Fletcher Group RCOE Webinar
University of Vermont Center on Rural Addiction
June 2, 2022

[00:00:00] **Michelle Day:** Good afternoon, everyone and welcome to The Fletcher Group Rural Center of Excellence's webinar series. Today's session is scheduled to run from 2:00 PM to 3:00 PM Eastern Standard Time. My name is Michelle Day and I'm your moderator for the session along with Janice Fulkerson and Erica Walker. A couple of brief housekeeping items, and then we'll begin.

You enter today's session on mute and your video was off and will remain so for the entirety of the webinar. Your chat feature is located at the bottom right of your screen. Use the drop-down feature to communicate with either the panelists only, or panelists and attendees. Please direct all questions regarding the webinar content to the Q and A section.

Be advised that this meeting is being recorded and will be available to you on our website. Once it has been transcribed, you can access our website at www.fletchergroup.Org. Also at the conclusion of today's session, there will be a short survey [00:01:00] regarding the webinar content. Your participation in that survey is greatly appreciated and will only take a few moments to complete.

Our speakers today are joining us from the University of Vermont Center on Rural Addiction. Dr. Gayle Rose is Co-Director of the Clinical and Translational Cores for the UVM Center on Rural Addiction and an Assistant Professor of Psychiatry at UVM.

As a researcher, she has directed and contributed to projects broadly focused on clinical health services and patient self-directed care for behavioral health and substance misuse. In particular, her work has focused on application of various technologies to the identification and treatment of substance misuse in outpatient settings,

and on the integration of behavioral health in primary care.

Julia Shaw comes to CORA with 10 years of [00:02:00] experience in HIV, hepatitis C and healthcare system research and policy advocacy. She is passionate about healthcare access and health equity. Prior to joining CORA, Julia was the policy analyst at Vermont Office of the Healthcare Advocate, where she advocated on behalf of Vermonters for healthcare system improvements.

Previously, Julia managed a number of HIV prevention and reproductive health research studies at the Centers for Behavioral and Preventative Medicine at the Miriam Hospital and Brown University, where she gained experience in quantitative and qualitative data collection and analysis. Julia holds a master's in Public Health from Brown University.

And a bachelor of arts from the New York University. She has directly served Vermonters as a volunteer HIV test counselor at Vermont Care since 2013.

Jen Lyon-Horne has over 20 years of [00:03:00] experience working with children, adults, and family to address substance use and mental health needs, including identifying and addressing barriers, individual's experience and accessing appropriate treatment. Throughout her career

Jen has partnered with other providers, agencies, and organizations to promote multi-disciplinary treatment for clients.

Jennifer Noel served as a clinical social worker in Maine with a variety of populations and eventually ran a private practice. She then made a career shift and taught at the undergraduate and graduate level.

Jenny has always been interested in issues surrounding addictions. Before returning to her home state of Vermont in fall 2020, she was a tobacco treatment educator for Maine's Health Center for Tobacco Independence, where she developed educational resources and deliver presentations virtually and throughout the state. She holds a BA in Psychology from the University of Vermont and an MSW from the Boston University School of Social [00:04:00] Work.

Gail, Julia, Jen and Jenny. The floor is yours.

[00:04:16] **Julia Shaw:** Thanks so much, uh, good afternoon. And thank you. So The Fletcher Group for having us, we're really excited to be here today. My name is Julia Shaw. I am the Surveillance and Evaluation Core Manager at the University of Vermont Center on Rural Addiction or UVM CORA. Um, our mission at UVM CORA is to expand addiction treatment capacity in rural communities, by providing consultation resources, training, and evidence-based technical assistance to health care providers and community organizations.

Our main objectives are to identify real time needs of rural communities to deliver evidence-based technical assistance and training and to disseminate education and resources on evidence-based treatment and prevention to rural providers and [00:05:00] policy makers. UVM's CORA primary service area includes rural areas of Vermont, New Hampshire, Maine, and Northern New York.

And our center is also designed to provide services nationally, and we do serve clients in rural areas throughout the country. We have four cores within UVM CORA our surveillance and evaluation core, which I will speak to today, our best practices core, our education and outreach core and our newest group, which is the clinical and translational core.

And you'll hear about each of these cores in today's presentation. So throughout our presentation today, we'll use the example of Dr. Nelson. Dr. Nelson is a fictional healthcare practitioner who represents a typical client. We might work with that UVM CORA. For our purposes today, Dr. Nelson is a rural Maine primary care provider with 20 years of experience in a small private practice.

She is wavered to prescribe buprenorphine, but she's not currently treating patients with [00:06:00] medication for opioid use disorder. She wants to provide high quality care and wants to address all her patient's concerns each time they come to see her, particularly given the rural nature of her community and the transportation challenges that her patient space.

So our general process at UVM CORA, sorry, our general process that UVM CORA has been to first conduct a baseline, uh, has been to first conduct a baseline needs assessment in each state and our primary service areas. These are statewide surveys of practitioners and community stakeholders, which I'll speak to further later in the presentation. We then proactively reach out to survey respondents and offer our resources.

Our best practices core provides technical assistance in areas requested by the provider organization. And then we maintain those relationships and provide ongoing engagement and technical assistance. Our baseline needs assessments as well as our TA interactions inform our [00:07:00] education and outreach activities and help us decide which resources to create and disseminate.

So there's surveillance and evaluation core is where I work within UVM CORA. We do the data collection and analysis for the organization using

epidemiological methodologies to identify treatment needs and barriers in rural counties. We gather direct input from providers, patients, families, and policy makers using quantitative surveys and qualitative interviews.

We also monitor substance use patterns in rural communities by looking at larger data sources, including public health and claims data. Our work informs UVM CORA's technical assistance and outreach efforts. And we also disseminate data to our rural stakeholders. So, as I mentioned previously, we completed statewide baseline needs assessment surveys in Vermont, New Hampshire and Maine.

These surveys included substance use concerns, barriers to treatment, comfort treating substance use disorders, beliefs about treatment and [00:08:00] impacts of COVID-19. We also ask practitioners which UVM CORA resources would be most useful to them. And all of our baseline needs assessment data reports can be found on our website at UVM cora.org/resources.

Okay. So returning to Dr. Nelson, let's take a look at some of her concerns. So Dr. Nelson is worried about recent overdoses in her community. She's worried about increased stimulant, stimulant use, um, patients with chronic conditions who smoke and use alcohol. She's unsure if MOUD replaces one addiction for another, and she's worried her patients might divert their medication.

She's concerned about transportation challenges in her rural community, and she knows it's difficult for her patients to see different providers for each of their concerns. She worries that her patients won't discuss their substance use issues due to perceived stigma. And she's not confident that she knows the most current evidence-based treatments for substance use disorders.

So [00:09:00] focusing first on her second concern, she's worried that MOUD replaces one addiction within mother. This is something we do see in our data. Um, so in our baseline needs assessment survey, we asked practitioners to report their level of agreement with the statement medications given to treat people with opioid use disorder, replace addiction, to one kind of drug with another uh another.

These data are from our main baseline needs assessment. And if you look at the bottom row, you'll see that among practitioners who are not currently treating patients with MOUD 50% disagree with the statement while the remaining 50%

either agree or are unsure. In Maine the vast majority of our practitioner, respondents did have waivers to prescribe buprenorphine.

So many of these respondents like Dr. Nelson have waivers, but are not currently treating patients and have continuing worries about MOUD. So we know this is an area where there is significant opportunity for education. Looking at a few other [00:10:00] concerns um, medication diversion, stigma, and knowledge about evidence-based practices. Many rural Maine practitioners included these concerns in their top barriers to treating patients with MOUD for primary care providers

medication diversion was the second most endorsed barrier. Around one third of primary care practitioners selected lack of training and experience and stigma and bias and 17% cited, MOUD effectiveness concerns. And you can see that at among addiction medicine, practitioners, stigma was the most reported barrier.

So moving on to Dr. Nelson's goals, she wants to gain understanding of SUDs and how to treat them connect with colleagues who are up to date on SUD treatment, best practices and provide free education materials, and supplies to her patients who are at risk of overdose. These are the UVM CORA's services that practitioners rated as high priority.

And you'll see that each of Dr [00:11:00] Nelson's goals are represented here. So polysubstance support was the most requested resource and money practitioners like Dr. Nelson wanted support with co-occurring conditions, mentoring from champion providers, harm reduction supplies, and other technical assistance related to treatment best practices.

So the data that I just talked about are the kinds of things we use to inform our technical assistance, assistance and outreach activities. Um, and I'll hand it over now to Jen Lyon-Horne, who will talk about our best practices core and their technical assistance activities. Good afternoon, everyone.

[00:11:37] **Jennifer Lyon-Horne:** Thank you Julia so much.

I appreciate it. I am the UVM CORA Best Practices Core Manager. And much like that last, that last slide that Julia showed you. Um, this process really on the screen right now is the foundation of our core. This is how we go about providing technical assistance. Um, [00:12:00] and one of the inputs absolutely is the baseline needs assessment.

Um, we also receive requests for technical assistance through various other inputs as well. Um, but this is, this is the process that we, that we use in every, every technical assistance, um, interaction that we have and really each TA, or we call it a TA short for technical assistance. Cause that's, that's a bit of a tongue twister.

Each TA is unique because of this process. And so, you know, you have that first step of request. Um, then we, we connect with whoever's requesting the, um, the technical assistance and we talk a lot with them about what the unique needs are of their patients or their clients. And so we just kind of say to them, okay, tell us, tell us about your practice, tell us about your patients or your clients.

Um, you know, what's working for you. What could be, um, what could be helpful for you in terms of resources? [00:13:00] And then we actually identify what those resources are and how they can meet the unique needs of their patients and clients. The last step in that process is to disseminate the supplies. Um, and if there are other resources in UVM CORA, that would be helpful, which typically there are, we will then make that, um, that warm handoff to the appropriate, the appropriate core.

Next slide please.

So we actually, um, we address and have multiple conversations about multiple topics. Um, these six right here are the ones that we have been having most recently, I would say in the past, in the past year. Um, and again, we can, we can address any topics, any needs or, uh, of support that are helpful. But, um, today I'm going to just focus on a couple of them and talk about the resources we utilize to address these topics.

Next slide, [00:14:00] please. So, um, as most of, you know, overdoses have increased significantly in the last couple of years, um, some of that being due to fentanyl, being present in opioids and, and, um, and stimulants as well. Another thing that we saw was many states had to shift their resources to addressing COVID-19, which made it much more difficult to D um, to have access to Naloxone.

And w just as a, um, as an aside, I'm just saying Naloxone, but what we, um, what we distribute is intra-nasal Naloxone. So there is an intramuscular, but we, um, um, are doing the intra-nasal. So one of the things that was most concerning

to us was that syringe service programs especially were reporting that they had to prioritize Naloxone for only their high risk clients, which was really super concerning.

And so we made the decision to go [00:15:00] ahead and supplement the supply of Naloxone to folks as much as we, as much as they needed. Um, this, these numbers only are only documenting the number of doses that have been sent out since August, 2021. So we've certainly been doing it beyond that, but we just wanted to focus on the last 10 months or so.

So you'll see, in Vermont, we sent out over 1100 doses, New Hampshire, over 600 doses. And in Maine, almost 3000 doses for a total of over 4,600 doses. In many of the organizations, um, there really is a wide range of, of organizations, syringe service programs, recovery centers, peer centers, HIV and HCV resource centers.

Um, MOUD providers and MOUD stands for, uh, medications for opioid use, opioid use disorder, OB/GYN MOUD providers and family practice providers. And that is not an exhaustive list, but we want to do at [00:16:00] least identify, um, you know, some of, some of the organizations. Next slide, please.

So while we have focused our efforts in increasing access to Naloxone for providers and community partners, we realized that it's also important to figure out a way to have Naloxone available 24/7. A lot of those community partners and a lot of the medical providers obviously are, um, are only able to provide Naloxone during, during the hours that they're open.

Um, so we became aware of these opioid rescue kits that were developed, um, in an effort to increase bystander responses to an overdose and to make it easier. And. Um, these, the, the organization that we have connected with thus far around these is Naloxone box and, um, the Naloxone boxes come with, um, um, they, they don't come with enough, the Naloxone, although we do provide the [00:17:00] Naloxone and they have, uh, they also have a plastic face barrier in, in the, um, the kit as well, so that they can, the person can use that in an event of an overdose and doing rescue breathing.

And we, what we really, what we really were hoping to do was to distribute some of these in some places that, um, you know, might, might not typically, might not typically have Narcan, um, Naloxone. And so some of the places,

interestingly enough, have been, um, public places. So libraries, um ferry docks schools, um, town halls, convenience stores, um, you know, construction sites.

I mean, you could really, you could really put these, um, you re really put these Naloxone boxes in, in at, you know, anywhere. Um, one of the, one of the things that we're looking into is you're not supposed to mount these in cold states where the temperature may drop below four degrees because that's [00:18:00] when Naloxone can freeze.

And so we actually are right now doing some testing of some insulated bags to see if we could place the Naloxone in those insulated bags, which would then, um, keep the Narcan above four degrees, keep it from freezing. And again, so these could be used outside anywhere. Um, Um, so the, the only other thing that I want to mention in terms of being able to provide easier access to Naloxone is you probably have heard that there are some states that have been purchasing vending machines and filling those vending machines with Naloxone and other harm reduction supplies.

Um, so I just wanted to put that on, put that on your radar. Certainly, um, our center hopes to be able to pro to provide those at some point, but, um, it is right now, um, you know, we, we haven't been able to do that, but we're certainly watching whatever. What other states [00:19:00] are doing as well at. Oh, and the other thing, sorry to mention about the Naloxone boxes as we did, our core did work with Nalox Box to develop a protocol.

And, um, you know, part of the protocol was around identifying, working with, um, with first responders to really identify where they were responding to calls so that if, even if it was, um, you know, if it was a, um, an area where there was five or six houses where they typically were called to maybe there was a convenience store where, um, Nalox Box could be, um, could be mounted.

So that's, we really did, did work hard on this protocol to help kind of guide folks around where to use them, how to use them. Um, and that kind of thing. Next slide please.

So the other, um, the other harm reduction. Supplies that we have been providing our fentanyl test strips. And as you will see here, [00:20:00] just since, um, August of 2021, we have distributed over 57,000 fentanyl test strips. And, um, you know, I, if I don't know if all of you are familiar with, with what they are and why they're, so why they're so important, but, you know,

essentially fentanyl is present in most opioids now and also in a high percentage of stimulants.

And so really encouraging, we're sending these out to medical providers and community partners, and we're really encouraging people to have, um, conversations with the, with the clients that they're using and asking them to use these, these fentanyl test strips to test the drugs that they are using. And it doesn't, they don't necessarily just need to be used by people who are.

Um, who have an opioid dependence. I mean, people who are using drugs casually are also dying of overdoses. And, and in Vermont, I know that, um, fentanyl was in 90. I think it was 93% of the overdoses that, [00:21:00] that fatal overdoses that happened in 2021. So, um, it doesn't, um, the upside is that it certainly lets folks know that there's fentanyl and the drugs that they're using and it can help them to make, um, it actually has been shown to some degree to change.

People are changing their use patterns. Such as they're not using at all, um, they're using a smaller amount. They are using, they're not using by themselves. They have Narcan with Naloxone, with them, um, just in case. And they're also letting, um, letting other folks know that there's, there's fentanyl in that particular batch.

So it's just helping folks make informed decisions, which I think is, um, you know, makes a ton of sense. And these are some of the organizations, again, that we have distributed the fentanyl test strips to syringe service programs, recovery centers, peer centers, HIV, HCV, resource centers, MOUD providers, OB/GYN, [00:22:00] providers, and family practice providers.

And if that looks like it's the same list as it is for the folks that we've sent Naloxone to it is because those are, we are seeing a huge uptick in providers and community partners who really are working hard to help their patients and clients make the make safe decisions and stay alive. Um, fentanyl is, is, um, you know, is, has obviously contributed to the highest overdose levels we've ever seen.

Um, so it's, it's good to know that these, that these organizations and providers are utilizing these harm reduction tools. Next slide, please.

Initially we created a fentanyl test strips, sort of how, how to one pager and what we found was that it wasn't really likely that somebody was going to take a one pager folded up and stick it in their pocket and hold on to it, to, to [00:23:00] know how to use, um, how to use the test strips. And it's really important that they're used correctly so that you, um, so that the person gets accurate gets accurate information.

Um, one thing I will say as well, the test strips do identify if there is the presence of fentanyl, it does not identify the types of fentanyl that are in there nor does do they, um, do they identify the amount so. That's just an important limitation to know. So anyway, so we decided to develop these fentanyl test strip guides, which, um, are specific to, to they identify specific drugs and the specific route of use.

And then they, they, um, give the instructions on how to use them. So they are, um, they're small. They fold up into like a tiny little, almost essentially like the size of a business card and they're also perforated. So the person can just take, um, the, the piece that makes the most sense for them. [00:24:00] Next slide please.

So, as you can imagine, tobacco use in, um, in patients who are using opioids is, um, is a chronic is a chronic issue. And, um, and, and also a lot of folks who are on medications for opioid use disorder are concerned about quitting tobacco at the same time. They're concerned that it might, it might lead to, um, uh, reoccurance abuse.

And so as clinicians, we often don't, um, don't push tobacco cessation and, uh, the patients and clients also, um, you know, are, do not ask for it, but in a, in an effort to address this tobacco use in individuals, we developed these tobacco tool kits. And specifically these toolkits come with two weeks worth of nicotine replacement therapy because NRT, nicotine replacement [00:25:00] therapy, sampling has been shown to decrease cravings and decrease smoking and increase, increased quit rates.

And so the toolkits basically have a one pager about tobacco and opioid use. So it's just a fact sheet. There's a provider flowchart, which helps providers to know whether or not a tobacco toolkit makes the most sense for their patient. And then, um, just the, the how to use just, uh, an information sheet about how to use the nicotine patch.

Next slide, please. So I want to pull our process together a little bit and just give a couple of examples of TAs before I hand it over to, um, to Jenny Noel, our Education and Outreach Core Manager. So this is an example of a syringe service program TA that we did. So we certainly has discussed several topics, but, um, we [00:26:00] discussed pretty significantly reducing stigma in the community and in the workplace, there can be some stigma within, um, you know, within harm reduction workers and peer support workers.

And, um, so the other piece that we talked about was the need for Naloxone and potential use of Naloxone. So the supplies that we sent when this TA was done, we're fentanyl test strips, the fentanyl test strip pocket guides, Nalox Box and accessories, and then Naloxone to, um, to use both in, to fill the Knox boxes and also just to have for their clients.

The other steps that we developed were, um, doing a referral to the university of Rochester, which is another center of center of excellence. They have a train, the trainer program around stigma and bias. So we made the referral to them. We sent out the UVM CORA Stigma Resource Guide. We shared the resources page.[00:27:00]

It's specifically the community rounds webinar in which Dr. Peter Jackson discussed, um, SUD bias and addressing stigma in the clinical setting. And then we sent the UVM CORA Nalox Box protocol. Next slide, please.

And then the final example that I am going to include here is for an MOUD a rural MOUD provider. I should've put that in there. We discussed poly substance use. So tobacco, alcohol stimulant use homelessness and barriers to treatment. We sent lock spot, lock boxes and lock bags, because as Julia indicated, um, there's always, there's often concerned about diversion and pediatric overdose.

Um, those lock bat, boxes and lock bags, um, also are for folks who typically would not to be able, to be able to get take-homes. If they didn't have one of those supplies with them. [00:28:00] We sent along tobacco tool kits, and then we sent along prepaid cell phones. They're pre-filled with three months of service that would allow them to remain connected with their, um, the patient to be connected with their MOUD provider, especially during COVID.

And also because they're rural and, and, um, have difficulty accessing, accessing transportation. And then in terms of our next steps, we also sent along

the UVM CORA Contingency Management Resource Guide made a warm handoff to The Fletcher Group around recovery housing and provided the webinar, a recording of the alcohol use disorder webinar.

And I will now pass it onto my colleague. Jenny.

[00:28:49] **Jennifer Noel:** Thank you. Thank you, Jen. Um, hello, I am Jenny Noel. I'm the program manager for the education and outreach core. And [00:29:00] I will go ahead and talk about what our core does and how it might be helpful to Dr. Nelson or anyone who's listening. So as you can see on the slide here, The education and outreach core develops and disseminates resources on effective treatment and prevention approaches.

We provide support for professionals who seek information, um, who seek training and resources and evidence-based methods. Uh, people can get CMEs or CEUs, um, through the trainings as well. So education and outreach has several programs that Dr. Nelson could take advantage of the principal. One is the community rounds workshops series, which is a monthly webinar that Dr.

Nelson can attend, um, or she can access the recordings. And, um, in fact, Jen just mentioned one of the recordings that she sent along to, um, after a TA. [00:30:00] Uh, our core clinicians who make up the clinician advisory board are also available to organizations for presentations. We produce resources such as research, spotlights, um, resource and user guides and a quarterly newsletter that keeps everyone up to date, um, on recent news and CORA offerings and these and many other resources can be found on our website, UVMcora.org.

Next slide please.

All right. So here is Dr. Nelson again, and she's saying that she needs an easy way to learn about best practices in substance use treatment. Um, and she can find that at CORA, uh, through our library of webinar, recordings and slides, and, um, she can also sign up for the monthly live webinars. [00:31:00] And like I said, she can, uh, receive CMEs.

She can also get CMEs from, uh, watching any recording, if she does that within a month of the live event. Next slide, please. One of our most popular webinars was called Identifying Bias and Addressing Stigma in the Clinical Setting. And that occurred last April. It was presented by Dr. Peter Jackson, who is a member of our clinician advisory board.

He's spoke about the impact that bias and stigma can have on individuals and families affected by substance use, uh, strategies to decrease personal and organizational stigma and bias and the cultural implications of substance use stigma and bias in rural communities. Next slide please. Another example of a well attended webinar was a panel presentation [00:32:00] this past March and the topic was Alcohol Use Disorder in the Primary Care Setting.

Among other things, presenters explored, um, ways that rural communities can spread awareness about alcohol use disorder. They examined the biological basis for treating alcohol users with medications in the office, and they described steps to create and coordinate an effective practice model for, um, alcohol screening and patient care and rural primary care practices.

Next slide please. And here I'll do a quick plug for our next community rounds webinar, which is happening on July 13th. Our speakers will discuss the need for improved Naloxone distribution and rural communities. And they'll describe innovative technologies to increase access to Naloxone in order to reduce barriers and stigma and save [00:33:00] more lives.

So if you're interested in this, um, webinar, you can, uh, re register right now, um, at go.uvm.edu/naloxone. Next slide please. CORA is available to people like Dr. Nelson and rural organizations who are looking for presentations or individualized resources. So if you want to request something like that for your organization, you can fill out our education and outreach intake form at go.uvm.edu/eointake.

You see it on the screen there. Um, and this online survey, we'll walk you through some questions and give you a chance to describe exactly what you're looking for. Next slide. Uh, this slide is showing some examples of the types of resources that CORA creates. We have made user guides for things like fentanyl [00:34:00] test strips, which you saw earlier, resource guides on specific topics and research spotlights.

And you can find all of these at UVMcora.org/resources. Um, although into a little bit more detail about them coming up here, next slide.

Okay. So each quarter CORA publishes a, some synopses of research papers, key research papers. And if Dr. Nelson wants to access recent research on a specific topic, she'll find that our spotlights are rigorous, but they're digestible. And they do consider topics with a rural perspective in this spotlight here on

this slide, we explore the need for increased Naloxone distribution to reduce opioid overdose deaths in rural communities.

You can tell that we've really been focusing in on that topic recently at CORA. Next slide, please.[00:35:00]

And, um, our resource guides gather CORA curated information in one place. They focus on a particular topic area and provide links to foundational research websites, tool kits, webinar recordings, and more. So Dr. Nelson could consult this guide here, if she wants to learn more about substance use disorder stigma.

Next slide please. And here's another resource guide. This one is on contingency management for treating stimulant use disorder. And this guide includes some information that we wanted to highlight in this webinar. Um, it provides a link to a pilot project for a contingency management app, as well as a link to a video that quarter created for providers who want to learn about contingency manage.

Next slide, please. So we've included here [00:36:00] some more details about the contingency management app, and I'm going to hand it back to Jen Lyon-Horne for a minute. Um, so she can describe this pilot program and then I'll finish up. Go ahead.

[00:36:12] **Jennifer Lyon-Horne:** Thank you Jenny. Yeah. So this pilot project, um, is really focusing on people who are being prescribed medications for opioid use disorder and are still struggling with their stimulant use.

Um, for those of you who work in this field, you may see that there's, um, that there's the a number of folks that they, they end up being pretty. Um, they ended up being stable on their, their methadone or their buprenorphine, but stimulants they're just really, you know, really, really tough to, um, to be able to decrease their use around.

And so we've taken contingency management, which is. The gold standard for addressing substance use disorders. And we have [00:37:00] decided to pilot it in a, um, in an app, a phone app. So this is our contingency management app, a pilot program. It is, we're currently in the pilot phase. And right now it's, it's, uh, available in rural counties in Maine, Vermont and New Hampshire.

But, um, at some point we may, we may expand that. So you can see some of the details here. Um, I'll be happy to answer any questions for you after the, um,

after our presentation is, is done. Um, but as you can see where, you know, we set it up so that folks will be able to earn up to $599 and really trying to get those, the magnitude of those, um, of those incentives up there.

So, um, we'll, we'll see, we'll see how it goes, but we're really excited about this pilot. Thanks Jenny.

[00:37:50] **Jennifer Noel:** Absolutely. Okay. Next slide.

Okay. Um, so a few months ago we put the finishing [00:38:00] touches on a video called the Contingency Management Provider Training Video. And there are two versions of it. One that people can just watch straight through. And one that includes quizzes so people can get CMEs and the videos designed for healthcare providers and it explores why providers should consider contingency management with their patients who struggle with substance use. Uh, the evidence that supports the use of contingency management, the most important steps and considerations for using contingency management and resources available through UVM Cora to help support these efforts.

And, um, on the next slide, there is a short clip of this video.

[00:38:53] **Video Clip:** For 18 years, starting with cocaine years ago and now methamphetamine for the past eight years. John's [00:39:00] goal is to build a relationship with his children. I find a rewarding job. John lives in rural Vermont without reliable transportation, too far away from the clinic to go frequently in person. He was concerned this would prevent him from taking part in contingency management, but during a telehealth appointment, John's clinician confirms that he can take part remotely. We join John and his clinician midway through his video appointment. Already the clinician has explained what contingency management is and how abstinence reinforced by tangible reward is applied. Watch

as the clinician explains to John, the second principle of contingency management, how the target is measured with a plan for the immediate delivery of the incentive when the target behavior is produced. The plan includes the escalation of the incentive for consecutive successful production of the identified behaviors.

[00:39:52] **Clinician - Video:** As you and I already talked about our aim with the incentive system is to create a situation where you're getting straight up

positive reinforcement and [00:40:00] rewards for making these hard initial lifestyle changes.

Since it can take work to stop old habits that are no longer serving you and instead form new healthier habits. Now, I want to talk to you about the importance of abstinence. Studies show that the longer you abstain from cocaine, the better your chances of success down the road. It's great to abstain and come in with a negative sample occasionally, but we know that it's even more powerful and bodes well for your long-term success, to be able to string together continuous periods of abstinence.

It also gives your brain and body a chance to recover from negative effects from the stimulants you've been using over these past few years.

[00:40:43] **John - Video:** This sounds good and make sense, but how do I do that? I'm more of a one day at a time kind of guy.

[00:40:50] **Clinician - Video:** These incentives are strategically designed to support you, not only in staying away from stimulants, but then staying abstinent for an extended period.[00:41:00]

So for 12 weeks, you'll have a video call every Monday, Friday, where you'll submit a drug test. You'll do this by using an oral swab, which we'll send you. On your video call you'll open the swab and use it in front of your clinician. Then you'll review the results together. Make sense. Now I'll show you how the incentives process works.

This table lays out what you can earn. The first time you come in if your drug test is negative for methamphetamine and cocaine, then you would earn an incentive worth six dollars. Then for every negative sample after that, the incentive goes up by a dollar. Two negative drug tests in a row, which is the equivalent of a week of abstinence you get a $10 bonus. See on the table here. This means that the longer your tests are negative, the more you earn. And even the more each sample is worth over time. You start off low, but if your samples are negative, you can earn up to $50 in two [00:42:00] weeks. And over three months you could earn a total of $540 worth of vouchers.

That's some serious incentives.

[00:42:08] **John - Video:** And I could use those vouchers for my kids.

[00:42:12] **Clinician - Video:** Definitely. You can use them to do things altogether, like going out to dinner to the movies or something that you all enjoy. You can also use the vouchers for vocational training that could help with finding a job that you really like.

They can also help to pay some bills or other practical needs since sometimes it's these kinds of things that can build up and become so adversive and stressful that it sets you up for use even more.

[00:42:38] **John - Video:** That would be great.

[00:42:47] **Jennifer Noel:** Um, yeah, so that's our video. And again, you can find this video at UVMcora.org/resources, and that's what I have for you from the education and outreach core. And I will [00:43:00] turn it over to Dr. Gayle Rose. Who's going to talk about the Clinical and Translational Cores work.

[00:43:10] **Gail Rose:** Hi. Um, so I'm Gail Rose. My role is Director of the Clinical and Translational Core, which is the fourth of the four CORA cores. I'm gonna tell you about the, um, the clinical translational core was developed to take better advantage of our experts and to better bridge the needs that fell between technical assistance and community rounds.

Um, so the clinical and translational core provides consultation and expertise from an interdisciplinary team of faculty and staff fielding and Provo and prioritizing requests, synthesizing research, and developing, best practices for rural clinics and community partners. So we offer group or individual support and guidance [00:44:00] around substance use disorders for rural providers and staff, particularly in situations like providers who are new to addiction treatment

and aren't sure where to start with treating patients. Or providers who are seeing new patients and want to determine the appropriate level of care. Um, or providers who are managing complex patients or patients needing multidisciplinary care coordination. So if, for example, they have medical and psychiatric needs, or they're also pregnant or have unremitting other drug use.

Or, um, providers who are interested in new or expanded models of care, such as the hub and spoke system or initiation of buprenorphine treatment in the emergency department. Next slide, please. A key feature of the clinical and translational core is our clinician advisory board who are our local UVM and UVM health network experts.

They've advised us on all aspects of CORA and the [00:45:00] initiatives that we've undertaken. So to answer Dr. Nelson's question, are there clinicians in this region with expertise, training, substance use disorders? Um, our clinician advisory board serves as the liaison between CORA and rural providers and it offers expertise in consultation, in evidence-based treatment and patient centered care coordination to help us, and they help us design all of our CORA programming.

Next slide, please. One of the major initiatives you've undertaken is the clinical and translational scholarship program. It was designed to meet the needs of providers like Dr. Nelson, who are looking for experts in substance use, who can help their practices fill gaps in their knowledge. The clinical and translational scholarship program is an on-site intensive training, hosted by UVM Cora to educate a rural practice and current best practices for treating patients with substance use disorders.[00:46:00]

Next slide please. This spring, we received applications from practices in Vermont, New Hampshire, and we selected Cold Hollow Family Practice from Franklin county Vermont because their needs and goals were closely aligned with our expertise. And we've worked with them to develop a customized curriculum that included some of the topics listed on the side.

Um, like drug classes, diagnosis, and treatment comorbidities, stigma, adolescents, and family-based approaches and motivational interviewing. Next slide. We received some useful feedback from our guests that gave us ideas for specifically what to emphasize in our next iteration of the program. Um, we got great information and presenters, they love the interactive activity.

They requested more time for the group to discuss how to implement this in the office. Um, they thought it exceeded their expectations. Everyone was welcoming and made them comfortable and the format was [00:47:00] great. So, um, it's nice to have encouraging to have that positive feedback, um, that with this program, we are on the right track in terms of designing something that meets practitioners needs.

And now we're planning the next session. Next slide, please. Um, a fall session sometime in October, again in Burlington, and this is a center wide event. So even though it's clinical and translational core, that's hosting it, our planning team has representatives from all the other core's that you heard about earlier to make sure we're taking advantage of all that CORA has to offer.

And we'll be posting information on how to apply in the coming weeks. Next slide please. Another initiative of the clinical and translational core is our office hours pilot program. And the goal of this is to meet the needs of practitioners like Dr. Nelson, who want access to an expert clinician who can answer their questions.

When they come up, the office hours, we'll offer direct access to our clinical experts [00:48:00] in substance use disorders for rural providers. Um, it's currently under development and it's anticipated to launch in summer this coming summer, um, coming right up. And the way it will work is that the core clinicians will be available for one hour each week to discuss attending questions.

So attendees can register in advance. Um, and that way we'll anticipate what their concerns are and be prepared to address them. And also for us to track participation in order for us to evaluate this. Um, that's what our core has been up to. And I will now pass it to Julia who can continue, um, to summarize for us.

[00:48:43] **Julia Shaw:** Great. Thank you, Gail. Um, so just to summarize the services that we provided to Dr. Nelson, uh, our best practices core provided tele-health supplies to help address the transportation concerns raised by Dr. Nelson. They also provided harm reduction [00:49:00] supplies, medication resources, and lockboxes are contingency medicine management resource guide, tobacco tool kits, or referral to the University of Rochester for their stigma train the trainer program.

Um, our referral to our clinical and translational core and the CORA website, um, from our clinical and translational Corps, Dr. Nelson received office hours, information for consultation with one of our clinicians, as well as information on applying for our scholarship program. And then from our CORA website,

Dr. Nelson could access from our education and outreach core, our, um, education and CME from our past community rounds workshop sessions, um, through the webinar recordings, as well as our research spotlights and spotlights and resource guides. And then from our SME core, um, she could access means specific baseline needs, assessment, data reports that would be specific to, um, her [00:50:00] home state.

So thank you to everybody for, uh, coming to the presentation and I'll turn it back over to The Fletcher Group for facilitation of some questions and answers.

[00:50:12] **Milena Stott:** All right. Thank you so much to our partners for presenting today. We really appreciate all of the information. Um, I did get one question in about the use of fentanyl strips.

It seemed that, that there, um, in a state there's been interpreted, it's been interpreted that, uh, those strips are considered paraphernalia. And so, um, one question we have is have you seen this in other states and how have you, um, dealt with some of that stigma?

[00:50:47] **Jennifer Lyon-Horne:** Yeah, that's a great question. We have, um, some HRSA grantees who are in other states that have essentially said that their paraphernalia. And one of the things that we have done is we've, you know, dumb, done warm [00:51:00] handoffs to the Rochester Center of Excellence. Um, because it's, there's many people who need to understand the need to address stigma.

Which is, which is really important. The other piece that we've suggested is when they're developing their consortium's, um, for their, for their grants, their, their HRSA RCORP grants, we have suggested that they include, or that they invite, um, some, um, either a legislator or, um, a mayor or some, some type of, you know, sort of political supporter to be an active part of the process.

But really it comes down to, it comes down to education. Um, and, and we have seen that a lot of those legislator, legislatures are starting to address this, but to be honest with you, they, um, a lot of states are, you know, still, still view fentanyl test strips as paraphernalia. And, um, it's taking some time to really, you know, uh, to really [00:52:00] address, address this stigma.

[00:52:05] **Milena Stott:** Thank you so much for that response. And that is a great question. Um, I, that some states are creating legislation to specify what is and what isn't paraphenalia and what can, and can't be used in certain situations. There was also some discussion earlier in the chat about the vending machine. So it seems like there's some curiosity in the audience, and certainly some states were listed as having vending machines and then questions about freezing temperatures.

So I'm wondering if you could speak to freezing temperatures, I'd add that, you know, because of stigma, some law enforcement in certain areas has also expressed concern about carrying Narcan during freezing temperatures. Um, so maybe you could speak to some, um, conversations that you've had with communities to address the concern about the stability of Narcan.

[00:52:57] **Jennifer Lyon-Horne:** Sure. Um, so the first thing that we can, that I [00:53:00] can talk about a little bit is the vending machines I saw that Gretchen had, um, Gretchen who's on our team had responded. There are, there are a couple of different types of vending machines, at least with the company that we, that we kind of were we're looking into.

And so there are vending machines that are, um, that you can, you know, that are for the inside. They're not meant to handle the elements. And those are a little bit less, a little bit less expensive, but I think most of the vending machines that are being utilized especially, well, at least from what I was reading about in New York City is they're, um, they're purchasing the ones that are temperature controlled.

And they're, and they're also a little bit more hearty. So, um, in, in the tent, I think the cost is not, you know, significant if you sort of look at the big picture. Um, so I, I would certainly suggest looking, looking into that, but yeah, they're able to can to control the, um, the [00:54:00] climate of the vending machines, which is, which is pretty awesome.

And, you know, interestingly, I think it's, you know, up until a year ago, the wait time around the amount of time it would take to produce a vending machine and deliver it was, you know, really was about, uh, was a month to six weeks. But with a lot of states, really beginning to look into this, their production, um, you know, and, and, and time to deliver has certainly has, has gotten, has gotten longer.

Um, and in terms of them a lot. So, you know, we haven't, to be totally honest with you, we haven't done a ton of work around the freezing points of, um, and, and sort of, you know, the education for law enforcement. We have a lot of great community partners in Vermont that have been doing that work for a very, very, very long time with law enforcement and first responders.

There are, um, I did, you know, I mentioned that we were looking at some type of an insulated bag to [00:55:00] see, if it would keep the temperature above

freezing. And ironically, I saw that there was some folks here from, or at least one person from Colorado. Um, there's one on one insulated bag in particular that it's looks like Colorado

um, first responders, even those who are working at ski, um, you know, at ski resorts are using these insulated, these insulated bags. So. I think we will be able to, in terms of the Nalox Boxes anyways, I think we're going to be able to figure out a way to have these mounted outside, to create 24 7 access for folks.

Um, and like I said, you know, we, we often, I mean, we can certainly give resources to first responders that, that help them to understand Naloxone and that freezing point, but we, we really do rely a lot on our community partners. Um, you know, who've been doing that work for a long time. I don't know if that answers the question, but.

[00:55:53] **Milena Stott:** Yeah, no, that is, that is great.

I also think about the importance of educating clients on the freezing [00:56:00] temperatures for their personal, for their personal kits. There was a question that came in around the cost of the vending machines and if there's any, um, knowledge of kind of the, the cost.

[00:56:12] **Jennifer Lyon-Horne:** Yeah. The one with that we were looking at, which would hold 300 doses of Naloxone was, and it was temperature controlled was about $10,000.

And then to fill it with, um, you know, to completely fill it with the 300 doses would have been another $10,000. So it was around the $20,000 mark, which, you know, you know, if you think about all the money that we spend in terms of, you know, folks ending up in, in the emergency department because of overdoses, um, I mean, not to mention you cannot quantify the loss of life.

Um, it really is a relatively low cost. Um, you know, it's a, it's a low cost intervention, um, and approach, especially for, you know, legislators who [00:57:00] have the money out there that, you know, that pretty easily could earmark a couple of hundred thousand dollars to put vending machines in and around, um, you know, their town.

[00:57:10] **Milena Stott:** Okay, thank you so much for that. And then last question, and this should be a quick one, and then we have a video kind of at

our conclusion. Um, we, we know that you mentioned the states where your area focuses. There was a question around, um, access to your toolkits and TA if you're from outside of those areas, those focus areas.

[00:57:29] **Jennifer Lyon-Horne:** Yeah. That's a great question. So, because, um, even though those are the states that we have been, you know, that we've done the baseline needs assessment and where the folk, our focus really has been. We have recently been expanding. We have recently been expanding our TA to any rural, um, Persa, designated rural county in the United States.

So we've talked with folks in Washington and Ohio and New Mexico and Texas, and, um, we're we're and North Dakota, South Dakota. So we're, we're happy to [00:58:00] connect with, with, um, with, with any folks that are in those designated areas.

[00:58:12] **Milena Stott:** Thank you so much. One last question. Costs for the individual items in the vending machine. Is there an answer about that?

[00:58:21] **Jennifer Lyon-Horne:** So we go through Emergent and Emergent is, um, is, would we, I think it's, I think we purchased the two doses of Naloxone costs, 63 or $64 each. Um, an Emergent is the, is the actual company.

They have lots of other, you know, lots of other distributors, but we go through them and they're fast and they get the Naloxone out very quickly. Was that, that was the question. The specific question.

[00:58:51] **Gail Rose:** Yes, but the cost to the consumer, Jen.

[00:58:54] **Jennifer Lyon-Horne:** Oh, I so apologize. The cost of the consumers for everything actually that [00:59:00] we do that the center on rural addiction does is, is free.

We provide at no cost.

And the vending machines, um, the way they're set the company, this company set them up is that you would have to have most people you'd have to have like a personal code. What makes the most sense is just to have a code on the vending machine that would allow anybody to access that as much as they as much Narcan or Naloxone as they needed.

Thank you Gail, for that, that clarification.

[00:59:33] **Milena Stott:** Thank you everybody. Great questions. I'll turn it back over to Eric to close us off.

[00:59:40] **Erica Walker:** Thank you all so much for joining. We just have a quick closing video and we just asked if you could complete our survey. We'd greatly appreciate it. We really want to learn from your feedback. So have a wonderful rest of the day.

[00:59:58] **Michelle Day:** This concludes our webinar [01:00:00] session. Thank you so much for joining us today. Also, please tune in on the first Thursday of each month from 2:00 PM to 3:00 PM Eastern Standard Time where we'll be hosting subject matter experts from across the nation to bring you valuable tools and resources for rural recovery house operators and SUD professionals.

If you would like information on technical assistance, you can go to our website, again, www.fletchergroup.org, which I have also copied in the chat, and submit a technical assistance request. Lastly, please take a moment to respond to the survey questions once they become available on your screen. Your feedback is very important and greatly appreciate.

Thank you and have a blessed day.