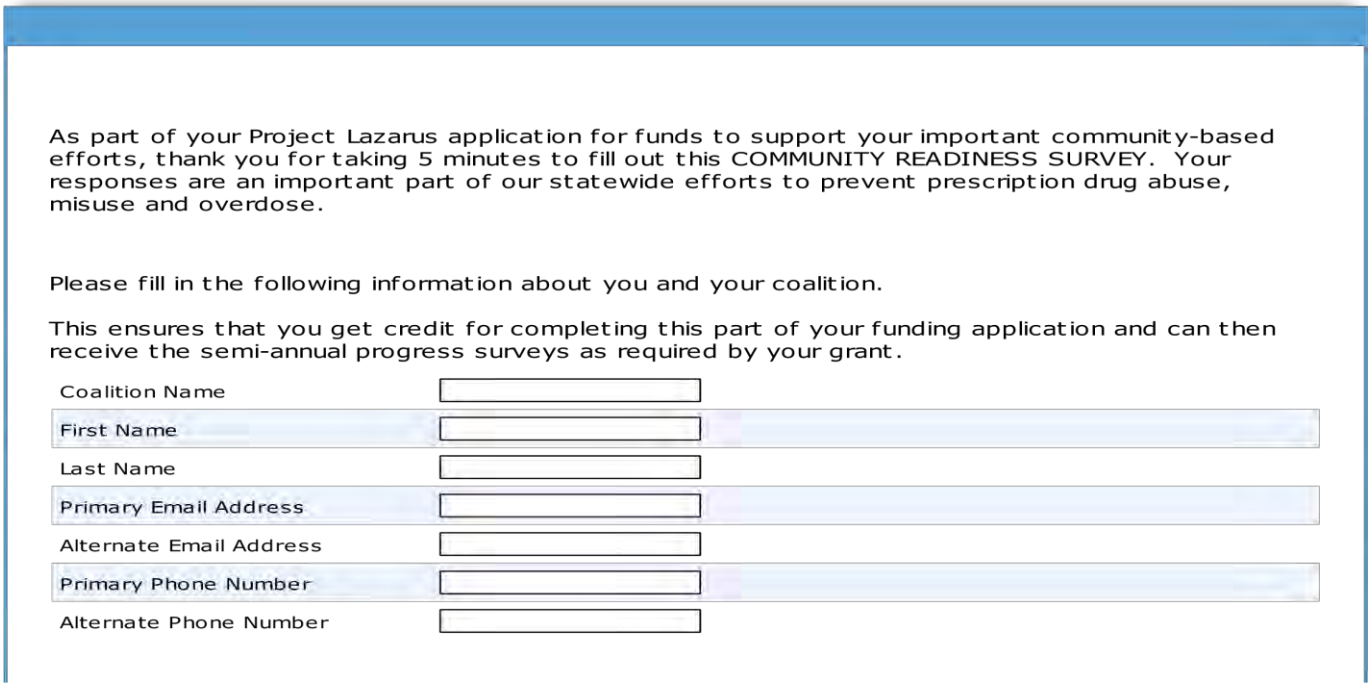
__ **Other - Please Describe**: _____

2. Marketing/Communication activities related to this community objective: • **Bring awareness to local media who have previously provided coverage of increasing number of unintentional deaths due to poisoning (drug related).** • **Assist in initiating and promoting local Continuing Medical Education for local physicians pertaining to prescription drug abuse.** • **Create and disseminate information to promote participation and usage of Controlled substance Reporting System to prevent doctor shopping and multiple uses of pharmacies.** • **Education for general population and school age children regarding substance abuse** • **Promote "in Church" training programs for awareness, treatment and how to help those suffering from substance abuse.** • **Local media; newspaper and radio specifically utilized to provide coverage of problems and solutions**	Lead agency: **Wilkes community Health Council Substance Abuse Task Force** Other agencies: **Substance Abuse Task Force of Wilkes Community Health Council** as part of Healthy Carolinians promoting awareness to problem by working with local news outlets, creating materials and speakers pertaining to substance abuse, its causes and affects and consequences. **Northwest Community Care Network and Chronic Pain** initiative working with Medicaid recipients to track over usage of prescription drugs and to better inform and provide resources for physicians and medical community in prescribing pain medications and treatments. **Wilkes Regional Medical Center** will continue to provide a liaison position to draw health care community together to collaborate on problems and issues pertaining to substance abuse.	**Substance Abuse Task Force** will continue with efforts to bring notice to the increase d number of overdose (unintentional poisoning) deaths in Wilkes County. More individuals and organizations will be asked to join in the effort to curb the increase, educate the public and seek out areas of treatment. **Northwest Community Care Network and Chronic Pain Initiative** will continue to meet on a regular basis as it is expanding outward to five additional counties within the region. They will begin promotion of Controlled Substance Reporting System, educating physicians to the aspects of prescription drug abuse and the development of guidelines for dispensing
3. Intervention: Educate local school personnel, medical community and general public regarding substance abuse. **Setting: Community** **Start Date - End Date (Begin 2009 and to continue with adjustments until 2020):**	Lead agency: **Substance Abuse Task Force** Other agencies: **Wilkes County Schools** will continue to allow access to students, families, parents and other teens who have been victims of substance abuse consequences to be able to speak in health classes and other forums. **Medical Community**: working with local hospital monthly Continuing Medical Education (CME) to provide topics and speakers pertaining to substance abuse, prescription drug usage and new protocols for prescribing narcotics for pain. Providing information, brochures and public relations to Medical Community regarding the Controlled Substance Reporting System which became active in NC Statewide July 1, 2007 and will continue through 2020.	This intervention is: _ New **X** Ongoing _ Completed Process: **Partnering with local MD's, Emergency Department, School Counselors and Nurses to provide information for greater awareness and knowledge to pinpoint abuse, know where treatment may be found and begin to provide referrals for such treatment.** **Output/ Impact: Emergency Department has established guidelines for provision of tighter prescription usage and referral to primary MD rather then supply pain meds for extended periods of time, which often results in a behavioral change among MD's and patients, as there is less access to controlled substances via this avenue. Provide PowerPoint and other such media to organizations and other health care services who may encounter those in abuse.** **Health/ Safety Outcomes**: **More Health care professionals have knowledge and information.** Progress to Date: **Presentations to local Dental Health Clinic and Dental Hygienist Association with graphic pictures and information to have them better identify signs of substance abuse.**
4. Intervention: Community Awareness Coordinator Setting: **Wilkes County Schools** Start Date - End Date **(04/2010-2012)**	Lead agency: Project Lazarus Other agencies: Other Counseling, Behavioral Health organizations and Wilkes County Schools	This is **X** New_ Ongoing **_** Completed Process: **Health education pertaining to substance abuse, what to look for and seek out those at risk**

		Output/ Impact: **Normal adolescent counsel was thirty individuals per month and number rose to over ninety.** Health/ Safety Outcomes: **School teachers, counselors and nurses now have greater knowledge and information to observe, intervene and refer those who maybe suffering or at risk to substance abuse.** Progress to Date: **Completed** **Expect to reapply to reinstitute the program via new grant and hiring of personnel.**
5. Intervention: **Provide liaison for community health and work with Substance Abuse Task Force to educate and network Health care community, local governments, County Schools, School Board, Civic Organizations and concerned citizens regarding prevention, treatment and programs promoted by Healthy Carolinians.** Setting: Local Community Start Date - End Date **(Begin 04/2010)**:	Lead agency: **Wilkes Community health Council of healthy Carolinians, Northwest Community Care network and Wilkes Regional Medical Center** Other agencies:	This is _ New **X** Ongoing _ Completed Process: Output/ Impact: Health/ Safety Outcomes: Progress to Date:
6. Intervention: **Provide additional community collaboration and support through the promotion and adoption of those items listed within the agency plan adopted by Project Lazarus and its working partners. A copy of the agency's plan is attached for review.**	Lead Agency: **Project Lazarus, Northwest Community Care Network, and The Chronic Pain Initiative.**	This is _New **X Ongoing** – Completer Process: **Complete agency/organizational plan with the evaluation process being the monitoring and validation of environmental changes as listed on the attached document.** Health/Safety Outcomes:
ONGOING INTERVENTIONS – List ongoing interventions under this heading. Use the same information as above. Insert extra rows as needed.		**Substance Abuse Task Force** has been recruiting various interested parties, victims of substance abuse and overdoses and medical community to better bring awareness to active and increasing problem of abuse and deaths in Wilkes County. Local news coverage has assisted in bringing attention and activity to the issue providing a major first step in community support. **The Task Force** has created a team of "victims" of the abuse as a speaker's bureau to share within the local schools, community organizations and churches for awareness of the problem and hopefully draw attention to those suffering to seek help and treatment. Grant for provision of individual for teaching and PR in local schools to promote awareness and knowledge of visible signs of at risk or usage of substance abuse. **Project Alert** provided a three-fold increase in adolescent counseling for substance abuse issues.

Community Readiness Survey

This survey includes statements about the attitudes and knowledge of the communities in your coalition's jurisdiction towards the problem and prevention of prescription drug abuse. For each of the questions, please choose the statement that most accurately captures the current state of your community. ***Check only one response.***



As part of your Project Lazarus application for funds to support your important community-based efforts, thank you for taking 5 minutes to fill out this COMMUNITY READINESS SURVEY. Your responses are an important part of our statewide efforts to prevent prescription drug abuse, misuse and overdose.

Please fill in the following information about you and your coalition.

This ensures that you get credit for completing this part of your funding application and can then receive the semi-annual progress surveys as required by your grant.

Coalition Name	
First Name	
Last Name	
Primary Email Address	
Alternate Email Address	
Primary Phone Number	
Alternate Phone Number	

1. What is the community climate around prescription drug abuse?

☐ The community does not see prescription drug abuse as a problem. It is an accepted part of community life. ‘‘It’s just the way things are.”

☐ There is little or no recognition that this is a community problem, or prevailing attitudes are “there’s nothing we can do” or “only ‘those’ people do that.”

☐ Community climate may not support but would not block prevention efforts.

☐ The attitude in the community is starting to reflect interest in prescription drug abuse. "We have to do something but don't know what to do."

☐ The attitude in the community is “we are concerned about this” and community members are beginning to reflect modest support for efforts.

☐ The attitude in the community is “This is our responsibility” and is beginning to reflect modest involvement in efforts.

☐ The majority of the community generally accepts programs, activities, or policies. Support may be somewhat passive.

☐ Some community members or groups may challenge specific programs, but the community in general is strongly supportive of the need for prevention. Participation level is high.

☐ All major segments of the community are highly supportive, and community members are actively involved in evaluating and improving efforts and demand accountability.

2. What is your community's knowledge level about the problem of prescription drug abuse?

☐ It is not viewed as a problem.

☐ There is no knowledge about the problem.

☐ Some people here may have this problem, but no immediate motivation to do anything about it.

☐ There is clear recognition that there is a local problem, but detailed information is lacking or depends on stereotypes.

☐ General information on local problems is available, but not based on formally collected data.

☐ There is enough information about the problem to justify doing something.

☐ Detailed information about local prevalence may be available and people know where to get specific information.

☐ There is considerable specific knowledge about prevalence and causes, risk factors, and consequences.

☐ Specific information about the problem is being used to target high risk groups and plan the types of prevention programs needed. Information about the effectiveness of local programs is available.

3. What level of involvement do local leaders (health, political, religious, tribal, etc.) have in prevention programming for prescription drug abuse? "Leadership" can include anyone in the community who is appointed to a leadership position or is influential in community affairs, i.e., an individual, a parent, a child, a teacher, a clergy person, etc.

☐ Leadership is resistant to prevention efforts.

☐ Leadership is passive, apathetic, or guarded.

☐ People have talked about doing something, but so far there isn't anyone who has really "taken charge." There may be a few concerned people, but they are not influential.

☐ There are identifiable leaders who are trying to get something started; a meeting or two may have been held to discuss problems.

☐ Leaders and others have been identified; a committee or committees have been formed and are meeting regularly to consider alternatives and make plans.

☐ Leaders are involved in programs or activities and may be enthusiastic because they are not yet aware of limitations or problems.

☐ Authorities and political leaders are solid supporters of continuing basic efforts.

☐ Multiple efforts are supported by leaders. Authorities, program staff, and community groups are all supportive of extending efforts.

☐ Authorities support multiple efforts, staff are highly trained, community leaders and volunteers are involved, and an independent evaluation team is functioning.

4. What is the current state of prescription drug abuse prevention programming in your community?

☐ Prevention is not important.

☐ No plans for prevention are likely in the near future.

☐ There aren't any immediate plans, but we will probably do something sometime.

☐ There have been community meetings or staff meetings, but no final decisions have been made about what we might do.

☐ One or more programs or activities are being planned or changes in policies are being considered and, where needed, staff are being selected and trained.

☐ One or more prevention programs, activities, or policies are being tried out now.

☐ One or more efforts have been running for several years and are fully expected to run indefinitely. No specific planning for anything else.

☐ Several different programs, activities, and policies are in place, covering different age groups and reaching a wide range of people. New programs or efforts are being developed based on evaluation data.

☐ Evaluation plans are routinely used to test effectiveness of many different efforts, and the results are being used to make changes and improvements.

5. What is your community's level of knowledge of prescription drug abuse prevention efforts?

☐ Community has no knowledge of the need for efforts addressing the issue.

☐ Community has no knowledge about existing prevention programs, activities, or policies.

☐ A few members of the community have heard about community prevention efforts, but have no information about what is done or how it is done.

☐ Some members of the community know about existing prevention efforts.

☐ Members of the community have general knowledge about local prevention efforts (e.g. purpose).

☐ An increasing number of community members have knowledge of local efforts and are trying to increase the knowledge of the general community about these efforts.

☐ There is evidence that the community has specific knowledge of local efforts including contact persons, training of staff, clients involved, etc.

☐ There is considerable community knowledge about a variety of different community prevention efforts, as well as supporting data related to level of program effectiveness.

☐ Community has accurate knowledge based on thorough evaluation data about how well the different local efforts are working, their benefits and limitations.

6. What is your community's attitude about supporting prescription drug overdose prevention efforts ***with resources****: people, money, time or space?*

☐ There is no need for resources to deal with this problem.

☐ Belief that there are no resources available for prevention or barriers to obtaining resources seems insurmountable.

☐ It might be possible to initiate prevention efforts, but not sure how much it would take, or where the resources would come from.

☐ A committee or person is finding out what might be needed for a prevention effort and is considering how the resources might be found.

☐ What is needed to staff and run a program or activity is known. A proposal has been prepared, submitted, and may have been approved. The people who will be involved have agreed to participate.

☐ Resources are available, but they are only from grant funds, outside funds, or a specific one time donation, or volunteers are running a program or activity, but it is temporary.

☐ A considerable part of support of ongoing efforts are from local sources that are expected to provide indefinite and continuous support.

☐ More than one program or activity or prevention policy is in place and is expected to be permanent, and there is additional support for further prevention efforts.

☐ There is continuous and secure support for basic programs and activities, evaluation is routinely expected and completed, and there are substantial resources for trying new efforts.

Thank you for taking the time to complete this COMMUNITY READINESS survey! Good luck with the rest of your application for funds and as you continue the important work you do!

If you have any questions about this survey, please contact Nidhi Sachdeva, MPH, CHES at nidhi@unc.edu or 919.966.0159 at the University of North Carolina Injury Prevention Research Center.

What We Invest	What We Will Do	Who We Will Reach	Learning/Action	Conditions
Inputs	**Activities**	**Outputs**	**Short/Medium-Term Outcomes**	**Long-Term Outcomes**
What do you need to get started?	**A. Develop Policies and Procedures for CRSS Program** • Develop job description. • Outline training details, schedule training and orientation. • Research liability insurance. • Determine # of hours, type of hiring, and billing or compensation structure. • Develop other forms for Community Recovery Specialists (CRS) to use, such as progress notes, assessment, treatment plan, time accountability form, travel log. • Create draft for on-call procedures and finalize with specialists, once hired. • Once CRS are hired, develop volunteer policies and procedures, including recruitment efforts. **B. Recruit Community Recovery Specialists** • Create promotional materials that describe the program (to potential specialists or others who may refer applicants). • Identify options to solicit applicant names/announce job openings. **C. Interview/Hire Community Recovery Specialists** • Research best practices in hiring and background investigation steps. • Create interview questions. • Create interview summary. • Create interview team. **D. Train Community Recovery Specialists** • Research and find training opportunities. • 40 hours training on: a) CISM; b) Harm reduction; c) MI; d) Professional Boundaries; e) Community Sector and Resources; and f) Life skills. • Develop schedule of trainings and orientation process. • Determine office space and equipment needs. **E. Build Referral and Response Relationship** • Create introductory promotional material to describe program for potential referral sources. • Create list of potential referral sources. • Create MOU with ED and other agencies. • Create PowerPoint to present to referrals and schedule presentations about the program. • Develop referral forms with procedures for making a referral.	**For CRS Staff** • Job Description for staff CRS developed. • Job Description for volunteer CRS developed. • 2 staff CRS hired. • 2 volunteer CRS engaged. • 40 hours of training provided to staff and volunteer CRS. • Referral Relationships Built. **For Program Participants** • # of people referred to the program. • # of people who stay in the program (for desired length). • # of people served by the program (RWJ application states 75).	**For CRS Staff** • Increased competencies among CRS, in a) Critical Incident Stress Management and Debriefing; b) Emergency Response; c) Use of/How to Train Others to Use Naloxone; d) Motivational Interviewing - Goal Setting Skills; e) Professional Boundaries; f) Use of Community Resources; and g) Life Skills. • Changes in attitudes, knowledge, understanding, application. • Retention, job satisfaction. **For Program Participants** • Improved lives: jobs, relationships, physical, emotional, and spiritual wellness • Additional non-using activities that replace using activities and reduce harmful patterns. • Reduced fear of stigma, increased affinity and acceptance with others. • Change in thoughts about self and others toward positive perceptions. • Support to live without drug and alcohol dependence. • Increased length of recovery, reduced relapses. • Perceived positive level of effective change in their lives from the intervention. • Life skills developed. • Replicate program for others.	• Reduced RX overdoses. • Reduced RX overdose deaths.

Your Planned Work | **Your Intended Results**

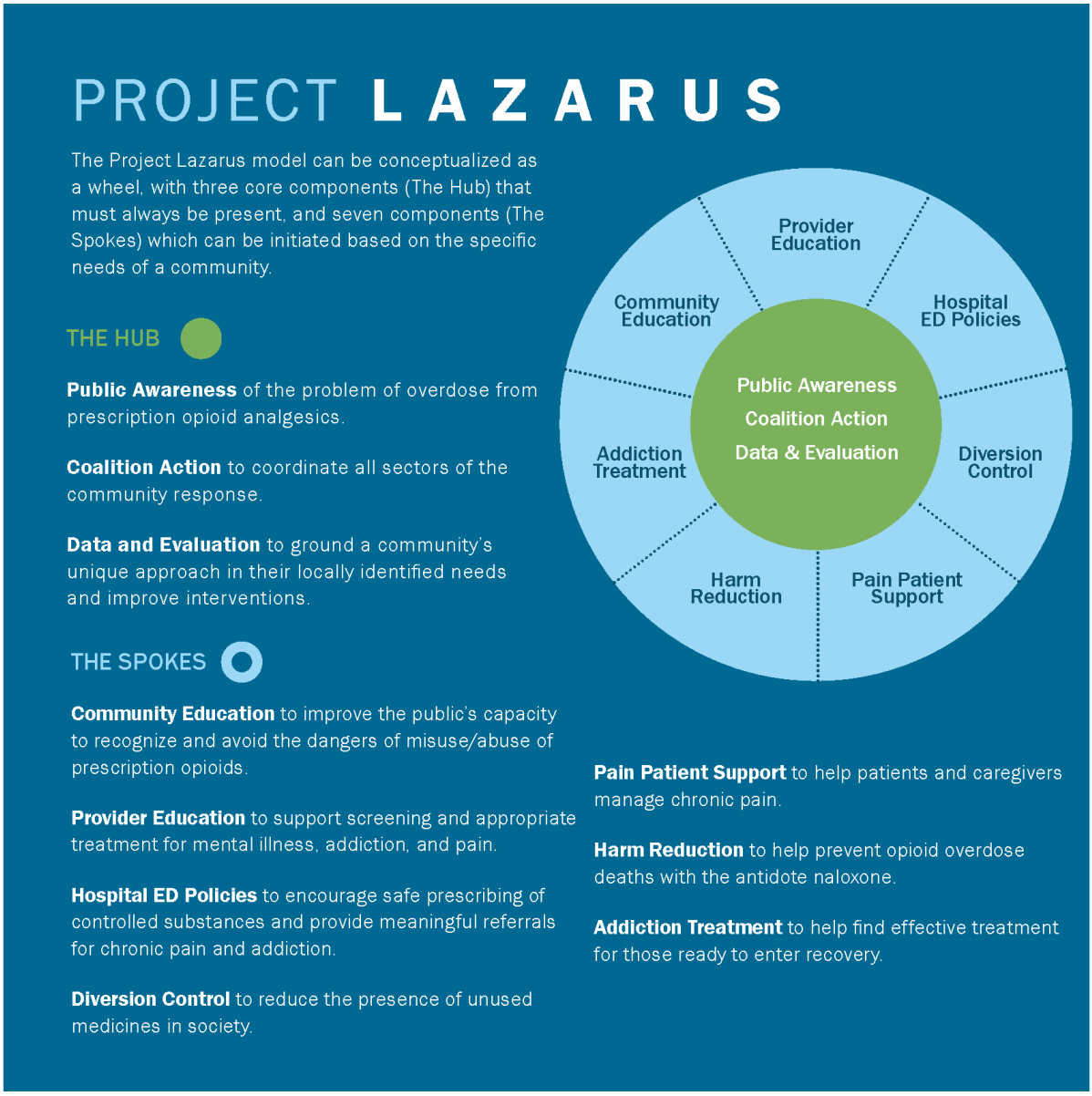
Request for Application, Part I

PROJECT LAZARUS
Community Coalition Grants Program
Request for Application
PART ONE: Description of Coalition and Activities

Background

Project Lazarus is pleased to announce the Project Lazarus Community Coalition Grants Program for North Carolina 2013-14. Grants of up to $10,000 have been allocated to each of the 100 NC counties to engage the Project Lazarus Model targeting prescription drug overdose (See Appendix A). Through a two-part application process, local coalitions that are working with Project Lazarus to prevent prescription drug misuse, abuse, diversion, and overdose in their communities may procure these grant funds. All grant funds will be dispersed throughout the first year prior to March 15, 2014.

Grantees will work on planning and implementing the prescription overdose prevention strategies, by following the seven "Spokes" of the Project Lazarus Model. (See Below)



Grantees may use these funds in various ways including to:

- Establish a multi-sector coalition
- Promote broad public awareness on the issue of prescriptions drug overdose
- Collect baseline county data for use in planning
- Develop objectives and strategies for addressing each area
- Implement and evaluate specific interventions

These are just a few examples. Each community's unique approach to address its prescription drug overdose problem is most welcome.

Application Process

The application is a two-part process. Part One involves an **initial description of your coalition and activities or your plans to begin and develop one**. Part Two includes **a request for a specific budget or a preliminary budget if you are just beginning a collation,** which will be sent out upon receipt, review, and approval of Part One**.** The deadline for Part One submissions is ten business days from receipt of this invitation.

Eligibility

Only one coalition per county will be funded.

Community-based coalitions who have a working relationship with Project Lazarus already or individuals and organizations who plan on initiating a working relationship with Project Lazarus to create a community coalition, ***and*** are located in one of the first year grant allocated counties are eligible to submit Part One of this application. Appendix A is a list of counties that have been designated as first year grant recipients along with a specified grant amount.

Part 1: Project Narrative

Please describe in up to 2 single spaced typed pages in 12 point font and one inch margins the following:

1. **What do you know about the prescription drug abuse/misuse/diversion/overdose problem in your county?** What data sources have you used to understand the issue locally? What does this data tell you about the problem in your community? You may want to attach news clippings, press releases, or articles related to this issues.
2. **At what stage of development is your community coalition?** Has one been established yet? If no, what steps have you taken to bring the key sectors and agencies together to establish a coalition? If yes, who is actively engaged with the coalition? How long has the coalition been meeting to work specifically on prescription drug overdose? What structures and documents (letters of support, strategic plan, mission statement, etc.) do you have in place that establish and guide the way in which the coalition currently functions? Has the coalition received funds from other agencies to work on this problem?
3. **What has been done to date, if anything, in your county to establish the key components of the "Hub" of the Project Lazarus Model, which includes a.) Public Awareness, b.) Coalition Action, or c.) Data and Evaluation?**
4. **Which activities, if any, has your county planned, implemented, and/or evaluated within the seven "Spokes" of the Project Lazarus Model which includes**: Community Education, Provider Education, Hospital Emergency Department Policies, Diversion Control, Pain Patient Support, Harm Reduction, and Addiction Treatment? **Please describe briefly what has been done and to what extent.**

5. **What plans or next steps will your coalition pursue to move your prescription overdose prevention work forward?** Where do you have the most traction already? What "Hub" components or "Spoke" activity categories are you hoping to improve and develop most?
6. **Indicate your commitment to respond to a biannual survey designed to record your coalition's activities in each of the counties you serve.** Please email nidhi@unc.edu to receive a link to the survey.

Appendices

Please also attach the following appendices with your letter of intent:

1. List of community sectors currently engaged. Eventually, a viable coalition will include a minimum of five community sectors. Project Lazarus will be involved in helping to establish or build additional sectors if needed.
2. Three or more letters of support from committed county sector leadership represented in your coalition.
3. If you already have an established coalition, please submit your Organizational Chart.

Instructions on where, when, how, and to whom to submit.

Please submit your completed Part One application package via email to **Fred Wells Brason II** at **fbrason@projectlazarus.org**. Please include all sections in a single PDF document. Also, include a cover letter with the name and contact information for the person submitting the application, the county for which you are submitting the application, and any other pertinent information. An electronic signature is sufficient for the cover letter.

Applications submitted **by 5pm on the tenth business day from receipt of this solicitation** will be accepted. If you are not able to meet this deadline or have any questions about the application process, please contact Project Lazarus at (336) 667-8100. All applicants will receive a notice of receipt of a complete application. If you do not receive such a notice and have submitted an application, please call Project Lazarus at the number above.

For more information about Project Lazarus, visit our website at www.projectlazarus.org

Thank you!

PROJECT LAZARUS COMMUNITY COALITION GRANTS PROGRAM - APPENDIX A

YEAR ONE GRANT RECIPIENTS 2013 - 2014					
COUNTIES	GRNT YR	GRNT AMT	COUNTIES	GRNT YR	GRNT AMT
ALEXANDER	1	$ 7,500	JONES	1	$ 10,000
ALLEGHENY	1	$ 7,500	LEE	1	$ 10,000
ANSON	1	$ 7,500	LENOIR	1	$ 10,000
ASHE	1	$ 7,500	LINCOLN	1	$ 7,500
AVERY	1	$ 7,500	MARTIN	1	$ 10,000
BEAUFORT	1	$ 10,000	MECKLENBURG	1	$ 7,500
BLADEN	1	$ 7,500	MONTGOMERY	1	$ 10,000
BRUNSWICK	1	$ 7,500	MOORE	1	$ 10,000
BURKE	1	$ 7,500	NEW HANOVER	1	$ 7,500
CABARRUS	1	$ 7,500	ONSLOW	1	$ 7,500
CALDWELL	1	$ 7,500	ORANGE	1	$ 7,500
CARTERET	1	$ 10,000	PAMLICO	1	$ 7,500
CATAWBA	1	$ 7,500	PENDER	1	$ 7,500
CLEVELAND	1	$ 7,500	PITT	1	$ 7,500
COLUMBUS	1	$ 7,500	RICHMOND	1	$ 10,000
CRAVEN	1	$ 10,000	ROWAN	1	$ 7,500
DUPLIN	1	$ 10,000	SCOTLAND	1	$ 10,000
GASTON	1	$ 7,500	STANLY	1	$ 7,500
HARNETT	1	$ 10,000	UNION	1	$ 7,500
HOKE	1	$ 10,000	WASHINGTON	1	$ 10,000
IREDELL	1	$ 7,500	WATAUGA	1	$ 7,500

Please note: The grant award for each county is predetermined based on the funding source. Though there is a difference in the grant amounts, attempts are ongoing to obtain additional funds for those counties receiving less than others.

Requests for Proposals, Part II

PROJECT LAZARUS
Request for Proposals
PART TWO: Specific Plan and Budget

Thank you for completing and returning Part One of your application. The level of development of your coalition suggests that you are ready to move to part two of this granting process. For this part we are requesting the following information:

1. A copy of your coalition's strategic plan (see Appendix A).
2. A preliminary budget that clearly links to your strategic plan (see Appendix B). If your Steering Committee is not in a position to provide a budget at this time, simply state that your budget draft will be part of the process of coalition development and capacity building. The budget is a working document and not all monies need to be budgeted at this stage of implementation.
3. A budget narrative in which you describe the proposed use for each expenditure category.
4. Additional letters of support, if any, that have been obtained since you submitted Part One. You are required to submit a minimum of five to complete your application.

Completion of Surveys

Surveys are vital to the evaluation of the Project Lazarus joint initiative. The UNC Injury and Prevention Research Center has created several ways to track the important difference this initiative will be making all across the state. If you have any questions about the survey, please email Nidhi Sachdeva at nidhi@unc.edu.

Surveys should be completed by those who have a broad overview of the county. Therein, they will be able to make assessments of the general readiness of the county residents to address prescription drug abuse/misuse/diversion/overdose and have an understanding of where the county's baseline is. Having several people review the surveys and complete them jointly is a very successful approach to getting a broad sense of the community's starting point as well.

1. Community Readiness Survey - https://unc.qualtrics.com/SE/?SID=SV_aia9ovcly0xfxoV

2. Baseline Survey – If you have ***not*** already completed the appropriate baseline surveys, you are required to complete all surveys that apply. For instance, you should respond to the links that reflect a starting point for when your coalition came into existence. If you have been working as a coalition since 2010, you are required to complete all of the links below.

Click here to complete the Rx Drug Coalition Survey Log, Years 2010-2011

Click here to complete the Rx Drug Coalition Survey Log, First Quarter (Q1), January - March 2012

Click here to complete the Rx Drug Coalition Survey Log, Second Quarter (Q2), April - June 2012

Click here to complete the Rx Drug Coalition Survey Log, Third Quarter (Q3), July - September 2012

Click here to complete the Rx Drug Coalition Survey Log, Fourth Quarter (Q4), October - December 2012

More about your budget

Please note that the funds available in this grant **may** be used for:

- Stipend for coalition coordinator.
- Materials, supplies, and resources needed to implement the proposed interventions. Examples include: curricula, materials, signage, and educational and promotional materials.
- Sub-contracted services necessary to carry out a portion of your programmatic efforts or for the acquisition of routine goods or services needed for the proposed intervention.
- Incentives to encourage participation in specific interventions.
- Training expenses but only for training(s) that will be provided as part of the intervention. Examples include: space rental, training materials, speaker fees, food at community forums.
- Travel and staff development - travel must be computed at rates up to the current State regulations and for in county coalition related work unless specific Project Lazarus regional meetings.

Funds available in this grant **may NOT be used for:**

- Replacement of funds from other sources from currently budgeted expenses such as current staff positions.
- Office equipment or computer hardware.
- Food for regularly scheduled coalition meetings.
- Alcohol.
- Administrative costs such as postage and office supplies.

Grant Submission Instructions

Please submit your completed Part Two application package via email to **Fred Wells Brason II** at grant@projectlazarus.org. Please include all sections in a single PDF document. Also include a cover letter with the name and contact information of the person submitting the application along with the county for which you are submitting the application. An electronic signature is sufficient for the cover letter. One RFA Part Two must be completed for each county separately, even if you are submitting for a multi-county effort.

Please submit applications by close of business on the date specified in the body of this email. If your coalition is not sufficiently established to complete some of the information requested, Project Lazarus is available to assist your county to mobilize, engage, establish, or build the capacity to complete the requirements of this RFA process. Incomplete applications will *not* risk the loss of the funds allocated for your county. Upon receipt of your completed application, you will be notified. A Memorandum of Understanding (MOU) with Project Lazarus will be completed when funds are dispensed. If you are not able to meet this deadline or have any questions about the application process, please contact Project Lazarus at (336) 667-8100.

Thank you!

Appendix B

STRATEGIC PLAN TEMPLATE

Issue/Problem Statement:

GOAL 1:

OBJECTIVE A:

ACTION STEPS	TIMEFRAME	RESPONSIBLE PARTIES

Rationale for Selected Prevention Strategies:

GOAL 2:

OBJECTIVE A:

ACTION STEPS	TIMEFRAME	RESPONSIBLE PARTIES

OBJECTIVE B:

ACTION STEPS	TIMEFRAME	RESPONSIBLE PARTIES

Rationale for Selected Prevention Strategies:

Appendix B

Budget & Budget Justification

Provide a detailed itemized budget and written justification consistent with planned activities of the project. Budget items should be realistic and clearly linked to project activities and expected outcomes.

Use the following categories for your itemized budget:

Name of Agency: _____

Budget Category:	**Amount:**
A. Coalition Coordinator Stipend	$ _____
B. Subcontracts	$ _____
C. Training	$ _____
D. Educational Materials	$ _____
E. Travel Expense Mileage: **X** miles @ **X** ¢ per mile	$ _____
F. Supplies	$ _____
G. Incentives	$ _____
H. Other	$ _____

Total Amount Requested $ _____

Budget Justification

A. Coalition Coordinator Stipend **Amount: $_____**

Provide job description including duties, responsibilities, and hours required.

B. Subcontracts **Amount: $ _____**

Provide justification for all subcontracted services. The justification should include the name of the contractor if known, the scope of work, the period of performance and expected outcomes or products. Explain how cost is deemed reasonable and necessary.

C. Training **Amount: $ _____**

List all expenses anticipated for training that will be provided as part of the intervention. Include rental space for training, training materials, speaker fees, and any other applicable expenses related to the training.

D. Educational Materials **Amount: $ _____**

List the type and approximate quantity of educational materials purchased to support the intervention and a brief description of how they will be used.

E. Travel **Amount: $_____**

Travel must be within the county only ***unless*** funds are used for Project Lazarus regional trainings or events. Identify titles of staff whose travel is supported, briefly explain the purpose of the travel and how it relates to the action plan, and provide an estimate of mileage and per diem costs showing how those expenses were calculated. (note: travel must be computed at rates up to but not exceeding the current State regulations).

F. Supplies **Amount: $ _____**

Provide a reasonable dollar amount for general office supplies like pens, paper, etc. Provide justification for supply items other than general office supplies. Show calculation of cost.

G. Incentives **Amount: $ _____**

List the type and approximate quantity of items that will be used to increase or motivate participation of volunteers in the project and data collection activities.

H. Other **Amount: $ _____**

Enter any other budgeted items here and explain how they are essential to the implementation of your proposed interventions.

Total Funds Requested: **Amount $ _____**

The Wilder Collaboration Factors Inventory

Name of Collaboration Project _____ Date _____

Statements about Your Collaborative Group:

Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
History of collaboration or cooperation in the community	1. Agencies in our community have a history of working together	1	2	3	4	5
	2. Trying to solve problems through collaboration has been common in this community. It's been done a lot before.	1	2	3	4	5
Collaborative group seen as a legitimate leader in the community	3. Leaders in this community who are not part of our collaborative group seem hopeful about what we can accomplish.	1	2	3	4	5
	4. Others (in this community) who are not a part of this collaboration would generally agree that the organizations involved in this collaborative project are the "right" organizations to make this work.	1	2	3	4	5
Favorable political and social climate	5. The political and social climate seems to be "right" for starting a collaborative project like this one.	1	2	3	4	5
	6. The time is right for this collaborative project.	1	2	3	4	5
Mutual respect, understanding, and trust	7. People involved in our collaboration always trust one another.	1	2	3	4	5
	8. I have a lot of respect for the other people involved in this collaboration.	1	2	3	4	5
Appropriate cross section of members	9. The people involved in our collaboration represent a cross section of those who have a stake in what we are trying to accomplish.	1	2	3	4	5
	10. All the organizations that we need to be members of this collaborative group have become members of the group.	1	2	3	4	5
Members see collaboration as in their self-interest	11. My organization will benefit from being involved in this collaboration.	1	2	3	4	5
Ability to compromise	12. People involved in our collaboration are willing to compromise on important aspects of our project.	1	2	3	4	5

Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
Members share a stake in both process and outcome	13. The organizations that belong to our collaborative group invest the right amount of time in our collaborative efforts.	1	2	3	4	5
	14. Everyone who is a member of our collaborative group wants this project to succeed.	1	2	3	4	5
	15. The level of commitment among the collaboration participants is high.	1	2	3	4	5
Multiple layers of participation	16. When the collaborative group makes major decisions, there is always enough time for members to take information back to their organizations to confer with colleagues about what the decision should be.	1	2	3	4	5
	17. Each of the people who participate in decisions in this collaborative group can speak for the entire organization they represent, not just a part.	1	2	3	4	5
Flexibility	18. There is a lot of flexibility when decisions are made; people are open to discussing different options.	1	2	3	4	5
	19. People in this collaborative group are open to different approaches to how we can do our work. They are willing to consider different ways of working.	1	2	3	4	5
Development of clear roles and policy guidelines	20. People in this collaborative group have a clear sense of their roles and responsibilities.	1	2	3	4	5
	21. There is a clear process for making decisions among the partners in this collaboration.	1	2	3	4	5
Adaptability	22. This collaboration is able to adapt to changing conditions, such as fewer funds than expected, changing political climate, or change in leadership.	1	2	3	4	5
	23. This group has the ability to survive even if it had to make major changes in its plans or add some new members in order to reach its goals.	1	2	3	4	5
	24. This collaborative group has tried to take on the right amount of work at the right pace.	1	2	3	4	5

Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
Appropriate pace of development	25. We are currently able to keep up with the work necessary to					
	coordinate all the people, organizations, and activities related to this collaborative project.	1	2	3	4	5
Open and frequent communication	26. People in this collaboration communicate openly with one another.	1	2	3	4	5
	27. I am informed as often as I should be about what goes on in the collaboration.	1	2	3	4	5
	28. The people who lead this collaborative group communicate well with the members.	1	2	3	4	5
Established informal relationships and communication links	29. Communication among the people in this collaborative group happens both at formal meetings and in informal ways.	1	2	3	4	5
	30. I personally have informal conversations about the project with others who are involved in this collaborative group.	1	2	3	4	5
Concrete, attainable goals and objectives	31. I have a clear understanding of what our collaboration is trying to accomplish.	1	2	3	4	5
	32. People in our collaborative group know and understand our goals.	1	2	3	4	5
	33. People in our collaborative group have established reasonable goals.	1	2	3	4	5
Shared vision	34. The people in this collaborative group are dedicated to the idea that we can make this project work.	1	2	3	4	5
	35. My ideas about what we want to accomplish with this collaboration seem to be the same as the ideas of others.	1	2	3	4	5
Unique purpose	36. What we are trying to accomplish with our collaborative project would be difficult for any single organization to accomplish by itself.	1	2	3	4	5
	37. No other organization in the community is trying to do exactly what we are trying to do.	1	2	3	4	5
Sufficient funds, staff, materials, and time	38. Our collaborative group had adequate funds to do what it wants to accomplish.	1	2	3	4	5
	39. Our collaborative group has adequate “people power” to do what it wants to accomplish.	1	2	3	4	5

Skilled leadership	40. The people in leadership positions for this collaboration have good skills for working with other people and organizations.	1	2	3	4	5

A free tool to assess how your collaboration is doing on 20 research-tested success factors.

The inventory takes about fifteen minutes to complete. It can be distributed to a small group of leaders in the collaborative, during a general meeting, or via mail to all members for the most complete picture. You can tally your score manually or online.

Take the free online inventory, or register your group to take the online inventory, and receive the group's summary scores for each of the 20 factors.

Order the book, *Collaboration: What makes it work, a review of research literature on factors influencing successful collaboration (2nd ed.),* for an in-depth review of collaboration research and to learn more about the development and use of the inventory.

Purchase the tool and instructions for administering, scoring, and interpreting the results, or view the inventory: Wilder Research List of 20 Collaboration Factors Inventory

A RAND study reports reliability data for the instrument.

Organizations are free to use the inventory for noncommercial use with the following citation:

Mattessich, P., Murray-Close, M., & Monsey, B. (2001). *Wilder Collaboration Factors Inventory*. St. Paul, MN: Wilder Research.

http://www.wilder.org/Wilder-Research/Research-Services/Pages/Wilder-Collaboration-Factors-Inventory.aspx

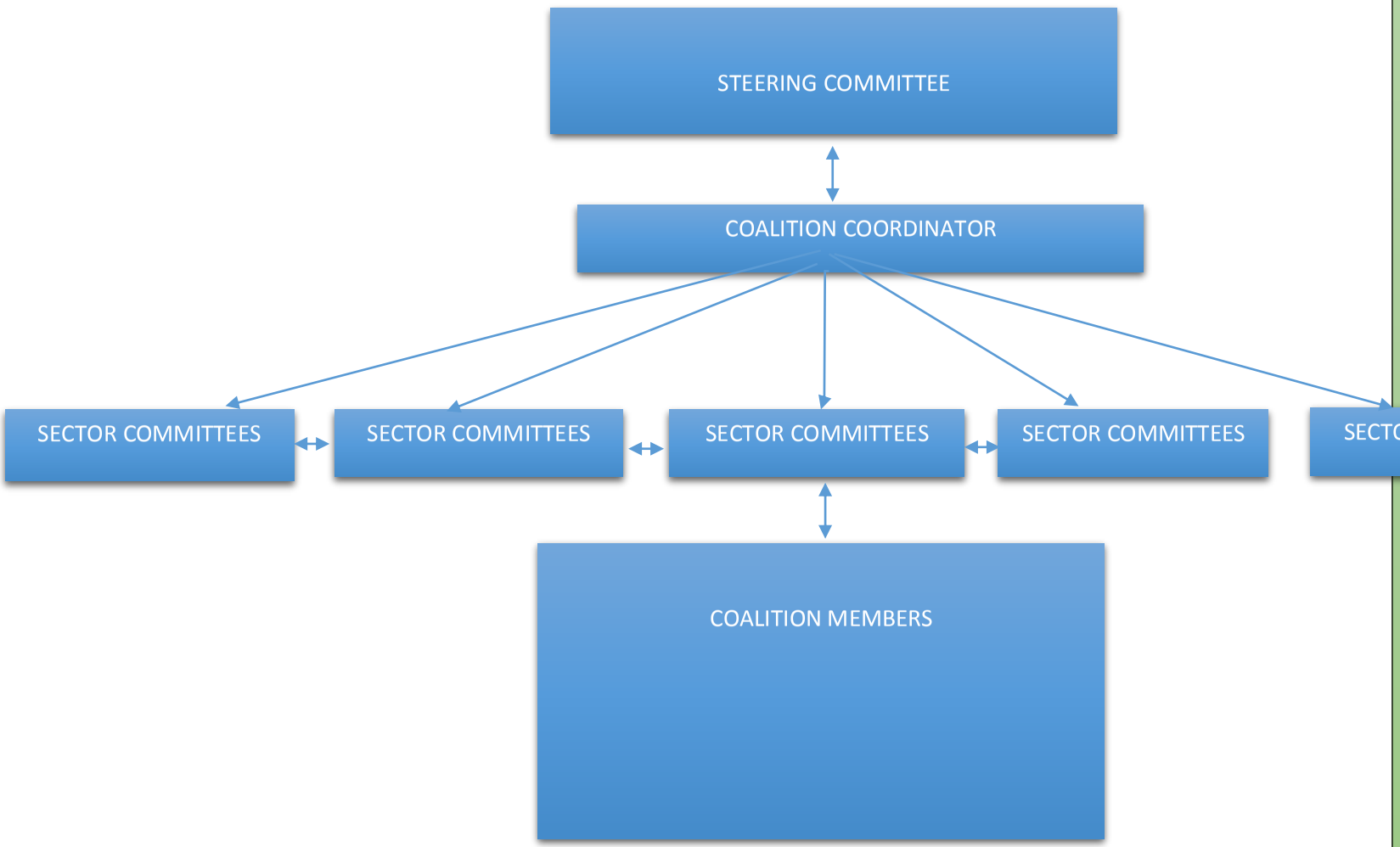
Section IV:

Project Lazarus Appendix

IV.III Templates

Various templates for coalition meetings and planning are provided in this section of the appendix.

Coalition Organizational Chart (Template)



Possible Sectors List

- Tribal
- Health Department
- Health Care Professionals
- Business/Industry
- Youth
- Recovery
- HIV/AIDS
- Local Government
- Law Enforcement
- Criminal Justice
- School Administration
- Treatment Providers
- Human Services Organizations
- Seniors
- Media
- Family
- Faith
- Fire Department/First Responders/EMS
- Medical Examiner/Coroner
- Pharmacy/Pharmacists
- Volunteer
- Veterinarian
- Civic
- Parents
- Youth-Serving Organizations

PROJECT LAZARUS

COMMUNITY FORUM: COUNTY

Join us to address prescription drug misuse, abuse, diversion, overdose, and managing chronic pain!

Project Lazarus and Community Care of North Carolina invite you to a special MEAL presentation on DAY, DATE at TIME located at LOCATION on ADDRESS. Keynote speaker will be Fred Wells Brason II, CEO of Project Lazarus.

Project Lazarus is an effective approach to the current issues surrounding prescription drug misuse, abuse, diversion, overdose, addiction to pain medication, and access to appropriate pain care. Together, through local and state collaboration, Project Lazarus and NAME County can reduce the number number of prescriptions that are misused and abused, persons addicted to prescription medications, and unintentional drug overdoses.

We encourage all community members and organizations desiring to work with Project Lazarus to attend the first NAME County Project Lazarus Forum on DAY, DATE.

Topics to be discussed include:

- **Local data for NAME County.**
- **What is needed for a successful community-based prescription overdose prevention program.**
- **The role of coalitions in overdose prevention and supporting people with chronic pain.**
- **How the Project Lazarus Model will be replicated in the NAME County region.**

Date: DAY, DATE
Time: TIME
Location: LOCATION, ADDRESS

Please RSVP to NAME, TITLE, on or before DAY, DATE at EMAIL.

Specific funding through the Kate B. Reynolds Trust and NC Office of Rural Health will provide for each County Coalition to address the issue of prescription drug misuse/abuse/diversion/overdose.

PROJECT LAZARUS

Thank you for attending our recent event. We would like to know about your experience so that we may continually improve the experience of our events. Please fill out the following survey and return it to Project Lazarus by mail or email. We appreciate your participation!

TOPIC	RATING				
	EXCELLENT	GOOD	FAIR	POOR	N/A
Overall, how would you rate this event?	☐	☐	☐	☐	☐
Please rate the following aspects of this event:					
Scheduling & Timing	☐	☐	☐	☐	☐
Food Services	☐	☐	☐	☐	☐
Parking & Directions	☐	☐	☐	☐	☐
Choice of Facility/Venue	☐	☐	☐	☐	☐
Ease of Access	☐	☐	☐	☐	☐
Comfort Level	☐	☐	☐	☐	☐
How would you rate your understanding of the information presented?	☐	☐	☐	☐	☐
	DEFINITELY	VERY	FAIRLY	NOT AT ALL	N/A
Based on your experience at this event, how *likely* are you to attend future events, workshops, and meetings? Please explain your answer.	☐	☐	☐	☐	☐
What was your favorite part of the event?					
What was your least favorite part of the event?					
	1	2	3	4	5
On a 5-point scale, with "1" being *no changes at all* and "5" being the *most changes*, rate your changes in attitude, understanding, or awareness concerning prescription drug overdose prevention in your community as a direct effect of this event.	☐	☐	☐	☐	☐
On a 5-point scale, with "1" being *not at all valuable* and "5" being *extremely valuable,* how valuable was this event for learning useful approaches and/or acquiring the needed skills to address the problem of prescription drug overdose?	☐	☐	☐	☐	☐
Please provide any comments or suggestions as to how we can improve our events in the future. Thank You!					

PROJECT LAZARUS

Thank you for volunteering at our recent event. We would like to know about your experience so that we may continually improve the volunteer experience at our events. Please fill out the following survey and return it to Project Lazarus by mail or email. We appreciate your participation!

TOPIC	RATING			
(OPTIONAL) NAME:	**(OPTIONAL) ADDRESS:**			
(OPTIONAL) AGE & GENDER:	**(OPTIONAL) CONTACT PHONE/EMAIL:**			
How did you learn about volunteering for this event?	**Advertisement** ☐	**Online** ☐	**Friend** ☐	**Other** ☐
How well organized was this event for volunteer involvement?	**Very** ☐	**Quite** ☐	**Fairly** ☐	**Not at All** ☐
How many days of volunteer work did you perform?	**<1** ☐	**1-2** ☐	**3-5** ☐	**5+** ☐
Were you satisfied with the number of hours you worked?	☐ Yes		☐ No	
Which aspects of the event were you involved with?				
Which of the following statements describes your satisfaction with the amount of work you were given?				
☐ I was very satisfied my workload.		☐ I was somewhat satisfied with my workload.		
☐ I wanted to do more work than I was given.		☐ I was overloaded with work.		
Were you satisfied with type of work you given?	☐ Yes		☐ No	
Did you feel that you were contributing to a good cause?	☐ Yes		☐ No	
Were you treated with respect by event leaders?	☐ Yes		☐ No	
What was your favorite part of this volunteer experience?				
What was your least favorite part of this volunteer experience?				
Please describe your overall volunteering experience at this event.				
Please provide comments and suggestions as to how we can improve the volunteer experience and events in the future.				

PROJECT LAZARUS

Thank you for being part of our coalition. We have missed your participation and would like to know about your experience with us so that we may continually improve our coalition and member experience. Please fill out the following survey and return it to Project Lazarus by mail or email. We appreciate your participation and feedback!

TOPIC	RESPONSE				
REASON FOR LEAVING					
What are your main reasons for leaving the coalition?					
Was there a particular incident or situation that led to your decision to leave? If yes, what specific suggestions can you provide for how we can better manage these types of issues in the future?					
What could we have been done to provide a basis for you to stay with us?					
What was most satisfying for you during your time with us? What was least satisfying or frustrating for you during your time with us?					
Had the opportunity been available, what do you feel that you could have done better or more for us? What extra responsibility would you have welcomed that you were not offered?					
How could the organization have enabled you to make fuller use of your capabilities and potential?					
TRAINING AND RECRUITMENT					
Do you feel that you were adequately trained, prepared, and developed for your role(s)? If not, what training would you have liked or needed to better perform your task(s)? Would different training have effected your decision to stay with or leave the coalition?					
Which training and developmental needs did you find most helpful and enjoyable?					
What improvements can be made to the way that you were given an orientation to the coalition?					
For recent recruits of less than 1 year: What do you think about the way you were recruited? How did the reality alter from your expectations when you first joined us?					
CULTURE					
On a 5-point scale, with "1" being *unacceptable* and with "5" being *excellent*, please rate the following aspects of our coalition meetings:	**5**	**4**	**3**	**2**	**1**
Scheduling & Timing	☐	☐	☐	☐	☐
Choice of Facility/Venue	☐	☐	☐	☐	☐
Comfort Level	☐	☐	☐	☐	☐

TOPIC	RESPONSE				
How would you describe the energy or 'feel' of the coalition?					
What can you say about communications and relations within your sector and other sectors? How can these be improved?					
What can you say about the motivation within the coalition? Does motivation need to be improved? If so, what suggestions can you offer for motivating members?					
How can the functionality of the coalition be improved?					
Do you feel that all members had a voice in the coalition? How can the coalition better gather information and use the views and experience of members?					
Did you find stress among coalition members? If so, how can the coalition reduce stress levels among members?					
Were you treated with respect from leadership?					
RETENTION					
On a 5-point scale, with "1" being *not at all* and with "5" being *very strong*, aside from the reason(s) you are leaving, how strongly were you attracted to committing to a long and developing relationship with us?	**5**	**4**	**3**	**2**	**1**
	☐	☐	☐	☐	☐
What can the coalition do to retain members?					
Is there anything you can say about your treatment from a discrimination or harassment perspective? Please explain.					
Would you consider joining us again or are you open to discussing the possibility of staying with the coalition?					
Overall, how do you feel about your experience with the coalition?	**Excellent**	**Good**	**Okay**	**Poor**	**Unsure**
	☐	☐	☐	☐	☐
Please provide any other comments or suggestions as to how we can improve our coalition in the future.					

If you would like to receive a follow-up phone call to discuss this Exit Interview and your experience with our coalition, please provide your phone number and the best time to reach you. Thank you for your time, consideration, and feedback!

Phone: _____

Time: _____

Meeting Agenda (Template)

Committee Name, Date, Location

6:00 – 6:15 Welcome & Introductions - Coalition Coordinator

- Minutes – accepted, corrected
- Announcements and Updates
- Report on Progress

6:15 – 7:00 Discussion on Topic 1 - Steering Committee Chair

- Item 1
- Item 2

7:00 – 7:30 Discussion on Topic 2 – Subcommittee Chair

- Item 3
- Item 4

7:30 – 8:00 Action/Outcome – Delegated Authority

- Preparation documents
- Vote to consider……..

8:00 – 8:05 Summary and Wrap-up

- Topics for next meeting

Next Meeting
Date, Time, Location

Minutes (Template)

Committee Name, Date, Location

Attendance: Name (Affiliation); Name (Affiliation)

Discussion Item	Action
Welcome and Introductions ▪	▪
Discussion Item ▪	▪
Discussion Item ▪	▪
Announcements & Updates ▪	▪
Summary and Wrap-up; Topics for next meeting ▪	▪

Next Meeting
Date, Time, Location

Submitted by: NAME

Sign-In Sheet (Template)

Committee Name

Date, Location

	Name	*Organization*	*Title*	*Email Address and Telephone Number (If new to committee or your information has changed, please list here)*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				

Membership Form Project Lazarus

Preferred Contact Information

Name (First, Middle, Last):		
Address:		
City:	State: NC	Zip Code:
Phone Number 1:	Phone Number 2:	Fax:
E-mail address:		

Current Employment (If Applicable)

Name of Organization/Agency:
Job Title:
Please briefly describe your job responsibilities:
The Organization is: ☐ Nonprofit ☐ For-profit ☐ Government ☐ Other
If other, please describe:

Demographic Information (optional)

Race/Ethnicity (Please check all that apply)

☐ Caucasian ☐ African American ☐ Latino ☐ Asian ☐ Native American ☐ Other:

Gender: ☐ Male ☐ Female

Please describe your past involvement with the coalition.

☐ Not applicable. I am a new coalition member.

Please describe your current involvement with the coalition.

☐ Not yet applicable. I am a new coalition member.

Please describe your involvement with other community-based organizations and efforts.

Skills, interests and experiences that help support the Coalition's work (please check all that apply).

- ☐ Strategic Planning
- ☐ Public Speaking
- ☐ Media Relations
- ☐ Youth Engagement
- ☐ Administration
- ☐ Multi-lingual. Please list language(s): _____
- ☐ Foreign Language Translation
- ☐ Community Outreach
- ☐ Grant Writing
- ☐ Evaluation/Assessment
- ☐ Graphic Design
- ☐ Other: _____
- ☐ Event Planning
- ☐ Data Collection/Research
- ☐ Data Entry/Transcription
- ☐ Data Analysis

How much time are you willing or able to contribute to coalition activities? _____ hours/week

Other comments?

Primary Areas of Interest

(see below for more information, check all that apply)

SPOKE AREAS

- ☐ Provider Education
- ☐ Hospital ED Policies
- ☐ Diversion Control
- ☐ Pain Patient Support
- ☐ Harm Reduction
- ☐ Addiction Treatment
- ☐ Community Education

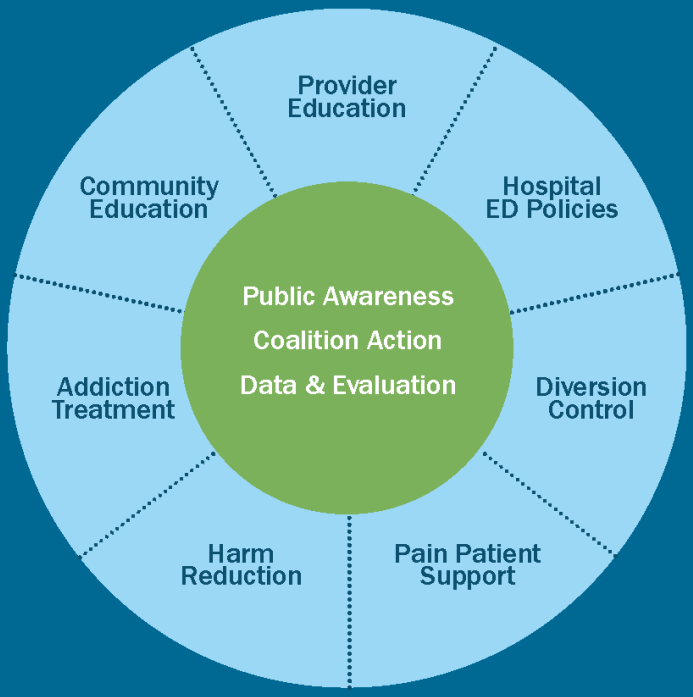
HUB AREAS

- ☐ Public Awareness
- ☐ Coalition Action
- ☐ Data & Evaluation

Thank you for your time, support of and commitment to the prevention of prescription drug misuse/abuse/diversion/overdose in our community!

PROJECT **L A Z A R U S**

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 Spokes) which can be initiated based on the specific needs of a community.



THE HUB

Public Awareness of the problem of overdose from prescription opioid analgesics.

Coalition Action to coordinate all sectors of the community response.

Data and Evaluation to ground a community's unique approach in their locally identified needs and improve interventions.

THE SPOKES

Community Education to improve the public's capacity to recognize and avoid the dangers of misuse/abuse of prescription opioids.

Provider Education to support screening and appropriate treatment for mental illness, addiction, and pain.

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Pain Patient Support to help patients and caregivers manage chronic pain.

Harm Reduction to help prevent opioid overdose deaths with the antidote naloxone.

Addiction Treatment to help find effective treatment for those ready to enter recovery.

Project Lazarus Spoke Descriptions

Spoke #1 - **Community Education**
Education is almost always the first response to address public health problems. While it is indeed an important strategy, the goals and objectives should be carefully defined. The line between awareness building and education is not strict, but there are differences. Whereas the community *awareness* activities can be thought of as sharing information, the community *education* activities are about changing skills, behaviors, and norms to actually address the issue.

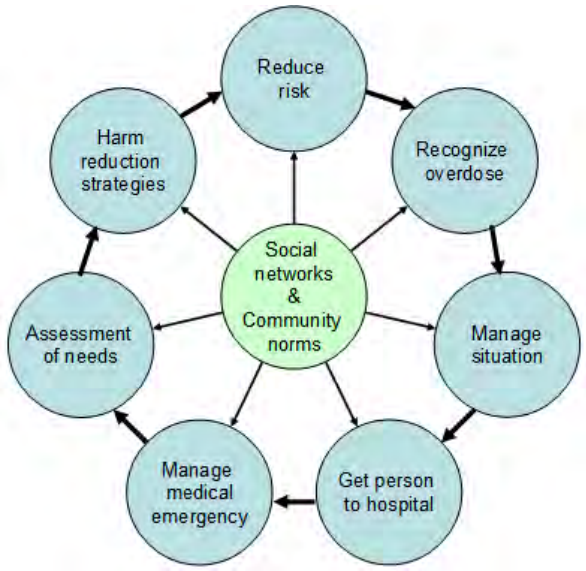
Spoke #2 - **Prescriber Education**
Chronic pain is recognized as a complicated medical condition requiring a substantial amount of knowledge and skill for appropriate evaluation, assessment, and management. Pain is sometimes treated in an emergency department with opioid-based medicine and often is not recognized as requiring pain-specific clinical expertise.
Prescriber education is most effective when provided by professional peers as opposed to concerned citizens. Members of the prescriber education sector group should include clinicians and they should work with other organizations offering continuing medical education to prescribers in the community to optimize their efforts. The local hospitals, statewide chronic pain organizations, local addiction treatment specialists, and local pain specialists are all examples of the kinds of resources that can support these efforts.

Spoke #3 - **Hospital Emergency Department Policies**
The emergency department (ED) is a source of many prescriptions for opioid analgesics. There are several factors that could increase the risk of adverse events in patients receiving controlled substances through the emergency department. Since there is no ongoing physician-to-patient relationship in most cases, the ED provider may not have readily available information regarding co-morbid medical conditions, other prescription medicines the patient is taking and possible drug-to-drug adverse interactions, or other patient factors that could increase the risk for overdose. There are also patients who exhibit “drug seeking behavior” and come through the emergency department, sometimes even multiple EDs, to get controlled medications either for unrelieved pain or because they have issues with dependence. For these reasons, it is recommended that hospital EDs develop a system-wide standard protocol with respect to prescribing narcotic analgesics.

Spoke #4 - **Diversion Control**
The majority of prescription painkillers used by teenagers without a doctor’s prescription come from legitimate prescriptions written for someone known to them. Pills being imported from other countries, gotten from dealers, or over the internet are considerably less common among young people. Because the way people get prescription drugs is different than illicit drugs (i.e. from a friend or family member vs. from a drug dealer or on the black market), the strategies for preventing access to prescription drugs must also be different. There are several main strategies, most of which require the involvement of law enforcement. One strategy is to reduce the overall supply of extra prescription medications available in communities for potential abuse/misuse/diversion/overdose. The ED policy points described above help in this effort. In addition, many people have medicine cabinets full of expired or unused prescriptions. Helping people to dispose of these medications in ways that are not harmful to the environment, as in flushing them down the toilet and into public water supplies, is a crucial piece of diversion control. For those controlled substances that need to remain in the home, locked storage containers can be made available and promoted. Another main strategy is to support capacity building among state and local law enforcement to identify, investigate, and prosecute illegal diversion activities. Promoting networking between law enforcement and local behavioral health and/or substance abuse treatment services is also an important strategy. The Crisis Intervention Team (CIT) model has been very well received in many communities.

Spoke #5 - **Pain Patient Support**
In the same way that prescribers benefit from additional education on managing chronic pain, the complexity of living with chronic pain makes supporting community members with pain vitally important. A factor that contributes to the complexity of the overdose situation in North Carolina is the overlap of pain patients who have previous or have developed substance use disorders. If people who have pain and people who have substance use disorders were separate non-overlapping groups, then an effective intervention might be simpler. However, whether the use of prescription drugs is legitimate or not is irrelevant when unintentional overdose deaths of all kinds can be prevented. No one deserves to die of an overdose no matter where the substance came from or why it was being used.

Spoke #6 - **Harm Reduction**
For people who, despite other efforts, are still at risk of overdose, overdose prevention can be conceptualized as a cycle including a series of stages where different actions are appropriate or effective at different times. At each stage there are opportunities to act and save a person's life. The actions that are appropriate and available are also influenced by "community norms" and by "social networks". An important harm reduction intervention is to equip people in the community with training and a medicine called naloxone to reverse overdoses.



Spoke #7 - **Expanding Access to Drug Treatment**
Drug treatment, especially opioid agonist therapy like methadone maintenance treatment or office-based buprenorphine treatment, has been shown to dramatically reduce overdose risk. Unfortunately, access to treatment is limited by two main factors: availability and accessibility of treatment options, and negative attitudes or stigma associated with addiction and drug treatment in general. Drug treatment options are underfunded in the US, and North Carolina is not an exception. Many people who seek help for their problematic drug use are unable to access treatment, encounter insurance barriers, month-long wait lists, programs that don't meet their needs, or programs they cannot afford. Regrettably, many people are only able to access drug treatment as a result of an arrest or criminal conviction. Advocating for increased funding of drug treatment and more qualified health care providers who are willing and able to provide these services can improve drug treatment access.

In addition to the possible logistical difficulties in accessing services, people with substance use disorders may not want to access drug treatment because of shame or fear of stigma. There is an increasing trend in people becoming addicted to prescription drugs; however, the community or individual perception may be that drug treatment is only for substances like alcohol, heroin, or cocaine, but not for prescription drugs. Community members and people struggling with addiction specifically need to be aware that there is a broad range of treatment options, including treatment for people addicted to prescription drugs which can be tailored to suit the needs of each individual. Additional advocacy work can be done to broaden the definition of drug treatment to include models of care that incorporate harm reduction principles and prioritize health, safety, and improving quality of life over strict abstinence.

Strategic Plan Template

Issue/Problem Statement:

GOAL 1:

OBJECTIVE A:

ACTION STEPS	TIMEFRAME	RESPONSIBLE PARTIES

Rationale for Selected Prevention Strategies:

GOAL 2:

OBJECTIVE A:

ACTION STEPS	TIMEFRAME	RESPONSIBLE PARTIES

OBJECTIVE B:

ACTION STEPS	TIMEFRAME	RESPONSIBLE PARTIES

Rationale for Selected Prevention Strategies:

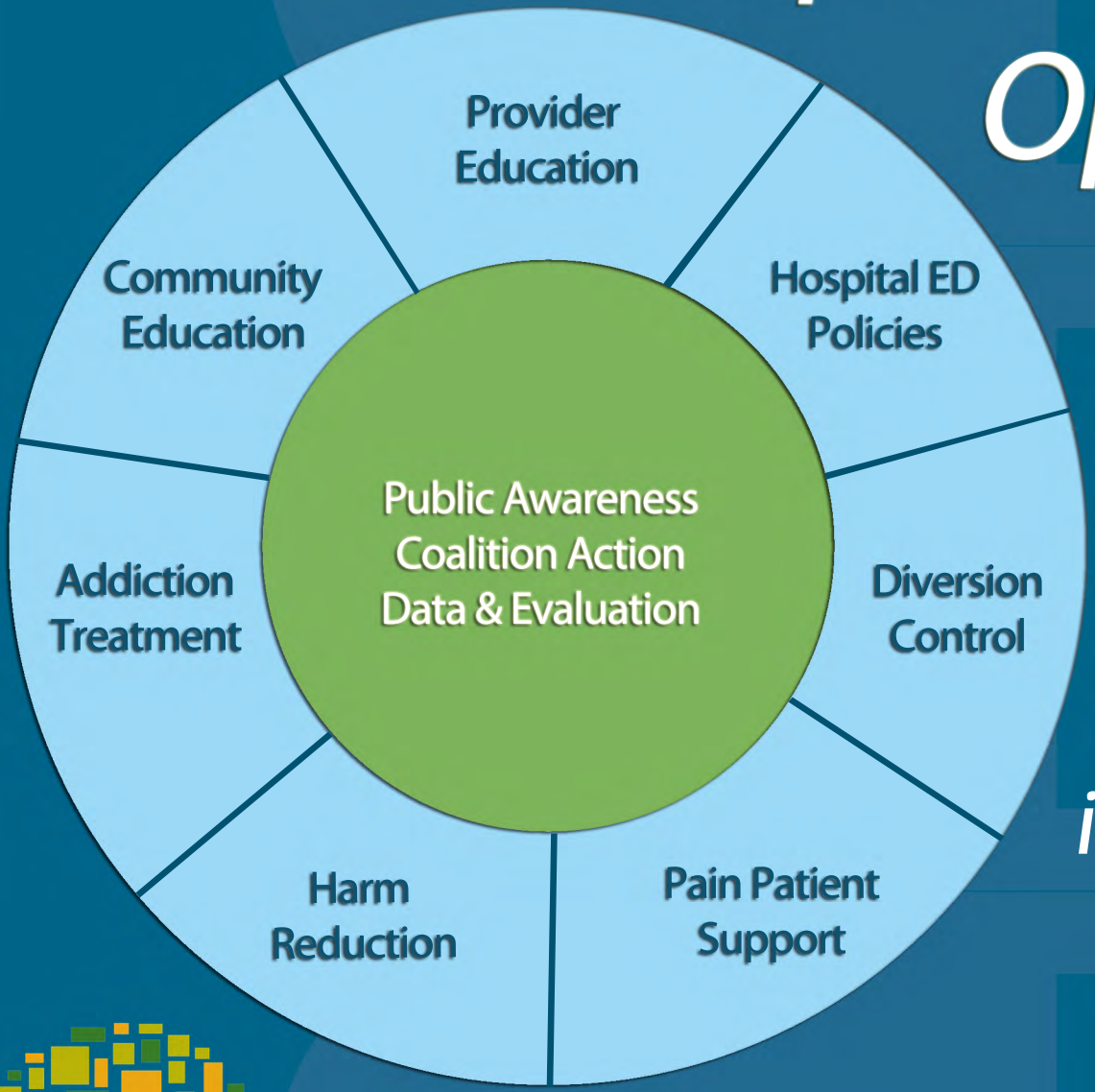
Section IV:

Project Lazarus Appendix

IV.IV Handouts

The items in this section of the appendix are available for download and may be printed and distributed for public awareness.

Prescription Opioid Overdose...



Prevent the Epidemic in Your Community Today!

PROJECT LAZARUS

projectlazarus.org

PROJECT LAZARUS

A Project of Community Care of North Carolina

PROJECT LAZARUS

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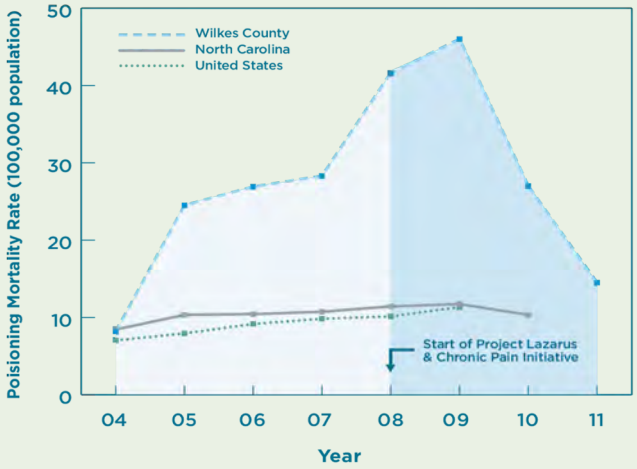
Poisoning Mortality Rate In Wilkes County, NC, & USA



The overdose death rate in Wilkes County dropped 69% in two years, after the start of Project Lazarus.

PROJECT LAZARUS

PROJECT LAZARUS
A Project of Community Care of North Carolina

PROJECT LAZARUS

Community Coalition Development

Stakeholders: These are the decision makers from key sectors that can assign resources such as personnel and finances to the coalition members. Examples include health directors, superintendents of schools, sheriffs, chiefs of police, directors of local substance abuse treatment facilities, heads of behavioral health services, hospital leaders, and physician leaders.

Community Forum: Stakeholders gather to share information with the broader community about the issue of prescription drug abuse/misuse/diversion/overdose in the county during a community forum. Forums are held, on average, 45 days after the initial stakeholders presentation. The forum serves two purposes: to raise awareness in the community and to draw the attention of other dedicated people who want to become part of an on-going coalition that drives those efforts.

Coalition Formation: The high level stakeholders should designate one person from each sector to be involved. The forum will have identified community members such as parents, teens, people in recovery, pain patients, and patient advocates. who would like to be involved, yet were not otherwise designated by the high level stakeholders. Together these interested parties form the coalition.

Steering Committee: This is the group of liaisons who have been delegated by each sectors' leadership, along with the most active of community representatives. The committee works closely with Project Lazarus in the establishment of the coalition and propels the ongoing work of the coalition after Project Lazarus pulls back. Steering committees should designate a Community Coalition Coordinator to maintain contact with Project Lazarus.

Sector Committee: Members of the coalition divide into sectors such as clinical care, public health, law enforcement, schools, and faith community. Each sector has one member from the steering committee. A series of workshops allow time for these sector groups to work through the primary goals and objectives for their sector and then report back to the coalition for discussion and alignment with the other sectors. Once all goals and objectives are finalized, it is the sector committee's responsibility to carry out objectives, strategies, tactics, and action plans in their specific environment. Members are also responsible for evaluating the results of their work in the specific sector in which they are involved.

PROJECT LAZARUS

Project Pill Drop

We Accept:

Prescriptions
Cold & Flu Meds
Pain Relievers
Cough Syrups
Topical Ointments
Vitamins
Pet Meds

Sharps Not Accepted

*Needles & Syringes Not Accepted

+1.336.667.8100 projectlazarus.org

PROJECT LAZARUS

Project Pill Drop

Take Correctly, Store Securely, Dispose Properly, Never Share™

Always keep medications stored securely and out of sight from children and guests.

Once a prescription has expired or no longer used, obscure any personal information on your prescription label with a black felt tip marker.

Dispose of the medication at the nearest "Project Pill Drop" container near you.

Project Lazarus Disposal Containers Near You:

+1.336.667.8100 projectpilldrop.org

PROJECT LAZARUS

Project Pill Drop

Take Correctly, Store Securely, Dispose Properly, Never Share™

Help avoid drug abuse by bringing your unused and expired medications to a disposal container in your area.

By taking appropriate measures to ensure that medications are stored securely and disposed of properly, we can be certain that prescription drugs and medications are not misused, abused, or diverted.

Unsecured and improperly disposed of medications are the number one source of access for children, teens, and by those seeking to abuse or divert, which can unintentionally lead to misuse and overdose.

What is Accepted?
Prescriptions
Cold & Flu Meds
Pain Relievers
Cough Syrups
Topical Ointments
Vitamins
Pet Meds

What is Not Accepted?
Needles
Syringes

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PROJECT LAZARUS
Prescription Medications:
Take Correctly, Store Securely,
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Medication Disposal Sites:
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