Opioid Podcast Series, Season 2, Episode 5: Management of Patients on MOUD: Key Takeaways and Series Wrap Up

Welcome to our final session of our webinar series, Ensuring Medication for Opioid Use Disorder Through the Care Continuum. I'm Candy Hanson with Superior Health Quality Alliance, and I'm going to be one of your hosts for this session. During this session, we are going to feature two guests with lived experience in recovery, as well as a returning speaker who will talk about an initiative she's been leading, working on the opioid crisis. And now I am going to turn it over to my co-host, Greg. Thank you, Candy. So, my name is Greg Sieradzki with HSAG and I have the privilege to introduce our guest speakers for today's session. First, you will hear from Terry Green-Wright, who is the Tennessee Recovery Navigator and recovery care coordinator for the Medication Assisted Treatment Clinic at Cherokee Health System, located in Knoxville, Tennessee. Terry is a certified peer recovery specialist. She obtained a bachelor's degree in psychology, concentrated in addiction counseling at Augusta University. She has been with Cherokee Health System MAT clinic for more than five years, and I've seen the clinic grew from 120 to currently 400 patients. She's very passionate about supporting the growth of MAT clinic to rural areas, educating our community against stigma, and helping as many people as possible that need substance use disorder treatment. Then Johnny Peoples. Johnny is a certified addiction treatment counselor and a mental health counselor in Orange County, California. Johnny has been comforting for more than 12 years. He has obtained his bachelor's degree in applied business management and an MBA in leadership. Johnny is currently health and fitness coordinator for the Moore Mental Health Center in Costa Mesa. He's also head track and field coach at Santa Ana College. Terry, the floor is yours. Hello, everybody, thank you so much for having me here for this opportunity, I very much appreciate it. Again, this is something that is very near and dear to my heart. As a certified peer-recovery specialist, to share my lived experience, to reduce stigma and bias for people that that suffer with addiction disorders as well as mental health disorders. I will start off my story starting when back when this became an addiction for me in my life. I was 14 years old and an addiction became my best friend and my everything. I came from a broken home. My parents were addicted. I was being molested from the age of 9 to 12 years old. By 14, I wanted to escape all the hardships that I endured for so many years. I began using drugs and alcohol after being prescribed hydrocodone and Xanax at the age of 14 for migraine headaches and anxiety. This was the gateway into insanity, rather than the help that I needed. I began to seek out higher doses, which eventually led me to highest doses of OxyContin, morphine, and heroin by intravenous use. I lost custody of my children. I became a sex worker, and I was in and out of abusive relationships. I did things I never thought that I would ever do. I'm able to see it was not a moral failure on my part. It was the insanity of addiction. When I was finally ready for sobriety, I moved to Johnson City and entered into an integrated program that provided medication assisted treatment with buprenorphine, intensive outpatient classes, traditional therapy, as well as community celebrate recovery meetings that I was attending. I had ended up spending a year and a half in Johnson City and moved back home to Knoxville, where I stayed on the continuum of care MOUD by engaging in a psychiatry clinic that continued medication assisted treatment with buprenorphine therapy, the traditional therapy group therapy and attended celebrate recovery meetings here in Knoxville. I stayed on buprenorphine up until five years ago when I tapered myself off of the buprenorphine, but I still continued to see as well as to this day, seek psychiatry for med management, traditional therapy and meetings. Unfortunately, as of three months ago, I had to restart buprenorphine due to being struck with chronic polyneuropathy, causing intense pain and cravings to use. So, I had spoke with my primary care physician and I tried naltrexone for approximately three weeks to try and help the cravings, but the cravings continued. After trying that for three weeks, I came off the naltrexone for two weeks and was placed back onto buprenorphine to maintain the cravings as well as maintaining my recovery. So out of 13 years of recovery, it will be 14 years in September. I have learned a lot through going back to school to receive my bachelor's degree in psychology it helped me learn more about addiction myself in return and how to help people that are suffering through the same things that I've been through with active addiction and the great world of recovery and living life again. So again, thank you all for having me. And I hope

that my lived experience can contribute to more education for people to know that, you know, again, this isn't a moral failure. These are real life events that happen in people's lives. And, you know, this this isn't the this wasn't the role in my life I ever expected to go down. But again, it happened. I've learned from a lot of it going back to school and getting my degree and learning psychology and addiction counseling, but also going through the traditional therapy and continuing that integrated health care system of the MOUD model as well. Johnny, would you like to go next? Yes. Hi. How are you all? My understanding has brought me to a place of serenity and peace in my life. And I'm grateful and honored that the folks would have me on here to share my experience, strength, and hope. My journey started October 4, of 2012. I got sober via indigent detox in Costa Mesa, California, called a Charlie Street Detox Center. There was about 28 men hopeless in nature, dying from the disease of alcoholism. Men are urinating, defecating on themselves and puking and seizing in buckets that I was sitting in there, you know, I didn't have that a lot of zeros in front of my name, a lot of zeros behind my name. And I was an absolute zero and I didn't know which way was up or down. And so, I got to that place over there and people were talking a lot about trusting God, clean house, and helping others. And I had no idea how to do that. And I was so grateful and honored to be there that everything that they asked me to do, I started doing. They were cleaning up buckets and stuff and put people in showers and washing them up and stuff and calling an ambulance for the men that we're seized and stuff like that. And the three days that I was in that center, I saw a man die from the disease, alcoholism. And I saw it prior to me going to that that center, I never thought I could die. And seeing that man die changed the trajectory of my life. But I didn't know anything about recovery. And there was a man I walked into the detox center, and he said, he's a he said he's an alcoholic. His name is John. He said if he wasn't drinking, he was thinking about it. And there I was sitting in a detox center where people were dying, a urinating, defecating on themselves and I still thought I can take a drink of alcohol. And needless to say, I wound up asking that man for help and he helped me work through the process of Alcoholics Anonymous to the 12 steps of Recovery via the Alcoholics Anonymous nig book and the a 12-hour workbook, and we work that stuff line by line, page by page. He asked me if I had to go out of my understanding, which I did, and he asked me if I were willing to go to any length for victory over alcohol, and I said yes. He drove 26 miles from Mission Viejo, California, met me at a Detox Center every Wednesday around 7:30 p.m. and he helped me change my life. He thrusted me into a life that I didn't know existed. Prior to coming to getting sober and in recovery I had worked with a lot of people. I did a lot of things in my life athletically that did that that people should say to make you successful, but yet I still drink and use drugs. And so that the life that I had before compels in comparison to the life I have today because it's the service of others. And I got the opportunity to learn about who I was and put things down on paper and understand that I had a disease and I needed to do something about it. And so, I'm grateful for that man that came into my life and helped me change my life. And with that experience, you know, I always thought about God. If I can if I can get well and start helping other people may be able to do that. And so, I talked to the sponsor that was sponsoring me and I left my education on the table back in 2001. And so, I decided to go on this recovery path of education. I wound up going to Cypress College in 2013 and enrolling in their Addiction Studies program, which was a two-year program to get certified in the state of California, to work in an MOUD facility. And so, I was able to do that. I went to school at night, I'm sorry, I worked in recovery at night, went to school during the day. I wound up getting my certified addiction treatment counselor certification in late 2012, early 2013, which allowed me to start working in MOUD facilities and stuff like that. So, I started at the low level. I started as a house manager. I learned about shift notes and learned about how to monitor behavior of patients and clients. And I worked my way all the way up into a counselor, a counselor one, a counselor two in the state of California, and then also worked my way up to program director. With that came a heavy responsibility. I got to also look at all the modalities and all the things that treatment entails as far as helping patients and clients, looking at it starting from a baseline all the way from intake all the way to discharge. And so with the experience that I had from being an alcoholic and an addict to do the education piece, I think it's very important that that I do that on a day to day basis and being able to understand that there's differences in every person, keep an open mind for new experience because every patient and client is different, everybody's different has different avenues of approach to help people. So, with my lived experience, I'm just grateful that God gave me the opportunity to sit down, to slow down and to keep my mind open and to learn the things that remain teachable, that they can help me continue to

help the patients, the clients I get opportunity to work with. And I'm honored and grateful and thankful to be on a panel like this, to share my experience, strength, and hope, and also to share the education that I have because I believe the to tie in together experience and education are two most important things, I believe a human being can have. I can have an experience, but I don't have the education. Then I won't be I won't be able to pass along the things that that can keep me teachable every single day. So, again, I'm honored to be here. I apologize. I wish I could I can be on to see faces. I like to see faces and eyeballs of the people that I'm talking to. Unfortunately, unfortunately, I'm here thought, so I'm grateful for it. Honored to be a part of this panel with every person that's on here. So, thank the Lord asked me to be here. I think Terry and Johnny, you should be proud of yourselves. You know, I commend you for having the courage to share your challenges and successes in your journey to recovery. And I think, you know, you should be so proud of helping now your community and the people who are who need the help now around about path to recovery. Thank you for sharing your stories. They're very powerful. So it's now my pleasure to introduce Lindsay Sarver. We join our guest speakers for the panel discussion. Lindsay Sarver is a community health improvement strategist with Healthy Jackson County Coalition, a cohort of over 300 community stakeholders seeking to improve the health of Jackson County and two areas in Indiana. Ms. Sarver has two decades of experience in social services, working with adults and adolescence experiencing serious mental illness, substance use, and individual and collective trauma. Lindsay's education is in justice systems with an emphasis on human rights from Arizona State University. She also has additional certification in chemical addiction counseling, obtained a master's in paralegal studies from the George Washington University, and had the privilege of studying the impact of collective and individual trauma in South Africa. Lindsay worked previously in Healthy Jackson County to create collaboration and address logistical and ideological barriers to success in clinical and community settings. Lindsay, would you like to tell us more about your work and maybe share your perspective about what you just heard from Terry and Johnny? Yes. Thanks so much and thanks, everybody, for being here. It's great to be invited and to Terry and Johnny for sharing so freely with us. Part of the work that I do that I've had the privilege of doing in the last few years through the MOUD program, has been working with our hospital and a range of community partners, including our local FQHC, our federally qualified health care clinic, our homeless shelter, our recovery community organizations, and other partners in the community to bring resources into place. Specifically, we were able to launch a warm hand-off MOUD Program out of the emergency department. Jackson County, Indiana, is in a rural community about halfway between Indianapolis and Louisville, Kentucky. We are the closest emergency room for a lot of people for about 50 miles or so. So, people who are experiencing an overdose within 50 miles typically get brought to where we are. And so, one of the things that I loved, the way Johnny mentioned, he wants to see the faces and the eyeballs of those he's talking to. And Terry mentioned the words like, I needed to learn that this wasn't a moral failure. I was living in chaotic addiction. And so one of the things we did in the warm handoff program was not only being able to offer induction for MOUD, but with buprenorphine from the emergency department and send our patients away with a supply of medication to help get them to that next appointment, but also to put in our recovery team of people with lived experience and community health workers for that pair of experience and education, as Johnny liked to call it, that are there to help our people who are living in chaotic addiction or experiencing a crisis, to help get from that crisis to the next spot, and then hopefully into stability and long term treatment. Over the six months of when we implemented that recovery team and our warm handoff to the end of the grant period, we had a 53% reduction in overdose rates. And I think that's because quite literally, our recovery specialists for saving people's lives, they were there to be there in a moment in the way that somebody like myself who doesn't have lived experience can just never be able to relate. They were able to help identify and build that client motivation for treatment and compliance to identify the right level of treatment. Are you ready for inpatient or outpatient setting? Do I just need to leave you with some naloxone? Because we're not ready to commit. But every time we meet somebody as a as I've heard it said, like, every encounter is an invitation for recovery. And so, the work that we do is about helping create those opportunities and those invitations for recovery. And then also logistically figuring out what we need to do in our hospital and in our community to build a space that doesn't have the stigma or doesn't have logistical barriers to participation. Things like do we have hiring practices that allow people with lived experience or who are just as affected to come into this space? How do we handle the relapse process that is

often a part of our addiction recovery method, right? Recovery is very rarely a straight line. So how do we handle that and how do we create opportunities not just for recovery for our patients, but for ongoing care so that we can incorporate those people that experience and so that we can support the people in our own community that we may not even have identified as people who are experiencing addiction or mental illness. So, I'm just so grateful to the Terry's and the Johnny's, and in our case, the Sara's and the Rita's and Ben's and the people in our own community who are making these life changing changes. And I'm honored to be a part of it. So, I encourage anybody who says, what can I do to really say being an ally is more than just saying good job, but really about examining your own selves and your own internal processes to figure out where that stigma and that bias and that discrimination might be hiding even accidentally, because we're not thinking through the things that people with lived experience really need. Thanks, Greg. Thank you, Lindsay. So, it was very powerful. So, thank you for sharing that. So, we are going to move on to the panel discussion. We wanted to get some takeaways from our previous sessions, and we asked our panelists if they wanted to elaborate a little bit more about some of the key takeaways we had a during those sessions. Terry, do you want to go first? Sure. So, my biggest I think discussion would have to be that all primary care providers should be prescribing medication assisted treatment for their patients or for their treatment with OUD. And a lot of it is the warm handoff, the transition of care? That's just something that we don't see. We need more Lindsay's. We need more Linsday's. And her teams working in this world. But as far as in our area, maintaining, MOUD through care transitions is unfortunately, it's rare. I rarely hear about patients coming into our facility at Cherokee Health Systems into our MAT clinic with their last MAT prescriber administering buprenorphine or a Vivitrol Naltrexone prescription to last until we can start treatment. And this is a serious problem in the world that we live in, considering that the DEA waiver no longer exists. So there's no reason but arrogance to send someone off without buprenorphine or Vivitrol prescription to last until they can get in to see a MAT clinic provider. So, there's that drop off that we see a lot. And again, this is where we need a lot more Lindsay's to help teams and other appropriate care providers, even to take in MOUD and OUD patients with prescription MOUD or medication for alcohol use disorder. So, in the perfect world, you know, we could see warm handoffs, but two thirds of the time, realistically, that it doesn't happen. Therefore, individuals that come from MAT clinics, the EDs of hospitals and inpatient facilities, they just do not provide warm handoffs. And a change really needs to be made. When patients go without MOUD, they fall out of care in early recovery, which unfortunately leads to tragic consequences. So, this is things that I have seen that I can actually say I have lived experience of just going through this. So primary care providers should definitely, definitely be prescribing medication assisted treatment. And again, with the DEA waiver dropped, we should see more of them doing that, more of them trying to get into grant-based programs and things like that. Because a lot of times these patients that I see, they're coming in with no insurance. They might need inpatient help. And, you know, if they're in our MAT clinic, yes, we can prescribe them buprenorphine to get them through until they can get into inpatient. So, we need more primary care doctors saying, okay, we'll prescribe and help this bridge this person with buprenorphine to help save their lives until they can get into inpatient or until they can get into a medication assisted treatment program. And so, I have a question for Johnny and Lindsey. So, since the removal of the X-waiver, did you see, as you see in your community, more primary care providers prescribing buprenorphine? In my area. You ask the question? Yeah, well, it's a little different for me out here in Southern California because I'm on a mental health side now. So, there's a lot more identifiers for, you know, the bio psychosocial criteria that allows us to use different modalities. So, if the buprenorphine is not available, we're looking at the last discharge from where that patient is coming from when they get to us and we have things in place right now based off that same criteria in a bio psychosocial to say, okay, well we don't have this available lets you utilize these like we have some of the we have, you know, naltrexone, vivitrol. So, from the last discharge, from wherever they came from, whether they be the hospital or just say detox, we might have other things in place like that that could be what we call a just a just a, uh, a quick, not a quick fix, but a quick solution to until we can do, we can medically evaluate them in the intake and see what those MATs may look like. So, for the answer, your question yes and yes. So, we have a couple other things that we can use. Part of that that patient are coming in and getting the care they need. So. I'll just add to that. And again, we're I'm on the other side of the country right here, halfway in the middle. And so, Jackson County, Indiana, one of the things we had hoped for.

I'm married to an X-waivered physician who started a program out there. So, it's something that was part of my work even before and then I get to see very personally watching my husband work as an MAT doctor who's a primary care doctor doing inmate and then with my work in the hospital. So, I kind of get it from all sides. But one of the things that we had hoped is that when that X-waiver went away without requiring that work and then just needing 8 hours of education, that we would see primary care providers say, okay, well, if they don't have that extra burden, I'm ready. I'm ready to go. And unfortunately, what I think has happened and what we continue to see happen is this frustrating resistance from primary care providers who either haven't had the education or are just afraid. Right. We went through we watched all the lawsuits with all the Oxy's. We've watched the lawsuits of people. We don't want to be pill pushers. We don't want to be doing this. And so, when that's where when I say if we want to be an ally of supporting people with lived experience in recovery, we need to be going after the logistical barriers. And one of those barriers is that continued stigma and lack of education for providers to say honestly and I'm sorry, this is so ungentle, but you cannot recover if you're dead. Right? And so, if our question is, well, I need to go help those people, those people are already your patients. Given the statistics of addiction in our community, if you are a primary care provider, those people are already your patients. They're just afraid to tell you because you are not creating an environment or asking the right questions. And so, if you want to be an ally of recovery, it doesn't matter if there's an X-wavier or not an X-wavier or if you're asking the questions to invite them to recovery. And if you're not treating addiction like you would treat heart disease or you would treat diabetes or you would treat anything else, some of our chronic medical health conditions we can treat with behavior modification. Sometimes you could be a vegan and eat very carefully and you're still going to get diabetes. And we don't tell you that you are moral failure because you take insulin. We just say it's time to take insulin. We don't tell you to die of liver disease because you have high cholesterol. We just say, let's treat your high cholesterol and we need to be doing that as primary care providers. So, we've had some opportunities. When we take primary care providers that say, I'm doing it, it's really not that hard. Let me teach you. And so that's we're providing that technical assistance and that consultation as a medical provider to other medical providers was able to help us go from one Medicaid accepting MOUD provider to six in the span of six months. But without the continued education and support and without working through the barriers from the upper-level management who maybe doesn't understand or putting in their recovery specialists that can handle the insurance questions or the missed appointments or the transportation barriers on the backend. Those are supports we need to really make primary care providers feel brave enough and supported enough to really engage, I think. Yeah. Can I add something to that? In addition to what you said about the about the, you know, what we do then when we do the insurance stuff as a counselor or as a therapist, it's like their thing that needs to be signed off on. So, we do an interpretive summary at the end. So just say for instance like, you know, there's a question about, you know, the, you know, biomedical conditions coming in and what does this patient need versus what this patient is not getting. So, I think in an interpretive summary, we I harp on those conditions that you talked about. There might be some diabetic stuff from arthritis up, some high blood pressure, some biomedical conditions that that patient might have that, you know, like they don't know. So, in that interpretive summary, we hammer home the importance of making sure that those MATs or whatever may need to be placed needs to be for that patient immediately. That you made a good point with that because I did one like a month ago where there was a patient, you know, obviously in need of some MATs and stuff like that. We knew that in the intake. But, you know, because the doctor said it didn't meet the criteria on the eighth and we weren't going to go that route, but we had to put in that interpretive summary how important it was to even get that patient stable. Does that make sense? But I'm just going to make one more statement about the medication. I know we have a lot of clinical providers on here, but for those who aren't, one of the questions we get a lot is what if I give somebody a three-day supply of buprenorphine? What if they just sell it or give it away or never come back, especially at the emergency department, even from our physician. So, what if we give you buprenorphine and we never see you again? Yeah. So that I would say when in doubt, hand it out, clinically speaking and with the studies done in California and in other states now for more than ten years, one of the best benefits of buprenorphine is specifically for opioid use disorder, is that it has a respiratory ceiling effect that protects you from additional overdose. So even if somebody we induct them and they say, I changed my mind and they go out and they try to use illicit substances, they found

out this. That buprenorphine we gave them for those 72 hours protects them for up to another 36 to 48 hours. That keeps them alive, even if they're using because it has a higher affinity for those opioid receptors that are in your brain to keep you alive. So even if we never see them again, we have another 36 to 48 hours to have another opportunity to engage in a right to recovery. That's one so that they're not going to just be a return patient in 12 hours to your emergency department. That's two. You're saving $5,000 to $8,000 for an opiate overdose. Even if we're not concerned about them as human beings, it's cost savings to give them $4 of meds instead of $8,000 for a repeat overdose. And additionally, when we put our recovery team in there, we had a more than 75% success rate at getting them from overdose with induction to their warm handoff appointment. And once they were in treatment, we had an 87% treatment compliance success rate with our opioid overdose individuals when they were partnered with our peer recovery coaches. So, I cannot stress and those peer recovery coaches, if you're paying them $20 an hour, for example, they have saved you if they get five people into recovery, they have paid for their annual salary in the first two months of working and hours have paid for their annual salary six times over already in the first eight months of working. So, it is a financially smart decision on top of being a morally right one. Thank you, Lindsay, very much. Yeah, go ahead, Terry. We have time. So, would you like to add something, Terry? Yes, I was just thanking, Lindsay, for everything that she said, because it everything is so true. And if we sometimes look at it so, you know, it's bad that we have people that place a price tag over a life, you know, and as what I do as CPRS, I'm a certified peer recovery specialist. So working in the integrated system that I work in, we, you know, it's not the greatest money in the world but we do what we do because we love it, because we're there with the lived experience to help these people and say, we know where you been and we're going to be here to meet you where you're at. The other thing was how we're at Cherokee. We are integrated system. So, we not only have the MAT clinic, we have primary care, we have dental, we have vision, we have Pedes, we have PHC psychologist, licensed clinical social workers. So, we have the whole range of integrated care, but, when we have all these primary care doctors that don't want to involve themselves in that, it hurts. You know, it's like, again, you promised to do no harm to your patient and you're treating them for, like Lindsey said, their diabetes, their cholesterol, but then when it comes down to the needing somebody in MAT, who do they call? They call me. Hey, Terry, I need you to either get this person in MAT or get them into inpatient. Okay. Well, you know that they need Naltrexone because they've quit drinking. Why not go ahead and just prescribe me, not have primary care doctors that won't even prescribe naltrexone. And it's so disheartening because they're your patients, you know? Like, my biggest motto is, just see the patient. Just see the patient. You know, don't say, oh, well, I'm double booked. I can't. Nope, I double, and triple booked myself one way or another. I'm coming to see that patient because if the iron's hot, they're striking, then I'm going to get them inpatient if that's what they want to do or they're wanting to do a bupe induction. Okay, I'm going to be there to help them just see the patient. And if we could have more primary care physicians to think that way and say they're not a dollar sign, they are not moral failures, they're another human being that I took the oath to do no harm. So, I'm going to help them every way I can. That is what we do need to see more of that. We unfortunately just don't see a lot of with the DEA waiver gone. So, it's you know, it is disheartening to see patients be turned down by primary care physicians when all they need is just, they need help, they need medication help, they need behavioral health help. And we should be able to provide that. Yeah. Thank you. Something else I wanted maybe to have your opinion. So, we took to the definition. We talked about supply. And when you look at this point like benefits of injectable, long-acting buprenorphine, big study. So, this is my understanding we tried to improve the telephone we sent of patients from hospitals to nursing homes to home health agencies. Whatever. And when I heard about this medication, one most medication, especially for people who are struggling with substance use disorder, but also mental health and maybe with homelessness. In California, I know a lot of physicians are trying to prescribing just because people are living on the streets, or they don't want to be steal for that medication, methadone. I don't make it literal. And but I know there are some areas in which studies very expensive. And sometimes when you prescribe, we study in the ED you are going to be paid. But if you prescribe in inpatient stay, you are going to get a bundle. And so, the hospital will have to cover a part of this cost. So, do you have any perspective about this study? One of you we work with sublocade and the MAT clinic and what we have discovered if insurance companies don't pay for it is very expensive. We are currently working on getting grants to try and help cover for sublocade because it is an

amazing medication for people like you said that suffer from homelessness because then they get a full 30-day supply with that injection. And I've seen patients once sublocade, they do great. I just recently had a patient come off the sublocade and she did amazing. And there wasn't a withdrawal period. Unlike if she was jumping from eight milligrams of Suboxone to completely off, there's going to be the withdrawal period. With her, she didn't experience withdrawal because it just slowly eased out of out of the body. And she did amazing. And maybe, like I said, got a few more patients that are on sublocade because the insurance pays for it. But I even see what's so sad is my nurse, our RN, in she's the one who does, pays and deals with the insurance and trying to get these people. Vivitrol and Sublocade are like pulling teeth because they say, oh, well, you know, we have to try other treatments first. If that doesn't work, then maybe we consider it, maybe we'll consider it, but then they want to reconsider it months down the road. So, we're seeing a big barrier of even insurance companies being an issue and our grants at the MAT Clinic does pay for Vivitrol so we can help people get on Vivitrol that don't have insurance and then the grant covers their medical needs as they're seeing their providers from their MAT clinic doctors to peer support and BMC, all that's included in the grant. So, like I said, we're trying to now work on a grant to get sublocade because it is an amazing new drug to help get people that are suffering with OUD a 30-day span. And funny thing and I'll stop, I had I remember the first two patients we ever tried on sublocade, and this has been three years ago. They had been on Suboxone for two years prior to getting on sublocade. And then they had said, you know what, it's been the greatest feeling and knowing that there could be a zombie apocalypse and I'm going to be okay. I'm going to be okay. I don't have to worry about dragging my medicine along with me and being sick, you know? And I just laughed about that, and I thought, you know, that is like a truth of, you know, patients that have problems with taking their meds on time, same time every day and compliance issues, basically, sublocade great way to go and it should be prescribed more often, especially at the ED when there's an overdose, because then you're giving them a 30-day supply, 30 days to live. So, you know, I think it's an amazing, amazing new drug and in MOUD, so hopefully we can start seeing more of that would be great. Piggy back on that just a little bit. Well, like prescribing subacute strain of the emergency department after an overdose has some problems because you need at least a seven day or so supply to know what your tolerance level is going to be. I would definitely say sublocade here but the others work. Medicaid does cover some of that in our state here in Indiana. But one of our biggest populations of concern are that underinsured, underinsured, or those people with the really high deductible health insurance plan because it turns into about $1,200 dollars a month process. However, I can like piggyback on Terry people saying I just need to make one right choice once a month. Right. We have individuals with serious mental illness who get their Risperdal once a month because having to decide to take your anti-psychotic medication when your brain is the thing that is sick and then trusting the thing that is sick to do the right thing is not always a logical expectation. And also, when we talk about that respiratory protective effects, like she said, that sublocade comes out very slowly. And the more months you are on it, the longer you have protection and that protection against withdrawal, but also protection against overdose. So, if somebody, for example, our justice affected population, if we start them onset sublocade for 60 to 90 days, getting out of jail, somebody who's just been released with substance use disorder out of jail is 100 times more likely to die in the first 48 hours upon release as the general population, 100 times. But if they've had some sublocade and we give them an injection on their way out the door, we are providing protection for those individuals that's protecting us against the ER visit costs of an overdose or death or just other suffering and trauma for that individual. So we definitely see those benefits and when we're concerned about diversion accidentally or otherwise, if there's intellectual deficiencies or there's a risk of diversion because you think you have to share your sublocade with your partner or somebody that's coming in that's pressuring you to take it, or you're staying in a homeless shelter and you can't protect your medication or any of those other reasons. Or in our case, you're in a rural community and there aren't enough pharmacies with enough sublocade or Suboxone. So, you may not be able to get your prescription for three or four or five days, so then you're stuck with what's on the street. Sublocade is a great way to make sure you are covered, and you don't have to keep finding that transportation or that bus token or that time off work to get to the pharmacy and get to the appointment to get the new prescription every 1 to 2 weeks. So, we definitely see the benefit of it. The cost is abysmal. So that's when we talk about logistical ways we could support in the hospital or in the field, writing those letters of medical necessity, making those arguments, lobbying for those changes, going

up to Congress and saying, I'm the physician and it's my medical expertise, that this is a medically necessary medication and method by which we administer it. Those are the conversations that need to be happening by all the people with the credentials that get listened to. So, Johnny, would you start us out by telling us more about the biomedical conditions that patients or people in recovery are experiencing? Yeah, absolutely. Yeah. So, what we do is, you know, when I'm doing, I meet, what a new patient we have what we call a bio psychosocial report thing that we get to do. It lists all the biomedical conditions that a patient may have prior to coming into treatment outside of their medical diagnosis of typical schizophrenia. So, some of the things are the parts of the day that diabetic have severe arthritis, high blood pressure, some type of kidney disease, trauma, complicated grief, social anxiety, chronic pain, suicidal ideation, PTSD. So, a lot of those are biomedical conditions. Prior to diagnosing that patient with their primary, you know, the primary issue would be some of those things. So those are some of the things a lot of the things that we see coming in, there's a myriad of those things. If you were to go, you could see that. But those are most of what that we deal with. Where I'm at right now, one of the major ones is trauma. We see a lot of trauma coming in, you know, with patients, rather, disclosed or undisclosed. And so those are those are some of the ones that I get opportunity to see every day prior to me doing the biopsychosocial and ASAM criteria. Thank you for that journey and thank you for bringing up the issue of trauma, because as we all know, the trauma has a huge impact on so many things in our lives. What are the most effective strategies and programs that people in recovery benefit the most? I love this one. It is so I do not believe that there's a singular strategy program that is most beneficial. I have found that not only in my recovery, but also working in the MAT clinic, that the most beneficial action is to use utilize all models of care and individualize it by the patient or client that you are working with at the time. It's about meeting people where they are at, where they have been, and what they have been through may take a certain type of medication and or a particular type of specialized therapy. Some people may need a higher level of care and need an inpatient detox and or inpatient services. This is a reason why assessments are so important is also to distinguish the care and individual needs. The individual needs. Certified peer recovery specialists cannot formally administer clinical assessments, but a CPRS can simply talk to the individual on a level playing ground of how addiction can control us, provide the next steps of and in or outpatient model of needs with the recovery or with the individual's input on what their goals are. So again, meeting them in the middle. And remember, we cannot expect an individual to do well in recovery if they are pressured into what an assessment says to do, though. So, it's kind of a double, double fold here of assessments are great. We need to use them. But at the same time, we still have to listen to the patient, and we rely on their related experience to develop trust and someone they can relate to in return. So therefore, we must meet the individual where they are at and where they can see themselves grow in an individualized treatment program that's fit for them. So, you know, assessments are good, they're great. We need to use them and have them charted because otherwise, you know, we don't know about some traumas until they finally tell us if it wasn't for assessments, we would you know, that's a way to know beforehand and say, hey, this is a behavioral healthcare option of seeing a traditional therapist for trauma therapy or individual trauma therapy. You know, and if they want to take that, then, okay, but at least offering to let them know what all their options are without pushing them into it and meeting them where they are, I think, is the most important strategy to use for people that are in recovery. And what's going to benefit the most is ultimately meeting them where they are and take all of these tools that we have as providers and utilize them to take it to the patient where they're at and say, this is what we have and making sure they're a part of their team. That's the biggest thing that we talk about in in our MAT clinic with our patients is, you know, we work as a team here with the doctors, with the peer support, with the BHCs, with case management, primary care. We all work as a team for you. We are here as a team for you. But we want you a part of this team. We want you to say, hey, I don't quite understand this option or hey, I'm not ready for this option. Pushing them into any option is just the best way to create, it feels like sometimes a relapse, a slip because they're feeling pushed so much into something that they don't know which way to go. And when that happens, that trust barrier breaks down. When the trust barrier breaks down the patient is going to be very set offish. So, meet them where they're at that meet them where they are at. That is the best model of care and strategy they use to benefit most patients. Fantastic. You hit the nail on the head. You know what I say in treatment or in patient care is ad infinitum. There are myriad of ways and strategies and things to help folks that are in recovery. You

know, obviously, there's meetings, there's therapists, there's counseling there, family therapy, just looking at some of the things that we do. There are the CBT, DVT, there's art therapy, patient may fitness, psychoeducation, psychotrauma. There are different things out in the community. You know, they can go to pilates, sound bath. So, it's just what the patient needs like when we identify the stuff in the on the exam, the bio psychosocial you know assessments and stuff keeping in mind this is the person still. This is s person that we're trying to reintegrate into back into society even more so quickly than slowly. I've seen that the more that we look at the person as a person, again, you know, trying to try to rebuild the whole person through the therapy, through the counseling, through our family sessions to our groups, just giving them a myriad of stuff. Also making sure that that's the person that this person needs to get back to their family. They have children. They have an employer that's dependent on that, or they're an employee or they're self-employed. They want to get back to those things. So, I think using all the things that you talked about, Terry, in addition to identifying those markers, those things that brought them into treatment, but also keeping them in a crisis to understand they need to get help. But also, if we can get it back in the community, if soon, if sooner than later, you know. But we're creating an avenue of approach to help these people with all types of things. Because I remember I can see so much stuff going on where I'm at right now. I can see a patient from day one, then see them day 6 and see a totally different person. When you keep an open mind for a new experience. Thank you so much for sharing that. And that's so, so important. I was on a webinar yesterday where the woman in recovery was saying she was told at the time she went through treatment that her next steps were to go to 90 NA meetings in 90 days. And someone asked her, did they ask you about your preferences? And she said, no, nobody asked me anything. They only told me what I needed to do. And I thought, Wow, that's really unfortunate. And the first question we have, what is your best piece of advice for individuals who are asking for help but do not due to abuse or trauma during their journey. Johnny? How do you deal with that when someone doesn't want to disclose trauma? Yes. Oh, I. I just say they're ready when they're ready. There's no set time limit on trauma, because it is a real risky. Risky. I think you have to really let the like for myself, you know, being in the counseling piece, I have to really turn it over to the therapist and as the therapy deal with that side, because it's a risky thing where you can create a lot more damage if you were to try to go down that path, that that path without the proper education. So, I just say when they're ready, they're ready. When the therapist identified that, you know, the barriers to disclosure, we always say discover, disclose and discard. And so, we have to discover what's going on first, allow that patient to disclose it and then if that when they're ready to discard it. So, I only deal with it on a small on a very, very minimal thing. And I let the therapist, a therapist do as I just say when the patient's ready, they can discover, disclose, and discard to the therapist. Great. Terry, did you have something to add to that or. No, I absolutely agree. I can actually speak to this in again lived experience, I currently have a patient that has suffered tremendous trauma. And she, you know, sees me as well as a behavioral health care provider that provides her with trauma therapy. So, I wanted to give the best help I can in the area when she wants to talk to me about it, because there are times that she wants to talk to me about her trauma. I'm not her therapist. And, you know, I think the supportive, listening, and emotional support are the two primary factors to giving the best care to a patient with trauma. And that's what I try to provide, is the supportive listening, the emotional care, as well as I, you know, did a little research, you know, on top of what I've learned and I worked as a team, I hooked up with her counselor and I was like, Hey, I found this 17-step strategy of different techniques to help with trauma. Would this be okay for me to apply? In general, it was like learning grounding techniques, learning breathing techniques, learning different stress management, basically, techniques, which is something we already cover as peer support is stress management techniques. So, this these were kind of like stress management techniques that we were able to use with her trauma. And over the past three months of seeing me and her trauma therapist in working hard, getting through her trauma, she had it was, two days ago, she came into clinic, and she was like, Terry, I had to say thank you because this has helped me so much of just having you to understand me, you to listen to me and help me. You know, it's not only the therapist helped me get through my trauma, but you've helped me get through my trauma by helping me to face some things and be there to listen to me and what I need. Can I add on to that real fast, just real quick? One of the things I did in I'll do on a personal experience was there was some severe trauma in my life from 5 to 7, and I got sober at 37 years old, and I carried that stuff with me for a long time. And when I got sober and I was in a meeting, there was a person,

individual that shared their same experience. And I was able to finally I was ready. I was 37 years old, and I had never talked to anybody about it. And I was able to I was able to talk to share. And so, I think also hearing someone else share how they got through it, how they get through it can help people when they're going to when they hear of shared experience. Absolutely. Yeah. Thank you so much for sharing that. I would never. Last point is that I would never go through with trying to do any strategies of trauma if I had not had the counselor say, you know, I wanted the counsel because I'm not a counselor, I'm not a therapist. And I tell my patients that I don't want to misconstrue anything and then trust that way. So, you know, like, I'll let them know. But at the same time, it's very important going through what I went through in my trauma. I needed a trauma therapist. Peer support would have been great, too. But, you know, I explain you definitely need to see a therapist because this can help you in a therapeutic way. And I may not be able to help you. And it helped me seeing a trauma therapist. So that's why I would recommend it, is kind of the approach that I take with it. Yeah, absolutely. Thanks so much for that. And trauma is one of those things that I have experienced trauma in my life as well. And it's just it's not one of those things that you just wake up and say, oh, I'm going to pretend like I didn't live my life with trauma today. You know, it just doesn't work that way. Right? And you have to do it. And you absolutely have to do it when it's the right time, because part of that is part of that is feeling safe enough to disclose. And that's scary. So, the next question I think is getting at like if so, the question is, I frequently hear people say addicts choose to live that way. I also hear people say they have to want to change. What is the best way to approach people who suffer with addiction when you really want to help them? And I'm assuming that that question is meaning that someone that maybe they care about or know they believe has an addiction and they want to help them. But the person is probably might not be at that place yet. In my experience, being sober, there are two sides. I'm only help inside and out. But as a recovering alcoholic, there's not there is absolutely nothing humanly that I can do until that person's absolutely ready. That person that person has to decide for themselves if they be an alcoholic or an addict. And a lot of people are ready, but already willing to go the length of victory over their disease. And that's my experience in alcohol's anonymous since I've been day one since I've been sober. And there's a part in our book that says, I'm an alcoholic and I cannot manage my own life, be, that there's probably no human power that can relieve me of my alcoholism. Seek God if he could and would if he ever saw it. And there is nothing on this planet that can relieve a person of alcoholism until they're ready to do it. Absolutely right. That's awesome. That what a powerful statement. Thank you so much for that answer. Terry, did you have something to add? Oh, no, I just I agree. Yeah. I think when somebody, you know, isn't ready, then you can throw every resource at them and wish for the best because they're not ready. But it never hurts to go ahead and give them the resources and the support to meet them where they're at until they are ready. Yes. Yeah. No, because if they feel supported and they feel like they have resources when they are ready, then boom, there you go. They got their support and they have that resource. So yeah, I absolutely agree with Johnny. Awesome. I'm just sorry if I can throw in. I'm not speaking as a person with a lived experience, but I just want to throw out there when we're somebody who maybe doesn't have lived experience and we see somebody who's experiencing addiction or living in chaotic addiction, and we say, well, I want to help them. I'm waiting for them to be ready. One of the things that I want to just highlight is that that readiness is not an on off switch. We don't just wake up one day and be like, today I decided to be sober. It doesn't happen like that. And Terry and Johnny have talked a lot about when they feel safe enough, when somebody has been willing to disclose, as clinicians, are we asking the question, are we offering harm reduction? Are we doing it without stigma or discrimination? Like, yes, you're not ready to start MOUD today, but would you be interested in taking some Narcan with you? Because I love you or I care about you and I want you safe then healthy than happy, right? It doesn't have to be a god that you love under my house. These are the rules of treatment, right? You can say like, I recognize where you are, and I care about you. And when you're ready, I'm here. And until you're ready, what can I do to keep you safe and alive until the next time we have this conversation? And so that's one of those like, you can't make someone recover, but you can constantly create the circumstances that open that invitation. And that's where our work as our allies lie. Narcan, harm reduction is so important. Harm reduction and Narcan. Definitely. If I have somebody that really needs inpatient, not ready for inpatient, I give them Narcan. Someobody tells me, hey, I've got a neighbor down the road that's addicted to opiates. I give them Narcan, our patients. I have Narcan in rooms, I have Narcan sitting out across from the blood

pressure chair where it is seen. And everybody knows that come in there, you take it, no questions asked. You can go back and get more if you need it. And, you know, that's that for me, as a general rule, harm reduction is, you know, making sure people have Narcan, you know, even if they're three years in recovery. Still, it never hurts to have Narcan. Yeah. Thank you so much. Let me just can add. Heather, Heather. I like it. I like what Heather said, you know, you know, obviously there's a there's a firmness to being, you know, to helping folks, but it also a kindness to like. And what Heather talked about is one of the things I do like. Obviously, you know, I'm in a program and I know, you know, I haven't had an experience in being sober now helping people. And we had also a question about stigma. If you have one or two sentences you would like to share with the audience, Lindsay, Terry, and Johnny. I could remember in active addiction, stigma was like I could just the eyes would lay on you whenever you would go to the ER and it would be like, Oh, you're just another repeat case. Know what you're in here for and turn around and just leave you in a room for hours on end and give no care or compassion of, okay, you know that I'm addicted to drugs, but you don't want to do anything to help me, you know? So, the stigma as it was, you know, now 13 years in recovering, working as a UT navigator for University of Tennessee Hospital, that is something we do as navigators. We help teach and educate our doctors, our case manager. Our RNs, you know, every person at the hospital, we're about to be doing a eight series podcast for the medical providers of the University of Tennessee on stigma and how it's going to be a panel full of people like me and Johnny that are in recovery, teach and educate these providers that, hey, you know, you work with me all the time now and you don't look at me any different. Although I was the one that was here in your emergency room years ago. And, you know, it was this is just another junkie in my ER. Yeah, we're not there, you know, we're not. We're not. We're people that are suffering from addiction. We're not moral failures. It is a medical condition. It needs to be treated. Now we're seeing a lot more providers being more understanding with getting the education and hearing from peer support, you know, of, hey, these people went through it and look how they have come out. They have come out on the top. They're helping people. They took on the education and they're such an important part of the community. So yeah, I mean, it's, it's still there. We're doing better at it, but it's still it's it is still there with some people. Yeah. Thank you, Terry. Johnny. And I'll just say, obviously, I know the stigma was out there, but I always just reframe it how people are and redirect their thinking, like, what if what if it was a loved one of yours? What would you think? I wish I'd just flip it around like that right when I want someone to talk that language, be conscious of how I'm talking about someone, what labels I'm placing on them to understand it. Mental health is a mental illness. It is a problem. You know, try to empower people, you know, be honest about it. Right. So those things. So, this is this one is a little it gets my heart because I don't understand when people place labels on things because label labels means I have already had an opinion on the experience and I want to have an opinion when I have an experience. That's a great way to put that, Johnny. Lindsay, did you have a last comment? I just my statement out to like I think I've seen the clinics too. What do we do to help people who don't just want drug seekers or these labels that we put on? I love Johnny's statement about labels, but essentially your job as a clinician, as a professional, as a healthcare professional is to keep people safe and then healthy and then happy. Our job is not to judge them as human beings or to call them moral failures. Our job is safe and healthy and happy and supporting that person to live their life the way they want to live it. And so, we need to recognize that addiction is a barrier to being safe and healthy and happy and then to treat that barrier like we would treat any other condition until we can get them into the status they want to be in. Absolutely. That's fantastic. Thank you, Lindsay. How thankful people are that you all shared your stories and your experiences. We just want to say thank you. Thank you all so much. Thank you so much to our guest speakers today. It's just been such a pleasure to have you all with us today.

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