Michelle Day: [00:00:00] 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 p.m. to 3 p.m. 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 entered 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&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. [00:01:00] 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.

Joining us today is Fletcher Group's own Anne Shields. Anne joins the Fletcher Group after many years of experience working with state Medicaid agencies, academic centers, community health centers, and behavioral health organizations to support the adoption and spread of integrated health and housing strategies. As the Associate Director of the University of Washington, Ames Center for Advancing Integrated Mental Health Solutions, and led an interdisciplinary team of psychiatrists, behavioral health clinicians, nurses, and others to provide training and technical assistance in diverse healthcare settings. During the early years of the opioid epidemic, she worked closely with SAMHSA, Washington and [00:02:00] California state agencies, academic centers, tribes, and community organizations to help plan and launch effective opioid treatment networks and housing strategies. In her previous work as an integrated care consultant, she helped organizations develop effective working relationships with foundations, with governments at the state and federal level, with provider associations, and with payers to help sustain important work in health and housing.

A nurse by training, Anne pivoted back to a public health advisory role during the first two years of the COVID pandemic and received the President's Volunteer Service Award in 2020 for her work with housing providers, senior centers, and tribes. She continues to work on site with housing providers to adopt evidence-based programs that address substance use, depression, and anxiety. Anne, [00:03:00] the floor is yours.

Anne Shields: Thanks, Michelle. Thanks everyone for joining us today. Um, so I'm going to, uh, let's go ahead. We're going to be talking today again about the framework for the 4th edition. More specifically, what we're going to talk about today is why the 4th edition is going to be so important to you all around recovery services, including housing.

And I just want to point out the, the acronyms that ASAM uses in its new chapter is Recovery Support Services, RSS, and that includes recovery housing. So for everyone, just to be clear, whenever we talk RSS, we're also talking housing. Talk about how we've characterized that relationship in ASAM now, I think it's important for housing operators and others to

understand a little bit about the conceptual framework and [00:04:00] research that supports, including recovery services in ASAM criteria.

And I'll share with you what the specific guidance is to treatment providers in evaluating RSS needs and recovery home placement, um, within the ASAM criteria. We want to leave plenty of time for hearing your ideas, discussion, Q & A. I'm going to add right now though, if you didn't see our last month's webinar, um, we were lucky enough to have Dr. Paul Early and Beth Sanders, uh, a clinician who is also a NARR co founder, um, and who are largely the co authors for this new chapter in the ASAM criteria. So um, we'll have a link in our chat here. It's a good one to view. Um, we'll be going into a little depth and building on what Dr. Early and Beth had to say last, last month. So let's go to the next slide. [00:05:00] So again, um, and this might be review, little bit of review for you if you were with us last month. Um, the new criteria was released in November. Um, why does it matter? Like who cares? We are not generally treatment providers on this webinar. We're recovery supports and services and housers.

Um, but this is the first edition to finally recognize and promote referrals in a more formal, systematic way to recovery supports. It's important because 45 state Medicaid programs use ASAM criteria for placement in SUD treatment services and programs. So, 26 states and Washington, D. C. include coverage of services in some of the ASAM criteria.

Now, I know a lot of people aren't aren't always fans of what feels like the bureaucracy [00:06:00] of the ASAM criteria, but it still matters. It's still going to open doors for recovery support services and strategies. Yes, Kyle. First time. So it's a big step forward for the work that many of us do. So let's go to the next slide.

The conceptual framework for recovery supports. All about recovery capital. Now, that might not be a new concept for you all, but it's often, it might be a new concept for a medical treatment provider who is prescribing MOUD and really hasn't thought about their, their work in addiction services in this way before.

So, I'm just going to quickly review that definition for recovery capital in case it's new to some of you. Um, a good resource for you to use, um, total resources [00:07:00] available to help a person find, maintain their recovery. Skills, abilities, knowledge. What resources do you need for basic needs in social and community support? So, the new 4th edition states upfront that clinical services and recovery support work in tandem to build recovery capital. This puts us on an equal playing field when we talk to insurers or other possible funders. So this is really an important concept. We'll be talking, we'll return to it later as we talk, go through our slides today.

The 2nd framework that is referred to is social model recovery support. Now, I think for many of you, that's not a new phrase. Um, but it's new to ASAM. So the addition notes that there are many [00:08:00] residences that utilize a social model to guide programs and structure, um, creating a therapeutic milieu, um, reinforcing skills, attitude for sustain.

So I wanted in this slide to give you some of the phrases and context in the new Chapter 15, because I think those are creating common language with, between providers, funders, Medicaid programs is going to be important in the future. So, so the value added here really is about, you know, safe, supportive recovery settings, free of, free of alcohol and illicit drugs.

This isn't new to, that's not a new concept to us, but it is new, newly introduced into what's been a medical framework. So, let's go on to the next slide. So, what evidence, uh, what's the science [00:09:00] behind ASAM, um, pointing out why recovery supports, um, matter? Why does it matter? Um, it matters because, again, like I've said, this is, this is how we're going to gain some ground in establishing ourselves as a, as a service for which we might receive payment and other kinds of support. So ASAM referenced over 60 studies. Systematic reviews, pulling together all kinds of qualitative and quantitative surveys and work, books and other resources. Basically defend including recovery capital as part of what is important for treatment providers to consider in developing a treatment plan. So I've included a couple of resources here.

And you see I got a QR code there. You can pull that up now or on your phone, email it to yourself as a way to look these up and [00:10:00] see if they're useful to you. Now, you may have to convince some old timers or skeptics about this. So this is just ammunition for you to be thinking about how you can guide those conversations around recovery capital. Um, now, unfortunately, many of these studies are behind a paywall. So I've just picked out four here. Three of them aren't behind a paywall, so you can pull up, read the whole thing. But the first, the 2010, I think it's just, it's important for you to be aware of that because you can use that study establishes over a decade of research that support

the importance of recovery cap, capital. So going back from 2010 all the way to, you'll see, um, the, uh, more recent one on this page, 2017, the validation of a brief assessment tool, the [00:11:00] BARC 10. Um, we've got lots of history and good science supporting this. Now, unfortunately, this BARC 10 is behind a paywall, but I'll have some slides later to share with you more information about the BARC 10. Okay, so let's go to the next slide.

ASAM cites, so the social model recovery support, again, these two studies aren't behind a paywall. That means you could pull these up, share them with your state Medicaid agency or another funder, um, as a way of, um, really helping them also understand and appreciate what you contribute to the recovery ecosystem.

Both of these were largely authored by Plocin, who's been an amazing supportive researcher and advisor in recovery housing [00:12:00] for many years. You see his first social model principles back in 2014, and also just published last year, Moving Social Model Recovery Forward, Recent Research on Sober Living Houses, and actually NARR was a co author on this. So, that's a great resource to consider sharing, um, locally. So, let's go to that next slide then.

So, there are a couple of health system concepts that are discussed here that I think are useful to understand. Important might be, yeah, maybe, but I think it's important to, again, be able to

speak the same language as a, as a prescriber or a medical clinic you might be working with. So, ASAM 4th edition [00:13:00] introduces the Chronic Care Model, and this is a framework that goes back 20 or more years.

And it was originally designed to improve the quality of care for people who are dealing with chronic diseases like diabetes, heart disease, sometimes depression, um, any kind of aging disease, uh, so this is, uh, sometimes, uh, this is new to some addiction providers in the treatment setting, um, and I know sometimes we've had some concern, I've heard concern from addiction, um, service providers that um, not everyone relapses, so is it that we really need to always have chronic care?

Well, ASAM has basically said we have to be prepared to manage this over the course of a lifetime. So the components of this model include self [00:14:00] management, delivery system design or redesign, um, to make care more planful and more timely for people who might be managing, um, and with occasional relapse, clinical information systems, and really better organization of health and community supports.

The other health system concept, um, that is introduced in fourth edition is Measurement Based Care. Often called MBC as a shorthand. Now, MBC has been around in, um, mental health treatment for many years. Um, this is, uh, newly introduced now in ASAM for addiction medicine providers. And also, um, I've just noted that SAMHSA also just came out with a new report focusing on substance use, SUD providers, where they are using [00:15:00] the same, the similar term, Measurement Informed Care, rather than Measurement Based Care.

So that's a, that's a good new resource for you all to look up on SAMHSA. Now, what is that? MDC is just a systematic routine assessment of symptoms and functioning. Now, we'll, we'll return later, um, to the BARC 10 to talk a little bit about how you might begin to, um, look at that if you aren't using it. Um, when we get to our discussion later, it'd be really nice to hear from anyone who might be using the BARC 10 already. So, I'll just tee that up in case, in case we have some users on board already. So, let's go on to the next slide then. So, again, going back to that Chronic Disease Model, the fourth edition, um, urges treatment providers [00:16:00] to consider these four steps in how they develop their programs. Encourage long term remission, obviously.

But they also ask people to provide regular recovery management checkups. If you have diabetes, you don't usually go more than three months without seeing your provider to check your blood sugar, for example. So what we're seeing is ASAM encouraging that people not just drop into the sea their treatment provider when things are going south, when they've had a difficult moment or relapse, but go in and continually manage and check in so they can get continued support.

So, these are these more planful visits for what ASAM calls remission monitoring as part of the treatment plan. And you can see how recovery support services will play a big role in that. Also, they want to [00:17:00] see everyone supporting a very rapid re engagement, um, acknowledging relapse. It can be part of this particular disease process.

So, um, rather than seeing it as a failure or, or an aberration in any way, um, to really incorporate, uh, relapse prevention and quick response to relapse into the treatment plan. Obviously, housing, recovery supports play a huge role in, um, helping people move into more stable recovery over time. So that's that chronic disease model that I, like, for example, you're talking to people in your state Medicaid agency. This is language they can relate to because they've worked in a Chronic Disease Model to develop programs and health systems in diabetes and heart disease for 20 years. [00:18:00] So, it's a good strategy for us all to learn about.

Let's go to the next slide. Also, that Chronic Care Model, I just want to point out again that the partnerships between treatment and recovery services are very explicit here. You can go online and Google your way to a million different presentations of the Chronic Care Model. It's been around that long, but I like to share this one particularly because it clearly sees community resources as important as the health system. Um, so this, this is just a nice visual for you to think about and perhaps use in developing conversations with funders or others. So next slide. I threw this slide in here just because it's important to, I just wanted to acknowledge for you all that we've been talking about the same stuff for years[00:19:00]

with just a different label. So, I mean, here is one of our recovery ecosystem slides. Chronic Care Model, Recovery Ecosystem, Supported Milieu. This all comes down to a strong web of community support, including safe housing for people in early stages of recovery as they become more stable. So I wasn't, I really put this in here to just make sure everybody's sort of connecting the dots between these different phrases and descriptors, because they really all are pointing in the same direction about the importance of community support and, and housing and treatment. Next slide.

So we're going to dive a little deeper into measurement based, or now we'll probably all start calling it measurement informed care because that's what SAMHSA is going to use. So, [00:20:00] um, using that Brief Assessment of Recovery Capital, BARC 10, to look at an individual's resources and strengths. So, why am I going to talk about this?

Because insurers are going to want you to use this. So if you haven't used it yet, this is going to be one of those givens, I believe, in understanding whether or not a community resource, any kind of recovery support or housing, should be covered by insurance or other funding sources. So the BARC 10, which was based on a much larger standardized measure, the ARC, um, and then over the course of really the last 10 years, um, researchers and, uh, clinicians have validated, i. e. they have tested and tested and tested to establish that it is giving us a good framework for treatment [00:21:00] planning. They validated this down to a 10 item, what's called strength based self report questionnaire. It should just take a few minutes for a person to complete on their own. Scores can range hugely, six to, you know, six to sixty are the scores. It is widely in use in some areas, not everywhere. I included a link here the QR code goes to, I thought, I found a useful pilot report in Virginia, where their peers Are using the Bark Pin to help establish a baseline and over time evaluate person's recovery capital to help basically determine the level of support they might need at any, any particular moment in time.

So, this is again, one of those, when you'll [00:22:00] see in that report, which, if you look at it, I found it interesting because they did run into some problems with peer specialists trying to administer this, this tool, i. e. state the question and then sometimes try to give guidance. These kinds of, uh, these kinds of tools are really made to be used as a self-report. The best way to use them, frankly, is to hand it on a piece of paper to your client or your patient and let them fill it out. Um, and it's similar to the PHQ 9 or GAIN or many of the other measurement tools that we use in behavioral health. Best way to do it is on your own rather than asking someone to administer.

So, let's go to the next slide and, uh, here are the general areas that the BARC 10 [00:23:00] covers. Now, I'm not going to spend a lot of time on this page, um, because I've already seen some questions in the chat about where can I get a copy. We've got a copy here for you, but basically, just so you have a general idea, um, substance sobriety, meaningful activities, risk taking, experience, social support, etc. These are all things that you are evaluating in your own ways, in your own programs, I'm sure, etc. Um, but maybe not in the same, uh, systematic approach that the BARC 10 uses. Um, so let's go to the next slide, which is actually, here is your items, and here is how you score it. And here's a link to a BARC 10 one pager that you can download and pilot or use,

so pretty straightforward. Now, I think three [00:24:00] to five minutes. Some people may take longer. I have a lot of experience in using the PHQ 9 and the GAIN in primary care, and frankly, all of these tools are best used and validated as a self report. So I will just hand, hand along that advice, um, not to read these questions to someone and score it for them, but let them do that work unless, unless they're really struggling with reading or in other ways, because that really allows, that really allows the individual to interpret it, what, what any of these particular items mean? I get lots of support from friends. Well, for some people, that might be two friends or one for others. It'll be twenty five. So it's better not to do anything that might lead them into looking at their level of support differently. Or the same as someone trying to read questions to them.

So, okay, let's go to the next slide. [00:25:00] This is just another version of, and another slide that we've often used here at Fletcher Group to just make it very clear that the BARC 10 can really help you demonstrate that residences build recovery capital. So, we've got a whole lot of different life skills and support we can provide in, in recovery residences, um, and not necessarily every one of these is necessary. But again, the BARC 10 is what is going to give you a huge leg up, um, in demonstrating to insurers or other possible funders the value you add to the treatment plan. Next slide. Here's another. I just threw this in here because again, we're all used kind of different verbiage for recovery [00:26:00] ecosystem in this slide, recovery residences in the previous slide.

I think it's going to be important for us to agree a little bit more on the same language, or at least use the language that the funder or the programs you're working with can recognize. So, if. So, for example, if therapeutic, therapeutic milieu is what the medical provider you partner with, um, recognizes, great, use it. We're not really getting hung up here on a particular label, all you see ASAM constricting that a little bit. Okay, next slide.

So, beyond just measurement based or Measurement Informed Care, what is ASAM's specific guidance to treatment providers about their referrals? So, and again, just to be [00:27:00] sure, BARC 10 is It is a good idea to learn about and trial or pilot, but it is not required in ASAM. It is not required of treatment providers in ASAM, although insurers might do so. But there are other ways to evaluate what ASAM calls a quote, recovery Environment Interaction. So here are the three areas that ASAM suggests that Treatment providers evaluate and document You know, is their patient able to function effectively? What are the physical, emotional safety factors in their current environment?

And also, obviously, a really big one, the likelihood of engaging in risky behavior or continued substance use in their current living situation. So, uh, these sort of sum total of this is, is my [00:28:00] patient going to be able to engage in a, in a supportive community as well? Well, maybe yes, maybe not. So, I think this is put this at this point, we have to consider how the housing first model fits in to ASAM 4th edition. And I'm sure there's a range of opinions about that. And ASAM makes a, in the, in the chapter 15, their new chapter on RSS, they make sort of a fleeting reference to housing first models. And I think there's a lot of work, but without any clear, clarity around that as yet, it's clearly work that we have yet to do.

If your patient isn't able to engage in a supportive community, maybe housing first is the place to start. But how do we help a person move from a housing first, the safety of housing first, into a supportive [00:29:00] community? I don't know, maybe we'll have some, hear from others about some ideas about how we're doing that or some examples, but I think that's going to be a real challenge for us in many places.

Okay, next slide. So there's been a lot of, I'm getting a lot of questions and attention about the new labels for housing, the four NARR labels which have changed or are changing. Now there's no there's no prescription that NAR affiliates or others do this, um, immediately. But I think over time, and I know and I've under, I understand from Beth that NARR is also revamping its website, you're going to see in place of the one, two, three, and four, you're going to see P, M, S, and C. So, this was done in large part because ASAM is already using numbers [00:30:00] and those of you who've seen the many pages of ASAM criteria instructions, 3. 1, 3. X, so on, that go for treatment providers, it was going to be very confusing. to have NARR use levels 1, 2, 3, and 4 when those weren't really going to line up with the Level 3 and so on that ASAM references.

So there was agreement last year for NARR to transition to Peer Run, Monitored, Supervised, and Clinical. So, I mean, the type P, the Peer Run, which, you know, Oxford Houses are typically the most widely known example. Um, the key characteristic is really just the same as Level 1 that you're all used to, democratically governed homes. And Monitored, sometimes called sober homes, sober living. Type 2 or [00:31:00] M, many of, many of us are, in that category, I'm not really going to talk at all about supervised or clinical because they almost really live in another world because treatment is more, more available and part of that world. Um, so, so anyway, we'll go on, but.

Any questions about this? It really came down to trying to come up with a system that would make it easier for people to, uh, easier for treatment providers to understand what they're looking for. Now, the fourth edition guidance. Um, it does have some other, um, specific recommendations to treatment providers about who to reach out to in the recovery support world, particularly recover, recovery housing, um, about what to look for and partnership with the recovery housing group.

And I do think we'll see more health systems and addiction treatment systems [00:32:00] starting to build or become interested in building more formal relationships with residences. And other support systems. So that'll be exciting. But first and foremost, ASAM's guidance to providers is, you must ensure those residences do not discourage use of addiction medication. Now, I, uh, my, my other role at the Fletcher Group is I am the, I'm, I'm the cheerleader for MOUD. So, I, we're happy to help in any way. I, I know that recovery residences in rural areas have for for good reason or not, there seems to be sort of a reputation that medications, addiction medications are not welcome in rural residences.

I was on a research webinar, [00:33:00] uh, last month where they actually polled the audience who thought no more than 25 percent of rural residences allowed medication on site. I don't know if that's true, and frankly, I don't think anybody really knows for sure what's true, but so we've got a reputation to kind of live down here, um, or reconsider.

We, at The Fletcher Group, we do have, if you have a home where you are still figuring that out, how to allow medications as required by ADA and, and Fair Housing now, if you're still struggling with that in any way, we're happy to help with educating staff or board members or anybody in the community on that. And we actually, we actually have a set of draft policies and procedures. We make it available in a Word document so you can tailor it. Anyway, we're happy to help in any way we can. We don't have that posted on our website because it's in Word, but it's a tool [00:34:00] that's available for any level of house and we're happy to just connect with me.

My email will be in the last slide and connect with us and we'll get that to you. So, so, okay, besides access to medications, on site staffing, governance model, again, this is that those new levels, P, M, et cetera. I'm not really sure how many treatment providers will be paying that much attention to this. But at some point, um, probably a clinic system like, uh, a large FQHC will probably look out and have a committee that goes out and assesses housing options, who can they send people to, what do they know about the policies and procedures, governance, et cetera, so that basically a treatment provider would have a list of these are the, these are the residences I can, we support and I will refer to.

So, that's probably coming down the pipe. [00:35:00] Not tomorrow, but soon. And again, evaluating to make sure those on site supports and services are there. You know, mutual support curriculum like the Smart Recovery, AA, whether it's spiritual, secular, or religious, which is how ASAM categorizes it. Um, are those available? Um, are those, are those effectively managed as well? And of course, employment training. They're going to be looking for what level of support is there. Culture, community, what are the rules for living

within the house, etc. So this is, this is all the kinds of stuff that many of you grapple with every day, right?

I think this list is useful to you in thinking about how to summarize your work and share it with treatment providers in a way where they'll understand that you're a good partner and they can work with you closely. So, next slide. [00:36:00] Yeah, we're wrapped up. I told you we're going to save lots of time. For discussion and QA, and we're there. Now, here's my email address below if you'd like the policies and procedures for bringing MOUD in to point out. And I'm going to pull up my chat and Milena, any questions?

Milena Stott: Hey, Anne so we have a few people that do want a copy of the MOUD, Kyle has noted for us that SAMHSA will soon publish, or hopefully soon publish, guidance around the intersection of recovery housing, and housing first, which was a result of a work group that they brought together in August of 2023. So thank you, Kyle, for that information. That is super helpful. Regarding questions, I do have one question. What recommendations do you have for those looking to implement [00:37:00] the new ASAM changes?

Anne Shields: Oh, um, well, okay. Who is the you? What kind of provider are you?

Milena Stott: It's a recovery house. It's a recovery house.

Anne Shields: Okay, and we're happy to help, help you strat, help all of you strategize on this. Um, my thought would be, um, Work with is basically make sure and bring. Bring the new ASAM Chapter 15 criteria to the attention of your state Medicaid agency to start. Now, you may get well received. You may not get well received. It depends on, you know, your state's politics and other situation, but make sure you're building working relationships with somebody in your state Medicaid program who understands the importance of residences. Make sure they [00:38:00] understand that you've now got ammunition. You can help them. You've got the science base. The American Society of Addiction Medicine is now behind this as working in tandem and as important.

So now if you watched or you were on our first webinar with Dr. Paul Earley. Paul was absolutely right that CMS, the federal agency over Medicaid and Medicare, is going to have a lot to say about this. CMS is the 900 pound gorilla in funding, in this kind of public medical and treatment funding. However, they're going to be slow.

I've worked several CMS projects like this in behavioral medicine, and it was two years. It was two years in getting there, so I would not hesitate to just start to build those relationships locally and see if you can't come [00:39:00] up with, come up with a program idea, or at least a pilot at the state level to pull ASAM, Chapter 15, RSS, into your state's addiction funding. So now you, anyway, happy to help strategize. And if you want someone like MiIena or me from the Fletcher Group to sort of come in and, you know, really try to sound like the, yeah, this is what's going on. We're also happy to try to, um, help you support, connect those dots more directly on the science side.

Uh, Fletcher Group, we also have a research team that can get access to more of the, uh, more of the tools if you want to share those more of those research papers. It's going to be an uphill battle and it's not going to happen easily. And 1 of the things Dr early pointed out was, you know, be careful what you [00:40:00] ask for. The good thing is you're now available and should be funded. ASAM has spoken. The bad news is you are also subject to the bureaucracy of funding. So we're going to be working this in many ways over the next few years. Okay, I'll stop. Other questions?

Milena Stott: Yeah, there is one. Someone is inquiring about the frequency in which you should administer the BARC 10. Do you do it only once at intake for Recovery House or do you do it periodically throughout to understand the changes that are taking place?

Anne Shields: I do not, I don't know if there's any, um, player expertise in that. Um, I think at this point, um, um, but I'm happy to, we should research this and if we, we'll get back to you if we, if we find anything. This tool is still relatively new in use. Is there anybody else on the call that is using the BARC? And how often are they using it? [00:41:00] Anyway, we could definitely unmute if people want to talk a little bit about how they're using the BARC 10. I do not have direct experience on this. I think what's. What ASAM is saying, in part, is that the treatment provider should start using the BARC 10. If they're going to refer to a residence or whatever, they use the BARC 10 to establish, yes, this is part of the treatment plan. Ensure you should pay for this, um, if possible and that way. So then probably a follow up in about quarterly to start. Yeah. Yeah.

Milena Stott: Anne, I do know, you know, there does have to be a pre and post measure. Right? And so we, what we don't know is the intervals at which you should um, measure them, you know, in general, when we're using tools like this, we use them to evaluate our progress. And so, and to document [00:42:00] our progress, or to look at, um, if progress isn't being made, where do we need to focus our attention? I think that that's the value of, you know, using Measurement Informed Care, which you did talk about, um, during the presentation is once you have your baseline measure, On the areas of which somebody needs support, you can cater your recovery support plan to support that individual in achieving those outcomes.

And, you know, my recommendation is to take credit for it and make sure that you're using it periodically to measure the things that you've closed the loop on. Um, we do have someone on here. Mr. Crabtree, um, or Ms. Crabtree, I can't tell by the, the, the name, um, that has been using it for a year. Um, and I don't know, you know, in this webinar style format, if there is a way to have you talk about it. Um, [00:43:00] But we'd be happy to follow up and learn more from you. Um, we do have another question, a lot of interest on the MOUD question, Anne, and one question that I have here is, what would be a good starting point for a rural recovery house that wants to accept MOUD, MAT patients, but is experiencing barriers from the community or its board, for example?

Anne Shields: Ah, okay. Good starting point. Um, board education is always important. We can help with that if you wish. Also, look for who, who are your local partners that are prescribing MOUD. Do you have a Federally Qualified Health Center, primary care provider

who's prescribing MOUD? If you can bring that person along to [00:44:00] be what I'm going to call your champion, to help you educate, a trusted local prescribing champion is going to go further than anything I can say or the feds are going to say.

So that's, that's one strategy. Now Federally Qualified Health Centers, um, I used to be working those often. They are good. They are very committed to addiction treatment and they are required by their federal funder to be so. Thank you. So, that's one strategy. Some of the rural hospitals have signed up, have stood up those programs. So, that would be a starting point I would suggest you look for. Yeah, in my experience, I also just want to say that once you start, raise that question with staff and board and others, what in my experience is, oh, 3 of your staff members [00:45:00] are using MOUD and have not ever been able to say that. So, that's the other experience.

So you'll find that there's more quiet support, especially in this terrible era of fentanyl, where it's very difficult, very, very difficult to move towards recovery without medications. So, I often say to people, That, you know, you don't want to sound like you're critical of your board members or your community because of their past stance on MOUD. Sometimes it's successful to say that made sense in the first years of the opioid epidemic, it does not make as much scientific sense with fentanyl. Because fentanyl is physiologically so much more challenging for a person to overcome without medication. Also, the good news is all the [00:46:00] concerns about diversion, uh, drug diversion, et cetera, um, those can be sort of set aside now that we have injectable, um, forms of buprenorphine.

And I think most of the prescribing experts in the country are starting to really get on board that the new injectables that last a month, um, or sometimes shorter term, but can last up to a month um, do a lot Better job if anyone has ever been exposed to fentanyl, whether or not they knew they were or not, but they just work better for most people. And then, um, that's not a medication that has to be managed on site. Just have to help people get access to the prescriber's office on a monthly basis. So, okay.

Milena Stott: Thank you.

Anne Shields: Yeah, I want to go back to a comment, though, that earlier someone commented, yes, you can go online and get yourself a hard copy for $165 [00:47:00] of ASAM. We did put in a request last month, and I'll be in contact to Beth and Dr. Earley again, because we're hoping that ASAM will make Chapter 15 available, just that chapter, um, for a much lower price, if that's all you need. So, you can wait for that and see if that happens or not, but I know that was a big request, um, for people who aren't treatment, um, but want to understand, um, the background and get the bibliography.

Milena Stott: All right, and, um, real quick, one more piece of advice for those looking to engage boards, um, we had a few providers here in the state where I work, where, um, the board got other board members together with other, from homes that had implemented it. To talk about the experience, and so they did this kind of, um, [00:48:00] support group around implementation and the reasons why to implement.

Um, we have Mr. Crabtree with us, who's going to talk about his use of the BARC 10. We also have David Lester, who commented that they are currently using it at intake and at 30, 90, and 180 days. Okay. And then at the end of the program, which is 12 to 18 months long. So, thank you, David and welcome Mr. Crabtree.

Mr. Crabtree: Thank you very much. I've been using the BARC 10 for over a year now in specialty courts, which includes adult drug courts and veterans treatment court. Basically, um we administer it to between each phase change. It's an minimum 18 month program. So we administer it at least, uh, it's a 5 phase program.

So, in between each phase. And it's excellent in measuring recovery [00:49:00] capital. And what we shoot for, according to the research, is 47 or above indicates that they are able to sustain their recovery over a longer period of time. So, you don't ever tell the, the client or participant that number. That's just what you are looking for um, as far as improvement, and we also use motivational interviewing in the sense where we ask the question, like, say, for example, on question 1, they gave themselves a 3, we would ask, why did you give yourself a 3? So we have a better understanding of where they are in their head. And then, after they answer that question, then we ask, What would it take for you to get to a four?

Where we're concentrating on progress, not perfection. We're not going to ask them, what would it take for you to get to a six? So by the time that they finish the program, they have increased their recovery capital in each one of those [00:50:00] categories, and we can assist them with those areas that need some more support.

Anne Shields: Wayne, could you, I'm going to ask you to back up and tell us how exactly you, um, do the BARC 10, do you hand a hard copy? Do you can you for people who aren't using it yet?

Mr. Crabtree: Yes, we have copies here. And like I said, in between each phase change, just like you said, it is self reported. We give that to them and they answer it themselves. Okay. Um, and we, we do score it for them because a lot of them, it's like, add the rows up in the columns and they get all mixed up. So we score it for them. Okay. And, you know, we basically comment and try to affirm them on the progress that they're making. And, you know, we will continue to support you in your recovery capital, um, increase.

Anne Shields: Great. I think one of the things we might be up against, I hope we're not, but, um, tools like the [00:51:00] PHQ 9, 9 symptoms of depression. And when you put those in a primary care setting, they put everything in an electronic record, and then a medical assistant pushes people to answer quickly. So, we've seen the validation of that tool as a self-report. You know, it's, it's not good. So we're going to have to be, I think, educating and figuring out how to make sure that if a treatment provider starts using this because the insurer says you got to in order to, for us to pay for X, Y, and Z, um, we're going to have to, we're going to need some, um, ammunition on to make sure that's well, well, you know, well executed, I guess.

Mr. Crabtree: Exactly.

Anne Shields: Okay.

Milena Stott: And Wayne, you are using your motivational interviewing skills and your MI ruler rule, it sounds like, to administrate. So I love that you've combined that evidence based practice in your administration of those tools. I [00:52:00] think it's super helpful.

Mr. Crabtree: Yes, I've found it to be such, yeah.

Milena Stott: Thank you so much for saying that. Kyle is giving some input, basically saying that not accepting the MOUD or MAR could have legal consequences. The Salvation Army lost a large lawsuit as a result. And you know, we do have some states taking a stance on that. Some even saying that you can't get access to state funding unless it's you allow for the use of that medication, um, in your home? So, uh, thank you so much for that comment. Um, super helpful. Um, and Anne, it looks like continued interest on the MOUD toolkit. So it's a really big topic for us today.

Anne Shields: Okay, well, we'll, we're trying, uh, we'll tee that up and get it out soon. Um, but again, we'll I can send draft policies and procedures and I'm happy to have a one-on-one conversation, um, um, [00:53:00] as can Milena to sort of strategize on local education and strategies around that. Uh. Fentanyl is the game changer I often point to because, frankly, you don't want to make people feel like their past decisions and opinions were just bad or wrong, so I often point to fentanyl. So, so I don't sound like I'm dinging people for something they held strongly to in past years. I just want them to move forward and say new era, new struggles. And so we've got to do it now.

Milena Stott: So, yeah, that's a great point, Anne. I feel like sometimes there's a fear because it's something new and you don't know how it's going to affect the community. I also think about how this, um, really kind of, uh, points us in the direction of really creating partnerships between, um, social health model and medical models of treatment, [00:54:00] right?

Where we have to work together to address these issues together because the medical providers are providing these medications and we need their partnership. Um, we need their availability. We need their consults. Um, and, you know, it kind of just goes to show how the importance of that medication becomes important in sustaining somebody's recovery within a, um, recovery home and how those services go hand in hand.

Um, someone just posted a link, uh, on some guidance on recovery housing and civil rights laws. Thank you, Corey, for that. So for those of you interested, um, in understanding, maybe this is something to share with boards as part of the dialogue of why it's important to have this conversation around the medication.

Anne Shields: And unfortunately, that's often where the conversation has to start. Um, uh, because, yeah, ADA, yeah, you don't want to cross [00:55:00] that one right now, but, um, you don't want to be made an example. But it would be wonderful if we had a better idea of how many residences are already comfortable, already have good programs.

Good access to MOUD. We're always interested in hearing about and highlighting folks who have figured this out because people learn best from examples, you know, tribes learning from tribes. So if you've got it figured out, we'd love to hear from you as well, even if you aren't struggling on that. And, um, Kyle, we can always end a little early, but I'm just going to ask, um, do you have any, is there anything you could share about the upcoming report about, uh, Housing First and, you know, trying to meld these worlds, Housing First and, uh, Recovery Residents, about the report that we'll [00:56:00] see soon, hopefully? I think that's on a lot of people's minds.

Milena Stott: It is. I think part of the, the challenge is, you know, getting people to the right setting. And then, you know, how do you, um, Kyle, we will have to up, um, upgrade you to a panelist and Michelle can help us do that in just a moment.

Michelle Day: Is that Kyle Duvall? Is that correct?

Milena Stott: Okay. Yes. Thank you, Michelle.

Anne Shields: Thank you. While you get that done, I, I've often wondered if this assumption of, you know, this concern about recovery residents and MOUD is part of what we Part of why we see a lot more funding going to permanent supportive housing, housing first, and not so much to the transitional models around recovery.

Kyle Duvall: So I'm here .

Anne Shields: Great.

Kyle Duvall: So some of us, uh, met in Washington DC area in August [00:57:00] as a working group. It really is as a result of the Excellence in Recovery Housing Act 2023. That, um, was um signed into law by President Biden on December 29, 2022. In that, that law, the preamble, uh, states clarifying the role of SAMHSA in promoting the availability of high quality recovery housing.

So, against that backdrop, there are multiple working groups. One is interagency, and this will be some good news to you folks, all of us out here. HUD, must be a co chair with SAMHSA in helping to fulfill that goal of promoting high quality recovery housing. Now, then what SAMHSA did was bring together, several of us, NARR was part of it, the National Alliance for Recovery Residents, the Housing First University, and about 64 of us, [00:58:00] and we had discussions on recovery housing, which ASAM makes the point that while recovery housing are for individuals with a substance use disorder seeking recovery, there are others that have substance use disorder that do not seek or want recovery.

And it's specifically is for the homeless population, obviously, but it can apply to anyone. So, there's where a Housing First model may be appropriate. Because, and so the other thing that came out in the text was, we hear a lot about harm reduction. Well, Recovery Housing and Housing First both do harm reduction just in different ways. And so the Housing First

University actually had a slide up embracing, um, abstinence-based treatment. And so there needs to be all types of [00:59:00] housing. We know that, and that's what brought us together. And the consensus is we are trying to find ways to work together rather than stigmatizing each other. So that's kind of a summary.

Milena Stott: Thank you so much for that, Kyle. We really appreciate it. And that's very true. Some folks, um, have different recovery paths and we want the housing setting to support that recovery path. Um, we have less than a minute left, so I just want to be mindful of everybody's time. Thank you so much to our audience members who stepped in, um, to help this great conversation. We always appreciate engagement from our audience.

Anne Shields: Thanks everyone for joining us. Um, uh, you've given us a lot of food for thought for how we might be able to engage you in some subsequent conversations as we really try to move this forward so we don't get, I guess, stuck and not move, uh, this new [01:00:00] opportunity forward. So, thanks very much.