FGI RCOE January Webinar
FGI Tools
January 5, 2023

[00:00:00] **Michelle Day:** [00:01:00] 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 dropdown feature to communicate with either the panelists only or panelists and attendees. Please direct all questions [00:02:00] regarding the webinar content to the Q & 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 regarding the webinar content. Your participation in that survey is greatly appreciated and will only take a few moments to complete.

Please join me in welcoming Fletcher Group's Rural SUD and Recovery Housing Specialists, Dr. Vicki Jozefowicz, and Anne Shields.

Vicki joined The Fletcher Group in 2022 after retiring from Kentucky River Foothills Development Council Community Action Agency, where for 22 years she held positions of executive director and chief administrative officer. In these roles, she served as the project director of Rural Communities Opioid Response Program Planning and Implementation grants. She oversaw the [00:03:00] development of both residential and outpatient recovery and treatment programs, as well as developed a transitional housing program for recovering women. Earlier in her career, she served as the executive director of the Chrysalis House, which is Kentucky's oldest transitional residential recovery center for women. In this role, she focused on programming for pregnant women and women with children. For more than 10 years. Dr. Jozefowicz served as an adjunct staff member at Eastern Kentucky University, where she taught graduate level courses in nonprofit leadership and grant writing.

Anne joined The Fletcher Group after years of experience working with state agencies, academic centers and community health centers and behavioral health organizations to support integrated behavioral health and housing programs. During earlier years of the opioid epidemic, she helped build the SAMHSA funded team at the University of Washington that planned and launched technical assistance and training for opioid treatment networks in Washington, in California state, Pacific [00:04:00] Northwest tribes, and community organizations.

Anne, Vicki, the floor is yours.

[00:04:13] **Dr. Vicki Jozefowicz:** Thank you. And thank you everyone for joining us today I'm going to be talking about conducting a community needs assessment. You may ask yourself, why is a community needs assessment important to recovery houses? Well, there's many reasons why assessment is important. By [00:05:00] assessing your community, you can gather and analyze information about its needs and available resources. This includes

identifying services and programs that are needed to support your recovery house but are not currently available.

Assessment helps recovery house operators learn about availability and gaps in services, employment opportunities for its residents. Public attitudes toward recovery and local sources of support. In addition to learning about what services exist or don't exist, assessment can help you learn whether the community has adequate job opportunities for residents of your recovery residence.

It can also help you assess public attitudes toward recovery. For example, how common in your community is NIMBY, or "*Not in My Backyard*", or stigma about people who use drugs? And perhaps most importantly, community assessment will help you determine if the community has [00:06:00] the potential to form a strong recovery ecosystem to support your residents in their long-term Recovery. Assessment identifies the most pressing issues facing your community and your recovery house.

You may wonder why the overall needs of the community are relevant to your recovery house. Recovery houses don't exist in a vacuum. Their success is largely influenced by the communities where they're located. Because of that, the needs of the overall community are certainly of relevance to the stability and sustainability of your recovery

house. Assessment determines the best way that you can address those issues by gathering input from a wide range of stakeholders. Recovery houses are better positioned to take actions that will contribute to improved attitudes toward the house, its programs, its residents, and recovery in [00:07:00] general. Next slide, please.

You're probably thinking about how much you already have to do for your recovery house, and you may wonder how complicated it is to conduct a community needs assessment. Well, the complexity of the needs assessment depends on your budget, your personnel resources, and your expertise. For example, consider how much money do you have that can be spent on extra employees or consultants to help conduct the assessment.

Do you have funds to pay for refreshments for focus groups, or to provide incentives to participants? And what about other associated expenses such as local travel supplies, printing, advertising, et cetera. And do you have personnel with the skills or time to collect and or analyze data? Larger facilities are better [00:08:00] positioned because they may possess the skills and resources to carry out their own assessments.

And this may also include smaller houses that have large parent organizations. Examples would be community mental health centers or community action agencies. Smaller facilities may gain support from local universities, healthcare organizations, community action, or head start programs that already conduct community assessments.

It's especially important for smaller recovery houses to connect with their local community action agency. Every county has one. You can find yours in the directory at the National

Community Action Partnerships website. To comply with federal funding requirements, all community action agencies must conduct a community needs assessment every three years.

As part of its assessment, your community action agency may be willing to include data collection and analysis for your recovery house, which would save you some [00:09:00] work. Next slide please.

Review your recovery house's original mission and vision statements to evaluate whether they're still on mark or if they need to be modified. This is actually a good recommendation whether you're doing it for a needs assessment or not. This is especially important if your house has been in operation for a while, or if changes in policies or practices have caused your mission or vision to become outdated.

Examples could include changes related to medication assisted recovery or expanded programs for women that now include their children. Keep in mind that if you amend your mission statement, the change will have to be approved by your board of directors, and your bylaws will also need to be amended. And depending on how significant the mission is changed; your articles of incorporation may also need to be amended. [00:10:00]

Consider how your needs assessment will best help you in planning, implementing, and promoting your project. The results of the assessment can help you in building community relationships that have long-term impacts on the success of your house. A desirable goal is to reach a point where your house is broadly viewed and supported as being an essential community service.

The assessment process is more effective if there's a clear understanding of the process to assure that the objectives of the assessment match its goals. Considering the investment of resources that you put into your needs assessment, it's important to understand how the assessments objectives align with your desired goals. You want your assessment results to help you devise a plan to sustain your recovery house. Next slide, please. [00:11:00]

There are different approaches to community assessments. Assessments can employ a single method or a combination of methods. Intensive approaches. Consider sources of primary data such as surveys, key informative interviews, focus groups, and community forums, and also secondary data including national, state, regional, or local sources. Primary data comes directly from a person responding to your questions.

Secondary data such as census data, crime reports, health department records, et cetera, can be used to support primary data. Your assessment will be stronger if you use more than one level of data. SWOT analysis can be used to identify internal strengths and weaknesses as well as external opportunities and threats. [00:12:00] This is a fairly uncomplicated process that's conducted using a flip chart or a whiteboard, or even a chalkboard that's divided into four squares. One each for strengths, weaknesses, opportunities, and threats. These quadrants are filled in based on stakeholder input. Remember, a stakeholder can be anyone who has an interest or investment in your project, and they may not always agree with you.

Next slide, please. Don't do all the work by yourself. Instead, appoint a community assessment team to help lead the assessment process. So, what does a community assessment team do? It helps decide whose input will be solicited, what questions will be asked, and its members serve as ambassadors for your assessment as well as for your recovery house.

Who should be on the [00:13:00] team? People with significant local influence and individuals and family members directly affected by substance use disorder. The members of your team don't have to hold official positions, but they must be well-respected in the community. The team should be diverse in its composition, should reflect the makeup of your community, and include people who are knowledgeable about substance use disorder. Remember that this team will support you throughout the entire needs assessment process, so choose the members carefully because it could be a long relationship. Next slide, please.

The steps to conducting a community needs assessment may vary from organization to organization. However, most assessments will include the following component. Defining the objectives of your community needs assessment. Before you begin the assessment [00:14:00] process, it is important to clearly define the purpose and scope of the assessment. This will help you determine the questions to ask, the data to collect, and the methods that you will use together and analyze the data. Be realistic about the resources that you have available for conducting the assessment. Consider skills, time, and money that's needed to complete an assessment. Do you have enough of all of these?

If you don't, where will you get help? This could be from volunteers or from in-kind contributions from other organizations such as healthcare or community action. Also, see if you can secure a grant from a local corporation or a foundation to cover some of the cost of your assessment. Identify who you want to query and then gather data from them. Potential community members who can be interviewed are unlimited. Examples, include people who've been [00:15:00] directly affected by SUD and their families, health and human service organizations, treatment recovery programs, colleges and schools, elected officials and churches, employers, chambers of commerce, workforce development programs, law enforcement, court systems, jail staff, and members of the general public.

You can collect data through surveys, questionnaires, focus groups, key informant interviews. Examples of key informants may be the mayor or the city manager, ministers, police chief, the hospital CEO, college President persons with SUD, et cetera, and or by conducting a SWOT analysis with broad stakeholder input.

Analyze the data that you've gathered. Data analysis sounds scary, but it doesn't have to be complicated. Basic data analysis can be performed by reviewing facilitator notes, [00:16:00] recorded interviews and survey feedback, and then sorting the responses into themes and categories. Qualitative data such as that's generated from Likert scale questionnaires can be tallied by hand, or a university may be willing to analyze the data for you.

The overall goal of data analysis is to identify the most pressing needs that are facing your recovery house and determine how to best address them.

Now you're ready to take action. Use your analyzed data and develop a written plan of action to address the identified needs. Include objective, task, responsible parties, and start and completion dates. Your action plan could focus on implementing new programs, strengthening or expanding existing programs, and partnering with other organizations to address needs.

[00:17:00] Lastly, monitor and evaluate your action plan. This ongoing task will help ensure that your efforts are responding to the needs of your community and in turn to those of your recovery house. This may involve collecting additional data or gathering feedback from community members about how they think your action plan is working. Don't forget to seek feedback of those who benefit directly from your services. After all, they're why your house exists. Next slide, please.

So to answer the question, is a community needs assessment essential? Yes, it absolutely is. Although community needs assessments require you to commit resources, they're essential because the recovery house's, long-term viability is dependent on the host community's perception of the house, availability of compelling local data that can be used to leverage program support, and [00:18:00] whether the project is used is viewed favorably in the community.

And you certainly don't want it to be you viewed, not favorably, or with hostility. To summarize, community needs assessments can help ensure the success of your recovery house because they help prepare you determine what needs to be accomplished to meet your goals. To learn more about assessing community needs, please see the How to Conduct a Rural Community Needs Assessment Toolkit. That's posted at www.FletcherGroup.org. A QR code for this resource will be provided at the end of today's webinar. Thank you for listening, and please put questions in the chat box.

Anne Shields: Thank you, Vicki. We're going to switch gears here now pretty quickly and talk [00:19:00] about medication assisted recovery. Uh, and, uh, before we get into the nuts and bolts of, uh, developing a work plan, um, how you want to work, uh, How you want to work more clearly in developing how you, um, bring and allow medications in your housing community. It's really going to be very important, uh, to fully appreciate that medications are a much more important treatment option than they were in the first phase of the opioid epidemic. Um, medications protect from overdose. They save lives. We are now in a very ugly phase of this epidemic. What some like to call the fentanyl era, but it's really not just fentanyl.

We've seen, you're all seeing this increase in fentanyl, uh, other illicit drugs, meth. Are all on the increase. It's really [00:20:00] a, what some people call a fourth phase or a phase of polypharmacy with both synthetic opioids and stimulants. What some people may not always appreciate, and you might have some of these folks on your staff or on your board, is that with exposure to fentanyl, which is not always chosen by your by people, it might be mixed in the drug supply without their knowledge.

But fentanyl and other synthetics can cause much more intense cravings. And it make, they make abstinence-based strategies for recovery much more difficult. And consequently, we have more and more people, particularly young people at risk of overdose and death. Uh, next slide, Erica. So just to share with you some, this is probably a slide you may have seen before, but this is the updated slide from SAMHSA and others. Look at those terrible steep curves for people, uh, the, the blue line for those people exposed to [00:21:00] fentanyl, um, or other synthetic opioids. And the next line on that steep curve represents meth. What people don't often appreciate is the rural picture where rural communities have been particularly hard hit by overdose deaths.

And something that we don't always see in the big picture like this slide, is how much more young people, people 18 and 25, and frankly we're even in my Washington communities, we see high school students inadvertently getting their hands and getting exposed to fentanyl and risking overdose. So, this is a really big concern. We're going to be seeing a lot more about, uh, federal efforts to address the overdose curve, um, in this next year. Next slide. Another really important consideration for you all, um, that just happened in 2022, this, this past spring, is that the US DOJ, [00:22:00] um, issued guidance on the opioid crisis around the Americans with Disabilities Act.

Um, that's been subject to different interpretation for a while, but they finally issued a very strong, very clear statement that, um, ADA protects anyone who chooses to use a prescribed medication for opioid use disorder. That may plot that guidance applies widely, not just to recovery housing, but also to jails, prisons, any other setting.

Um, and I think this is actually a really important enough federal, uh, guidance that, um, we've included here, not only you'll see at the bottom, um, the website you can go to, but I also thought we'd try out a QR code. So if you haven't used those before in a PowerPoint, hold your phone up right now and that, [00:23:00] that QR code will take you directly to, uh, this DOJ guidance. Um, which frankly is a little bit hard to find because they've already, it's already in the guidance archive. So try that out and, uh, you can give us feedback in the chat box if you like that QR code that we're trying today. Um, but that's, I think, a big important consideration for everyone. And I really encourage all of you to look at this guidance to yourself.

Next slide. So how do you start? Um, you know, if you, if you're new newly admitting or have residents in the house that are starting or, or are struggling and might benefit from medication, we really encourage that the best starting point for a housing community is to explore partnerships with healthcare providers and also, um, medication assisted treatment, MAT providers.

Sometimes, um, those are one and the same, [00:24:00] um, sometimes not. Uh, so by formal partnerships you might have a contract, you might develop a really formal expectation about the level of service and frequency of visitation, um, and how you would work with one or more healthcare partners, um, or you might have a more informal relationship that you want to develop with multiple healthcare partners who can adequately meet the needs of your residents.

So federally qualified health centers, FQHCs, community health centers, and rural health clinics, um, frankly, they make great partners. I've worked with FQHCs for years and that's part of my working background. But community health centers are also under, uh, an operational agreement, receive federal funds, operation funds, and they're really expected to step up and support MAT. [00:25:00] If you don't have a clinic

that's close by or is working with you now, you might consider reaching out to them to see if they might be able to work with you to develop a program together. Um, community health centers can apply for additional operational funds through HRSA to expand and improve their MAT programs. And so, they can't do that unless they have partners that help them expand their territory and their reach.

So, I encourage you to talk to community health centers or any rural health clinics, um, that are in your, within your area, whether they're serving your residents now or not, because they might be able to help you. Healthcare for the homeless programs, these are often operated by FQHCs, but there are a few hospital systems, especially rural hospital systems, um, healthcare for the homeless, sometimes called H C H.

Those are great programs to work with because, um, though they, they can [00:26:00] serve a broader than just completely unhoused population of folks. They can serve more than just the people living under the bridge. People that have been recently unhoused have a history, um, meets head requirements for housing needs they can work with. And HCH programs frankly have really good experience, um, in avoiding drug diversion. So, they're a great source of, uh, clinical resource for you around preventing diversion of any drugs. So, methadone clinics, um, federally designated as opioid treatment programs. OTPs, uh, methadone is a very effective medication against those exposed to fentanyl.

Some, in many. Well, the good thing about OTPs is very recently since the, uh, shutdown phase of the pandemic, they've been able [00:27:00] to allow stable, uh, patients to take home methadone prescriptions and store their own methadone for periods of, I believe, up to one month. Now that's recently been extended. So that creates a better possibility for, um, people who are in housing, are gainfully employed to not have the disruption of a daily visit to a methadone clinic.

So that might be something that you want to explore. And then finally we see more and more, um, around the country, more specialized, um, office-based and tele, telemedicine-based MAT clinical providers. Um, and these are often can accept Medicaid, can accept private insurance. Um, as an example, um, in the state of Alaska where I've lived in off and on and worked for many years, these kinds of specialized practices that were partly virtual. [00:28:00]

Um, and partly, um, and. In small clinics, usually near hospitals, we're a key part of open opening up medication assistance to many people when we just didn't have other providers in southeast Alaska, for example. Right now, we have a telemed, we have a specialized clinic who, um, sees patients one day a week in rural Idaho and in a, and they see them in a office that's lent to them by the local health department. So, these kinds of clinic, these kinds of

clinicians, often have a lot more flexibility to perhaps serve your home through a van or through a nearby one day a week clinical presence, following up virtually and by phone the rest of the time. So, okay. That's a little bit about those partnerships you should consider.

Uh, let's have the next slide. And now we're going to get into really sort of the [00:29:00] nuts and bolts of the meat here about policies and procedures for managing, um, storing these medications on site. Yes, you've got to develop procedures to safely store all M O U D medications for opioid use disorder on site.

The new Justice, Department of Justice guidance requires that you do so. Those medications are still the property responsibility of the resident. So, there's, it's very important that you have very clear policies about ownership and responsibility here. Though their property and of the resident responsibility of the residents. That doesn't mean you can't have the staff involved to make sure that the usage and the dose is locked, logged daily, monitored, secure storage, monitored by others [00:30:00] on site. There's a lot of ways you might go about doing that. Um, for example, um, a, a very typical protocol I've seen work well in a couple of the houses is basically there's one hour a day when the medication box is unlocked.

Everyone's expected to come in for their medication at that time. So, there's other kinds of medications, injectable that we won't talk about today, but also make this a much easier test than it might have been. It's going to be important that your policies state that you're going to immediately address any behaviors that look like, uh, they're putting residents, others at risk through diversion. Failure to follow the policies and use those medications appropriately. Preventing theft or diversion. I'm moving over here to the second column here. I just want to be clear that though the Department of Justice requires that you develop [00:31:00] procedures and allow M O U D to be stored, used appropriately on site.

That does not, it does not state that other medications that can create risk, um, high risk of diversion and other problems on site, you can still prevent those from being stored and used on site if you so choose. However, what I really strongly recommend is that you seek guidance on a regular basis from an expert clinician group or an expert clinician in reviewing and updating any of the lists that you think should be prohibited on site.

Um, Recovery housing we're, we're not a clinical service. We really have to lean on our clinicians to do so. So, to really guide us on that. So, for example, I, as I mentioned earlier, healthcare for homeless clinicians have a lot of experience with diversion. So that they're a great resource if you're working with one of those programs.

I'm working with a [00:32:00] house right now who actually ask, um, the clinical group in their Department of Corrections because if anybody's got great experience in diversion, it's corrections, right? So, if those, if those clinicians can work with you on a regular basis to make sure that your prohibited medications are, um, you, you know that they make sense, they make sense, and that, um, clinicians, um, would support that rather than just, uh, a drug that maybe has a risk

but might in some circumstances be necessary, um, for a particular resident, um, under prescription from their, uh, provider. Now, because of, you still probably will get asked and will need to be able to make a case-by-case determination for some medications. Um, one of the issues that, um, one of our, uh, one of the NARR affiliates brought to my attention [00:33:00] recently is they're increasingly being asked to admit, pa, admit residents who have serious mental illness and are on an array of, uh, medications, um, for serious mental illness like bipolar, psychosis, other histories.

Now, your best case, your best scenario there is to really look at this on a case-by-case basis, uh, rather than try to, uh, prevent that admission. Simply because of that medication and diagnosis. So I think ADA, um, I'm not a lawyer. I'm a nurse by training, but in my experience, working with ADA considerations, it's really about a person's level of function, not about the medications they need to take.

If you can store M O U D on site, you can probably store psychiatric medications on site. So the real question is going to be whether the behavior of that resident or [00:34:00] potential resident is going to fit well and be supportive of the broader housing community. So, all right, next slide. So, we have written, uh, policies and procedures that, um, we are, they are not as yet posted on the website, but we're happy to make them available to you to tailor to your own program needs.

Um, now again, we base this on, I base these mostly on a couple of the houses I was working with at the time. Um, we have them developed for, at different NARR levels, recognizing that with different staffing requirements, um, and ability, we didn't, uh, things could look very different at, at each house. However, um, I know one of the affiliates I just shared these with said, nah, we don't need all those three levels. We're going to boil it down to one, tailor it to our rural counties and share it that way. And that's fine. We just [00:35:00] wanted to give you all a start. Um, on policies that would clearly reflect, um, your compliance with ADA guidance around M O U D. And how you can safely also continue to manage medications on site as well as maintain some, um, prohibit, prohibited medications should they create too large of a risk of diversion for you.

So, you can contact me or reach out to the TA portal. Here's, here's, this will take you straight to the portal if you're interested in, um, reaching out to us to get a copy of those, um, so that you might tailor them as you choose. So next slide, I think is, and just some other considerations to think about as you're addressing, um, the potential for stigma or bias and concern around using medications. I just, uh, your work plan really builds [00:36:00] on that two-way communication. If you are starting or newly admitting people using medication assisted recovery, it's really important that you share the information widely about that. Let people understand the ADA requirements, help people understand that medications are about saving lives right now.

As we work our way into this, through this really terrible, difficult fourth phase of this epidemic where Fentanyl and other synthetics are having, uh, really a terrible outcome for many people. Create lots of opportunities for folks to ask questions. Um, I worked with a couple of houses where they, people were surprised to realize that actually

staff were on medications and had never felt free to share that information. So, you'll, you'll find those surprises as you create those opportunities. Encourage you to bring in a, a trusted local clinical presence, um, which [00:37:00] with whatever groups you're working with, whether that's your board or your staff, your residents, to help people get all their questions answered about any of the medications for substance use disorder.

Um, if you can get that healthcare partner to participate with you and your team on a regular basis and really help you develop and advise on some best practices for managing, um, that's a great strategy if you can do so. So let's go on to the next slide. Checking my time here. Okay. And just lastly, want to point out that, um, Some 12, 12 step strategies. Have we, we've seen some strong evidence basis that 12 Step strategies can be great and can be very supportive of people in recovery. In fact, there is, they're found in one analysis to be as supportive as virtually anything we do [00:38:00] clinically. Um, the difficulty is that some 12 step programs are less accommodating of people on medications. And, and because of that very individualized approach around MAT, um, in some 12 step approaches, um, we want you to encourage everyone to consider bringing in additional, uh, curriculum or additional strategies.

Um, so one of the, one of the strategies, SMART Recovery, which is, um, it's a great program. It can be operated as, as both an ongoing program, but actually 12 sessions that can repeat. Um, it's based solidly in good evidence-based practice. Um, and right now, for example, I am, I've just recruited a couple of smart program facilitators to work with the group I'm working with here in Washington State, who are also AA facilitators. So, this is a good [00:39:00] bridge to build SMART. You may see SMART as, uh, an add-on, um, or you might see it as an alternative. Um, but many people have a foot, many of the, the volunteer facilitators for SMART Recovery, um, which you can find online. You can go to the QR code or they're easy, they're easy to find with a Google.

They'll tell you all about local, uh, volunteer providers as well as local and state level coordinators so that you can think about doing that. Also, uh, The, the Betty Ford Foundation has, um, the COR 12 curriculum, comprehensive opioid response with 12 steps. Now, it's a great program. Unfortunately it costs money, so, so, but it's worth looking at that program, looking at some of the PowerPoints and other resources that they make freely available online as well.

So, so these are a couple of ways [00:40:00] to think about how, um, support groups and curriculum can be broadened. Um, especially if you are, might have some residents or some staff who might still be struggling with the idea of using medications, um, in the house. So, I think that's it. Our, our last slide, um, I just want to thank everybody for joining us.

We have plenty of time here for some questions if you have any. And I put again, the two QR codes up here which will take you, we know The Fletcher Group website is pretty busy and sometimes it's hard to find your way to things. So if you hold your phone up to these QR codes, they're going to take you directly to Vicki's needs assessment documents and directly to the seven, uh, the document around implementing medication assisted recovery. Um, so this is one way to go straight there, and then you can either look in on your phone or email it

to yourself that way. And Vicki and I [00:41:00] have put our emails here if you also want to reach out directly that way as well. So, all right. I think we're ready to open up for. Questions or comments? Absolutely.

[00:41:12] **Karen Coburn:** Yes. Thank you so much Vicki and Anne. This is such great information that you've shared today around medication assisted recovery and around conducting, community needs assessment. And it's so important and powerful for especially rural Recovery housing, uh, to use these tools and this information, uh, to make your houses, you know, better, more streamlined and more effective for the folks who reside there.

So, thank you again. We do have a couple of questions. I think one Vick i's already answered that was in the chat, but it was, is there a format for our community needs assessment? Uh, Vicki, would you mind sharing a little bit about that real quick, uh, to the rest of the group?

[00:41:58] **Dr. Vicki Jozefowicz:** Certainly there's guidance from [00:42:00] several sources that are located in the resource section of the toolkit that can be reached through the QR code.

It's on The Fletcher Group website. Community Action Agency one from the CDC. There's, there's probably more information than the person would, would like to have, but many sources.

[00:42:19] **Karen Coburn:** Isn't that great. And was you, you, I just, you know, I have a simple question or you feel like it's a simple question, but yeah the depth of what you can find when you start digging around is, is just immense. So, yeah, we do try to, you know, pare that down for folks and make it a little easier to digest. And so, thank you for that Vicki. James is asking, are you familiar with any studies on the efficacy of a program that combines MAT availability and COR 12 as part of the program?

[00:42:55] **Anne Shields:** Oh, um, Great question. No, I am not, [00:43:00] um, I can't, um, I will not, I can't put my finger on a specific research. Um, frankly, part of what's going on in research right now is we're playing catch up in this terrible fentanyl era. People are seeing, we know medications work with fentanyl and the synthetics, but, um, a lot of, a lot of clinicians are really operating on, uh, more on shared case review, sharing best strategies than we're seeing good clinical studies. But it's a great question, but I don't really know of anything that I could send you right now.

[00:43:36] **Karen Coburn:** Okay. Rachael mentions that you mentioned HRSA funding specific to MAT. Can you elaborate on that?

[00:43:43] **Anne Shields:** Yeah, so, um, HRSA provides operational support to FQHCs and rural health centers all over the country. Uh, They always, so, and frankly, they have been asked [00:44:00] to step up their game on MAT for some years now, and many are doing an amazing job and many are starting to offer more and more medications than just one, um, injectable.

And that's going to be important because medications, the new formulations of buprenorphine are those that are most active against fentanyl and the synthetics. So anyway, so you've got HRSA making operational funds available. Frankly, in the omnibus budget, bill and other, you know, the, right now there's a lot of pressure on those federally funded healthcare providers to up their game to help address this terrible overdose epidemic.

So I would really encourage you, if you're not seeing an easy way to partner with a local, um, community health center or rural health clinic. Sit down with them, talk about whether or not you, they, you might be considered part of how they could submit [00:45:00] a proposal for additional operational funds so that they could serve you better.

Maybe they can get a van that can go to all the houses. Maybe they could partner with your NARR affiliate. I'm obviously making this up, so that the good rounded houses. Um, we do have a van now. It's not an, it's, it's not an FQHC van, but we have a van that's starting to round in rural Montana. So there are all kinds of strategies like this for you to explore that would make medications, um, uh, available without leaving the site potentially if advanced service is feasible, um, or at least can be well coordinated with your existing programs so people don't lose program time because they got to go to a clinic that's far away.

[00:45:47] **Karen Coburn:** So, okay. Yeah. Great. Thank you, Anne.

[00:45:50] **Anne Shields:** Yeah.

[00:45:50] **Karen Coburn:** Um, this one, and, and this may be for both you, but for Vicki, um, so my community has some NIMBY issues. Would it be recommended to include some of [00:46:00] these folks on our community needs assessment team? Uh, or will it make it more difficult for my house?

[00:46:07] **Dr. Vicki Jozefowicz:** Well, it could make it difficult, but it's going to be difficult anyway. And one way that makes people feel even worse is when they feel like they aren't heard. So if it was me, I would invite the people with Nimbyism and, you know, hope to be able to make some changes that can get them to, to see your program. And the best thing to do to get people to understand recovering people is introduce them to a few of them. You know, let them see that they're not any different than anybody else. And, um, you know, maybe you'll win somebody over, but pretending that they don't exist is not a very effective strategy. So yes, I would definitely involve them.

[00:46:48] **Karen Coburn:** All right. Thank you. Um, we have a lot of questions, so I'm trying to get to them and it looks like we're good on time. Uh, Matt wants to know what are some of the ways that residents can [00:47:00] help address the stigma that exist in community around in, in communities, around MAT?

[00:47:14] **Anne Shields:** Well, frankly, one way to address this issue differently is really how I approached it at the start of my brief presentation today. I mean, what I said to you all

pretty clearly is we are in a different phase of an ugly epidemic, growing uglier, and taking more lives. 106,000 people died last year.

Many, many more young people died than in previous years. So, I'm always very careful not to say, not to sound like I'm ever, you know, dinging or criticizing someone who was able to get off, uh, alcohol use or [00:48:00] stop using opioids. When it was oxycodone that we were worried about, frankly, it was a lot more feasible to kick that through abstinence than it is to kick the much more intense, um, and more frequent cravings that come with the synthetics and fentanyl.

So, I just view it as, uh, what you did 10 years ago may have changed. Now what you need to do is going to be different. So, I don't know if that's helpful, but that's been my approach, um, to help people get their heads around how often medications might save lives now.

[00:48:39] **Karen Coburn:** Okay. Thank you Anne.And just tie to that, what, what medications work for people on fentanyl? Are there any?

[00:48:51] **Anne Shields:** Uh, so, so the best news, and again, we're, we aren't seeing the big randomized control studies yet, but we're seeing good response to the new formulations of Buprenorphine. Now, buprenorphine has always been a daily sublingual medication for many years, but since 2017, it's now available as an inject. An injectable, it lasts the whole month. And I'm hearing, um, when I sit in on case conferences with clinicians, I'm hearing, um, a lot of enthusiasm about, uh, response to that [00:50:00] medication when administered in that way, which is good. There're also some early studies that show that buprenorphine is a good combination drug, promising combination drug to address people to help people get off meth. So, and you know, so, so that's really an important drug. Obviously if you're, uh, housing operator, the idea of an injectable formulation like sublocade is a whole lot easier to think about managing than daily, than a daily med. So, I'm happy to talk, um, with anybody about that separately and send you other resources to look at that.

[00:50:40] **Karen Coburn:** Okay.

[00:50:40] **Anne Shields:** I think ADA, I'll just add that I think ADA requires that you allow either formulation in your house, so both oral and injectable. So, I think it's not an either or, um, keep that in mind, but people are seeing really good responses to the, to the [00:51:00] injectable sublocade.

[00:51:01] **Karen Coburn:** Okay. Thank you, Anne.

[00:51:02] **Anne Shields:** Yeah.

[00:51:03] **Karen Coburn:** Um, what classifications or sites of care are required to do a CHNA under the Affordable Care Act? Uh, this is from Paul. He said, I knew hospitals had to, but didn't know if residential LTAC, nursing homes, et cetera, do. Can you address?

[00:51:20] **Anne Shields:** CHNA?

[00:51:22] **Dr. Vicki Jozefowicz:** Community Health needs assessment.

[00:51:24] **Anne Shields:** Okay.

[00:51:25] **Dr. Vicki Jozefowicz:** I know that hospitals are, and so are health departments. I'm not aware that, um, treatment or recovery centers are required to do them. I, I don't know that they are or not, but I've never heard of any. And again, realizing that that hospitals, um, health departments are required to conduct the assessments, you know, that could save some work by partnering with them.

[00:51:52] **Karen Coburn:** Okay. Thank you, Vicki.

[00:51:54] **Anne Shields:** And I, I would just add that I, I know of one rural hospital [00:52:00] system that has a healthcare for the homeless grant. So, they don't advertise it in a big way. I'm, cause they serve everyone. Um, but, um, you look for those kinds of, um, federal supports that would, might change what that rural hospital has to do or is required to do, um, and how they might support you.

[00:52:28] **Karen Coburn:** Thank you. Thank you both. Um, and again, Vicki, um, you mentioned that there might be a cost. Is, is there a rough amount that, um, a group or an organization or a committee should set aside for a community needs assessment?

[00:52:44] **Dr. Vicki Jozefowicz:** No, it really depends on how much of the work that an organization is able to do itself. You know, how professional that they want their, their final product to do, uh, to be, and, you know, can you find volunteers or others that will cover [00:53:00] some of the cost. But there are costs, you know, there's, there's going to be advertising of your community forums. Um, you know, if people are coming to your forums, they're going to expect some refreshments. Longer interviews. People may want an incentive for participating in that, supplies for the meeting if you're having to pay for data analysis. Then that could be an expense. So, you know, the goal is with anything having to do with the nonprofit, you want to get everything free or get somebody else to pay for it, if you can arrange to do that.

[00:53:37] **Karen Coburn:** Okay, thank you. Um, another one here, uh, are there, or this is from Matt again. Are there good resources available for MAT usage for pregnant women?

[00:53:50] **Anne Shields:** Yes. And, but I think, um, Matt, I think they vary a little bit state to state. So, for example, um, in my home state, um, the [00:54:00] state actually supports a local passionate provider, , who's developed a, a huge and very extensive program for pregnant and parenting women and, um, and really follows women all over the state. And helps local providers manage them. But in, and in some other states, there's an academic center of excellence to serve, um, women and children struggling with, women and pregnant

women struggling with addiction. So, you kind of have to look locally to see what the state or local resources developed.

[00:54:36] **Karen Coburn:** Okay, thank you. Um, and thank you for your question, Matt. Um, uh, from Jeff, why has it taken NIDA so long to develop m a t for methamphetamine? Did they focus too much on opiates?

[00:54:52] **Anne Shields:** I, I have no idea, Jeff. Um, I, I don't know how difficult a clin the [00:55:00] clinical proposition of a addressing meth really is. Um, but the, it's so sad. The fact that all I can say right now is we have promising combination meds. Um, it's, it's a very sad, uh, situation. But, um, the best ways for you to stay on top of this are, um, you know, there, there's just a few strong experts around the country that are speaking to this nationally. Um, I, I'll send out some names. I'm sorry, I'm not, I don't want to, um, look like I'm pointing to the right expert right here, but if you want to contact me, I'll, I'll tell you who I'm following to try to stay on top of things. Um, I think the other reality is, is, you know, fentanyl hick different parts of the country at different times, so it was really bad in parts of the country and then it hit other parts of the country two or three years later. So, it's been this very uneven, um, how do we respond this, [00:56:00] especially in the middle of a pandemic. So.

[00:56:05] **Karen Coburn:** Yeah, I think that's, um, I, I think that's really accurate. Is it does kind of, I mean even with, um, I mean just what we're seeing with even like covid numbers, it just kind of hits in different places at different times and you'll have big ups and downs, um, that you're not expecting, um, in one location versus another for a time. Uh, it almost seems like they're a safe haven and then, you know, but it eventually works its way there. Um, can you share just real quickly, um, so you're using MAT and MAR, can you share the difference in why we might use one versus the other?

[00:56:45] **Anne Shields:** We like the term medication assisted recovery, MAR, um, and, you know, it just, it's what we're about, it's about supporting recovery. Um, but frankly, I, I use MAT because I know many of you [00:57:00] hear that locally all the time. And the providers, healthcare providers out there who've been providing, um, treatment, MAT for 10 years, now, they're going to scratch their heads if you say MAR. So you end up using both terms somewhat interchangeably, is the way I view it.

So if you, if I think if I were to say MAR provider, healthcare provider to somewhat at my state agency, they'd say, what are you talking about? So, um, but I do like the concept of medication assisted recovery. I mean, that's what we're about in housing and supports and seeing medications as a part of that recovery, um, approach.

[00:57:46] **Karen Coburn:** thank you. Um, and, and yeah, you want it to be that people first and you know, person first language and, um, you know, make it, you know, um, more focused on, on the person in recovery as opposed to [00:58:00] the, you know, treatment itself. It's their work. Um, so Vicki, this one is, uh, back to you about the community needs assessment.

So, once we have the results of the assessment, what do we do with them? How do we release those? Is it, uh, do you make a big press release? Do you do a big, you know, booklet? What, what do you recommend? Um, we do with the, the results of the, that information?

[00:58:24] **Dr. Vicki Jozefowicz:** Sure. Dissemination is a common step. I didn't include it in the outline that, that I did, but it is a, a usual step to a community needs assessment. It can be done through, you know, hosting a, a community, uh, release. And if you're going to do that, you might want to get some community leader to kind of co-host the release of that. You could have a press conference, um, presented at different workshops, different group [00:59:00] meetings, release it, uh, both in writing and through oral presentations. You know, it's kind of endless on how you can release the information, but you know, you do want to get the, the word out. You know, we studied our community and this is what we learned, you know, this is what we have, this is what we don't have. This is what's, you know, specific to the needs of us having a recovery house. And you know, there's probably going to be information that will support the need for the recovery house.

[00:59:32] **Karen Coburn:** Okay. Excellent. Thank you. Um, so we have, uh, a little less than two minutes, so I'm going to hit these real, real quick. Uh, so, uh, Jeff wants to know, he says, are we really going to be able to impact, uh, the overdose problem until the administration tightens up borders and stops fentanyl from coming in? I don't know that that's something Fletcher Group can answer necessarily. Uh, that's a, a bigger issue than, than we can wrap arms around. But, um, [01:00:00] Anne, Vicki, anything you want to, to respond with that?

[01:00:04] **Anne Shields:** Yeah, Jeff, just that and being around for many decades, you're right, but now we have a synthetic, um, meth that's manufactured in large factory sec, factory settings in Mexico. I would just also add that fentanyl's not just coming up the across the border. Um, recently there's a huge bus to New York State where, uh, large ships coming through the canal were bringing in huge quantities of drugs into the US and to Europe. So it's not just the border where we're seeing these drugs come in. They're coming in through all our major ports. So.

[01:00:43] **Karen Coburn:** Okay. Thank you. And then, uh, the last question I'm seeing right now is, where does Vivitrol or Antagonist therapy fit for patients relative to addressing OUD and satisfying cravings? That's, that's from Paul.

Anne Shields: Uh, the, what I see in tracking, uh, the [01:01:00] experts and reading the case [01:01:01] studies and sitting in on case conferences right now, that is that methadone and buprenorphine formulations seem to be more effective for people who've been exposed to fentanyl, whether it's their drug of choice or they're inadvertently exposed, but, but it's not Vivitrol that's working, um, in those. Now Vivitrol is also not, has not been useful around meth. So, the, the promising treatments are all based on buprenorphine with other medications. So Vivitrol is just probably not your best strategy these days, but that's really an emerging clinical consensus. Um, moving more away from Vivitrol to Buprenorphine or methadone.

[01:01:55] **Karen Coburn:** All right, well, thank you so much. We're at our time, and Vicki, [01:02:00] this has been fantastic. Really appreciate the information you've shared with us today about MAT slash MAR and community needs assessment. And, uh, if you need more information about any of the things that were covered, uh, you can certainly go to our website at www.FletcherGroup.org.

Um, we will have this webinar, uh, on our YouTube channel and, uh, access through our website about midweek next week. It's usually up no later than Wednesday. Uh, and so you'll be able to go back and watch this video or share it out with other people. Again, Anne Vicki, really, really appreciate your time today and for everyone being here and asking questions and being engaged with us, uh, at with The Fletcher Group webinar and we'll see you again next month.

Thank you all.