

Addressing Rural Substance Use with the RCORP Rural Centers of Excellence – 3/3/2020

Kristine Sande:

Hello everyone and thanks for joining us today. I'm Kristine Sande, and I'm the Program Director for the Rural Health Information Hub. I'd like to welcome you to today's webinar, Addressing Rural Substance Use with the RCORP Rural Centers of Excellence. I will quickly run through some housekeeping items, before we begin the webinar. We do hope to have time for your questions at the end of the webinar. If you do have questions for our presenters, please submit those towards the end of the webinar, using the Q&A button at the bottom of your screen. We have provided a PDF copy of the presentation on the RHlhub website, and that's accessible through the URL on your screen, and we have also sent the link via the chat function in Zoom. For technical issues during the webinar, we ask that you visit the Zoom help center at support.zoom.us. It is now my pleasure to introduce our speakers for today's webinar.

Our first speaker will be Dr. Stacey Sigmon, and she's a tenured associate professor in the University of Vermont, College of Medicine with 25 years of experience conducting addiction research, particularly aimed at developing more efficacious treatments for opioid use disorder. Dr. Sigmon is past president of the American psychological Association's division on psychopharmacology and substance abuse, and in 2020 will serve as president of the college on problems of drug dependence, the oldest and largest US organization dedicated to advancing the scientific study of addiction.

Next we will hear from Dr. Ernie Fletcher. Dr. Fletcher is a fighter pilot board certified physician, statesman and healthcare visionary, and was elected in 1998 to the first of three consecutive terms in the United States house of representatives. In 2003, he was elected the 60th governor of Kentucky. As founder of the Fletcher Group, Ernie continues a legacy of innovative public service that promises to extend the company's unique model of recovery ecosystems to states across the country.

And finally we'll hear from Dr. Gloria Baciewicz. She is a professor of clinical psychiatry and medical director of strong recovery at the University of Rochester. She is certified in treating addiction by the American Board of Preventive Medicine, and board certified in psychiatry, with added qualifications in addiction psychiatry. Welcome to all our speakers. Thank you for being with us today, and with that I will turn it over to Stacey.

Stacey Sigmon:

All right. So, as was already mentioned, I'm up here in the University of Vermont in Burlington, Vermont. And I'm a psychologist that is part of a longstanding addiction research group here at the University of Vermont. We're located in the college of medicine here within the department of psychiatry inside of that. And so, our program has a long history of conducting drug abuse treatment research, identifying new treatments and more effective treatments for all forms of substance use disorders, but my focus in the past 10, 15 years has really been on opioid abuse disorder.

And so, our Center of Excellence is primarily, and dedicated to helping patients by helping providers. So the rural practitioners and staff, they're all on the front lines, and our overarching mission is to help expand capacity for OUD, and other SUD treatment in HRSA designated rural counties by really serving as a resource for evidence-based consultation, resources, training, and technical assistance to these frontline providers. So, essentially we've been for several decades now really in the ivory tower of developing and evaluating, evidence-based, novel treatments for substance use disorders. And now we're excited to have an opportunity to help translate those and disseminate those to the front lines. And so, our primary aims are that by arming

providers with evidence-based tools, we might help to reduce what they experience as barriers. Sometimes that ranges from concerns about medication adherence among their patients, or perhaps clinical administrative burdens, lack of support. And through this multi-pronged approach, our long-term aim is to increase their confidence and capacity for treating SUD patients, and essentially at assistance level increase the access to evidence based treatment.

As I mentioned, we've been here for about 30 years of University of Vermont, and we've conducted, typically our research has been funded primarily from NIH grants, although sometimes they're also foundation, and other sources of support as well. And our primary focus over those decades has been to, as I mentioned, develop and test, and then disseminate evidence on science-based treatments. This has ranged from treatments for opiate use disorder including medication regimens as well as treating OUD among special populations including opiate dependent pregnant women, and their near mates. We've also been engaged in developing and sharing novel kind of models of care, that can help decompress the systems. And in Vermont we had developed a hub and spoke model of care that's been potentially interesting and of interest to folks. And although there are also other ER models that we're engaged in, ED initiation of the morphine, low barrier buprenorphine, and other models, paradigms.

We certainly as you can imagine, have a big focus on opiate use disorder and other forms of addiction in rural geographic areas. And towards that extent we've done also a lot of work on newly developed, long-lasting forms that we've been working, which are exciting. And I think they hold potentially a lot of great promise for rural areas because instead of having to take the meds every day, patients can come in, at the longest is only twice a year for a six month implant that produce a steady state levels for that duration of time. There are also weekly and monthly shots. So, it's an exciting time to be involved in opiate treatment and research, especially in rural areas, but our work is not being limited to opiates. So, you have a longstanding research program and treating psycho-motor stimulant use, as well as cigarette smoking, especially in vulnerable populations, infectious disease, overdose, and even prescribed evidence-based contraceptive use among high risk patients. And so, as you can see below what we really have always made an aim to try and disseminate our evidence based treatments to professional colleagues through high impact scientific peer reviewed journals.

In terms of getting to our center, more specifically, we have three primary cores that will be the focus of this center, the Central on Rural Addiction or CORA. And the first I'll describe kind of dovetails with our primary aims in center start up, which is in phase one to use epidemiological methods to identify treatment needs and barriers. And so, essentially we have a surveillance and evaluation core led by faculty and staff with expertise in, at the methodologies and data savvy, more data savvy than me. Our first aim is to develop, and distribute a baseline needs assessment to really identify the perceived barriers being experienced in initially our three states that are our target areas Vermont, New Hampshire, and Maine.

We'll be collecting real time personal input from not only the providers and staff, but also a wide range of community stakeholders, policy makers, hospital staff, law enforcement, concerned patients, folks who perhaps need treatment, but are not getting it as well as their family members and community members more generally. So, our first aim in phase one is to essentially do a very thorough data collection process to really make sure that we have our thumb on the pulse of the real time barriers and challenges. And all of this information will really help to inform the phase two, which I'll described next of our other course, digging in and seeking to provide the practitioners and the staff with evidence-based methods that directly address their concerns.

So, this gets to the best practices core that I mentioned, the second of the three cores. Again, the aim is to provide science based solutions for different barriers related to treating OUD and other SUDs. And there are a variety of categories of evidence based practices that we're working hard to develop, and we're thinking of it as our menu of services. But here are a few of them include evidence-based assessments. And so, oftentimes the community providers don't have the tools they need to, for example, get an objective measure of opiate withdrawal that can inform dosing decisions whenever you're buprenorphine provider or also using standardized measures like the addiction severity index or measures of anxiety, depression, other needs, other areas of psychosocial functioning, those tools can be really helpful for making sure that we pay our patients with the appropriate intensity of treatment that they need.

But often these assessments are not out, widely available in the trenches. So, we'll be offering those as well as training those and ongoing support. Similarly, we've developed our group here and been working with a number of protocols that leverage technology assisted components to help reduce the burden of both the providers and patients and to help promote clinical stability and mediate a proper medication adherence among patients. Some of these we've reported on in recent randomized trials include; portable computerized medication dispensers, and phone-based systems that can work, conduct a nightly check-in call as well as generate random callbacks, which can be really pivotal security features of whenever you have patients receiving take home medicines. And so, all of that hardware and software, we could be in a position to provide free of charge to rural providers, as well as help in implementing, learning how to use these methods, and continuing to support their ongoing use of problem solving.

Similarly, we provide consultation, and support on all other co-occurring issues. Often our opiate dependent patients, we've learned, the studies have shown that they're likely to die from their cigarette smoking, than the opiate use, especially if they're in treatment. So, we have efficacious behavioral interventions that we've developed for special populations of patients with OUD, pregnant women who typically cannot receive a first line Pharmacare therapies. And so, we have the resources and the support to offer to address those as well as occurring PTSD, anxiety, depression, other parenting needs, family planning, just the whole gamut. And again, we're building out and soon to distribute a menu of services that gives more details on these things.

I guess finally it's just more of a higher-level systems based consultation on expanded models of care. I mentioned the hub and spoke that we had developed and there seems to be a lot of interest nationally in adopting hybrids of that model, but also whether it's initiating people in opioid treatment in an ED setting or other novel models. We have a number of faculty experts here that are eager to provide consultation to folks who may be interested in trying on other models that might work for their rural communities.

The exciting thing, as I should mention is that; we're working to flush out our current menu of services based on evidence based practices that we and others have developed. But then it's really important for us to stay ahead of the curve and continue to adopt and disseminate new methodologies as they become available as well. Some of those examples that I've already mentioned, whether the assessments, I mentioned the ASI and withdrawal assessment. But also, a couple of us here had developed what's called a treatment need questionnaire, which is a very brief screener that we developed with the aim of helping providers figure out whether a new patient is presented for treatment would be more appropriate perhaps for people who are being versus methadone for an overlap setting versus an OTP setting and kind of the intensity of treatment.

So, that has been a wide, increasingly used measure. And then just a nod to the other technology assisted components. Oh, we also have expertise in urine testing, fentanyl test strips, overdose, provision of Narcan. We've developed some educational modules that are delivered via iPad on the topics of preventing opiate overdose, Hep C, and HIV that we have the patients in our studies complete. And have actually been shown to produce significant improvements in knowledge in these areas. And they are pretty low burden to use. And so, we can even provide rural providers with literally iPads that are already preloaded with the knowledge assessments on the topics of opiate overdose, Hep C, and HIV as well as the educational, the self-administered educational modules.

Several others addressing the co-occurrence problems. As I mentioned, we've had a long standing body of work addressing whether it's smoking or cocaine or methamphetamine use or PTSD, other co-occurring issues. That are so common in our patients, and so it can be available for consultation on that. I'm trying to be quick about this, but certainly always happy to answer any questions about specific aspects of our services.

We also are lucky to have a Clinician Advisory Board of experts that are really the champion opiate treatment providers in our area, and they are able to be continuously available, for a provider or staff that may wish to have a consultation on how to deal with a complex patient with a need to coordinate multiple cares. We have, Dr. Meyer is a specialist in treating opiate dependent pregnant women and their babies. And often that work really requires a whole village in terms of coordinating care across a number of service providers and areas. Whether it's how to taper a patient, how to adopt the patient, how to deal with their other co-occurring cocaine use, just a wide range of issues that our Clinician Advisory Board is happy to respond and provide, mentoring, and support, and coaching around.

Our final of the three course is an outreach course. So this, our aim is going to be to really develop a robust portfolio of educational outreach activities. And some of us will be informed by the data that we collect in the baseline needs assessment that I mentioned a few minutes ago, and our questions out to providers and staff are, how would you prefer to receive information and support and resources? And so, we're yet to really identify what their wishes are, but it's interesting, some of these listed here are those that we have included in the original grant proposal.

It's interesting we're also learning that there's an interest among rural providers to actually having a more intimate small scale, in person learning lunch type of arrangement. Where we actually, our mobile army of staff could come to their rural practice, bring whatever evidence, best practices are of most interest. Maybe it's the computerized medication dispenser or an IVR phone system or manualized therapy or smoking cessation intervention or how to use a breathalyzer or how to do Narcan administration or fentanyl drug testing. And we can actually take the hardware and software to their site and spend as much time as they have really getting hands on training and providing that more of a personalized setting. And so, that's really the high level view of our center and the three primary course, what we hope to accomplish and really the areas that we are eager to provide consultation to anyone who is interested. And so, I think I'm now supposed to turn it over to Ernie. Ernie Fletcher of the Fletcher group. Thanks everybody.

Ernie Fletcher:

Okay, well thanks everyone, and I'm Ernie Fletcher. We're Fletcher Group. I'm going to go through these slides fairly quickly. I've got a fairly large slide deck. We wanted that more for information for you all as they're forwarded to you and we'll try to hit the high points here so that we'll have plenty of time for Q&A. Back when I was governor in 2004, we started a program called Recovery Kentucky. It was based on bringing braided funding together out of HUD, food

stamps, Department of Corrections per diem as we would take diverted offenders with SUD, and we were able to develop what we have now as 18 centers, 2100 beds. And we treat about 3,800 individuals a year. These are run by different behavioral health groups and nonprofits that are vested within the communities where these are located.

Interesting enough, we have several of those, about five of them in our rural communities. We'll give... There's one in a small nod county. The other is, there's one in Henderson, in a community and a county of about 25,000. And so, they're able to operate within rural communities and they draw for example, folks out of corrections from all across the state. Interesting, even we had a girl we were working with bring her even from Montana in one of the states to bring across to Recovery Kentucky. So interesting, they can be located in rural communities, serve the rural community, be a good member of the community, and be able to survive economically.

Outcomes, we are recognized as SAMHSA as an evidence based program. Here's some of the outcomes. I won't go through them, but they are done by the University of Kentucky Center of Drug and Alcohol Research, and it's a fairly rigorous, it is self-reported, so you have the bias on that. But it's a fairly rigorous system, and a rigorous analysis or survey for the purpose of collecting outcomes. We've had these for eight years, small variations from year to year, but there are the outcomes.

We're dedicated really to expanding quality recovery housing and to develop an increase in the science base, and evidence base in recovery housing, and particularly focused on serving the most vulnerable. Our grant is focused on those in the criminal justice system as well as the homeless individuals. We've also focused as we'll show on some other ethnic variation, and some vulnerable populations from an ethnicity standpoint. We're national reach, evidence based, and housing focused, as I mentioned.

Some of our partners, the two main partners are right in the middle, Kentucky Injury Prevention and Research Center is our co-investigator. Dr. Terry Bunn is a full professor, has as a lot of experience. Has worked with OD2A grants. He also is working with multiple grants in the area of addiction, and she is providing the kind of the research backbone for what we're doing.

We cover the full spectrum even though the Recovery Kentucky centers hold about 100 to 120 individuals, we are really looking at being a center of excellence and have developed partnerships with other individuals to be able to provide technical assistance for the full spectrum of recovery housing. The National Association of Recovery Alliances or National Alliance of Recovery Residencies rather is our other major partner. They are probably the largest and definitive and have been recognized by SAMHSA as well as the Association for Recovery Housing.

Here gives you the different levels, one through four. As I mentioned, the Recovery Kentucky is more of a level four. Oxford house, which is just more of a small house that a group of people will rent. They have an organizational structure there. It's self-run. So, you go all the way from that level one up to a large institution. The Recovery Kentucky do have professionals within the facility as well. Even though it is a social base peer support, base system. This ends up being as far as recovery about a level 3.1 to 3.5 ASAM level. As we look at the recovery of pathways, we see that we're part of the full continuum of care. Historically, there's been a bit of a tension between the medical model and social recovery. A lot of the folks with lived experience had some problems with MAT, some folks in MAT really hadn't necessarily had a great experience in the benefits of some recovery housing run as a therapeutic community.

We've worked with, for example, another partner is a Hazelton Betty Ford to bring these two together. We see that both of them are important. Some people need much larger residential support, job training, and the other things in order to fill that recovery capital. So, in this cloud you can see that we try to bring all these things together, and we even call this a recovery ecosystem that we like to develop within a community.

Challenges, recovery housing is largely non-science based. A lot of it isn't. We have some evidence base as we mentioned. There's a lot of fraud and abuse in it, and there's a lack of resources. And it's really hard for folks with SUD that are looking for a facility for a longer stay. As you know that the transition, the neuro changes takes anywhere from six to 12 months, and up to a year before there's some normalization, and you still have a baseline difference even after you normalize the person's neurological impact from OUD or SUD.

Rural communities, I don't need to tell you all this, so I'll just pass this by, but you have a lot of challenges within rural communities, some overlap with urban center, very unique. We are looking at, and we're working across a number of states we'll show, but we've included some Hispanic, Native Americans, and African Americans, as well as those within the Appalachian regional. But you find that some of these populations have unique cultural challenges and we, as we're building the science base, we want to be able to address those as well. We're HRSA grant. We'll talk about that. We look at it. So our effort is being collaborative, bringing a lot of these silos together on the full continuum of care and not being competitive in nature. First is surveillance and basically it's doing an environmental scan of the counties that we've targeted to see what resources are there, what's available, what organizations exist. Not only that within the states to see is there a strategy from the state level on recovery housing that includes that component of the continuum of care.

We are developing portals in a portal for several reasons. We have or for different aspects of the portal. One, is to bring data in, so we are developing an outcomes portal for recovery housing. We want to integrate that with any IT systems that recovery housing may be, so it's automatic, but we are developing a system where we can bring in different data outcomes data, and also make that available for all researchers across the country as well. Additionally, we want to build a recovery housing registry. We'll talk about, we have a slide on that, so we'll go forward. We also want to provide a portal for education, which a lot of the folks that are establishing recovery housing don't have the training or educational materials available. We're working with NAR that already has some other states have some, and then the state alliances or affiliates will have some training materials. We want to bring that together and we're developing more as well as part of this Rural Center of Excellence on recovery housing.

The RH directory, I'll mention just briefly. It's very difficult for folks with addiction to find good recovery housing, and to know what's actually a solid program versus what is a sham. And we've read the history particularly there was some in Florida with some fraudulent recovery housing that we're not providing treatment, but sometimes even making the matters worse. Through our directory, we're pulling that in with an API. We're working, for example, in Oregon, we just met with the individual in Oregon. They're developing a recovery housing directory for their states. It's hard to know where these facilities are because some of them are not... there's not a whole licensing program, et cetera, for the facilities. And we want to bring that into a national directory. So we're working with, even Safe Project that is another group that we've added since I put this slide on to develop a recovery housing directory.

We do this by boots on the ground. We've got folks in all of our states that are there to integrate with the community, find out what the working groups on, find out what's on the ground in these, and join that effort to become a part to provide technical assistance for them. We have a

project now going that develops and recovery housing in about 11 States, with this way of operating. We also realized that it's important because of the funding stream. Some come out of HUD with low income housing tax credits, federal home loan grants. We also bring in Project-Based Section 8. We bring in corrections that it's important to work from the top down as it would a bottom up.

So, we'll work with the governor's offices and states. We'll work with the housing offices as well as the commissioners of corrections. We also work with the local level, local health departments, as well as the state health departments, but local community efforts and other organizations and nonprofits within the local organizations to help them develop. Because it's important that we feel like the recovery housing is fully run by folks that are locally. It's going to be a good part of the community and a good organization that has experience in behavioral health and SUD as well as having some personal interest in the community. For example, I mentioned vulnerable population, the highest incidence overdose mortalities among Native Americans. There's actually, the total quantity is not as high, but the rate is substantially higher.

Our current targeted states you can see them, Washington, Oregon, Idaho, and Montana. We're also down in Georgia. We're in Kentucky, West Virginia, and Ohio. We're actually beginning to add Tennessee, and Mississippi to that as well. These are the counties that we target. We're tasked to respond to request from any county across the US, but these are the targeted counties that we report the HRSA grant required outcomes data or data on these counties. Here's West Virginia, here is Kentucky, here's Georgia. And then we've got Washington, Oregon, and Montana, and Idaho.

The road ahead, our goals as I said is to really develop the science behind recovery housing so that we increase the quality, increase the quantity of recovery housing. We've seen an inadequacy of capacity, at least in our experience across the country that is particularly high in rural communities. We're here with a team, more of a collaboration to bring a number of organizations together, to address the full continuum of care. And in the implementation of this, we really are looking at a number of strategies that we use. But we are, as I said, we're boots on the ground, top down, bottom up in our activities. We have with on our website on fletchergroup.org website. We have a TA request form fill out that comes right into our Smartsheets operational and management program system. And then we begin to engage those. Even though we're only targeting eight states at this time, we already have projects, as I mentioned in 11 States.

Again, our goal and impact is to expand treatment and recovery. We believe that this can make a contribution to reducing the overdose deaths. And the other thing is that we really want to build that recovery capital and individual and address recovery management. So we have a lot of efforts on training, education, job placement for meaningful employment. That has a significant impacts on the rates of relapse. It's really about people. There's a few testimonies here you can see, and here's our information, and that wraps it up. Thank you all for the time. And I think next is Gloria with the University of Rochester, one of our Rural Center of Excellence, and Gloria, it's all yours.

Gloria Baciewicz:

Okay. Thank you. The host has unmuted me. All right. So I'm Gloria Baciewicz, and I am the co-PI of University of Rochester Medicine Recovery Center of Excellence. We are located in Rochester, New York. We have a focus on reducing morbidity and mortality from synthetic opioids. We have two primary aims. Our task is to work with specific counties in Kentucky, Ohio, and West Virginia to understand what this crisis looks like in their communities and what they are doing to address it. We want to identify existing evidence based practices and disseminate them and to offer technical assistance. We also have an aim to test emerging best practices in the southern

tier of New York State, creating a support net to meet persons with a substance use disorder where they are. And we also focus on that word, ecosystem of recovery, which needs to, happen especially after the initial treatment takes place. People need to follow up with their primary care doctors or other health settings.

Rochester has a population of 200,000, but we are actually located in a greater metropolitan area of over a million, which includes nine counties. And many of our markets are in fact, rural in upstate New York. New York includes 14 counties, which are designated as Appalachian counties, and we've already been working in some of them. This is a list of the specific counties that we'll be working with in Ohio, Kentucky, West Virginia as well. We can also share our work with any US community looking to reduce morbidity and mortality from synthetic opioids.

So, what is the challenge of providing treatment for opioid use disorder in rural areas? Well, there are several, places to access care, but many of the doors are closed. The PCP office may be overwhelmed with attending to urgent medical needs and coping with a large practice with very little coverage. The mental health agency, may not be available nearby or there may be a very long waiting list for it. Substance use treatment may be available nearby or maybe, quite a drive away. There may be a waiting list as well and it may not have available the full spectrum of medication assisted treatment options for substance use disorder treatment. The Emergency Department is the one open door because it is open 24/7. But part of the problem is there they're just putting out a fire and they need to discharge you to make room for other people. Many people go to as many, go to different hospitals as well to see if they can find a better answer in a different place.

Oops, I got to go back. So when we looked at best practices, we found no better list than the one that is already identified by the Center for Disease Control for treatment of opioid use disorder, and that includes targeted Naloxone distribution, medication assisted treatment, academic detailing, elimination of prior auth requirements for opioid use disorder medications, screening for fentanyl, and routine tox testing, 9/11, and Good Samaritan Laws, which actually these are present in most states by now. So that's a good thing. Also Naloxone distribution in treatment centers and criminal justice settings. Medication assisted treatment in criminal justice settings, and upon release, and initiating buprenorphine, based medication assisted treatment in Emergency Departments, syringe and syringe services programs.

So, this slide goes back to that first aim to share evidence based practices that reduce morbidity and mortality related to synthetic opioid use. So, we have various inputs that we've been collecting data from, community needs assessments, literature search. We're going to be going on some community outreach tours, and our activities include the identification core to identify the various problems and challenges and barriers and also the adaptation core to try and adapt some of these evidence based practices for challenges associated with rural communities. Then we have the output core, which is a dissemination core. And dissemination, we often think of that as a unidirectional thing. We're disseminating knowledge, and information to practice settings, and the prioritized audience, the patient population, the community. It does sound unidirectional, but to be effective, these dissemination strategies really need to include input from these communities, and various stakeholders. So, we'll focus on that as well.

We have a technical assistance core, and we've already been providing technical assistance to some agencies and we have an outcome core to study evaluation data. This slide relates to that second aim. Continuing to work with and evaluate the emerging best practices that reduce morbidity and mortality related to synthetic opioid use in the New York counties where we've already been working. So, we want to look at treatment on demand. Our goal is to get immediate access for everyone for opioid use disorder treatment. That's been something we've

been working for, for many years and we're trying to get that going in some of the southern tier communities in New York.

In the Emergency Departments, we want to give out Naloxone, and do some prescreening for opioid use disorder, and start people on buprenorphine, and link them with peers from local treatment programs. We also have a model in which we have a psychiatric assessment officer available, and a peer counselor to assess for mental health problems, and provide referral and so forth. We have access to a full range of treatment options. It may be at a distance sometimes, but we're developing various... We're looking at various mobile practices, and telemedicine practices, to help with that. We want to be providing medication assisted treatment via telemedicine, and we hope to also spread the use of methadone when needed because some of these communities have a lot of access to buprenorphine, at least short term. But methadone is not as accessible in some areas. And of course we want to work with the primary care folks to be in partnership with the community and we have an evaluation component for this as well. So, I think I'll stop there and give this to Kristine Sande who is going to manage the question part of this.

Kristine Sande: Thanks so much for those presentations. They were all very interesting. At this point, we will open up the webinar for questions. So, at the bottom of your screen you should see a Q&A icon. If you click on that, you can open the question box, and submit your questions for any of our speakers today. So, while we wait, I do have a question for Gloria. You talked about the adaptation core related to best practices and evidence based programs. Can you tell us a little bit about what that might look like in terms of adapting practices for rural?

Gloria Baciewicz: Yep. I'll unmute myself. So, what that might look like is studying maybe cultural differences, but also things like the distances involved. That is impressive, especially when you are working in an area which is subject to very difficult wintry weather, such as New York state. So we need to think about, adaptations such as, telemedicine, and mobile units that might be able to evaluate people, and assist primary care folks, and things like that. That's mainly what we'd be looking at.

Kristine Sande: Okay. And we do have another question for you, Gloria. For the initial and follow-up assessment, what screening tools do you use?

Gloria Baciewicz: For the initial file and follow-up assessment for what, individual patients or communities?

Kristine Sande: I don't know that.

Gloria Baciewicz: Because at this point, at least in our treatment agency, we're not using the Addiction Severity Index, though in New York State many of the questions for some of the forms that New York uses to study outcome are the same as Addiction Severity Index. So, it's based on that, and different states have different parameters as well. So, that's another thing that we need to understand.

Kristine Sande: Okay. And the person who asked the question did clarify that they were asking about individuals.

Gloria Baciewicz: Okay.

Kristine Sande: All right. Another question, when talking about treatment in the recovery housing, what does that look like? This person says, "I often say we are recovering housing, not treatment. We require our program participants to attend IOP. Maybe we should offer more." Thoughts on that? Maybe Dr. Fletcher.

Ernie Fletcher: That's a good question. As far as this, the integration of MAT into recovery housing and the treatment or I will say the medical models and the social recovery models is evolving now. Hazelden Betty Ford did that with a core 12, and what is involved in some of our recovery housing that we have... that I had mentioned. There's an FQHC that may be co-located. Oftentimes there is a behavioral health, either comprehensive care or behavioral health certified organization that is also running the recovery housing. So, that allows them to take care of the medication assisted treatment as well as comorbidities. And as you know, there's an increase in Hep C, HIV, depending on the type of drug use there.

What we're also saying is the fact that we're seeing a shift from opioids, particularly in Appalachia back to crystal meth, which was really the drug of choice back when we first developed these in 2004. So, with that, oftentimes you'll see, and even in the OUD patients, they're not single drug users. Most of them or probably 80% or a good portion of them are polydrug users. And with that you can include the medication assistant treatment, but we have a longer stay in a lot of these recovery housing, and it may be actually the Recovery Kentucky is nine to 24 months, so you end up addressing the other social determinants. But how you manage the medications within that and the treatment does vary from house to house. It does require that you have, so the clinical aspect of it either within the facility or closely coordinated with the facility. I hope that answers that.

Kristine Sande: All right. Thank you. I am not seeing any other questions right now. We'll maybe just give it a little bit of time. If anybody has any remaining questions, please enter them at this time. So, Ernie, you had mentioned the recovery housing directory that you're putting together. How do you evaluate those programs?

Ernie Fletcher: Well, you went right to the-

Kristine Sande: Sorry.

Ernie Fletcher: To the most challenging part of this.

Kristine Sande: Well, it seems like it would be.

Ernie Fletcher: Well, it is. One of the things that we're doing with NAR, this Recovery Residents Alliance that has state affiliates is that we're working with states and there's a number of states that have certification for the recovery housing usually on a voluntary basis. And so, we can use that as one measure of quality. We are looking at client evaluations similar to you see, say in hotel.com if you did that or if you've been in Airbnb you can read what other residents or other clients have said.

We are really putting together a number of data elements that we can use for quality, and we're surveying recovery housing operators for that as well as we want to. We're developing a tool, a focus group or a working group that includes not only the operators but some of the clients, and those that are in recovery to develop that. But that's a difficult task. We don't want it to keep us from being on there. But what we have come up with so far is that if they are certified through the state and we can recognize that as a certified recovery housing, it's not, we can't vouch for it, but we would like to have folks go out and not only inspect a house that we can put that on there just to make sure that we eliminate those that are really not legitimate recovery houses.

Kristine Sande: Right.

Ernie Fletcher: Any help on that would be welcomed because it is a difficult task.

Kristine Sande: Yes. I can see where that would be a challenge. Another question came in asking, when will Kentucky have a conference on recovery housing?

Ernie Fletcher: We may just have to do that. We're having... actually we're setting up a conference with the... I think it's the Opioid Response Network. We're doing one on stigma. What we found, we work a lot with corrections, and what we have seen is that there are number of judges that have concerns about diverting some of the SUD offenders into treatment and recovery because if something happens, it ends up falling back to their responsibility within the community. So, we're doing a conference that's going to be on recovery housing. We're looking at that in probably late summer this year along with ORN, and we're going to cover recovery housing, but we also want to address that stigma and the tension between MAT or medical model in recovery housing that has existed traditionally. I think that's beginning to resolve. I don't know if that answers the question. If an individual give us... contact us, we'll be glad to, and publish with you all as well when that's established.

Kristine Sande: Sure, we'd be happy to share that. Another question just came in, how will we be addressing shame, stigma in these counties specifically with cultural differences, gaining a trust within communities to see the whole of the people in their life stories? Anyone want to address that?

Ernie Fletcher: I don't want to capitalize, but I will say, and this is Ernie again, in our Native Americans, we're already working on a couple of reservations in Montana. And the first thing we did is to hire a Native American with lived experience. And that's our interface so that you have some immediate trust there. But that's a real challenge, and we're working through that. So I think somebody identified, obviously they have experience, whoever asked that, that that can be a real challenge there to develop trust.

Kristine Sande: Right, right.

Gloria Baciewicz: This is Gloria. I'd like to say that, if you were to survey everybody who works as a treatment providers of any sort in the addiction treatment world, we would all say that we address shame and stigma on a daily basis especially who have people have suffered trauma, et cetera. It's a big question, and we often think that we will address stigma by providing education. Education is certainly a helpful thing in general, but there's also research that tells us that having people meet each other is important. Having people walk a mile in someone else's shoes, at least get to meet them and hear their concerns, and so forth will help decrease stigma. Maybe this will be important for families too, but that's certainly a big part of it. Yes.

Stacey Sigmon: This is Stacey from the University of Vermont. I think this is very much on our mind as well. And as part of the hopes of us after we implement the initial survey based baseline needs assessments of providers and community stakeholders, we also plan to follow up with the second phase of in-person qualitative interviews with the individual patients or folks who need treatment, but aren't in it, community members, and their family members because we think that. And those will be some of the questions that we use as well to try to get a bead on their concerns about stigma and those types of issues that they're experiencing in their communities.

Kristine Sande: Great. Thank you. I think we will end on that note. Stigma is certainly a very important topic in all this. So, maybe a good note to end on. I apologize for some of the technology hiccups that we have experienced today. Thank you all for bearing with us on that. On behalf of the Rural Health Information Hub, again, thank you to our speakers, and thanks to everyone who joined us today. A survey will automatically open at the end of today's webinar, and we encourage you to complete that survey to provide us with the feedback that we can use in hosting future webinars. The slides used in today's webinar are currently available at

www.ruralhealthinfo.org/webinars. In addition, a recording and a transcript of today's webinar will be made available on the RHHub website, and sent to you all by email in the near future so that you can listen again or share the presentation. Thank you again for joining us, and have a great day.