Opioid Podcast Series, Season 2, Episode 3: Sustaining Recovery for Patients on MOUD; Formal Presentation

And welcome to this webinar series, Ensuring Medication for Opioid Use Disorder Through the Care Continuum. I'm Carey Sorenson with Great Plains Quality Innovation Network, and I'm going to be one of your hosts for this session. During this session, we will mainly discuss how to support people in recovery beyond the walls of hospitals, nursing homes, and OTPs. This series is a collaboration of all QIN-QIOs in which national experts across the healthcare continuum provide robust educational content to address the opioid epidemic. I am proud and honored to be a part of this initiative, and I'd like to thank all of my QIO colleagues for contributing to the success of the series. We are excited to hear from our guest speakers. I am going to let my co-host Angelita Hendrickson from Q source introduce Dr. Ryan Sarver. Hello, everyone. It is my proud honor to be able to introduce Dr. Ryan Sarver. He is a board-certified family physician and fellow with the American Academy of Family Physicians, specializing in pain medicine. He is an adjunct assistant professor of clinical medicine for Indiana University School of Medicine. Dr. Sarver has developed and implemented integrated MOUD in primary care models of care in Pennsylvania and Indiana. He is currently working with the Veterans Administration to develop an inpatient pain management program for patients suffering from complex pain and substance use disorder. Then you'll be hearing from Heather Brandt and Jake Ruder. Heather Brandt works for the North Dakota Department of Health and Human Services Behavioral Health Division. As the manager of Behavioral Health Community Support's, Jake Ruder is a program administrator with the North Dakota Department of Health and Human Services, Adult and Aging Services section. In this role, he oversees a transition and diversion service, assisting individuals with varied disabilities with a return to the community or to maintain their community living with support services. Jake was the money follows the person grant program administrator for North Dakota from 2007 to 2022, working on enhancing the use of Medicaid for community services. On that. I'm going to turn it over to you, Dr. Sarver. Hey, good afternoon and thanks for having me. All right. So today I want to talk about a program that through the help of many different people before me, we all stand on the shoulders of giants and trying to tackle this large, massive problem we have the in United States and that's how to really give people access to treatments we know save lives. The treatments we're going to be talking about today are medications for opiate use disorder and really how we can get that through primary care. That's going to be the number one area where patients are going to feel most comfortable because they're with their providers who know them the best and where there are the most access points for patients, because oftentimes they come in for, you know, acute complaints, chronic disease management, or just preventative health. And this is somewhere whereas physicians or practitioners and physician associates, we can really make the biggest difference in patients lives by offering these medications. So as an overview, I'll be talking a little bit about addiction as a disease of the brain, the lifesaving treatments that are available for opiate use disorder, some changes to the data 2000 law that the Biden administration made, which makes prescribing Suboxone easier as well as, you know, a little plug for why all physicians and nurse practitioners and physician associates should be prescribing these medications. So, let's talk about addiction. Addiction is not a moral failure. In fact, this is a common, unfortunately, robust belief by not only the community, our culture at large, but by patients themselves. I'll have to spend a large portion of my visit whenever I'm doing an induction for medication for opiate disorder on counseling patients their disease is not something they did to themselves. This is not their fault. This is not a moral failure. Addiction is a chronic relapsing disease of the brain. Now, are there things you can do to worsen your disease or to spark your disease? Of course, the same can be said for diabetes, right? There are genetic predispositions, diabetes. People will say, you know, I like to joke, and we say that, you know, patients say, oh, yeah, diabetes runs in my family, and I jokes they ha ha, nobody runs in your family. Right. These are the jokes. There are things that we can do in our lives or of modifiable lifestyle factors that can put you at risk for developing diabetes. If you eat a whole food plant-based diet, you intermittent fast, you exercise daily. Even if you have a strong family history of diabetes, you probably will not have an HbA1c above 6.5 and we won't say that you have diabetes. The same can be said

for addiction. If you have a strong family history, a lot of people say, oh yeah, my parents drank, that's how they dealt with their problems. Aha. And now we talk about you having also not only a genetic predisposition, but you have generational trauma in your family, whether it's through addiction, mental health, justice affected individuals or violence or emotional, physical, sexual abuse in your family history. These are predisposing factors to addiction that can make it more likely that you will use a substance to overcome some sort of negative consequence in your past negative feeling that you want to overcome, and you activate that part of your brain, which is predispose to addiction. So that's the work that we need to do, is to let everybody know that addiction is not a moral failure. It is a chronic, relapsing, treatable disease of the brain, and there are robust treatments available that will save people's lives now. So that's what we need to get out there into the community that these medications are available. They are not complex to prescribe, and they absolutely change people's lives. So, let's talk about the medications that are available for opiate use disorder. So, the first one is Naltrexone. Its trade name is Vivitrol. Vivitrol is a once monthly injection of an opioid blocker. So, these are for patients who either have both opiate use disorder as well as alcohol use disorder. Because Vivitrol can be used for alcohol use disorder, it decreases cravings for alcohol consumption or they're just not a good candidate for being on an opioid, then naltrexone is a really good choice for them. They come into the office, they get an injection once a month and they go about their business, they're not going to be high. If they go out and they use, then that opioid will be blocked. So, naltrexone is like a long-acting Narcan. So, they walk around with Narcan all the time. Some limitations there. Naltrexone being an opioid blocker, they will need a medical alert bracelet if they do use this medication, because if they do need an emergency surgery, anesthesia will need to know about that because we do use opioids for anesthesia induction. So, they'll need to know that they've been on Naltrexone. If they need to have an elective surgery, then they'll want to hold off, stop their Naltrexone for at least 28 days before going forward with their elective surgery. So those are some considerations there. The next one is methadone. Methadone has been around for a very long time. It's a long acting, full agonist opioid. Now, when we talk about agonists, what we're talking about is turning on the opioid system all the way. It's a full agonist. Naltrexone, we said that's a blocker, right? So, a blocker is an antagonist. It blocks the system, methadone turns it on all the way, just like your oxycodone and your morphine, your heroin's, all of those medications, opium, those all turn the system on all the way. Methadone is long acting so people don't get their extreme high that they would with heroin or or fentanyl or any of the other slightly shorter acting medications. And methadone can only be prescribed through an opioid treatment programs, so an OTP. You can't prescribe that in an outpatient primary care clinic. So, patients who are good candidates for methadone would need to go to their, quote unquote, methadone clinic, which is an OTP. Now, let's talk about the last one, which is a real game changer, and that's buprenorphine, trade names are Suboxone. Suboxone is buprenorphine and naloxone. A lot of people will say, oh, well, buprenorphine has naloxone in it, and then it locks in the blocker, that's what stops you from being able to use. That's not true. So, buprenorphine is absorbed through the mucous membrane, so they put it under their tongue. It's either sublingual or oral mucosa, and it's absorbed there in your mouth. You don't swallow it. Naloxone is not that naloxone is Narcan. So that's your blocker, that's not absorbed. The naloxone is actually in this formulation to prevent diversion, so, people don't put it into a needle and inject in their arm because then they'll Narcan themselves. So, it's not actually the naloxone in Suboxone, which is blocking any action. It's that buprenorphine is not a full agonist like methadone, it's a partial agonist. It only turns the system on halfway. And so, what will happen is if somebody is currently in active use and they have a full agonist opioid on board, let's say they just used oxycodone several hours ago or they're on fentanyl in the past day or they're currently using methadone. If they start suboxone or buprenorphine, then what happens is their system goes from full agonist opioid down to partial agonist, so it goes down to halfway and they will have symptoms of withdrawal, which is why buprenorphine, you have to have an induction schedule for them where they stop their full agonist opioid depending on the half-life of whatever medication they're on, they stop that for a period. They go into mild to moderate withdrawal and then they start their buprenorphine or suboxone. Other formulations of buprenorphine are Subutex that is buprenorphine without naloxone. So, the buprenorphine by itself, as well as a depo injection, which would be sublocade and sublocade once there, once they're stable on buprenorphine for at least a week, they can transition over to a once monthly injection of sublocade, reducing the need for pills. Or if you currently

have patients using Subutex or Suboxone, they'll talk about the terrible, terrible flavor and the inconvenience of having to leave a tablet or a film underneath their tongue for up to 30 minutes at a time, up to three times a day. It can become quite inconvenient. And so that's where sublocade can be a really good option. In addition to that, sublocade can be used in more structured environments, such as for patients who are incarcerated so that you don't have to deal with a film or a tablet. They get there once monthly injection, and they go about their way. So, it's a really great option for patients who aren't good candidates for pills or films or just don't have access. So that's where the sublocade injection comes into contact. Now let's talk about the X-waiver. So many people probably are familiar with the X-waiver. That was part of the data 2000 law. If you wanted to prescribe buprenorphine for opiate use disorder, you had to get additional training. That's an eight-hour training for physicians or 24 hours of training for nurse practitioners and physician associates in order to get what was called an X-waiver attached to your DEA license. And then this would give you permission to prescribe buprenorphine a couple of years ago. The Biden administration eliminated the need for an X-waiver. So, what this means is if you were a provider, has a DEA license, they can now prescribe buprenorphine. So, there is no longer a hurdle or a block from any primary care provider in providing this lifesaving medication. So, all primary care providers should be offering this. The patient load is huge. The consequences of opioid use disorder are deadly. So, there's no reason that we shouldn't, as primary care providers, be providing this medication to all of our patients. So now let's talk about points of entry for our patients. The primary point of entry for all patients, whenever something terrible happens, is the emergency department. And this is where emergency departments really need to have a warm handoff program. So, they need to find out which providers in their community offer buprenorphine. And if you're a primary care provider, that should be you. They need to have a social work staff who can meet the patient, preferably, that would be somebody who is a peer recovery specialist, who has lived experience and has training in dealing with patients who are in active, chaotic addiction. And that person can then triage the patient in the emergency department into an outpatient visit in order to continue buprenorphine therapy. Now, the special thing about emergency department warm handoff is they should be administered buprenorphine right then and there. So, if you have a patient who comes in and they have suffered an overdose of an opioid and they're given Narcan, they are currently actively in withdrawal because you've given them a blocker or an antagonist. So, at that point, you can administer buprenorphine. Buprenorphine will then remove their ability, or it'll remove the symptoms of the withdrawal. And the neat thing about buprenorphine is it has a really high affinity for the receptor. That means it really likes to hold on and bind tightly to those opioid receptors and it will knock other things off. So, if they go out after they leave the emergency department and they if they've taken buprenorphine in the ED, they go out and they use heroin, the heroin is not going to work very well because the buprenorphine will stay tight on that receptor. In addition to that, the neat thing about buprenorphine is it has a ceiling effect on respiratory depression. So that means it actually stops people from overdosing because you don't get that same level of respiratory de-pressure with buprenorphine as you do with the full agonist. So, all emergency departments really should be administered buprenorphine to stop people from going out reusing heroin or fentanyl and overdosing again in the field. Buprenorphine actually saved their life. So, the warm hand off the emergency department provider will provide a dose of buprenorphine, so they'll induce them right then and there. The social worker, case management, or the peer recovery specialist will then triage the patient to an outpatient provider of buprenorphine, and that provider will see them in the next 24 to 72 hours upon discharge from the emergency department. The patient will then get a prescription for buprenorphine in hand and Narcan so that they can continue their buprenorphine. And if they do go out and use, they will be protected. If they stop the buprenorphine, they'll have Narcan in case they use again. In the clinic, so, for primary care providers in the clinic, we should be screening for substance use disorders in all the major boards now recommend this. So, we should be screening for it's a USPSTF recommendation to screen for alcohol use disorder to screen for poly substance use. And you can just ask them, you know, have you used opioids in the past week? Do you have a remote history of opioid use disorder? Maybe you have a patient who comes in you think they're, quote unquote, drug seeking. Why is that? Or do they feel they need an opioid for their pain? You can screen them at that point if they have opioid use disorder. And if they do, then you can start them on buprenorphine and really save their life. Or if you are a primary care provider and you have patients who are being seen pain management and they fail out

of pain management. Unfortunately, for patients who are in pain management, they may have iatrogenic opioid use disorder, so maybe they don't meet all the DSM five criteria for active chaotic addiction. But as a medical community, we may have given them opiate use disorder, in which case they may be an appropriate candidate for continuing buprenorphine with their primary care provider. So that's, you know, an opportunity for you to help out patients who have failed at pain management. I know in the medical community we've really failed in healing patients. Hey, look, we know you've given you tons and tons of opioids. And you know what? At this point, it's no longer recommended that we prescribe them to you, so I can't give them to you anymore. These are patients who then go out onto the streets, and they will try to get them off the street. And I'm here to tell you everything on the street is fentanyl now. So, if they try to use a pressed pill of oxycodone, that's not a prescription, that's fentanyl. If they use heroin, that's fentanyl. And even worse, there's now something called xylazine in the drug supply. They're going to use that and they're going to wind up dead. So, you have an opportunity to save people's lives by inquiring about why it is they need an opioid, where they're out with their pain management and start providing buprenorphine to them to save their life. As somebody who prescribes buprenorphine, you can also get referrals from other primary care providers. So, they may not want to prescribe, maybe they're not comfortable with it and they don't want to do it. In which case you can be the person who really steps up and save people's lives. So, for the points of entry, this is for the warm handoff program. Let's say that they enter the emergency department for an overdose. They would then be triage. The PRC is a peer recovery coach or peer recovery specialist within connect to the patients, to social work, triage them, and find out if they're appropriate for rehab. Maybe they're not safe for outpatient treatment. Maybe they are safe for outpatient treatment, but they're living situation is a little too chaotic to just be in a primary care office. They would then go to an intensive outpatient treatment program or an, IOP, and they would be then triage to probably an opioid treatment program or OTP for either methadone or buprenorphine or naltrexone. If they are deemed appropriate candidates for outpatient MOUD induction and then referral to one of the primary care providers who provides buprenorphine, then they can be given the medication. They're in the emergency department and given a small prescription for that in an appointment set and they would get a referral for counseling. It's recommended that all patients who are on medication for use disorder have substance abuse counseling, and the community health worker will then connect the patients to the appropriate community provider. The neat thing about a peer recovery specialist is once these patients leave the emergency department, sometimes they get lost to follow up. This is where the peer recovery specialist comes into play, is that they will have the phone number of the patient and they can reach out to the patient or maybe the patient has trouble making their appointment because they don't have money, they don't have gas, they don't have a ride. Whatever it is, that is the social determinant of their health, it's blocking them from care the peer recovery specialist is there in order for the patients to call, overcome that barrier and get them into their appointment so they can be seen and continue their life saving treatment. And that's really where a robust peer recovery specialist and case management team comes into play for either an emergency department or your primary care office, where, if you had are in a federally qualified health care center or a patient centered medical home, these are robust programs that you really should have that are recommended to help out patients with opiate use disorder and poly substance use, or really just any patients who are experiencing traumatic life events or have a real robust needs in their social determinants of health. This can be uncovered and really make your no-show rate go down and make your appointments much easier to deal with if you have these social workers who can come and help you. So now let's talk about the clinic flow. So, the clinic flow for a MOUD patient is really not that much different than a regular a regular visit. The only difference is you will do a UDS. Yes. Although there's some argument as to whether or not that's needed, and you'll have informed consent. Some people call this a contract. We really don't like to call it a contract because it's not a contract. It's informed consent where you acknowledge that you told the patient about all the risks of using buprenorphine and you've come to an agreement that this is the best course of action using shared decision making. And you set the expectations right away. You know, you'll have patients who are used to being in active chaotic addiction and they'll try to get their medication any which way they can, and they'll try to get it all hours of the night. As primary care providers, we often work regular hours, and we aren't going to be available overnight or on weekends to deal with an emergency. So, you can either have a robust peer recovery specialist or community health worker, social worker who can deal with patients after

hours, or you just have to set the expectation that if something goes wrong with your medication, it needs to be dealt with during clinic hours. And patients usually understand that and we're often not they're very compliant with that. So, a couple of the pitfalls is that with people with lived experience, should be a part of your treatment program. People with lived experience are going to understand a lot of the trauma that's involved in addiction. If patients don't have generational trauma, which more than likely they do. So, if you're not currently informed with trauma informed care, you should get educated with trauma informed care. Addiction will lead to trauma in their lives. So, they when they come to you, they're going to have trauma. And that's really where a peer recovery specialists come into play. They know what your patients have been through, and they can help guide them through the treatment program. Administrative hurdles. A lot of times you'll you can go to your administration, say, I want to start treating people with opiate use order and our administration may say, no, it's too big of a burden or we don't want, quote unquote, those people that there's a lot of stigma out there. And these patients will have higher detrimental social determinants of health. So, they may be a larger burden to be a larger burden of Medicaid patients, because people in active chaotic addiction have often got, you know, damaged their relationships and they don't have that social safety network. But that's where we can come into play. We can have social work there, available, we can have a peer recovery specialist available to guide these patients in the treatments and save their lives. We've been called upon by every aspect of healthcare and the federal government to step up to reach out and start treating these patients. And really, it's no different than our patients with Medicare and Medicaid who are living in deplorable situations, who are, it seems like, non-compliant with their medications. Your community health worker can help them as well. You probably have patients who are difficult. You think they're noncompliant with their medications. But it turns out there's some reason maybe they have to choose their family members healthcare, or they have to choose to eat that week rather than buying their medication. And we won't really know that unless we ask. So, we really have to stop the stigma against patients who are, quote unquote, noncompliant or those people or those patients and meet them where they're at. If we do that, we can save their lives. So, for patients supports, these are the different areas that patients support that you should look into having a peer recovery specialist having a robust relationship with behavioral health. If you don't have that in your office where you're a local federally qualified health care center is so if you can't treat patients with Medicaid, then you can send them or maybe they need Medicaid, and you don't have the support specialist to help them get Medicaid. They can help them out with that where your nearest opiate treatment program is. So, they can be if they need methadone or they need an intensive outpatient treatment program, IOP you can send them to the OTP and where your rehabs in your detox centers are and then how to get transportation to that. So, some places have Medicare, as some places they need to have an ambulance take them if you figure out how that is. So that if you do find out where your patients are at and they're not safe for outpatient treatment programs, you know where to plug them into and get them the help they need. So, thank you very much for your time. Thank you, Dr. Sarver. That was a great presentation and a great lead into some of the topics I'm going to be talking about today. So as Carrie said at the beginning of our presentation today, my name is Heather Brandt. It's great to meet all of you. I work for the state of North Dakota within Health and Human Services. I manage a fairly new team here. So, we just we created a team a few years back to expand and enhance our recovery, our community-based recovery support services. And I get the honor of leading that team. So just to paint a little bit of a picture of the history and gaps and where some of these needs were identified was back in 2016, one of our partners at the Department of Corrections did a study really showing that judges were using incarceration to help people access treatment and support services in their community. And near that same time, there was a 2018 study of our behavioral health system and it was determined at that time that our behavioral health system was very heavily, primarily crisis oriented and paid inadequate attention to those rehabilitative and community-based services. Next slide. Again, just another slide highlighting that study from 2018 that people need access to community-based services and supports outside of those services that they might access that are crisis oriented. So, we wanted to work to change the system's response to people who are struggling with addiction, mental health, and help them make connection to recovery support services. We wanted to invest in local or community-based solutions, regionally focused across North Dakota, North Dakota as a very frontier and rural state. And so, we knew that had to be part of the solution, as well as we wanted to engage with faith, faith based, culturally specific groups, and

private providers that were interested in providing services. And so really helping to create more behavioral health workforce as well. And so originally this was actually part of a justice reinvestment initiative in North Dakota, and we targeted people who were on parole and probation, utilizing a corrections assessment tool to identify those individuals with the most risks. And we were building programs and services that were gonna provide care, coordination, and peer support. And Dr. Sarver talked a lot about recovery specialist and peer support specialist. The program that was developed as a result that was born was called Free Through Recovery. Free Through Recovery was an initiative that was built with the Department of Corrections and Rehabilitation and our division, the Department of Health and Human Services, Behavioral Health Division. The first goal, and I want to emphasize that Free Through Recovery is a state funded program. And the next program I'm going to talk about is a state funded program, so through the legislative session, we received funding to support the implementation of these services. And then I'm going to talk a little bit about a Medicaid program at the end as well. So, our goal with Freedom Through Recovery was to improve engagement and services participants engaging with that care coordinator who identifies their needs and helps them find creative, effective, pro-social ways to meet those needs. Along with engaging with the peer support specialist who is really that day to day, week to week provider that's providing those services and supports to that person. Goal two was to provide access to individualized services that were responsive to each person's specific needs. So those care coordination agencies were establishing provider formal relationships with behavioral health care providers, housing resources, employment resources, really trying to figure out whatever the needs of their community might be and trying to connect individuals to those services and supports. And then at that same time, we heard back from those providers and communities that were identifying and reporting service gaps or barriers to meeting the needs of participants specific to their region. And then goal three was I talked about it a little bit was but was really to expand the behavioral health workforce when we started partnering and doing listening sessions we had a wide range of providers consisting of large statewide organizations to one person shops all serving the community help making sure that our providers represented every area of service, culture, gender, faith, etc., and really working together to meet the needs of our communities. So, this is just kind of a snapshot or a picture of a person receiving services, and they were community or regionally based providers and we at the state entered into a contract or a provider agreement with the with those providers we paid on and we still pay on a per person outcome based rates incentivizing engagement and wellness. You know, we talk a lot about in behavioral health, you know, somebody's not sick enough to qualify for those services or supports and we really wanted to start changing the narrative around that in North Dakota, where we were paying providers for wellness and incentivizing them to engage with people. So really breaking down some of those barriers. And then the providers that we contract with are the ones delivering the care coordination and peer support services. So, some of the successes and challenges that one of the biggest successes with the development and expansion of behavioral health workforce in our community is we have now up to upwards of 60 providers that are providing these services across North Dakota and currently have around 370 active or trained care coordinators that are also serving. But at that same time, we had challenges and so there were rising capacity needs that we had to deal with as administrators and really wanting to pay attention to quality of care and services and developing good internal quality and data analysis to see, you know, what, what the program was doing and how it was serving people and looking to see that we were measuring those correct outcomes. So, in 2019, we decided that Free Through Recovery in that model of care with care coordination and peer support services was really successful and we wanted to expand it beyond that DOCR-specific population. And we launched a program called Community Connect. Next slide. And just a little bit here again, it was a very similar model where we had provider agreements with local community providers to provide those services. They are paid again per person, outcome-based rates, incentivizing engagement, and wellness. And some of those similar challenges occurred but we saw with Community Connect, we saw even more providers serving specific populations, domestic violence survivors, new American foreign born immigrant populations, and just really serving individuals outside of the state level criminal justice system. One of the other things we implemented as a result of that was, we also implemented in this program was a care coordination code of ethics and some of those very similar challenges to Free Through Recovery as we noticed the program was, it's very easy to qualify for those services and supports and so, we had a rising capacity needs and we only had

limited budget. And so, we were also paying attention to quality of care and what those services and supports that are providers were providing across North Dakota. So, I just highlighted, you know, two state funded programs that we have developed in North Dakota since 2018, and at that same time, what was occurring was we had submitted in partnership with Medicaid, a 1915-I state Medicaid amendment plan. And so, I'm sure many of you on the call have heard of 1915-I. So, I'll just talk briefly around what our Medicaid state plan looks like in North Dakota under 1915-I. And it's really that it's in basic terms, it's the amendment to our state Medicaid plan that was designed to fill gaps in our behavioral health delivery system throughout North Dakota. So really wrapping around and providing those services and supports as close at home as possible and helping people maintain wellness. This is just a great visual of who is eligible for this services and programs. You know, there's people enrolled in Medicaid or Medicaid expansion in North Dakota, there are individuals with behavioral health needs, and then there are individuals who would be eligible for those 1915-I services. And we have a very robust 1915-I plan in North Dakota, and it's something we're very proud of. And these are the 12 supportive services that can now be built to Medicaid and Medicaid expansion for those individuals that qualify for 1915-I. And so just really broadly want to talk about the benefits to developing of these state programs and as well as this Medicaid 1915-I state plan is we were able to really build community and state capacity to respond to our behavioral health needs, business development, rural and frontier, business development, and provider development. We created additional employment opportunities and pathways to behavioral health careers. We had providers that are regionally and locally based, meeting those unique needs of each community. The services might look different depending on which region or community you lived in. We now had service providers that were working in those regions that could then identify those gaps in services and supports. And then what we've also been able to do with this is develop a lot of ongoing training and technical assistance for these providers. And so really, like I've emphasized a few times building, building support for people, but also building capacity to respond to the behavioral health needs of individuals in North Dakota. And these are just a few other support programs that we could highlight that help support people with opioid use disorders that might be transitioning from, you know, hospital settings or residential settings back to their community. In North Dakota, we have a substance use disorder voucher really meant to fill those gaps in reimbursement for providers and to expand options for people that are looking to receive services. We have a recovery housing assistance program. We have a mental health directory. We're in rolling out a mental health bed registry so that providers and individuals can see where those available residential options are within the state. And then also, we do a lot of work with North Dakota brain injury. And with that, I will pass it over to my coworker, Jake. Thank you. Thank you, Heather. So is Heather. Said, I'm Jake Router. I, I work with our Adult and Aging Services section within the Health and Human Services world, and we've actively partnered with Heather and the other behavioral health staff, especially around any of these substance-use related needs that folks are dealing with. And so what I wanted to talk about is just some experiences that we've had trying to support individuals that are either already in the community or trying to transition out of a group setting of some kind, like a substance use treatment facility, sober living, maybe they're coming out of assisted living, basic care, maybe out of a nursing home, that kind of thing. And so, the first one I want to talk about is is a transition and diversion services pilot project that we're operating. And we've been involved with this since 2020. But when the American Rescue Plan Act funds became available under Section 9817, we found that there was an opportunity to enhance and expand our home and community-based services options. And so we focused on two areas. One was diversion, meaning we wanted to help folks remain in the community with the supports they need. And the second is transition, where we provided a transition coordinator, a housing facilitator, and then the funds to help them remain in their own home or transition. And how does this apply to our conversation today? I wanted you to know that in in ‘23, for example, we had 241 transitions and 87 of those came from a substance use treatment facility. Again, a combination of either a treatment or sober living environment. So in comparison, we've already assisted 41 individuals with transition in the first three months of 2024. So, we went from 87. We're at 41. I'm guessing if we were able to continue on that path, we're going to get well into the hundreds of folks that we've been able to assist, which really emphasizes the profound need for this service. I can tell you that we were not prepared initially to serve this population when we started. So, the engagement with our behavioral health service system has been really important. And not only is it addressing the needs of the folks that we’re

transitioning or that are already in the community, it's identified some real gaps. So, what I wanted to talk about and Heather's been an active part of this is, you know, we're serving adults with physical disabilities or older adults and they're presenting with significant behavioral health needs, including opioid related dependance or other types of substances. And what we found is two things. One, our behavioral health providers are not really equipped to assist with the activities of daily living that folks are coming to the table with. Even with the opiate dependance or other substance use dependency, as well as the fact that the folks that are designed and trained to provide that that assistance with those daily activities like bathing and dressing, they're not equipped or trained to respond to the behavioral health needs. And so, it's a real challenge. And so, we're really working right now with Heather in the behavioral health staff to develop training for the providers to support the behavior health needs of the folks that were now getting referred for support services. If we cannot bring the two together, as you know, in the in the rural state of North Dakota, it's difficult to help people remain successful and especially when we're dealing with a an opiate dependance. You know, we know that folks are going to relapse. They're going to need additional supports and referrals. So, we want to make sure that we're able to respond to that. So as Heather's already mentioned, peer support is an area that is really crucial to success. Not only does it help folks address their behavioral health-related support needs, but it does also look at things like, you know, that need for companionship and socialization when they may have, you know, burned all their bridges with those folks that were in their life, like their friends and family. And so, we're working on collaboratively with our peer support network that behavioral health is developed to try to add some additional training for those peer supporters that they can also now understand some of the age or disability related needs of folks that need also the peer support for their substance related issues. And so, it's really an effective conversation that we're having. So, the other the other transition services that we have available in North Dakota, and I start with Money Follows the Person Grant. And that grant really focuses on individuals on Medicaid transitioning from an institutional setting that's paid for by Medicaid. And you can imagine folks coming out of nursing facilities, hospitals, or an intermediate care facility for someone with an intellectual disability. Some of those folks are presenting, you know, with opiate or other substance use disorder. What we've found a lot of times is folks in those nursing facilities are being admitted because of their substance use issue. Many times, the challenge for the facilities is to how best to address that. And I know we've got quite some ways to go because typically people become, you know, you know, the drugs become unavailable. And so, they're not using. But the need for follow up post-discharge has not change in and are often not addressed. It's another area that we've now engaged with the nursing facilities and our professionals across the state to say, okay, how can we best address this, support the need for intervention or supports, well, in these institutional settings so that when they transition out, you know, we've addressed those issues and now have a plan to continue to support their recovery, post-discharge. We also have transition services in our Medicaid waiver and in the 1915-I state plan that Heather mentioned. So, each of our waivers, we have an aging and disabilities waiver, a developmental disabilities waiver, and then, of course, the state plan. So, all of those transition services are now cognizant of the need to make sure that each one of these areas are addressed, that we're coordinating services with our behavioral health teams, and making some plans for free discharge intervention and supports, as well as those supports they're going to need after they transition out. So, one of the obviously important areas when it comes to either helping folks stay in the community or return to the community is really that issue of housing navigation. How do we help folks either remain in their home or find a place to live that meets their needs and have access to the supports that they're there in need of in order to be successful. So, when we look at this, what we've done in North Dakota is we've used the Money Follows the Person Grant funding, and we've used our ARPA dollars as I talked about, we've used other funds through the homeless, what's called a homeless grant, emergency solutions grant, the behavioral health programs like Community Connect, Free Through Recovery and our North Dakota Rent Health, or Housing Stabilization Program. So, all of those programs bring a taste of housing navigation, you know, looking at how do we help the individual find their home? How do we identify housing subsidies or rental assistance? That is necessary for them to afford those units and then working closely with them, you know, to help them understand the obligations they have, their rights and responsibilities as a renter, and make sure that they're compliant with the lease agreement, working with connecting them to services if necessary, addressing those home modifications or the needed accommodations

that they might need to be able to successfully occupy their unit, and then actively participate in that planning process throughout the effort. So, it's a crucial piece of transition and or diversion from institutional care. And clearly, when it comes to connecting individuals to services, these housing professionals really need to closely work with behavioral health resources available with our transition staff so that everybody is collaborating on developing a plan to optimize potential success. So, the other the other two services that I want to highlight, and I don't have a lot of detail here, but we also have state funded home and community-based services for our individuals that experience a physical disability or individuals that have that are older. And so that the service payments for the elderly and disabled really are able to assist anybody on that is on Medicaid, but anybody that meets our eligibility criteria, financially. So, they have functional need for assistance, and they have less than $50,000 in assets, less than $2,000 income; that services available to them. And with our expanded service payments that really is targeted at folks that are at that risk of going into group settings. So again, another example of state funding similar to the Free Through Recovery and Community Connect, the state has committed dollars to help people remain in their home. And again, as I mentioned before, these providers do not have that behavioral health expertise so those things that we're trying to accomplish with the training, with peer support, really come into play. So, Heather and I certainly are both available, and I can tell you that we worked very collaboratively, and we continue to try to problem solve for folks that need support services for their activities of daily living like bathing healthcare related issues, as well as how do we collaborate to meet their behavioral health needs. So, with that, I'll turn it back over to the moderator. It is now my pleasure to introduce Lindsey Sarver, and Lindsey is a community health improvement strategist for Healthy Jackson County Coalition in Indiana. She works through the local hospital and the coalition to create collaboration and address logistical and ideological barriers to success in clinical and community settings, seeking to improve mental health and substance use interventions. Lindsey, would you like to tell our audience a little bit about what you'll be talking about? Thank you Angelita, it's a pleasure to be here today. And just my thanks to our speakers today for teaching us so many things and all that you brought. Our next section is really going to be talking about kind of the how to's and the success and the benefits and the barriers and the pitfalls that come with creating those community collaborations that really address the solutions that we're seeing. And we all know one of the biggest challenges of MOUD is that those social needs affecting health, like housing, like food insecurity, like our justice affected population, and that we're never experiencing an addiction or a mental health crisis in a vacuum. And so, the solutions need to be coordinated. They need to be collaborative; they need to be happening at the same time. And there's no organization that can do all of that themselves. So, I'll be talking a little bit about some of the successes we've had with the Healthy Jackson County Coalition here in Indiana, as well as some of the things that we've experienced that we've learned from along the way. Thanks. Thank you, Lindsay. I think we will move into our question-and-answer discussion period here for the last few minutes of our session. I think the first question we have here is for Dr. Sarver. You said that buprenorphine will stop the patient from feeling the effects of the opioid they prefer to the full effect. Wouldn't this ultimately result in the patient taking more of that drug to get the full effect? That's a great question, and this is really a multi-faceted question. The question is, one, why do patients use drugs? And that really depends on the patient. Once somebody who's been in addiction for a while, one of the main drivers of continuing to use drugs such as heroin or pills is so they don't have the negative consequences of their use, so they don't go into withdrawal So the buprenorphine can block that and they won't go into withdrawal. So, it will stop that. Another aspect is patients want to cover up pain, whether that's physical pain or emotional pain. And buprenorphine is an effective analgesic for up to 8 hours. And so, if it's physical pain, buprenorphine is actually a wonderful medication for pain management. So, it will cover that as well. So, the question is, will they go and use more of their quote unquote, desired medication? Unlikely. What will happen is they just won't take the buprenorphine and they'll go back to active chaotic addiction, which is where your peer recovery specialist comes into play, where they can triage this patient to a more appropriate treatment plan, whether that's a rehab, if they're not safe for outpatient treatment or a more intensive, intensive outpatient treatment program with an OTP. Great question. Thank you. We have another question for you, Dr. Sarver. If this buprenorphine is blocking the hair when they just took after getting it in the ER, what if they then take another dose of heroin to get whatever they are looking for? Then what happens? So, you can, and this is an interesting question because this is a question that

I got asked by surgeons like probably a decade ago. How in the world do we get pain control with somebody with buprenorphine? Buprenorphine is an opioid partial agonist, so it turns the system on halfway and it has high affinity for the receptor, which means it will block other medications. However, high affinity doesn't mean that it will permanently block all those medications. Those medications will come on and provide some analgesia. So, if you have a patient on buprenorphine, you can still give them Vicodin or Percocet or, you know, hydrocodone, oxycodone for dental procedures or for acute pain. That's perfectly acceptable and it will work. It's just not going to be as effective. So, the same thing, if somebody goes and use heroin, they're not going to get that same high. They might get a little bit of extra opioid on top, so, they may feel a little bit of more analgesia, they may feel a tiny bit of euphoria, but it's not going to be the same thing that they're used to, the heroin. And this goes back to the question of whether or not the patient is appropriate for outpatient treatment. Are they stable? Do they really want to be in recovery? Those are questions that a peer recovery coach is going to ask them to find out if they're appropriate for a primary care outpatient treatment program or if it's better that they're in a rehab for up to 30 days. So, they can really work on the drivers of their continued substance use or an intensive outpatient treatment program where they go there every day, rather than being seen by you once a week, once every couple of weeks to once every four weeks. So really, that comes into to triaging the patient appropriately. And are they going to continue to use the heroin? You know, that really depends on where they're at with their substance use. If they continue to use the heroin, they will not get the same effect, but they will get some effect. Great question. Thank you. Dr. Sarver to add on to that, I think another question was what would be for those who are not seeking opportunities for recovery? You know, if you're diabetic patient doesn't want to use their insulin, there's not much you can do. Right. We don't in the medical community, we believe in patient autonomy. So, if the patient and this is America, it's a free country. Patients can feel free to live their lives the way they want to and deal with their consequences. If they're not ready to be in recovery, then you do everything you can to educate them, give them the resources, and then hope they come around. And Dr. Sarver, if I can just add on to that question about what do you do when they're not ready to be in recovery? I think we had a really lovely former recovery coach make a comment about how well they make connections and I can definitely see from what we've seen in our emergency department and our really amazing recovery team staff, that's our community health worker and our peer recovery coaches. It is very hard to overstate how important it is to have somebody there with lived experience and somebody there to be an ally who can really take the time with those patients, who can really help, say, you know, what do you need? And not everybody is ready for recovery at that moment. Not everyone is going to say today is the day I want to get into recovery, and that's reality. But what we can do is offer them Narcan, we can offer them harm reduction supplies. And every time we encounter that patient, we have to remember that's an invitation to recovery. And so, we've had individuals who have come and then come back and then come back. And we thought, well, geez, all I'm doing is handing out Narcan. And then several months later, they say, today's the day. I need help, I need a treatment program. And we've seen those success stories. And it's a really beautiful thing to see somebody that we were sure was going to end up in an unsuccessful overdose reversal, that they were ultimately going to lose their life. And instead, after those encounters, they're now in recovery and they're now in sustained recovery because they went through that process. So, I would say never give up on that. Well, I guess they're just not ready for recovery mentality because we are all and it's a chronic relapsing condition. Right. So, you might see somebody that was in recovery that's now back in chaotic addiction. But every time we meet them, we can start with harm reduction to reduce the collateral effects. So, the last question is, I'm wondering if any of the discussed addiction treatment modalities such as the injection affects those who have a psych diagnosis, such as schizophrenia, is a smaller dose prescribed? I'm thinking it depends on the severity of the symptoms and age, right? No, actually there are two doses of sublocade. That's injectable depo buprenorphine, 100 milligrams and 300 milligrams. And it depends on the patient, not their diagnosis. In fact, a lot of times with patients who have schizophrenia, they will require higher doses of medication. So, what we do is you initially get a 100-milligram injection, you come back to the clinic, if you continue to have cravings, then you get a 300 and you continue either 100 or 300 monthly thereafter, depending on effect. So, gone do psych diagnosis come into play really? That's going to come into play with how well they're able to deal with the sort of social determinants of health and how severe their psychosis is. But not that doesn't usually affect the dose of the medication that we provide.

Thank you, Dr. Sarver. So, the next question is for Heather. How did you go about collaborating with so many community members? Yeah, I think that question might be in relation to how did we engage with so many providers and community members across North Dakota? So initially we did listening sessions to kind of talk about what the work we were wanting to do and to get feedback on how that model could work across communities. And then as we started to build providers in those different regions across the state, we started doing regionally based provider meetings. So, meeting with those providers in that region. And then any time, you know, really got to be good word of mouth. So, you know, then bumping up against people, receiving services and supports in those programs or, you know, hearing about it from others that we would meet with them and talk through that. And I think one of the bigger parts of the reasons why Free Through Recovery and Community Connect was appealing to so many providers and provided so many opportunities for expansion of behavioral health workforce to provide supportive services to people was that we really made the programs not have to have a lot of administrative weight to pull for organization. So, a smaller organization without a big budget could afford to start providing services in this program. So sometimes we even saw people that were working somewhere else, you know, full time might start their own business part time and start providing these services. And so, it just really is like low barrier. And then we provided the training and all of those things at no cost. And so, they were able to provide we're able to provide a three-day care coordination training that's required and also a five day peer support training at no cost to that providing agency. And then we reimburse for travel, hotel rooms, things like that that can make it a barrier. And so, when we're talking about these state funded programs in the federally funded Medicaid programs, a lot of times these organizations needed a lot more financial support and technical assistance to make the transition to becoming Medicaid billing organizations, which is what our state is going through right now. Thank you, Heather. And we wanted to let you know that the Biden-Harris administration just announced a new White House initiated national challenge to save lives from overdose. The challenge is a nationwide call to action to stakeholders across all sectors to save lives by committing to increasing training on and access to lifesaving opioid overdose reversal medications. This challenge is encouraging all organizations and businesses across communities in the U.S. to ensure that communities are trained and have access to this lifesaving medication. So please look at that dedicated webpage.

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