

1-10-2018

The Role of Rural Hospitals in Addressing Opioid and Other Substance Use Problems

John A. Gale

Maine Rural Health Research Center, Cutler Institute for Health and Social Policy, Muskie School of Public Service, University of Southern Maine

Follow this and additional works at: https://digitalcommons.usm.maine.edu/behavioral_health



Part of the [Community Health and Preventive Medicine Commons](#), [Health Policy Commons](#), [Health Services Research Commons](#), [Public Policy Commons](#), and the [Substance Abuse and Addiction Commons](#)

Recommended Citation

Gale J. The Role of Rural Hospitals in Addressing Opioid and Other Substance Use Problems. Presented at the Small Rural Hospital Transition HELP Webinar; January 10, 2018.

This Article is brought to you for free and open access by the Maine Rural Health Research Center (MRHRC) at USM Digital Commons. It has been accepted for inclusion in Mental Health / Substance Use Disorders by an authorized administrator of USM Digital Commons. For more information, please contact jessica.c.hovey@maine.edu.

The Role of Rural Hospitals in Addressing Opioid and Other Substance Use Problems

John Gale, MS

National Rural Health Resource Center
SHRT HELP Webinar
January 10, 2018

UNIVERSITY OF SOUTHERN MAINE

Muskie School of Public Service



Acknowledgements

Support for this work was provided by the Federal Office of Rural Health Policy within the Health Services and Resources Administration.

Learning Objectives

- Brief introduction to rural opioid and other substance use (O/SU) issues
- Socioeconomic drivers of rural O/SU
- Why should rural hospitals engage in O/SU initiatives?
- Component parts of an effective O/SU system of care
 - Prevention, Treatment, Recovery
- Importance of community engagement
- Hospital strategies and evidence-based strategies

Key Take Away Messages

- If you have seen one rural community.....
- It takes a village - Community engagement and involvement are central to addressing O/SU
- Hospitals can play a central role addressing O/SU
 - Community benefit/CHNA obligations
 - Leadership role in the community
 - An important population health issue
- Models must be adapted to the geographic, resource, and cultural realities of rural areas

Important Strategy Area # 1 - Prevention

- Opioid harms extend to all users not just those using heroin or misusing prescription medications
- Discourage/delay onset of O/SU
- Focus on children, adolescents, and young adults
- Minimize related high risk behaviors
- Strategies can be external and community focused
 - Community organizing and education
- Internal, quality oriented activities
 - Reducing supply of opioids prescribed
 - Use of prescription drug monitoring programs
 - Offer alternative pain-management strategies
 - Provide opportunities to dispose of unneeded medications

Important Strategy Area # 2 - Treatment

- Implement consistent O/SU screening for all patients
 - Screening, brief intervention, and referral to treatment
- Develop referral relationships with SU/MH providers
- Explore local treatment opportunities
 - Medication assisted treatment – buprenorphine
 - Integrated behavioral health/SU/primary care services
 - Specialty substance use services
- Collaborative treatment programs – hub and spoke
- Overdose reversal programs
- Develop alternative pain management programs
- Work with law enforcement to provide a treatment alternative to incarceration

Important Strategy Area # 3 - Recovery

- The third and often overlooked strategy to address O/SU disorders
- Provide support through programs or a structured milieu to support sobriety and substance free living
- Ideally, recovery begins before treatment
- Addresses social, rehabilitation, and vocational issues
- Provides a community to reinforce sobriety

Rural O/SU in the United States

- Overall rates of rural and urban O/SU are comparable
- At the sub-population level, variations emerge
- Past year alcohol, OxyContin, and meth use is higher among rural youth
- Rural 8th graders are more likely to use amphetamines, crack cocaine, cocaine, marijuana, and alcohol
- Rural youth first try alcohol at a younger age and have higher rates of driving under the influence
- Opioid use is higher among rural youth, young adults, women experiencing domestic violence, and in states with large rural populations
- Opioid overdose deaths are growing faster in rural counties

Socioeconomic Drivers of Rural O/SU



Barriers to Treatment in Rural Communities



Categories of Misused Substances

Categories	Examples
Alcohol	<ul style="list-style-type: none">• Beer, wine, malt liquor, distilled spirits
Illicit drugs	<ul style="list-style-type: none">• Cocaine, including crack• Heroin• Hallucinogens• Methamphetamines, including crystal meth• Marijuana, including hashish• Synthetic drugs, including K2, Spice, and “bath salts”• Prescription medications used for nonmedical purposes<ul style="list-style-type: none">○ Pain Relievers - synthetic, semi-synthetic, and non-synthetic opioid medications○ Tranquilizers and muscle relaxants○ Stimulants and methamphetamine○ Sedatives and any barbiturates
Over the counter drugs and other substances	<ul style="list-style-type: none">• Cough and cold medicines• Inhalants, including amyl nitrite, cleaning fluids, gasoline and lighter gases, anesthetics, solvents, spray paint, nitrous oxide

Rural Place as a Driver of SUDs

- Rural places suffer from a variety of health and socio-economic disparities
 - Greater sense of stigma
 - Higher sense of isolation and hopelessness
 - Lower education rates
 - Higher rates of poverty
 - Fewer opportunities for employment
 - Higher rates of chronic illnesses
- Influence of cultural, ethnic, religious differences

Why Should Hospitals Engage in O/SU initiatives?

- Problems are not limited to O/SUDs, but include many other health and safety problems
- Many patients treated for medical issues also have O/SUDs that complicate their treatment
- O/SU has serious economic consequences
- Tax-exempt and publicly owned hospitals have an obligation to address unmet community needs
- Rural hospitals can play an effective role in addressing O/SU
- It provides an opportunity for collaborative action by hospitals and community stakeholders
- It is the right thing to do!

A Public Health Model for O/SU

- Systematic data collection on scope, characteristics, and consequences of substance misuse
- Identify risk and protective factors for O/SU and factors that could be modified through interventions
- Collaborative efforts to address social, environmental, or economic drivers of O/SU
- Effective prevention and treatment interventions and recovery supports in a wide range of settings
- Monitor the impact of interventions on O/SU, related problems, and risk and protective factors
- Community leadership that mobilizes community organizations and resources to address O/SU

A Comprehensive Approach Is Needed

- Enhanced O/SU public education and demand for more effective policies and practices to address them
- Implementation of evidence-based prevention policies and programs to prevent O/SU and related harms
- Access to evidence-based treatment services, integrated with mainstream health care
- Recovery support services to assist individuals in maintaining remission and preventing relapse
- Research-informed public policies and financing strategies to ensure that O/SU services are accessible, compassionate, efficient, and sustainable

Prevention Strategies

Prevention

- Well supported scientific evidence for robust risk and prevention factors that predict O/SU use
- Evidence-based (EB) prevention programs effectively prevent initiation, harmful use, and related problems
- Prevention is cost-effective at different stages of the lifespan from infancy to adulthood
- Communities and populations have different levels of risk, protection, and O/SU
- Communities are an important organizing force for bring effective EB prevention programs to scale
- Key: Cross sector community coalitions to assess local risk and protective factors, O/SU problems, and implement EB interventions to match local priorities

Prevention

- Prevention is about the healthy and safe development of children and youth to realize their talents and become contributing members of their community and society
- Primary objective - Help people avoid or delay initiation into the use of drugs or to avoid developing disorders if they have already started
- Contributes to the positive engagement of children, young people and adults with their families, schools, workplace and community

Activities to Engage Communities

- Community Organization and Engagement
- Prescriber education and behavior
- Supply reduction and diversion control
- Pain patient services and drug safety
- Drug treatment and demand reduction
- Harm reduction
- Community-based prevention education

Evidence-based community organizing models

- Project Lazarus -
 - In all North Carolina Counties
 - In rural communities across the country - Project Bald Eagle, Williamsport, PA
- Project Vision, Rutland, VT
 - Uses a Drug Market Intervention model and community collaboration/engagement to reduce the supply of opioids
- SAMHSA'S Recovery Oriented Systems of Care
- Communities That Care

Key elements of effective community coalitions

- Understanding the community's needs and resources
- Widely shared and comprehensive vision
- Clear and focused strategic plan
- Diverse membership: key community leaders, local government officials, and volunteers
- Strong leadership and committed partners
- Diversified funding
- Well-managed structure: organized administration, effective communication among participants, and a comprehensive evaluation plan

Project Lazarus – Hub Activities

- Hub activities are central components supporting all other activities and reflect a community-based, bottom-up public health approach
 - Build public awareness of substance use through broad-based educational efforts and the use of local data to drive awareness
 - Coalition building and action to engage a broad range of community providers, agencies, and organizations
 - Identify data needs for planning and evaluation to build awareness, tailor programs to local needs, track progress, and sustain support and funding

Project Lazarus – Spoke Activities

- Spoke activities are optional areas of evidence-based prevention initiatives that communities can select and reflect a medical and law enforcement-based, top-down public health approach
 - Community education
 - Provider education
 - Hospital emergency department policies
 - Diversion control
 - Pain patient support
 - Addressing the consequences of use
 - Addiction treatment

Project Vision – Addressing Supply Issues

- Project Vision, Rutland, VT
 - Goals: empower communities, strengthen neighborhoods, help people, change the future
 - Committees: Crime/Safety, Substance Abuse, Community/Neighborhoods/Housing
 - Use a Drug Market Intervention model and community collaboration/engagement to reduce the supply of opioids (heroin and illicitly distributed prescription opioids) in rural Rutland VT

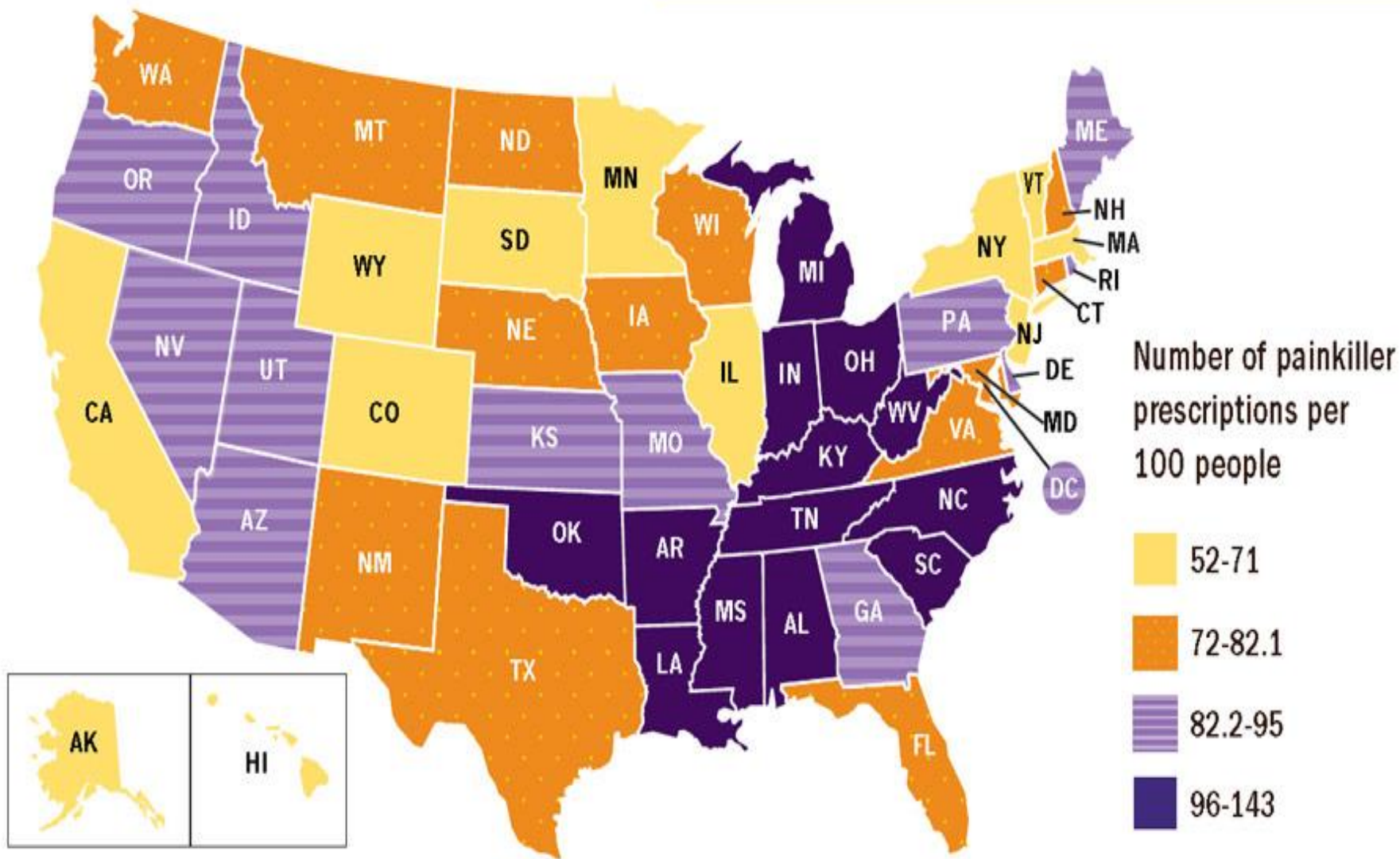
Community Based Prevention Education

- School-based education, including pledge cards
- Red Ribbon campaign - warnings not to share attached to dispensed prescription packages
- Billboard containing message against sharing medications
- Presentations at colleges, community forums, civic organizations, churches, etc.
- Radio and newspaper spots

Evidence-Based Prevention Models

- Helping Kids PROSPER)
- Strong African American Families-Teen (SAAF-T)
- keepin' it REAL Rural
- Madison Outreach and Services through Telehealth (MOST) Network
- 4P's Plus Pregnancy Support
- Spit It Out-West Virginia
- Mothers and Infants Sober Together
- Gloucester ANGEL Program
- Contingency Management Smoking Cessation in Appalachia

Some states have more painkiller prescriptions per person than others.



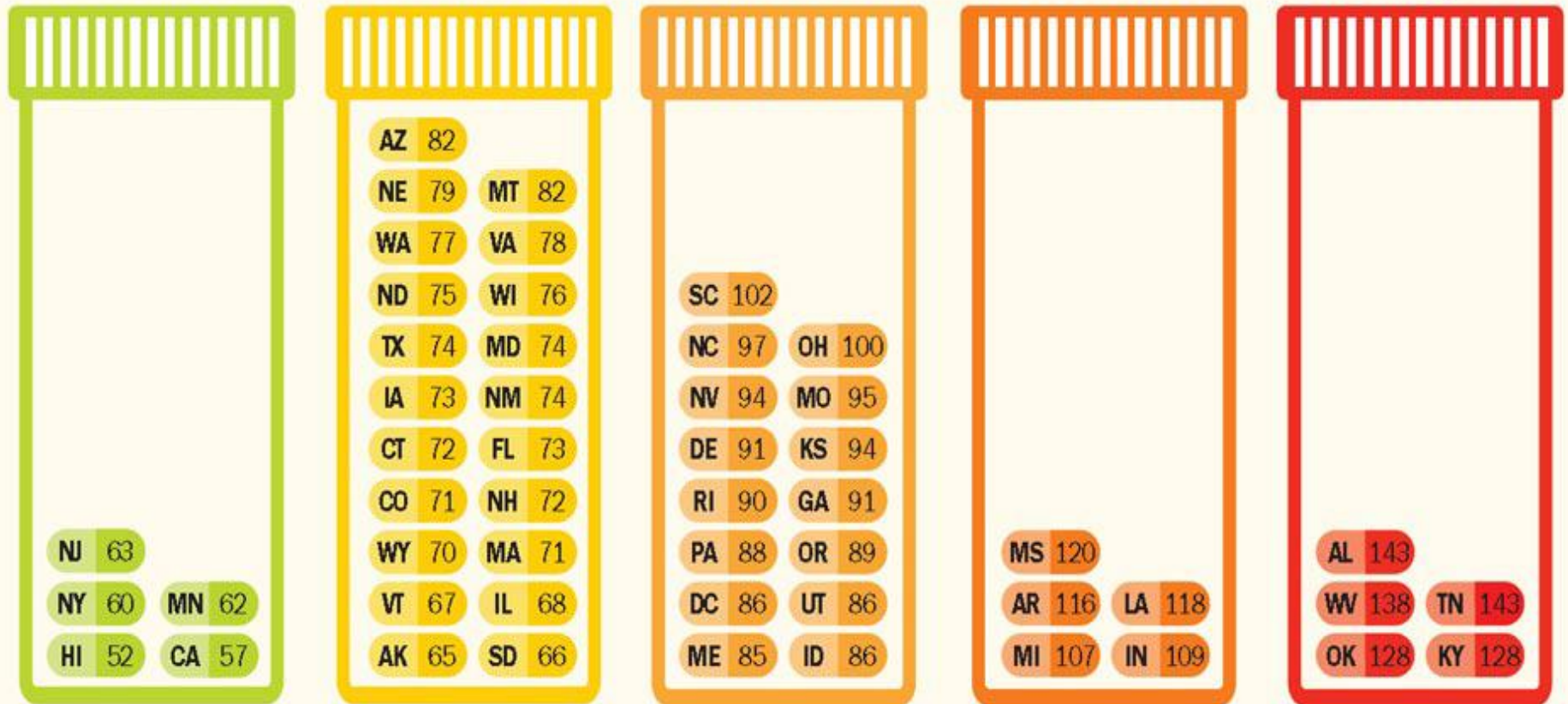
Health care providers in different states prescribe at different levels.

Number of painkiller prescriptions per 100 people

Lowest

Average

Highest



State Abbreviation

GA 91

Number of painkiller prescriptions per 100 people

Prescriber Education and Behaviour

- One-on-one prescriber education on pain management
- Continuing medical education on pain management
- Licensing actions against criminal prescribing
- Implement and monitor evidence-based prescribing guidelines among all providers
 - CDC guidelines, state programs such as Washington state
- **Strongly** encourage use of prescription drug monitoring programs
- Think about an “oxy free” emergency department
- Harm Reduction - Naloxone and Opioid user education on overdose prevention and response

Hospital Prevention Strategies

- Participate in community-based prevention programs as part of hospital's community benefit and/or community/population health initiatives
- Quality improvement: Focus on supply reduction
 - Prescribing guidelines
 - Encourage greater use of prescription drug monitoring programs
 - Use Project ECHO to support prescribing and pain management capacity of local providers
 - Implement an “oxy-free” emergency department
 - Engage in harm reduction strategies

Oxy-Free Emergency Departments

- Emergency departments are a significant source of opioid prescriptions and a frequent target for those seeking opioids
- Guidelines for emergency department prescribing developed by the Washington State Department of Health in conjunction with the Washington Chapter of the College of Emergency Physicians and the Washington Hospital Association
- Included limitations on the prescription of opioids in EDs and the concept of an “oxy-free zone” (in which the ED would limit prescribing of the class of drugs that include OxyContin and replacing lost or stolen opioid prescriptions)

Oxy-Free EDs (cont'd)

- Initiative has helped to reduce the rates of ED visits by “frequent users” seeking opioid prescriptions by individuals with low-acuity diagnoses
- Washington Medicaid estimated ED savings in their non-managed care population at \$33.6 million after admissions
- Evaluation shows that hospitals are pleased with this strategy but some experienced early reductions in patient satisfaction scores related to pain management

Evidence-Based Supply Management Programs

- Midcoast Maine Prescription Opioid Reduction Program
- Nevada Rural Opioid Overdose Reversal (NROOR)
- “Oxy-Free” EDs – McKenzie Health System
- Reducing Opioid Prescribing by Providing Pain Management Services- Salem Township Hospital

Midcoast Maine Prescription Opioid Reduction Program

- Implemented opioid prescribing guidelines for dental pain in two rural EDs in Maine
- Driven by ED chairman with input from physician group
- ED patients who request refills of controlled prescriptions, have multiple controlled substance prescriptions, or have multiple previous ED visits for painful conditions
- Guidelines recommend the use of analgesic alternatives such as nerve blocks and immobilization
- Results after 12 months - reductions in rates of opioid prescriptions and visits for dental pain

Nevada Rural Opioid Overdose Reversal Program

- Statewide partnership led by Desert View Hospital to improve access to naloxone and provide training for first responders and family off those at risk of overdose
 - Distributed naloxone to EMS agencies staffed only by basic-level EMTs
 - Enabled distribution of naloxone to at-risk individuals and family members
 - Educated healthcare providers on prescription drug use and abuse as well as legislative changes pertinent to prescribers
 - Provided public education and outreach about overdoses
- Results
 - 117 EMTs were trained on the administration of naloxone

Oxy-Free Emergency Departments

- Emergency departments are a significant source of opioid prescriptions and a frequent target for those seeking opioids
- Guidelines for emergency department prescribing developed by the Washington State Department of Health in conjunction with the Washington Chapter of the College of Emergency Physicians and the Washington Hospital Association
- Included limitations on the prescription of opioids in EDs and the concept of an “oxy-free zone” (in which the ED would limit prescribing of the class of drugs that include OxyContin and replacing lost or stolen opioid prescriptions)

Oxy-Free EDs (cont'd)

- Initiative has helped to reduce the rates of ED visits by “frequent users” seeking opioid prescriptions by individuals with low-acuity diagnoses
- Washington Medicaid estimated ED savings in their non-managed care population at \$33.6 million after admissions
- Evaluation shows that hospitals are pleased with this strategy but some experienced early reductions in patient satisfaction scores related to pain management

“Oxy-Free” EDs –McKenzie Health System

- The “oxy free” ED was developed in Washington State
- In February 2013, McKenzie Health System's ED discontinued dispensing narcotic and sedative medications for complaints of chronic pain
- Results – 60% reduction in opioid prescription abuse within a 12 month period and reduced utilization of unnecessary and costly diagnostic work-ups
- Staff met with community mental health officials, county health officials, local primary care providers, law enforcement, pharmacies to explain the initiative
- Engaged in patient education

“Oxy-Free” EDs –McKenzie Health System (con’t)

- Process:
 - Thorough medical exam to rule out medical emergencies
 - Review of patient's complete file, including internal health records, outside health records, drug screening tests
 - If patient presents with a chronic pain condition or suspected narcotics abuses, physician will inform patient of the dangers of narcotic drug abuse and may not prescribe a narcotic pain medication
 - May receive a non-narcotic pain medication and information about O/SU programs and /or pain management specialists
 - If a narcotic pain medication is prescribed after careful review by the physician, it is only for a very limited amount of pills, until the patient can be seen by his or her physician

Reducing Opioid Prescribing by Providing Pain Management Services

- Due to the limited availability of pain management services in rural communities, many providers rely on prescription opioids as a primary treatment modality
- Rural primary care providers often have limited experience with the management of chronic pain
- Strategies
 - Expand access to pain management services through contracts and/or telehealth
 - Improve the capacity of local providers to manage pain through use of program such as Project ECHO

Expanding Local Pain Management Services: Salem Township Hospital

- Salem Township recruited a pain specialist to travel an hour from Marion, Ill., twice a month to treat patients.
 - Considering expansion to three to four times a month.
- Patients are seen in one hour increments
- Provides trigger-point injections for long-term pain and promotes physical therapy and alternative treatments
- Patients continuing with opioids must agree to regular drug tests and not ask for early refills
- Over 3 to 4 months, only 3 out of 56 patients have chosen to stick with opioids
- Investment was minimal, at about \$25,000 for capital equipment

Telehealth-Based Pain Management Program: Martha's Vineyard Hospital (MVH)

- Due to its island location off Cape Cod, MVH worked with Massachusetts General Hospital's Center for Pain Management to offer a pain service via telehealth
- MGH providers see patients in a telepain clinic 3 days per month and conduct on-site visits twice per month
- Services include initial consults and follow-up visits
- Vital signs/patients notes are recorded in a shared EHR
- An RN, trained in physical examination of pain and medical management, performs patient exams under direct physician supervision via live videoconference and also verbally announced all findings

Telehealth-Based Pain Management Program: Martha's Vineyard Hospital (con't)

- Physical examinations are repeated by the physician during on-site visits prior to patient intervention
- Laboratory data and imaging studies are reviewed in the shared HER
- Over 13 months, 49 patients participated in 238 telepain video clinics and 121 on-site interventions
- Patients report reduced travel costs, improved access to care, and general satisfaction with the service
- Patients rated their satisfaction with care received by telepain lower than in-person visits and thought it harder to develop a relationship with the doctor
- This highlights the challenge of building a patient-physician relationship remotely

University of Washington's Telepain Program

- UW School of Medicine's Division of Pain Management offers a TelePain program to increase primary care providers' pain management & opioid prescribing skills
- Weekly videoconferences provide didactic presentations from the UW Pain Medicine curriculum, case presentations from community clinicians, interactive consultations with pain specialists, and the use of measurement-based clinical instruments to assess treatment effectiveness and outcomes
- Benefits include increased providers access to educational and consultative support for pain management, improved patient outcomes, and enhanced patient and provider satisfaction

Treatment Strategies

Provider Strategies and Treatment Services

- Rural residents deserve the same level of access to the full range of substance use treatment services as urban residents
- Substance use is a chronic, relapsing disease, rather than an acute, episodic condition
 - Requires ongoing level of services
 - Reflects a primary care-based system of care framework
 - Conserves resources by matching services to patient needs using a level of care criteria

Treatment and Access Realities

- Treatment access and completion is a problem
 - Less than 50% admitted to Tx complete
 - Over 50% discharged use AOD in the first year following discharge (80% of those within the first 90 days)
 - “Durability” (15% relapse rate) takes 4-5 yrs of remission
 - Professionally-directed, post-discharge continuing care can enhance recovery outcomes, but only 1 in 5 clients actually receives such care
 - Distance to services is correlated with treatment completion (longer travel distances are associated with lower rates of completion)

Barriers to MAT Treatment

- Poor coverage for MAT services – OTPs are cash only services in some states
- Services are often clustered around urban centers – requiring long travel distances for rural residents
- Many buprenorphine providers operate below capacity
- MAT services are not enough – substance use, mental health, care coordination are needed
- Greater attention is needed on what happens after treatment – peer support and recovery services are needed to reduce likelihood of relapse

Definition of a System of Care

- An integrated spectrum of effective, community-based services and supports for rural people and their families at risk for or struggling with drug and substance use challenges
 - Organized into a coordinated network
 - Builds meaningful partnerships with individuals and their families
 - Addresses their cultural and linguistic needs, to help them function better at home, in school, in the community, and throughout life.

Structure of Treatment Services

- Use of a regional orientation/model
- Reflects the realities of rural resource limitations
- Uses technology (e.g., telehealth, mobile phones, etc.) to address distance barriers and maldistribution of resources across urban and rural areas
- Integration across services systems:
 - Substance use,
 - Mental health, and
 - Primary care

Principals for Treatment

- Treatment must be available, accessible, attractive, and appropriate for needs
- Ethical standards must be adhered
- Requires effective coordination between the criminal justice system and health and social services
- SUDs should be viewed as a health problem rather than criminal behavior: users should be treated in the health care rather than the criminal justice system when possible

Principals for Treatment (cont'd)

- Based on scientific evidence and respond to specific needs of individuals with drug use disorders
- Should respond to the needs of special subgroups and conditions
- Should ensure good clinical governance of treatment services and programs for drug use disorders.
- Integrated treatment policies, services, procedures, approaches and linkages must be constantly monitored and evaluated

Screening for O/SUDs

- Screening, Brief Intervention, and Referral to Treatment
 - SBIRT is an evidence-based, universal public health approach used to identify, prevent, and reduce substance use disorders
 - All patients complete a brief screen (S) annually that assesses risk for problems related to substance use
 - Individuals at-risk receive a brief intervention (BI) by a medical professional on site. The BI addresses the individual's substance use and assists with establishing a plan to reduce use
 - When indicated, patients may also be referred to a specialty treatment provider for assessment (RT)

Pullman Regional Hospital Emergency Department

- A Critical Access Hospital in rural Whitman County in the State of Washington
- Active participant in a 5 year grant to implement SBIRT in urban and rural Washington settings
- Findings
 - Pullman screened 87.7% of patients receiving Medicaid funded health care at least 1 month in the year prior to SBIRT screening
 - Of this group, 10.3% received a brief intervention, 1.2% received brief treatment, 0.8% received a referral to treatment, and 14.4% had an unknown status
 - Facilities were generally successful at incorporating screening protocols into their workflows

Model Hospital-Based Treatment Programs

- Bridgton Hospital – Buprenorphine prescribing program
- Benefits
 - Lower regulatory/licensure barriers than methadone programs
 - SAMHSA prescribing waiver is comparatively easy to obtain
 - Can be integrated into primary care system
 - Gold standard of treatment for opioids
- Challenges
 - Buprenorphine alone is not sufficient to meet all patient needs
 - Can be difficult to incorporate into a busy practice without additional support
 - Linkages with bigger systems of care are needed

Bridgton Hospital Buprenorphine Clinic

- Coordinated efforts between Bridgton Hospital, North Bridgton Family Practice, Crooked River Counseling
 - Program has enrolled 200 patients in a rural Maine community
 - Started in 2009
 - Four physicians and two nurse practitioners prescribe buprenorphine in their primary care practice (North Bridgton)
 - Crooked River Counseling provides intensive outpatient counseling and group therapy for the patients
 - Bridgton Hospital provides comprehensive maternity care to women with OUD during their pregnancy
 - Services are interconnected and coordinated across providers
 - Key is the collaborative approach and communication

Nurse Navigator & Recovery Specialist Program

- Based in Western Pennsylvania, the program serves the residents of Armstrong, Clarion, and Indiana counties
- Consortium is made up of the Armstrong-Indiana-Clarion Drug and Alcohol Commission and 9 partners using a care coordinator/manager model to prevent and treat chronic illnesses related to O/SUDs
- Staffed by a Recovery Specialist and Nurse Navigator provider

Nurse Navigator & Recovery Specialist Program

- **Services:**

- Health and resiliency education Outreach Services
- Physical and behavioral health planning Case Mgt Services
- Substance abuse treatment services Recovery Support
- Wellness groups and therapy sessions

- **Results over three years**

- Assisted 364 clients with 2,433 client encounters
- Reduced ED visits each year
- Reduced clients with 1 or more hospital admissions
- Increased client's reporting positive perceptions of their health

Supporting MAT and OUD Services - Vermont

- Vermont's Hub and Spoke model supports the use of buprenorphine by primary care and community providers
 - Comprehensive care management
 - Care coordination and referral to local resources
 - Care transitions
 - Individual and family supports
 - Health promotion
 - Expands use of buprenorphine in primary care
 - Recognizes importance of mental health and traditional substance use services in treating opioid problems
 - Efficient use of scarce resources
 - Provides care in less stigmatizing settings

Vermont Hub and Spoke (cont'd)

- Regional specialty treatment centers serve as the hubs
 - Coordinate care of individuals with complex OUDs and co-occurring SU and MH disorders
 - Provide full range of OUD care and support community providers by providing consultative support to primary care and other providers prescribing buprenorphine
- Physicians prescribing buprenorphine and collaborating health and addictions professionals serve as the spokes
 - Dispense buprenorphine, monitor adherence to treatment, coordinate access to recovery supports, and provide counseling, contingency mgt, and case mgt services
- Funded through Medicaid waiver

Recovery Strategies

Recovery

- “Recovery is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life.” SAMHSA
- Four dimensions that define a healthy life in recovery:
 - Health - Managing one’s disease(s) or symptoms; making informed choices that support physical/emotional wellbeing
 - Home – Having a safe and stable place to live
 - Purpose – Participating in meaningful daily activities and having the independence, income ,resources to participate in society
 - Community – Engaging in relationships and social networks that provide support, friendship, love, and hope
- Hospitals can coordinate with local recovery programs

Recovery – Community Programs

- Does community create a supportive environment for recovery?
 - Stigma reduction – opportunities for a new start
 - Employment opportunities
 - Educational opportunities
 - Social, recreational outlets
 - Connection to cultural heritage
 - Twelve step programs
 - Peer support

Evidence-Based Recovery Programs

- Department of Veteran's Affairs – Peer Recovery
 - Recruit veterans in recovery to support those going through the process
- Australian mental health peer support
 - Goal – avoidance of unnecessary hospitalizations
- Turning Point Center, Rutland, VT
 - Part of the Vermont Recovery Network
- Supporting Peer Recovery: The RECOVER Project, Franklin County, MA



The Rural Health Research Gateway provides access to all publications and projects from seven research centers funded by the Federal Office of Rural Health Policy

Visit our website for more information.



Contact Information

John A, Gale, MS

Research Associate

Maine Rural Health Research Center

Muskie School of Public Service

University of Southern Maine

PO Box 9300

Portland, ME 04104-9300

John.gale@maine.edu

207.228.8246



Maine
Rural Health
Research Center