Opioid Overdoses Continue to Worsen

From “Emergency Department Data Show Rapid Increases in Opioid Overdoses” by the CDC, 3/06:

“Data from emergency departments (EDs) show that the U.S. opioid overdose epidemic continues to worsen, according to the latest Vital Signs report by the Centers for Disease Control and Prevention (CDC).”

“The report examines the data available to CDC on ED visits for opioid overdoses across multiple states. Overall, ED visits (reported by 52 jurisdictions in 45 states) for suspected opioid overdoses increased 30 percent in the U.S., from July 2016 through September 2017. Opioid overdoses increased for men and women, all age groups, and all regions, but varied by state, with rural/urban differences. The findings highlight the need for enhanced prevention and treatment efforts in EDs and for greater access to evidence-based opioid use disorder treatments, including medication-assisted treatment and harm reduction services.”

“Long before we receive data from death certificates, emergency department data can point to alarming increases in opioid overdoses,” said CDC Acting Director Anne Schuchat, M.D. “This fast-moving epidemic affects both men and women, and people of every age. It does not respect state or county lines and is still increasing in every region in the United States.””

“Data from 16 states in CDC’s Enhanced State Opioid Overdose Surveillance (ESOOS) Program were analyzed, showing quarterly trends by state and rural/urban differences from July 2016 through September 2017. Overall, ED visits for suspected opioid overdoses increased 35 percent in these 16 states hit hard by the epidemic. The data show:

- Eight states from three U.S. regions reporting substantial increases—25 percent or greater—in the rate of opioid overdose ED visits.
- Significant increases in all states reporting in the Midwest, including Wisconsin (109 percent), Illinois (66 percent), Indiana (35 percent), Ohio (28 percent), and Missouri (21 percent).
- Considerable variation among states in the Northeast and Southeast; some states reported substantial increases and others modest decreases.
- Continued rises in cities and towns of all types. Highest rate increases (54 percent) were in large central metropolitan areas (a population of 1 million or more and covering a principal city).”

“The sharp increases and variation across states and counties indicate the need for better coordination to address overdose outbreaks spreading across county
and state borders. Closer coordination between public health and public safety agencies can support identification of changes in supply and use of illicit opioids, further allowing communities to take appropriate action to reduce opioid overdoses.”

“CDC examined data from the National Syndromic Surveillance Program (NSSP) BioSense platform. Analysis of data from 52 jurisdictions in 45 states, which covers over 60 percent of ED visits in the U.S., found that from July 2016 through September 2017:

- All five U.S. regions experienced rate increases; the largest was in the Midwest (70 percent), followed by the West (40 percent), Northeast (21 percent), Southwest (20 percent), and Southeast (14 percent).

- Every demographic group experienced substantial rate increases, including men (30 percent) and women (24 percent) and people ages 25-34 (31 percent), 35-54 (36 percent), and 55 or older (32 percent).”

“The report noted the central role of state and local health departments in coordinating responses to opioid overdoses. Health departments can:

- Alert communities to rapid increases in overdoses seen in EDs and coordinate an informed and timely response.

- Increase naloxone distribution (an overdose-reversing drug) to first responders, family and friends, and other community members in affected areas, as policies permit.

- Increase availability of and access to treatment services, including mental health services and medication-assisted treatment for opioid use disorder.

- Support programs that reduce harms which can occur when injecting opioids, including those that offer screening for HIV and hepatitis B and C, in combination with referral to treatment.

- Support the use of the CDC Guideline for Prescribing Opioids for Chronic Pain which encourages using prescription drug monitoring programs (PDMPs) to inform clinical practice.

“Research shows that people who have had an overdose are more likely to have another. Emergency department education and post-overdose protocols, including providing naloxone and linking people to treatment, are critical needs,’ said Alana Vivolo-Kantor, Ph.D., behavioral scientist in CDC’s National Center for Injury Prevention and Control. ‘Data on opioid overdoses treated in emergency departments can inform timely, strategic, and coordinated response efforts in the community as well.’ ”

For more information about opioid overdose and prevention, please visit www.cdc.gov/drugoverdose.

---

Our Collective Influence

by Jeremy Levin, RWHC Director of Advocacy:

Every March we bring our Board of rural hospital CEOs together for RWHC’s annual retreat and ask them to invite another senior staff to join them. This annual five-hour session has taken different formats during my nine year tenure—from last year’s retreat with the co-chairs of CMS’ Rural Health Council to advocates coming to speak from national rural health organizations and some more traditional strategic planning sessions as well.
This year was a mix where we heard from Alan Morgan, CEO at the National Rural Health Association, sharing his thoughts about the present state and future of rural health; followed by four long-term RWHC Board Members from around the state who shared reactions they had to Alan’s presentation but primarily their thoughts about what they saw as the opportunities and challenges in their own communities; and we finished up in the afternoon with a strategic planning session led by Jo Anne Preston, RWHC’s Workforce & Organizational Development Senior Manager, where we addressed five strategic questions through a series of small group discussions.

As a senior staff member I led the discussion relative to “How do we take more advantage of the current attention to rural to further build upon our collective influence?” While much of my role was to facilitate and record participants’ thoughts, I found it my personal reflection to this question interesting as I worked to summarize the groups work.

Obviously, parts of this country and much of the world woke up on Wednesday, November 9, 2016 to learn about the collective influence that rural America can have, and I have written more specifically about this subject in this space before. While the increase in attention to the plights of rural America by the media and politicians has been important in policy discussions and decisions, the collective influence of rural America should seek parity, because residents of rural America are just as important as residents in urban and suburban America.

We live in an interdependent country with interdependent markets that rely on each other for the production and consumption of goods and services. Production of grain and livestock in rural America aide to consumption of nourishment in urban areas, and production of power and broadband radiate out from urban centers and need to connect us all for “a more perfect union.”

In Washington, DC, we have historically seen a bit of a divide where generally speaking, rural America has seen stronger bipartisan support on public policy issues from the U.S. Senate than the U.S. House of Representatives. This makes empirical sense since senators represent a whole state compared to parochial interests of a district or region that is based on pollution.

However, I can point to recent efforts and ongoing efforts in public policy unity and that is the scourge of opioid abuse that has overwhelmed this country, affecting rural and urban alike. Strong, collective, bipartisan action was taken with the passage of the Comprehensive Addiction and Recovery Act (CARA) and 21st Century Cures Act. In Wisconsin, RWHC is working with the University of Wisconsin to look at how we can work together to both train and educate clinicians on the best ways of combating addiction to opioids, methamphetamine and alcohol to help our communities, and also the best way to provide medical assisted treatment across our state.

Our efforts need to be collective in addressing addiction. I work in and represent rural areas of this state and live in an urban area; our workforce across the state is being weighed down by addiction. Our markets are interdependent, so to maintain the production and consumption of goods and services that we all rely on, we need to make sure that we all use our collective influence to solve problems that affect our broader communities.
Southwest Wisconsin Recovery Pathways

From Walter J. Orzechowski, Executive Director, Southwestern Wisconsin Community Action Program:

“Southwestern Wisconsin, a rural dairy farming region, has extremely limited resources to address the growing opioid epidemic. People do not have sufficient access to intensive treatment, nor do they have a place to go while they engage in the recovery process. Unfortunately, even those who do receive some treatment never recover and end up back in the emergency room, jail, or die from overdose.”

“The primary hospitals and medical clinics in Iowa and Richland counties have stepped up and begun to administer opioid addiction medications in support of the county-based substance abuse programs. However, the system of care for people addicted to opioids in both counties is not able to treat all people in need because of provider shortages. It is also not designed to support ongoing recovery. This means that even for those who do get some treatment, they are very likely to relapse and not recover from addiction.”

“With funding from a UW School of Medicine and Public Health Wisconsin Partnership Program Community Impact Grant Project and Administered through Southwestern Wisconsin Community Action Program (SWCAP), the Southwest Wisconsin Recovery Pathways initiative intends to fundamentally change how people recover from opioid use disorder and become healthy members of their communities. Strategies include:

- **Increase Medication Assisted Treatment capacity in primary care**—We will link to support and education for primary care providers (physicians and nurse practitioners) to improve capacity to support early care and ongoing treatment, with some providers obtaining addiction medicine certification or waivers.

- **Sober living/Recovery housing development**—SWCAP has abundant experience in acquiring and rehabbing housing. Setting up these living environments is of critical importance to the success of this recovery program, since addicted people often need to be removed from negative peer influences and triggers, and have a safe supportive place to be while in recovery.

- **Peer support specialists**—These positions would receive federally approved substance abuse peer specialist training. Peer specialists will be in daily contact with people living in sober living facilities and coordinate services and provide peer coaching, case management and accountability.

- **Early care**—We will help facilitate development of an early care (first critical 20-30 days) treatment workflow and protocol in each county. Peer specialists will be in contact with addicted individuals within the first 24 hours of being identified, often in local emergency rooms or jails, and will connect them with community services and treatment, including sober living and MAT.

- **Ongoing treatment**—Staff at county-funded behavioral health care facilities will provide appropriate ongoing substance abuse counseling and will work with peer specialists, drug court, and prescribing physician to coordinate patient/client care.

- **Wraparound integration and coordination with community programs and job training and placement**—Peer support specialists will link sober living clients to transportation, medical and mental health services, Narcotics Anonymous or Smart Recovery, economic supports, insurance advocacy, job training programs, volunteer and job opportunities, etc. Community Action Programs are particularly well-suited to be hubs for these wraparound services and case management.

- **Foster law enforcement and legal system change**—to reduce likelihood and impact of negative court/criminal records, which can follow people into recovery and limit opportunities to be self-sufficient and healthy.

- **Increase community support and reduce stigma**—increase capacity and sustainability of peer support groups and networks.”
A rise in opioid overdoses is detected. What now?

**Naloxone** is a drug that can reverse the effects of opioid overdose and can be life-saving if administered in time.

Medication-assisted treatment (MAT) for opioid use disorder (OUD) can aid in preventing repeat overdoses. MAT combines the use of medication (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies.

- Offer naloxone and training to patient’s family and friends, in case the patient has another overdose.
- Connect patients with hospital case managers or peer navigators to link them to follow-up treatment and services.
- Plan for the increasing number of patients with opioid-related conditions, including overdose, injection-related concerns, and withdrawal.

**Local Emergency Department**

**First Responders | Public Safety | Law Enforcement Officers**

- Get adequate supply and training for naloxone administration.
- Identify changes in illicit drug supply and work with state and local health departments to respond effectively.
- Collaborate with public health departments and health systems to enhance linkage to treatment and services.

**Mental Health and Substance Abuse Treatment Providers**

- Increase treatment services, including MAT for OUD.
- Increase and coordinate mental health services for conditions that often occur with OUD.

**Community-Based Organizations**

**Community Members**

- Connect with organizations in the community that provide public health services, treatment, counseling, and naloxone distribution.

**Local Health Departments**

- Alert the community to the rapid increase in opioid overdoses seen in emergency departments and inform strategic plans and timely responses.
- Ensure an adequate naloxone supply.
- Increase availability and access to necessary services.
- Coordinate with key community groups to detect and respond to any changes in illicit drug use.

Coordinated, informed efforts can better prevent opioid overdoses and deaths.

“Achieving Rural Health Equity”

From “Achieving Rural Health Equity and Well-Being: Proceedings of a Workshop” by the National Academies of Sciences, Engineering, and Medicine, 3/14/17:

“Rural areas have histories, economies, and cultures that differ from those of cities and from one rural area to another. Understanding these differences is critical to taking steps to improve health and well-being in rural areas and to reduce health disparities among rural populations.”

“To explore the impacts of economic, demographic, and social issues in rural communities and to learn about asset-based approaches to addressing the associated challenges, the Roundtable on Population Health Improvement and the Roundtable on the Promotion of Health Equity of the National Academies of Sciences, Engineering, and Medicine held a workshop in June, 2017. This Proceedings of a Workshop synthesizes the discussions held at the workshop, highlights the speakers’ perspectives on rural health equity and well-being, and provides an overview of showcased initiatives and approaches to meeting the particular challenges and opportunities in improving health in rural communities.”

The report is available at https://goo.gl/8M2WWH as a free pdf; below are “highlights and main points of final reflections made by individual speakers:

“The social determinants of health and [available] assets and resources can differ between urban and rural areas. Understanding and changing these root causes of disparities can help reduce those disparities.”

“Poverty plays an overwhelming role in generating challenges in rural communities.”

“The sparseness of the population in rural communities can make it more difficult to gather data and expand programs that address health disparities.”

“Despite their differences, many of the problems rural and urban areas face are similar, including problems of access, transportation, and education. The commonality of problems creates an opportunity for shared approaches to solutions.”

“Rural clinics, federally qualified health centers, community health workers, and telehealth are especially suited for rural areas.”

“Because of the role of poverty, linkages with people working on economic and community development can be particularly important.”

“The history of rural America is an integral part of the history of the United States. Both have been shaped by how the nation was formed, the influence of slavery and the confiscation of land, and the struggle against oppression. It is a living history, and America is a changing land.”

“Rural inequities are a superb example of the intersectionality of the factors that contribute to disparities. It is bad to be poor, even worse to be poor and a person of color, and even worse to be poor and a person of color, undocumented, living in a rural area with limited educational opportunities, and no access to transportation. We need to consider the whole person and the intersectionality of inequities when we think about how to address inequity.”
2018 County Health Rankings Released

From an email from the University of Wisconsin Population Health Institute, 3/14/17:

“Among many new features, an updated peer county comparison tool gives you another way to gauge the health of your community by selecting from a list of counties that are similar to yours based on key demographic, social, and economic indicators.”

Available at: http://www.countyhealthrankings.org

Leadership Insights: “Inheriting a Team”

The Leadership Insights series is by Jo Anne Preston, RWHC Workforce & Organizational Development Senior Manager. Back issues at www.RWHC.com.

“Most promotions to management roles come with a honeymoon phase of excitement, but the glow can dim when the realization hits that the team you inherited may not be exactly the team you would have chosen. Some specific challenges you may face:

1. They have been without a manager for a while, and don’t really think they need one now, thank you very much.

2. One (or more) of them applied for your job and did not get it.

3. One of them used to be in your manager position. They have stepped down from the responsibilities, but still hold a lot of influence with the team, and not always in line with your vision.

4. You have big ideas for growth and improvements, but the team sees no downside to the status quo of the past and no upside to changing.

5. The previous manager was beloved, and changing anything feels like you are criticizing a saint.

6. They are old enough to be your parents and it is a daily challenge to be taken seriously.”

“First, know that these are challenges you can face and address successfully, and you are not alone. Take a deep breath and remember that you were chosen for this role to lead. Leading takes courage so take heart! Whether you are just getting started with your new team, or you want a ‘re-start’ button, build your confidence and allow your team to see your leadership come through as you consider the following:

Apologize for actual mistakes, but not for existing. Reframe your thinking about guilt: ‘We are at work to work, so why would I need to apologize or feel guilty for asking people to do work?’

Ask for their help. You truly can’t achieve your department’s goals without their help, so ask for it. ‘I need your help to make this happen; can I count on you to ______?’ Get specific in your ask so people have the opportunity to be specific in their commitment, which helps you with accountability later.

Be both bold AND clear about your vision. Build a focal point for the future where people would desire to go. It helps guide your actions. Do today’s actions help you get there? If yes, great. Reinforce. If no, partner with the team to explore what correction/action will help.

Write up and share your ‘owner’s manual.’ We share this tool in preceptor training (email me for a copy). It is a simple questionnaire of, ‘Here are some things to know about my personality, my hot buttons, what works best in communicating with me, how I like to structure my day, my non-negotiables,’ etc.

Write a couple of sentences about how you want to be thought of in 10 years. Use it to guide your behavior, composure and attitude today. Post it where you can see it, or create a reminder text or email to send it to yourself. Ask a mentor to check in with you periodically on your adherence to it. Taking the long view in leadership will help in the short run tough times.

Address the elephant in the room, and then request to move on. The ‘elephant’ may be the
age/experience difference, or the other person wanting the job and not getting it.

**Remember empathy first.** Put yourself in their spot, acknowledge how it might feel to them. LISTEN to them. Then ask, ‘I want this to work for both of us. What can we do to move our relationship to a better place?’ We can’t demand a person move on from their feelings, but when we truly listen and make time for meaningful dialogue, we are allowing them to move on. Big difference.

**Remember change resistance is almost always about fear.** Share the sense of urgency (the why) of changing. Find a way to show what is in it for THEM. Reassure that you will provide the resources to help them be successful in the new way, and then do so.

**Give it time.** Use your frustration as a symptom instead of a driver. If you find yourself feeling frustrated, it is an opportunity to ask yourself, what are you taking personally that is not about you?

**Change your team members if you need to.** This is last for a reason. A whole new workforce team is not waiting for anyone these days. Work with what you have and coach to build and grow your people, an investment worth making! But if they cannot or will not ultimately go where you are leading, keeping them may be more detrimental to the whole team and will reflect on you if you continue to allow underperformance. Prepare by getting coaching yourself when you face this dilemma so that you can be ready for this tough conversation.”

Contact Jo Anne Preston for individual or group coaching at jpreston@RWHC.com or 608-644-3261. For info re the RWHC Leadership Series go to www.RWHC.com/Services.aspx or contact Carrie Ballweg at cballweg@RWHC.com or 608-643-2343.

**Upcoming RWHC Leadership Programs**
- 4/3 - Project Management and Team Facilitation
- 4/13 - Hiring the Right Person for the Job
- 5/16 - Peer Today, Boss Tomorrow
- 6/8 - Coaching for Performance

**Non-Members Welcome.** Register & other events at:
www.RWHC.com/Services.aspx

Space Intentionally Left Blank For Mailing