Caring for Women with Opioid Use Disorder Webinar
September 15, 2022 3:00-4:00 PM EST
Transcript

WEBVTT

All right. Thanks a lot.

Thanks. Everyone for joining. Can we go ahead and hop to the next slide? We'll get started with.

Thank you so much. Good afternoon and welcome to today's event on caring for women with opioid use disorder. My name is Nancy Mautone-Smith. I'm the director of the HRSA office of Women's health. This event was developed in collaboration with the Um HRSA's office of intergovernmental and external affairs in Regions three and nine, and is part of our

Women's Health Leadership Series. This event is being held in recognition of National Recovery month, which runs through the month of September

next slide, please.

So first a bit about our agency, and as you get to know us, please help us get to know you better by adding into the chat your name your organization, and where you're joining us from

the health resources and Services Administration or HRSA is an operating division of US Department of Health and Human services, and we support a broad range of programs to provide health care to people who are geographically isolated, economically or medically challenged. And every year person programs serve tens of millions of people, including people with HIV/AIDS credit, women, mothers, and their families, and those otherwise unable to access quality, health care.

This event is being held in recognition of national recovery. Month. A national observance held every September to promote and support new evidence-based treatment and recovery practices the emergence of a strong and proud recovery community, and the dedication of service providers and community members across the nation who make recovery in all of its forms possible

during today's event. You'll first hear about national Recovery month, and HRSA's work in Behavioral Health

from the HRSA Office of Special Health Initiatives, next HRSA's office of Women help will provide an overview of the caring for women with opioid use disorder, a toolkit for organizational leaders and providers that we rolled out in January of two thousand and twenty one, and then we'll move to a discussion on implementation of this toolkit in clinical and social

settings, by hearing from healthcare professionals from the Johns Hopkins University and Valley Health.

Next, I'd like to introduce Patsy Cunningham. Patsy is a behavioral health adviser at the Health Resources and Services Administration in the office of Special Health initiatives. In this role she provides advice and guidance

to HRSA the senior leadership on policy development and coordination for behavioral health issues that impact department of Health and human services at HRSA.

Patsy has over fourteen years experience in the behavioral health field, and she previously served as a supervisor. Public Health analyst for the Behavioral and Public Health branch in HRSA's Bureau of Health workforce

in that bureau. She was responsible for developing behavioral and public health policies and programs that improve health outcomes of underserved populations by increasing access to quality care, balancing the supply of providers and improving distribution of providers in areas with highest need.

Prior to joining us at herself. She worked at behavioral health systems, Baltimore, Baltimore's local Behavioral Health Authority, where she was a provider and consumer coordinator, and then promoted to the manager of the Compliance unit.

Patsy holds a Master of arts in mental health counseling, and is a licensed, clinical, professional counselor and a national certified counselor. Her clinical expertise includes serving minors with the history of trauma

out of home placements and involvement in the child welfare. System. She also has extensive experience, serving adults who were experiencing homelessness, had a dual diagnosis and were involved in the criminal justice system. We're so glad to have you with us, Patsy over to you.

Thank you so much, Nancy, and, as mentioned, my name is Patty Cunningham. I'm delighted to join this woman's leadership series with you all today uh for national recovery month, and just really excited about the presentation that you're over here. Um! I'll be sharing information on personal initiatives that are funded related to the behavioral health needs with the emphasis on their use disorders. But first I would like to focus more on Women's behavioral health next slide, please.

So more than one in five women in the United States experienced a mental health condition in the past year, such as depression and or anxiety in two thousand and seventeen data shows nineteen point. Five million females, aged eighteen or older, reported having used an illicit drug in the past year

so from one thousand nine hundred and ninety-nine to two thousand and seventeen, the death rate from drug, overdose among women, aged thirty to sixty four years, old, increased by two hundred and sixty percent

drug overdose deaths involving antidepressants, biodiversepines, cocaine, heroin, prescription, opioids, and synthetic opioids, all increased among women, aged thirty sixty four years old

the average age of death. For drug overdose deaths, increased by nearly three years. Overdose deaths are most common among forty five to fifty to fifty four-year-olds.

The current opioid epidemic has produced important differences by sex and gender, with increased rates of use in overdose deaths. In women. Significant mental health concerns for women include co-curance psychiatric disorders and suicide

expanded medication-assisted treatment for

perinatal opioid use disorder is crucial. So our effective treatments exist for opioid use. Disorders they are often not accessible and a minority of in a minority of patients are treated,

which, you know, HRSA is very instrumental in Um have targeted efforts to be able to address many of these challenges, as it's very important, not only for the health of women, but also for their family members over those deaths, continue to be ah unacceptably high and targeted efforts are needed to reduce the number of deaths deaths in this involvement of the day.

Next slide, please.

So, as mentioned, i'll be discussing some of our efforts here at HRSA that we are engaged in, and that we fund, in order to address many of the issues that I know that want to slap before this one.

So HRSA funds nearly one thousand four hundred health centers in approximately one hundred health center program. Look-a-like organizations totalling more than fourteen thousand service delivery sites and communities across the country

in two thousand and twenty one. Our health centers achieved a historic milestone of serving more than thirty million people. These health centers deliver comprehensive primary health care, including mental health and substance, use services to the nation's underserved individuals and families,

communities across the country in two thousand and twenty one. Our health centers achieved.

Excuse me, in two thousand and twenty-one um of the thirty million people served by the HRSA-funded health centers more than seventy million are female, which is about fifty, seven percent of the patient population.

Next i'll talk a little bit about our rural community's, albeit response program also referred to. Yes, same site also referred to as artwork.

And so our core was first launched in FY2018 as an opioid-specific initiative, and since that time it really has expanded to address other substances including psycho-stimulates and broader behavioral health challenges in rural areas

our current grantees have served forty seven States in two territories, reaching one thousand five hundred plus rural counties.

Our parents have a strong emphasis on strengthening behavioral health workforce in rural areas, and it also has opportunities where they're recruiting and training providers to treat patients with behavioral health, including SUD, Needs award recipients form multi sector consortium to implement a range of prevention, treatment and recovery activities that are targeted for unique needs of their families.

Our rural community's opioid response program. Neonatal Estimates syndrome program has a total investment of approximately twenty million dollars, and this program really focuses on reducing incidents and the impact of neonatal fastness syndrome. A drum withdrawal syndrome that occurs shortly after an effort is on in rural communities, by improvement, systems of care, family support, and social terms of health, by providing approximately forty community bases.

Next, which is very important. And Um honestly has been a topic of the conversation for the past almost year or more workforce development opportunities. We all understand that there are work for shortages throughout various systems, not like the behavioral health system, but a part of the work that hers is doing in our workforce

area is really looking at where there are shortages as well as looking at opportunities to improve, so as it relates to women's health. Our our 2023 budget proposes fifty million dollars to address these social determinants of health, which may in part include efforts to maternal mental health and address substance use disorders for pregnant, lactating, and post-partum individuals included in areas with significant, racial and ethnic disparities and maternal health

what caps

um. In addition,

we also have efforts through our national maternal mental health hotline, which was actually launched on Mother's day May eight of two thousand and twenty-two, and this is a national free twenty four hour Confidential hotline to support pregnant and post-partum individuals, facing mental health challenges, and their loved ones. So not only are the individual, the

the pregnant person able to and postpartum person able to access these services, but their family members are as well because I mentioned earlier. It's not only the individual, but also the family structure that is also impacted. When a woman has a substance disorder,

qualified counselors staff and um at the hotline provide support resources and referrals, both in English and Spanish, via voice and text. So people get the help they need when they need it.

They're also interpreter services available in sixty additional languages. Um. This hotline is staffed by counselors that are licensed or certified return on child health professionals, including nurses, doctors, mental health clinicians, students, certified peer support specialists, and those have been training and providing cultural, competent and trauma informed support.

Lastly, I want to mention our public health

Um approaches to Perinatal Substances The Association for Maternal and Child Health Programs, the Association of State and Territory Health Officials and HRSA maternal child. There are producing a supplement to the Maternal and Child Health Journal on Public Health approaches to Perinatal substances. This supplement will actually feature articles on policies and programs that address the needs of women with substance use disorders and their families during their perinatal period.

The supplement will feature a wide range of authors from community-based organizations State and Local Health Departments and academia. The deadline to submit the manuscript is October the first. If you're interested in submitting, please reach out to AMCHP.

Contact information, and other relevant links are located in the chat box, and I think that should have been dropped just now. So please make sure you connect to that.

So, um! As mentioned, Nancy mentioned, we had um other speakers who are going to be engaging with here today. I will be engaging with you all throughout this process, introducing those speakers, and then hopefully at the end, We'll have time for some facilitated discussion. But next I would like to introduce my colleague, Mr. Stephen Hayes, who's a Public health analyst in HRSA's Office of Women's Health,

where his portfolio includes behavioral health, violence prevention and response in American Indian and Alaskan native health.

He currently coordinates the office of women's health activities in support of the development of a new agency-wide strategy to address intimate partner violence and recently led an effort to develop a toolkit for HRSA-supported providers and their organizations to help them better meet the needs of women with opioid use systems,

Stephen. The floor is yours.

Thank you so much, Patsy, and if we can talk to the next slide,

an excellent overview of first investments in this space, and so i'm very fortunate to be able to share. Ah, a lot of work that's gone in the last two years, specifically focusing on opioid use disorder, and i'm especially excited today to be able to be kind of teeing up and leading into conversations that we'll have from experts in the field who are doing this work and and meeting patients where they are. I want to just also recognize our partners in regions nine and three, especially Dr. Nidhi Jain, Sarah Minnick, and Kara Pilote who have been absolutely instrumental in making this Webinar possible, and also our colleague, Ellen Hendrix, here within HRSA. wh we just hop to the next slide please.

Perfect. So today we're going to be talking as mentioned about this this caring for what we would use disorder toolkit. Um, i'm going to give a brief overview of the development of that toolkit. Spend a little time on the format of it. Highlight how to navigate it. And then we're going to dive into the three focus areas, or, as we call the pillars of the toolkit, which are listed on the slide here. Um, We also want to make connections today to National Recovery month, and to the HHS Overdose Prevention strategy, both of which are ongoing efforts

and really acknowledged areas of interest in learning more from you. And what you're doing in the field, and how we can support that work. We're especially interested in hearing about whether you've been able to use any of the resources included in the tool kit, but also, if you have any questions about them, so to be respectful of everyone's time, my email will be included in the final slide of this portion, so please feel free to reach out with any. Follow up questions. There

I have to to the next one slide, please.

Thank you. So

team up kind of where this work began for our office. Um to start. Obviously, this is universal baseline, opioid use disorder, as i'm sure most of us in the line are aware where we d, as a type of substance, use disorder people with a you misuse illegal, synthetic, or prescription. Opioids and opioids include drugs like heroin,

if not treated oud, can lead to addiction, health problems, or death. But fortunately there are also many treatments available for oud, including medications for opioid use, disorder or mOUD.

When we started this conversation with our partners across HHS. Um. And within HRSA, we use the data that was available to us then. So i'm going to sign some of that now, acknowledging that some of these things have shifted slightly. Um! But one thing that unfortunately is not, is that OUD Is not going and evolving public health crisis that disproportionately affects women, which is why it was a particular interest to whatever you age here with the person

available data at the time told us that deaths from opioid overdoses among women increased more than four hundred and seventy one percent from one thousand nine hundred and ninety, nine to two thousand and fifteen.

And compared to the already extremely high two hundred and eighteen percent increase among men at the time. Women were also more likely than men to receive prescriptions for opioids, to use them chronically, and to have prescriptions for higher doses as well as receiving prescriptions from multiple doctors.

And we also, in the data that was available to us at the time, saw very clearly that women we use. We're also progressing to dependence more quickly than men. As a result of a number of NIH-funded studies and experience more craving for, more like less so the need was very clear. The disproportionate impact was clear. And then on top of that, as it became available in early January the twenty-one, we were thinking through the impacts of the COVID-19 pandemic continues. Now, obviously, as we know, those have exacerbated the disproportionate impacts and also increased

overall. So we're going to talk a little bit about that today as well. I'm sure extending beyond just oud. But we also knew at the time, and know now that poly substance. Use especially stimulants and alcohol. Exacerbate these disproportionate impacts, and want to acknowledge that, as you forward with our conversation,

the last thing I want to point out here about the unique impact on women is that person. OWH Has a commitment to looking at women's health across the life course. So we are not focused on any particular point in a woman's life. We want to emphasize that by oud affects one of all ages, including adolescents, middle age and later years. Obviously it has the adverse impact on individuals who are pregnant, and also the complexities of substance. Exposed. Pregnancies are a priority for the agency work on. So, thanks for having the next slide

um

here with some background here, as you heard from Nancy, our director during her. So wh we sit in the office of the administrator, and a critical part of our charge, is listening and learning about patient realities, and then elevating those experiences to our partners. That's within HRSA. And beyond, so we can better meet the populations that we serve where they are, and that is a lot of what guided how to toolkit was, develop. Our office uses consultations as a vital tool, and how we are aware of what's going on in the field, but also identify areas for activity

and assisted by a contractor. We We further deployed that consultation-driven model to collect perspectives and feedback from subject matter experts and key stakeholders across the country, two of which we'll hear from today. Um. These we we had five consultation sessions over the course of eighteen months across the country, and those focus on describing me identifying key elements of coordinated care and providing feedback on the actual toolkit itself. I want to also kind of recognize the amount of time and generosity that went into that process.

So from subject matter experts across the country, folks extending from academia, community health centers, addiction, medicine, social services, patient advocate groups, state and local public health, and critically also individuals with live experience. We hope that's reflected in the nature of the toolkit and its accessibility.

The toolkit is intended to be a guide really to help health care and other social service Organizations and leaders provide and improve the care coordination from with oud in their settings. And so,

while it is targeted towards HRSA-supported settings. The principles laid out within it are applicable beyond those, and we also think that some of the resources in book. It can apply to your work with women with substance use disorder more broadly.

That's again recognizing here that only substance use is not new, and is an uncommon, and that the principles of harm reduction that we've described in this Toolkit, along with those of Treatment and Prevention, are consistent with an existing HHS overdose prevention strategy. Um. Lastly, on this slide we also recognize that oud continues to evolve,

so the broader context of substance use with stimulant use and poly substance use more generally continue to make up a broader context of the work in this space overall. And while this tool is focused on oud, we want to emphasize that its key takeaways are applicable beyond. Just so you, aside from one technical table, it's related to medications.

So, thanks hopping to the next slide. Then we wanted to kind of conceptualize it and guide ourselves in in theory and evidence before we embarked on the actual toolkit pieces.

And so what you see here is our conceptual framework or care coordination model, as we called it, to guide that process.

I won't go into too much steps in this but what I will say is that we recognize that if we were focusing on organizational and provider levels, it was critical that we acknowledge the structural barriers that

existed, and the external conditions that influence that so thinking about.

For instance, in in our consultations we heard a lot about the policy and payment context of care for women with oud, and how that can be a barrier.

Obviously that's something that as organizations and providers.

We are not necessarily positioned to address directly, but we also know that there's some things that stem from these structural factors or these external impacts that can positively or negatively affect our work thinking about the

COVID-19 pandemic we've seen that sometimes there's some been some positive effects, and how we can do this work with telehealth waivers and similar flexibilities. but also an exacerbation of barriers

obviously so, the real takeaway from this is emphasizing our focus on placing women and their their networks at the core of the work that's going on in this area.

So, thanks hopping to the next slide. we've talked a little bit about the context of the toolkit.

So delving into it here. the front of the toolkit is designed to kind of set the tone of how you can. use this resource.

We want to emphasize that we recognize folks before the the pandemic.

We're already experiencing a lot of ta for fatigue, and that was a real focal point of our consultations with folks who were the intended and users of this toolkit, and the way that we were encouraged that

we could kind of navigate around those things whereby leveraging things like these icons that you see here for tools and key takeaways, but also the document itself.

When you access it as a pdf, hyperlinks between these sections and recognizes that folks aren't going to come to a particular section, having read the preceding ones.

So one thing that i'll emphasize is we get to sort of the the focal points of the toolkit itself is how it is referential of recurring themes, and those themes are reflected in

the 3 key pillars we talked about of shifting the culture around.

Addiction treatment of meeting women where they are, and of developing partnerships to bolster supportive services.

We really want to emphasize here also that stakeholders kind of carried with us along the way.

The fact that kind of trying to oh, be overly specific in our descriptions of some of the things that are achievable in certain settings is makes it a less approachable document.

So we do speak in some terms that might be a little bit more general here, but it's in an effort to make it so that they can be more applicable in in different settings, and also critically have community input to tailor them rather

than us telling folks how to tailored a community if that makes sense.

So hopping to the next slide. The practical tool that you see here is on page 40 of the toolkit.

Actually, this is a self assessment for organizations and providers.

We think it can be useful to start with this self-assessment.

It's divided again into those 3 pillars of this this work here in the focus areas.

It also is a good way to kind of level set around language within an organization even, and ensuring that folks are understanding terms to mean the same thing when they're using them, which is a disconnect.

We heard a lot about during our subject matter expert engagement.

We encourage you to consider starting with the self assessment and reviewing the tools that might be your lowest scoring section and reviewing the additional resources.

But we also recognize that it can help, quickly identify parts where you might have strengths right now that you can continue to bolster in your work.

Since this self-assessment was created specifically for the toolkit, we recognize that it might not be a clear metric for broadly evaluating your progress in all of the areas, So if you go to page 42 of

the toolkit. we've included some accepted metrics that exist right now for monitoring evaluation purposes.

We were trying to be purposeful also, so that you could track and report back on your successes to different different audiences.

Those metrics might be things that you're familiar with already, or that you could integrate into your existing monitoring schedules. so pivoting now to the 3 pillars on the next slide please, Thank you the first as I mentioned was

shifting the culture around addiction and treatment and so I want to emphasize here that this this is purposefully place is the first pillar that I'm sure that's not a surprise to those on the line but the feedback that we got

consistently around all the variables that unfortunately, many of us are familiar with working in this space around stigma, around a lack of access because of structural barriers, absence of transportation, or just folks having a sort of internal

shame about being able to access services all stemmed from how it is that we talk about, and how it is that that affects what we do in addiction, medicine, and treatment.

There so real thing that is reiterated throughout the toolkit, no matter what resource you're looking at, is the importance of recognizing, how we can treat substance us as a kind of medical disease and how it is not a

moral failing. it is something that requires treatment, and also the treatment in the case of Oud, in particular, exists.

That is effective, and we have a lot of evidence to bolster that the tools in this section included addiction as a chronic medical disease and Evidence-based treatment Options for opioid use disorder.

These use a key takeaway and myth versus fact, format as well as a guiding table with an overview of mOUD that's available in prescription and we're excited to see also how this resource

again that was rolled out in early ‘21 is still consistent with principles in the overdose prevention.

Strategy, especially under the treatment wing, thinking about broadening access to evidence-based care that increases willingness to engage in treatment, but also increasing the uptake of evidence-based treatment, delivery, improving engagement, and retention, and

care we'll we'll talk about themes from this pillar and the other one. So if we go to the next slide and look at our second pillar of engaging with what we would use to disorder and care

The this is one that had kind of the most kind of like recurring thought and discussion about in terms of how it is that we ensure that our patient visits, our effective starting points or continuation points for getting into care or at a minimum

meeting folks where they are in terms of what their needs are in that moment. One thing that will probably not come as a surprise, though, is that trauma informed care strategies kind of carry through the importance of doing those things anyway, so they

are front and center and sort of the description of the resources that exist within this section.

Those tools include strategies for organizations, to provide trauma-informed care navigating first appointments with women, with oud and engaging women's support systems, recognizing that folks are You know parts of

networks. they're not necessarily modelists this also uses, the key takeaways and strategies and tip highlight boxes, section as well as a focus focal points for providing organization leaders to work on making their organizations more

responsive to individual needs. We We also know that there may be something that presents kind of as a most urgent clinical item in a clinical visit.

But if something like custody or experiencing violence, or any other in cute and condition are the most important things to a patient that's where we need to start to meet with them, so the resources in this section kind of talk about

how organizations can do that have providers can. And here again a connection to the existing overdose prevention strategy in enabling access to and encouraging use of integrated recovery support services under the recovery services

umbrella, and also working on the treatment piece.

But so, as we pivot to what it is that makes these supportive services and other wraparound services possible, we go to the last section here on the next slide of the toolkit, which is about creating a maintaining

partnerships and so we're gonna close on this thought, because deepening and expanding the service is available to our people through meaningful collaboration with other units, teams, and organizations, is something that's

achievable within our own organizations and with other partners in our area.

And this is something that is true at the Federal level, and all the way down to the local level as well.

The tools in here emphasize something that We've seen very clearly before, but especially in the context of COVID-19.

That public health is truly in everything, and then addressing substance, use, or any priority area requires extending our expertise and capabilities to partnerships in our communities.

So the tools in here are designed to help create meaningful and lasting and engage relationships with partners in your community, and uses examples from a home visiting program as well as other examples of partners to consider that might be outside of the sort of

traditional public health unless it's referred to sometimes but from a HRSA Wh. perspective to close here. We also wanted to kind of emphasize it, you know, as we have tried to convey throughout the toolkit

and hope that you've seen in your application of it in the field people are more than their conditions, and their strength and needs are not always immediately apparent, but the infrastructure needed to support them.

Certainly doesn't exist in any single place regardless of what those needs are, and we can always be doing more to help connect those necessary services and partnerships.

For instance, as this section of the toolkit focuses on are more than just warm handoffs, it's an ongoing and dynamic process, we hope that this is something that makes it easier in your settings and that we can

be a partner to you, moving forward. So on the last slide we have my contact information again.

The slides are being dropped in the chat as well.

Please feel free to reach out with any questions or comments and we welcome that kind of engagement going forward.

I'll pass it back to Patsy for excellent other speakers.

Thank you. Thank you so much. Stephen. Our next speaker is an expert in the field.

Dr. Michael Finger Hood, Dr. Fingerhood is a professor of Medicine and Public health at Johns Hopkins University, and Chief of the division of a addiction medicine that John's Hopkins Baby Medical Center the Mission of his career has been

to promote and improve the provision of medical care to patients with substance use disorder, with the development of innovative programs related to care of these individuals in 1994 that Fingerhood created the comprehensive care practice, a primary care practice largely devoted to providing care to individuals with substance use disorders.

Dr. Pinkonite, thank you so you're gonna hear from me.

How much I enjoy taking care of patients. I hope and i'm gonna I do this by introducing you to one of my own patients, and try to convince you how the toolkit is used whenever we provide patient care next

slide Bye, This is a a woman I met about 2 years ago is actually a probably in the fall of 2,020

She's 28 year old woman seen for her first visit she had multiple emergency department visits for back pain one opioid, overdose, and many fill prescription foxy code on for many providers that I could

see through our pdmp, where we can look at fill prescription drugs, and I don't know perhaps more.

3 years ago. History of Hiv, and I do hiv care as well, not on medication.

Hypertension, and then I I want to emphasize.

The red is ways to think about applying the toolkit so unemployed lives at home with a 2 year old daughter, so she has an obligation there.

So that's that factoring how we think about providing her care, and has insufficient access to food.

And I I want to say this is something we should be asking, and I I I am sure that it's very few providers, primary care settings.

You specifically ask about access to food and something that we need to get better at.

So we need to get better at looking at social insurance of health.

And realizing how much these things impact someone's health especially as they may choose whether to buy food or a Copayan or prescription.

For example. her agenda was getting a script.

Fox, and my agenda was building rapport again in red.

Get here engaged in medical care. I think that we're engaged is a two-way street, which we'll talk more about initiating treatment for open use.

Disorder. So I want emphasize that when someone is in front of you I call them touch points right?

So you never wanna feel that you missed the touch point.

So I had X, you know, at conversation with the patient, that I could potentially assume the setting of Fentanyl in 2,022 to 20.

In this instance can save their life, and I know that in order to provide her Medicare. I have to be able to address her social needs and find ways to give hope, and and I think that's a common theme like one of the

slides mentioned to giving hope next slide so i'm gonna fast forward, and then we're gonna fill in some of the gaps, too.

So after 4 months i'd say there 7 times and 2 of them were telemedicines.

Remember she had a 2 year old child, so transportation may cost something if she comes to see me at that point she couldn't come with her 2 year old child to a medical visit, and might not be feasible so telemedicine

is a great way to make visits convenient for women.

You may have children at home and and she felt engaged in care.

And we're gonna talk about what patients what makes patients feel like they're engaged.

She's in recovery. She was treated medication the office setting with people north in locks home, and the road recoveries in red, and and I just what the way it is to recovery.

And I point this out to patients is i'm try to convince patients that recovering means making today better than yesterday.

And you'll hear more about the word but never use the word clean i'm gonna medication for hypertension. she's here.

It's a medication for hiv by a load is on the tech school.

She had a pact time and no emergency visits so.

But the real measures success. Besides, those were she self-described to remove itself.

Its team as much improved that relationship with family we're gonna talk more about that.

I actually, can provide food at medical visits she meets with our pure recovery coach. you'll see the discussion of peer recovery coaches in the toolkit, and, in fact, I think they should be an essential

part of most primary care clinics, and we were able to coordinate clear care with her in order to get her food assistance as well with food stamps and she's working part time bye so I I this is one

of my favorite paintings and this was edwin munch, who battled himself alcohol's disorder, and it it his original name for this painting was despair, and and I see the heading overcome

despair. So i'm gonna offer to you that for many of us. We're actually the person in the front, as we try to take care of so many patients desperately need that our patients are actually the ones.

If you look in the water in the midst of an abyss that they don't know with how to escape, and we need to help them get out of that of this.

And I I I now you sometimes view that the person who's looking at that railing who may jump into the business.

Perhaps the next person in our waiting room next slide a few years ago, with some medical students we decided to do a qualitative study, asking 2 related questions that are slightly nuanced, and i'm going to go quickly so what we asked

was one. What should providers expect from their patients with addiction?

The the and then we did analysis, and we tried to come up with themes, and it turns out to be not difficult to come up with unifying themes.

And still down to 2 things, the desire to receive care that would improve health and engagement and care based on trust and rapport. And And

This was mentioned over and over again, so it was really easy to come up with these 2 distilled answers.

Now the next slide shows a slightly different question, which is what you patients with addiction need from their providers.

A user. Yeah, there was a little bit more variation, and I included all 5 of the most common, and these were really at the forefront.

So they really wait above most other themes. And they really inform a knowledge about addiction, a duty to treat so pretty.

The the patients use this term a duty to treat right that we're obligated to do this a focus on overall health, to engage patients and care again that that's on the toolkit, right engaging patients being patients where they are

patient-centered care, and treating the full scope of illness.

And these are the 3 terms that they used isolation, projection, and creating hope and isolation.

I think I I always want to point out that addiction is very isolating. and even though you may be using, and certainly you know, they're during covid people unfortunately are more likely to isolate news alone.

And that contributed to higher overdose deaths. But to to bring these to the forefront and discussion, I think it was really important.

Next slide the team. The 3 things I discussed with patients at first is shame, and and I bring this to the forefront. and and one of the reasons I bring to the forefront also even my patients, who are doing well

is because I'm afraid that if they're doing well and they have a slip that those that they'll be ashamed to tell me so.

I always discuss as I meet them, and I bring this to the forefront, and it's it's for poor building as well.

Next slide. Self-esteem is the second issue, and we work on this throughout.

At the time I take care of patients, and I think this is useful, Right?

You The best thing you do for yourself is stop using drugs the patient.

I don't deserve the best what else can I do and then we need to acknowledge that's where our patients frequently are, and it's it's a clear obstacle sometimes to recovery, and

again. Bringing it to the surface is really well. next slide, you know, the third piece which our patients will at work on forever is coping skills.

And there's so much to coping unfortunately even from a young age.

Many people through movies or commercials. Learn, for instance, that you can cope with stress by having a trank or going to happy hour.

But our patients have beyond that right so they're coping with It's a bit partner violence ptsd ask my patients how many of you seen someone who's died after an overdose almost everyone will say Yes, how

many have you. seen someone who's been shot how many of you know it's It's just the have seen somebody ha get assaulted.

How many have you been mugged? So all of that is in here, and anniversaries of the acting are also often a coping difficulty as well?

So we discussed this, and I and I always discussed it in a way that also at the end of this, is there anything you anticipate over the next few weeks that will create a obstacle to your coping and and we talk about it next slide. So recovery is about progression not perfection. and I think it's important for all this to realize right.

These are all components of recovery most of these words we've mentioned already, and we'll they're all of them are in the toolkit by self-direction patient center, and and one of the things I I always

say to patients, especially if they've gone to 12 step meetings. is that they may have heard the phrase within the 12 steps that they're powerless over.

You know they're drinking or yeah drug use but I I think that we have to be careful when we say that because recovery should give them empowerment, and the empowerment is to make their lives better to get help to be

in a, you know, healthy relationships to have the social terms of health improve.

So. And so I think all of these pieces are important.

Next slide. I just want to emphasize again.

I mentioned. 12 step meetings is we have to be careful because many patients, unfortunately, will get this message.

You're not recovery. if you're on medication and I discussed this with patients, and this can come from 12 step groups and family members come from friends, and I anticipate that at some point my patient's gonna hear

this from someone, and and we bring it. Have a conversation about how to respond.

That that medication, just like any other illness whether it be diabetes or something else is something that helps us, and we shouldn't view medication for obese to sort in any other ways.

Medication for hypertension or diabetes.

So So one of the goals i've always had is to try to help patients as much possible.

In one setting So we created a program. initially.

It was a program based out of Boston called Health Leads.

But then we created our our own program we'll help. this for the connections, and I I encourage people to be creative, and you really do have to do as much as possible couple to a medical visit.

So we have a Hopkins undergraduate students who get some credits.

As part of a course, and we have 16 of them.

This semester, for instance, and they they can help patients.

So I should also say through the Maryland Food Bank. we have a food pantry on site which, has been amazing.

We have different types of meals we had. We have food for people who have to different weight, depending if they have to take it on a bus or not.

We also have computer access, and we've teams up and been able to help directly help patients longer at their visit.

Sign up for things like Ids for food stamps for housing.

So a student will sit them with sit with them, and we have direct linkage into databases.

We've got ability to do some zoom nations and we are what's called * B.

To help with transportation. we've gotten through a lot of community activation and through seeking of grants and begging for help, ability to help people with things like transportation.

But fly transportation furniture we've teamed up with dentist, with teams up with a variety of things I mean every time we found something where we didn't wasn't sure how we could help

them usually found found a way and we we do this in a very deliberate way.

It's the the app actually the students can documents in our health record, which is really useful.

Next slide. I just wanted to point out. I only have 2 more slides.

That we did a study. So so one of the questions I think that people offered was, Well, can you show this is effective?

And and how do you find, for instance, having a pure recovery coach?

You have to make a choice of who you want in your office.

Right. We only need office staff and you have to decide Who's important. This is a study. We did where we looked at Medicaid.

Patients who received buprenorphine treatment, for in our primary care setting versus patients who receive primary care and treatment for for Ou d was people working in a different setting.

So Ccp. was our setting, Not Ccp. was not integrated.

Care. So I just want to point out. So our 6 one for attention is almost 80%. not.

Ccp. was that 60%. But what's important you looked at total cost of healthcare, and what we were able to get by and from the State to look at Medicaid data, and we were all this show So given cost.

Savings in overall healthcare costs right this doesn't even factory in you know other costs associated with not the continuing treatment for a big use disorder.

So it's it's beneficial not only to patient satisfaction, but also to health care system cost next slide this way in part of the toolkit is also fighting stigma.

I know there's somebody on this call from Boston Medical Center.

So we use this a little bit from them, like from Michael Botticelli.

We adapted it. you could actually go look at our worth matter, stigma, pledge, and I encourage wherever you are to consider creating your own pledge to fight them up.

Thank you. Thank you so much, Doctor Fingerhood. Next we will hear from another expert in the field.

Rachel Moreno, Chief of staff and Chief transformation officer, who has been with valley health for 6 months, focusing much of our effort on extending access to behavior, health and medication.

Assistant treatment and Valley Health Service area. Rachel is responsible for the operational oversight and development of select health centers and programs include in behavior.

Health, medication, assistant treatment, pediatrics, dental, and the woman infants and children programs.

Rachel received her bachelors in public health from Oregon, State, University, and masters in healthcare administration.

From Marshall University. Rachel over to you thank you so much, Patsy, i'm really happy to be here this afternoon, and i'm hoping I can share a little bit with you all about how we've applied this

toolkit at Valley Health, and also give some tips and recommendations.

If you're looking to start services or enhance the services that you currently offer, I know we could talk about this for hours. so if you have any questions, feel free to drop that in the chat or my contact information will be at the end, of

the slides as well. next slide a little bit about valley health so you can understand how we're situated.

We are federally qualified Health Center, based out of Southern West Virginia.

As you can see from the map, we have quite a few different health center locations spread across 6 different counties in West Virginia and one in Ohio.

We also border Kentucky. so we see patients from both of those States.

We offer a variety of service lines. Some of our health centers are fully comprehensive, and offer every service line.

Some may have primary care and dental but no mental health services.

For example, the service lines that we'll talk most about today are primary care and behavioral health, and recovery services.

Next slide, and 2021 to give you a little bit of an idea of the amount of individuals that we see, and the size we saw upwards of 88,000 unique individuals across our service area.

68% of our patients that are between the ages of 15 and 64 are women.

We have quite a large women's health program in our service. area, and I felt like that was pertinent to our discussion today.

About 54% of our patients are at or below 100% of the Federal poverty guideline which may speak to some of the additional needs of they have, or social determinants of health.

That we aim to address in the program, and then I also included a breakdown of our payers.

We are in an expansion state which has been incredibly helpful in terms of providing appropriate coverage for substance use, disorder treatment, not only for feasibility for our patients, but also sustainability of our program

program next slide. So of our 30 plus clinics, we offer medication for opioid use.

Disorder. At 2 of our health centers in 2,016 West Virginia passed some legislature that requires office-based medication assisted treatment programs to be registered with.

The State. I believe this is unique to our State, that there may be similarities in other States.

We? There's also some additional parameters about where you can open new clinics, and so for right now what we do to reduce barriers regarding transportation is to incorporate tele health and then

also provide transportation assistance and collaborate with Medicaid transportation services.

We do not have any standalone addiction treatment center.

The 2 places in which we offer this or in an integrated setting, which is something that's incredibly important to us, and much like what Dr.

Finger had presented on those service line. But those health centers include primary care. Ps.

V. 2 I. N. and Behavioral Health Variety of Clinicians practice in our program.

The bulk of the providers are primary care providers, whether they're family medicine physicians or family nurse practitioners.

But we do have it over the Gym and emergency department position, practicing in the program as well.

That might be for 4 h, a week, or 24 h a week.

It really just depends, especially as we look at other access needs throughout the system.

I will say, having other disciplines. Work in the program has been really helpful in shifting the culture in various departments, or, for example, back at our local er for those positions have been able to take knowledge with them and help change

the over there next slide. So, looking at the different components, much like what Dr.

Fingers had presented. We are very strong advocates for providing as many services on site as possible.

I will say that it is important to be creative, as you mentioned, and for us these services evolved over time.

We have a physician who wanted to start prescribing medication for opioid use, disorder back in 2,009.

And so that's when our journey started, but initially for example, we contracted out for therapy services we recently added to your coaching the last couple of years.

So it's certainly been an evolving process we do offer buprenorphine and naltrexone as well as vitro, and we refer out for methadone because we're not able to prescribe

it in our health center, and that's all determined on an individualized basis with patient feedback and involvement and assessment by our clinicians.

We also couple this with individual and group therapy, which we do have State regulations and Medicaid regulations, as far as the frequency of those services.

Peer coaching that's offered through collaborative services. physical healthcare, which oftentimes is delivered by the same primary care provider delivering the addiction treatment.

But first example, if a patient is seeing one of our er physicians, they'll be referred for primary care.

Usually the same health center that they're being seen so we reduce.

You know any issues that they may face with transportation and also going to a new health center that may seem new.

Them. We also have case managers, which is one of the most critical components of the program to address those social determinants of health, housing, transportation, food, employment, education, or child care.

Next Slide talked about, and the Stephen talked about shifting.

The culture has been very important, and looking at addiction as a chronic medical disease rather than a moral failing.

A couple examples about how we've done that at valley and I think it's it's been really critical in terms of increase in expanding access to services is by involving various specialties and integrating addiction services with other service

lines, not trying to separate the services and making sure that we have as many people involved as possible.

We also provide training on stigma and language to our employees, and continually continuously emphasize a comprehensive care model.

So regardless of. If somebody is in one of our addiction treatment programs, we are assessing for social determinants of health and screening for mental health and substance use issues.

We also have significant leadership involvement. and support and they set the tone for the culture at valley, and how we view addiction, and we also sell, celebrate recovery.

So we're happy that we're going to be having a recovery event later this month, and just in the first 24 h of our fundraise there are staff, although we're able to raise $3,000 to put back towards that event for our

patient next slide, so that've indicated our program has certainly evolved over time in the services that we've offered, and recently, you know, it's come to our attention the the need to focus more on Trauma informed care and so we started providing annual training on common informed care

for all employees at Valley, but our chief managers and patient advocates in our program also receive additional training through the West Virginia parental partnership.

We do serve pregnant and post part of women in the program, and we're part of some additional brain activities that lend some additional resources.

We also offer female providers and female only groups for those patients to express a need for that, and i'll share it later in a patient then.

Yet where that was really important. We also have very transparent policies about what we may need to engage cps, and we also try to helpful foster that relationship and make sure that patients are engaged in participating in treatment planning

and goal study, and that we are trying to identify what success means to them, and and what that progression looks like.

We also try to celebrate certain milestones in our Patient's lives that may otherwise contribute to additional shame.

As Dr. Finger has spoke about the picture that you'll see is a baby shower that was being thrown for a couple of our participants, and we know that there's increasing for women that are pregnant who have a substance

use disorder. next slide. The next part about is about navigating first appointments that you've probably seen in the toolkit.

We try to strive to be flexible and accommodating as possible.

We do not have a late policy for first appointments, or a number of times that you can reschedule.

We want to make sure that that door stays open and we acknowledge and recognize that if somebody doesn't come to their plan, it's it's most likely not because they don't want to be there but because they're

facing other challenges with getting there. whether it's transportation or childcare, or perhaps stigma around medication assisted treatment.

So we try to openly discuss those barriers and work through them.

We also want to focus on rapport building from from our experience, most of our patients, if they voluntarily leave treatment, it's within the first 90 days, and no matter when somebody links treatment if they do so voluntarily, we wanna make sure

that there's always an open door for them. to come back, and that we built enough trust and report that they are not concerned that there will be any judgment when they come back to that.

We also allow small children to accompany women to visit, including group therapy, and then we arrange for child care services for children of older ages.

Next slide. Engaging women support systems is also very critical. As Stephen spoke about a couple of the ways that we do that are by prioritizing getting women support systems into treatment.

So I can tell you that at any given time we've had 5 or 6 family numbers in our program, all seen different providers to try to reduce any conflict.

But we have made that a priority noting that it's going to be helpful for the success of the woman who's already in our program.

We also engage other providers, and that care whether they have an Ovt. Iii. and the primary care provider, or does test and facilitate opportunities to meet other women in recovery.

The picture that you see here is of our Mt. medical director, Dr.

Lee and Levine and one of our social workers, Michaela Whitlow, and they coordinated an event with another addiction treatment provider in the area.

So facilitate an opportunity for women to meet one another, and we also have access to the chest app which gives access to additional peer supported services.

Next slide. As I mentioned earlier, we have evolved services over time we've been slowly able to add additional services through collaboration or through additional resources.

Certainly in person's been very helpful in that with the different grant and funding opportunities that have come out.

We certainly taken advantage of that to expand access and to be creative in what we offer.

Collaboration has also been incredibly important couple of examples and There's plenty.

There's there's more than us that are just listed on the slide here.

But, for example, recovery point is a local peer-based organization, and they provide recovery.

Peer recovery services. for our program and they've been doing that for the last couple of years this is helpful from a couple of different perspectives.

One. They're the expert in doing so and so it was helpful to lean on them, for that also in our State as an Sq. we're not able to build for pure recovery services, but they are and so it helps.

From a sustainability perspective, and making sure that we can continue with those services.

We also work really closely with milly's place which was the first Nas center in the country, and they offer prenatal education to our patients.

They talk about what the treatment for under this looks like, and they also try to diffuse figures while patients are in treatment.

Sometimes our patients who are pregnant and are actively in treatment, want to discontinue medication before delivery, largely based about some of the fears and some of the concerns.

And so we try to work through that with them to make the best decision possible for their care.

We also work with the jumps at work school of medicine on research projects, and creating opportunities for recovery, employment, and a variety of different other community organizations.

I think a critical part of this is not only to enhance the services that we offer, but to connect patients once they've connected with us, and they're engaged in services reaching out to another organization.

Can seem a little bit daunting, and so we try to help facilitate that asively possibly can and connect them with organizations that we know are going to provide trauma-informed, care and you are going to work with

them to identify the different needs and resources that they have.

Next slide all right, moving forward, I recognize the picture's a little gloomy.

I did not do that intentionally. We we think the future is certainly bright and hopeful.

Some of the things that we want to focus on is further integration within our women's health.

Clinics. As I mentioned, we have a very large program and we'd like to get more ou d treatment and behavioral health services on site.

We want to address access concerns for a more rural population through policy change, and make sure that we're better understanding the trends in our communicate in our community, and sharing information appropriately.

Next slide. All right, a couple of patients, And yet some examples.

We have a 31 year old female who was referred multiple times over the course of a few years.

I think this is important, as it relates to the toolkit and navigating first appointment.

There was never any penalty for this one not engaging in services.

The first time she'd been referred after a few Overdoses at the local hospital. The most recent time she was referred to was in her third trimester, and she was using Harold Math and Thc.

And she had a history of trauma that preceded her substance

Use. Part of the liberation is educated about topics like pink controller and delivery.

The possibility of Nas, and what Nas treatment looks like.

As I mentioned before, some of our patients will want to stop treatment or stop medication use because of fears about what that's going to look like in the hospital.

So we'll have sometimes even labor and delivery Come and talk to our groups about this next slide from a support system perspective.

This individual's partner is now engaged, in treatment with us which was also part of a safety plan with cps initially. When she started in the program she was unhoused, and working with the city, mission, and she's now had stable housing for almost a year

She also recently transferred, transitioned her medication from Daley Oral for Norfolk to the monthly supplicate instruction.

She was initially hesitant about it, but is shared with our, and it was her choice.

But she share with our staff that she's happy about the decision that she made and has worked through other coping skills that have been helpful in making that transition.

Next slide. More than yet. we have a 41 year old female she's established with the primary care provider at Volley Hall, and she had a history by polar disorders, who was Federal ideation and heroin use she'd

also been also for psychotropic medications. For over a year she was referred to addiction treatment, and we initiated Mt.

The following day as well. psychiatric services i'm valing. We do have instant access to Mit, where patients can walk in 5 days a week, or be referred 5 days a week from any providers within valley or community

providers and get services that day, and then we also prioritize getting impeachment in our substance treatment programs into psychiatric care.

Unfortunately, during her time and treatment she experienced a sexual assault, and after that assault she requested to be moved to a female group which we were able to accommodate.

She also expressed his comfort, being around males in the office next slide.

So we accommodated with a separate waiting area for her to wait for her appointments, where she did not have to be surrounded by other male patients.

She also became employed part-time and initially wanted to work in a stocking room where she didn't have to interact with a lot of customers.

And over time, as she worked through her trauma and became more comfortable, interacting with people.

She started working the front, and she's now been promoted to an assistant manager.

Position. she's also working towards long-term housing and her driver's license and is pregnant.

Her partner is also in our program next slide. Some of the recommendations that I want to leave you with today are to collaborate, and also Dr.

Finger has said to be created the services are incredibly important and while I know it can seem daunting to provide all of the services at one time there's certainly our community partners who share the same mission.

And we're going to be more effective at offering comprehensive care when we're not in Silos Supported leadership is also critical, especially if you're just starting services or need to address culture.

You can help to when you get their support. It can be easier to allocate resources, especially if you're looking to expand.

And I also recommend to reach out for how learn and shadow other providers and clinics in your area.

See what they're doing. there's no need I think to be competitive in this arena.

We can learn a lot from one another, and we all start somewhere.

So again, if you have any further questions, please drop them in the chat or reach out.

Following the presentation: Thank you. Thank you so much, Rachel.

And unfortunately we are at time, so we will not be able to answer questions.

Live here right now. However, we will get your questions to the speakers.

And facilitate a response for those questions.

But we did want to take this opportunity to think everyone for joining us today at this leadership series, as well as just acknowledge and reiterate that there are links to the toolkit and the chat box as

well as links. If you are interested in, say, in for the supplement that I mentioned earlier, there's also links on the initiatives that are reference as a release to those funding opportunities that are really focusing in on this work here

so once again, Just think, Our experts were doing this great work in the field.

There are a lot of discussion that you know we could have had.

However, we are short for time. so i'm just thank you all again for your time, and thank you offering engaging today.