Haley Hartle, NAADAC: Welcome in everybody. We are going to get started here in about two minutes at three Pm. Eastern time. We are super excited to have you here today? Um, We're looking forward to Today's Webinar.

Haley Hartle, NAADAC: Right, everybody. Welcome. We are super excited to have you here today. Um! We are happy to have you join us for today's Webinar Um. The title is integrated Dynamic Care. Model for Medication, assisted Treatment and recovery, and we'll be hearing from Benjamin Nordstrom and Samson Teklomerium.

Haley Hartle, NAADAC: My name is Hayley Hartle, and i'm the training Programs manager here at Nedak, the Association for Addiction professionals. I'll be facilitating facilitating the training today, and then with me behind the scenes is our training and customer care specialist, Alison White. She'll be answering any issues or questions you may have that Aren't specifically, for our Webinar presenters today. Um! So you have a lot of support. Allison will also be sharing some links to the powerpoint slides the references,

Haley Hartle, NAADAC: um, and those other resources that you can find on the web page. Our permanent homepage for our webinars is www dotnate dot org forward slash webinars. So be sure to bookmark that web page and stay up to date on the latest in addiction education.

Haley Hartle, NAADAC: We are using zoom webinar for today's live event. You'll notice the zoom control panel on your end. That looks like the one on my slide at the bottom of your screen.

Haley Hartle, NAADAC: Um! There are a few things to be aware of. The first is the chat box in the chat box you can introduce where you're listening in from you can communicate with other attendees. Um, and you can also send us individual messages if you're having issues. Um, whether hearing things, or if you would like access to additional resources.

Haley Hartle, NAADAC: Um! And then the second is that Q. A. Box? That's where we would ask you to post all of your questions for our presenters. Those are the questions we'll be asking during our live Q. A. Portion today. At the end of the Webinar

Haley Hartle, NAADAC: Um, we'll either reply to those via text and type, or we'll answer those live. Once we get to that live. Q. A. Portion.

Haley Hartle, NAADAC: The last thing to be aware of is that live transcript. Um, We are using zoom webinar for our close captioning today

Haley Hartle, NAADAC: that has been enabled so you can just click on show subtitle. I don't think it shows the Cc button anymore. Um! But if you click on the ellipses, you should be able to see access to that. And if you're having trouble, just let us know.

Haley Hartle, NAADAC: Lastly, in the chat box. We will be posting those handouts in that web page where you can access all of that as well as our user friendly instructional guide on how to access the online ce quiz, and immediately earn your certificate After attending today's webinar.

Haley Hartle, NAADAC: This is what it'll look like when you go to take that Ce quiz. This is the same web page you would have used to register for the Webinar Um. Everything will be permanently hosted at Www. Dot org forward slash, integrated dynamic care Model Webinar.

Haley Hartle, NAADAC: If this is your first time going through our Ce process, please be sure to use that instructional guide that is shown below that yellow arrow on my screen.

Haley Hartle, NAADAC: This will help you through the process. It gives you screenshots. If you're having issues, you can always email us at Ce. At Nadak Org that see is in continuing as an education at Nadak dot Org.

Haley Hartle, NAADAC: Please note, if you do need that certificate to say, Live on it. You have to take and pass the ce quiz and download the certificate within twenty-four hours for it to have that live webinar

Haley Hartle, NAADAC: um component on it. So be sure to do both of those steps. Um, both taking and passing the Webinar as, or the Webinar quiz, as well as downloading that certificate.

Haley Hartle, NAADAC: Any social workers with us today. Please stay on. At the end of the presentation we will be showing a two minute brief video on how to add that license number to your certificates.

Haley Hartle, NAADAC: And now we get to introduce our presenters for today's Webinar Um. So our first presenter is Benjamin Nordstrom. Benjamin nordstrom is a board certified addiction psychiatrist. Prior to coming to Behavioral Health Group.

Haley Hartle, NAADAC: He was on the faculty of the Medical schools of Dartmouth College and the University of Pennsylvania, where he led addiction, treatment services, and taught at the undergraduate, graduate and postgraduate level. Nordstrom was previously the chief clinical officer, and later the Ceo of Phoenix. House.

Haley Hartle, NAADAC: He has served on the Asam Committee that generated national practice guidelines for the use of medications in the treatment of opioid opioid use disorder, and was a co-leader of the quality Improvement learning, collaborative as part of the state of Vermont's hub and folk initiative.

Haley Hartle, NAADAC: In addition, Nordstrom has been deployed twice as a psychiatrist with the army reserves,

Haley Hartle, NAADAC: and our second presenter today is Samson Techlomerium.

Haley Hartle, NAADAC: Samson is the Vice President of Clinical Services for Behavioral Health Group. He's an accomplished leader with a history of driving organizational results with learning and development solutions known for implementing initiatives that support organizational priorities and produce measurable outcomes. He's been a leader in the field of addiction treatment for over ten years

Haley Hartle, NAADAC: he was formerly the director of training and professional development. Here, at Nedak.

Haley Hartle, NAADAC: He is a certified lead trainer for the cognitive behavioral interventions for substance, abuse, curriculum,

Haley Hartle, NAADAC: Teclomerium previously worked for the Phoenix House Foundation as the National Director of learning, and development.

Haley Hartle, NAADAC: So without further ado. I will hand things over to our presenters, and we'll get started.

Samson Teklemariam: Thank you so much, Hayley. Thanks, Nadak. Um. Sorry I was trying to get my screen sharing um. I think I got it there. Um! We'll welcome everyone. Um! So this is our our um session on integrated dynamic care Model for medicaid medication, assisted treatment and recovery. Um, here are learning objectives. We've listed them online, but we're really going to go into what this model is, and why it's necessary. We're going to talk a lot about um medication. Assisted treatment for opioid treatment programs and office space assistant treatment programs otps and oba.

Samson Teklemariam: Um If you don't know what it is. We'll do a quick poll in a minute um to see where you're at with that um, and then, of course, i'll hand it over to um to Dr. Ben Norton, who's here

with us today? So Nadak first polling question jumping right in. I am curious. Who is in the room. Um, I I see some of you all in the chat box. Good to see some familiar names. Thanks for the love um, and and I won't call you out. So you're not listed in a recording forever. Um! But the polling question is up here. Who's in the room uh mainly based on your

Samson Teklemariam: um primary job, title, nurse, prescriber provider, um a license counselor Uh, that can be mental health counts or professional counselor. Addiction, counselor, um we're social worker certified addiction counts for appear. Um. So we'll give you like, I guess, Hayley. Twenty more seconds to answer.

Haley Hartle, NAADAC: Yep. We've got about seventy-seven of people that have participated. So we'll give them just a few more seconds, and then i'll share the results.

Samson Teklemariam: Oh, good. Okay, We got a good blend. So about two um medical nurse provide uh prescriber physician uh thirty-nine percent, almost forty. So the majority of you are a licensed um counselor or license social worker, a license addiction and Counselor um twenty-seven of you certified addiction, counselor about eight percent peers uh twenty five percent other I wish I could have put more. I'm sure other is a blend of, you know, executive administrative student who knows um, all right. So we got. We got another poll,

Samson Teklemariam: and we're gonna do another poll. But in the chat box. I'm curious. Why, here, why are you in this Webinar? What was it like? I'm curious what it was That kind of jumped out at you when you read it other than you know.

Samson Teklemariam: I'm sure you like. You know the Ethiopian name, your technologies. I love it.

Samson Teklemariam: Fifteen letters. I kind of see this guy? Um, but other other than other than you know me and Ben uh, you know what brought you here? Why, why did you join this training. So if you could drop that in the chat box i'd love to know um, and then there's a second polling question. I know what otps and robots are. Um! I may have cheated and given it to you, but uh, yes, no, we're. I currently work at one, or worked at one before.

Samson Teklemariam: Give you just a little bit to answer this one.

Samson Teklemariam: Okay, okay, so forty-seven of you. The majority don't know what an otp or an obt is um twenty-three percent of you currently work at one or have awesome Thirty of you do know um that's great. So um thank you so much for for uh sharing in that. So in the chat box, Ben. So I'm. I'm curious. Those of you who are just now joining. Um! What's your? Why, why did you choose this Webinar, you know you know you'd be honest. I need cease, you know. Renewal. My renewal is next week, and I procrastinated

Samson Teklemariam: um. So Mfp. Fellow, we've got some Fp. Fellows who I love you all. Um, uh! That's a minority fellowship program for those of you who aren't where you can apply now for next Year's fellowship, I think it's open, Don to learn some of you. Oh, Colin works alongside with medical providers. Um!

Samson Teklemariam: You run an otp so always looking for innovation. New thoughts great, that's good to hear,

Samson Teklemariam: because i'm facilitating the training. Thank you. Phyllis

Samson Teklemariam: uh Phyllis is with the critical issues of the Black Community Committee. Awesome committee contributor.

Benjamin Nordstrom: Uh, let's see. Ellen says you currently work in a telehealth mit program. So doing some virtual work. I'm interested what others are doing so great. Keep Keep those coming in the chat box. Um, I I I want us to. I'm i'm glad we're hearing about your Why, i'm going to let Ben kind of talk

about his. Why and and what brings us here, and i'll, I'll turn this over to you, Ben. Sure all right. Well, Thank you. Um, Sam, and and and thanks everybody for for having me. And I'm really excited to talk with you about about about all this, and certainly you know, I think at this point

Benjamin Nordstrom: everybody kind of knows what's going on with the opioid crisis in this country, and that um, you know we're we're at a level of overdose deaths that's really unprecedented since

Benjamin Nordstrom: um, you know, one thousand nine hundred and ninety-nine when the crisis kind of kicked off in earnest we've lost more people to drug over those deaths in this country than we've lost. Uh to all wars that this country has fought combined, and that's including,

Benjamin Nordstrom: you know, combat related deaths as well as you know, back in civil war and things people died of infections and dysentery and stuff like that. We've lost more people to drug over those deaths in the past twenty years than uh than we have to to warfare. Um! And you don't have to be, uh, you know, a real

Benjamin Nordstrom: consumer of the news for this sort of kind of permeated into everybody's consciousness, and realize what a what a problem opioids, and uh, especially opioid, overdose death has become in this country.

Benjamin Nordstrom: But I think one of the important things to point out is like we. We've been here before. Not quite this bad. But we we've struggled with this issue that a number of times in our past,

Benjamin Nordstrom: and interesting like um, Really, the first time we had an opioid crisis in this country was around uh the turn of the previous century,

Benjamin Nordstrom: so interestingly at back in the late eighteen hundreds, early, nineteen hundreds. The the typical opioid use disorder. Patient was fell into two classes. One was a civil war veteran who had uh injuries that um continued to give them uh all kinds of discomfort, and so they used usually opium or morphine

Benjamin Nordstrom: um to to that. But the other big core uh of opioid use to sort of patients were were um women, and usually kind of middle to upper class women. Uh very frequently, uh having discomfort related to childbirth and injuries related to childbirth,

Benjamin Nordstrom: and so people had a very, very sympathetic disposition towards opioid use disorder patients until the end of the eighteen hundreds.

Benjamin Nordstrom: Then a couple of things happened. One is their pharmaceuticals in Germany discovered that if you put a a molecule called an acetal group onto more feed

Benjamin Nordstrom: um, you put two of those acetal groups onto a a molecule of morphine. The morphine got to people's brains a lot faster.

Benjamin Nordstrom: Um! And uh, they discovered this, and they uh had just they previously discovered that if you put acetal groups on the sales of a cellicylic acid, you'd make a C to cellic acid. And they said,

Benjamin Nordstrom: Okay, that's aspirin and aspirin was a huge uh success for them from a business perspective. And so when they added those the single groups to morphine, they named it. They wanted it to sound like aspirin. So they needed heroin.

Benjamin Nordstrom: And uh, your pharmaceutical started producing heroin and heroin because it gets to the brain faster, was much more addictive. So that came uh over into the United States. And uh,

Benjamin Nordstrom: we developed a heroin problem. As a result, our first hero and epidemic was in

the early part of the one thousand nine hundreds. We

Benjamin Nordstrom: now at that time um heroin and morphine and opium and cocaine and cannabis could all be bought over the counter in pharmacies without a prescription. Um! Anybody can come off the street and just buy any of those things and use it.

Benjamin Nordstrom: So this led to, especially when when heroin was available

Benjamin Nordstrom: to a lot of people misusing heroin. And

Benjamin Nordstrom: what happened was the Uh people who were kind of became kind of the the typical opioid users shifted. And in the United States, where we what we had was a lot of. And this happens in a lot of cultures. The first group to really kind of get snared up in a in a new drug or a different kind of drug, is our young immigrant men who are working away from their families who are back in their country origin. They don't have the same reinforcers. They don't have the same support

Benjamin Nordstrom: that uh other people do, And so they're particularly vulnerable to developing problems. So what that meant to the United States is all of a sudden. Um! A bunch of people who are perceived as ethnic. Others we're using heroin, and the did it. The

Benjamin Nordstrom: perception of opioid use to disorder patient shifting dramatically from being very supportive. What it was uh middle and upper class women and veterans to an an ethnic, other using a new kind of drug heroin. Um, and people became very negative about opioid use disorder patients,

Benjamin Nordstrom: so that, taken with some stuff that the State Department was doing back in in one thousand nine hundred and fourteen,

Benjamin Nordstrom: led to the passage of what was called the Harrison Narcotic Act, and that met for the first time. Heroin could not be bought over the counter in the United States. Better prescription.

Benjamin Nordstrom: So what happened was immediately a bunch of people who were using heroin regularly suddenly had no access to it,

Benjamin Nordstrom: and so the first maintenance clinic started almost immediately after the Harrison Arcadic was passed, so people could come to these clinics, and they would be assessed by a physician, and then given a prescription for heroin or for you know. They also did cocaine out of these, so that people could continue to have the the drug that they were using without having to get it illegally without getting it in the black Market, where it's potentially tainted, and things like that.

Benjamin Nordstrom: So our first experiment with opioid replacement really happened over a hundred years ago,

Benjamin Nordstrom: and now some of these clinics were great. Some of them were really well run. They were, uh, they had very, very idealistic and committed um uh health care providers delivering these services. But a bunch of the other ones were basically drug dealers. They were just pushers, and this led to a lot of problems.

Benjamin Nordstrom: And uh, then World War one started, and basically the Supreme Court came in and said, Uh, after a couple of legal cases said,

Benjamin Nordstrom: You cannot give opioids to opioid use disorder patients, you know, but they just called opium addicts back in the day. You can't give that those medications, those people that is not a legitimate use, and the Government closed it down. So all those maintenance programs had to shut,

Benjamin Nordstrom: and we had nothing effective to offer the treatment of opioid use disorder

patients for decades. As a result,

Benjamin Nordstrom: Um, the Federal Government opened a uh a facility at Lexington, Kentucky kind of colloquial, called the Farm, where they try different things. But nothing really worked until Methadone was sort of repurposed for this in the mid one thousand nine hundred and sixtys. So essentially you can go to the next slide.

Benjamin Nordstrom: So what what was happening that? Well, by this time, in the mid sixties we were in the middle of our third heroin epidemic in this country we had an intervening one just before World War Ii. Um! That was brought about uh the end of which is brought about largely because, uh, they swept up most of the kind of

Benjamin Nordstrom: young men of using age and put them into uniform, and we had a very stripped naval blockade around the country, and the heroin supply drive up. But then, in the sixties it came back,

Benjamin Nordstrom: and so we had our third heroin epidemic. Now there was an endocrinologist, um named Dole, Dr. Dole, who worked at Rockefeller, Rockefeller University, um and uh had a partner marine Icelander

Benjamin Nordstrom: Um, who is a another physician who uh, you know we're working on the upper east side of Manhattan and and Doles train right in.

Benjamin Nordstrom: He came through the city and looked out, and was seeing all these people using heroin on this three corners and things like that, and he's an endocrinologist right? He treated diabetes, and he started to have the thought. Well, what if,

Benjamin Nordstrom: in the same way that a diabetic has lost the ability to make insulin, Maybe, you know, and if you replace the insulin, the diabetic does fine, Maybe if we replace the opioid they're using with a safer alternative, they can get their lives back.

Benjamin Nordstrom: And so they went to. They picked Methadone um because of some of the properties of Methadone, that the most important one is that it lasts for at least twenty four hours a single dose last for at least twenty four hours, so you could just keep people from going into withdrawal. Right?

Benjamin Nordstrom: But there's a second piece to it. So not only can you stop people from going into withdrawal, and you take away the negatively reinforcing properties of ongoing drug use just you know they're using to stop from getting sick, but then you can take the dose and slowly increase it over time

Benjamin Nordstrom: to get to the point where, if they use the the amount of heroin they can realistically find on the street. They just don't feel it.

Benjamin Nordstrom: It. Just doesn't it doesn't register. And so now you can address positive reinforcement that way. And so they looked at doing this in a number of studies, and they found that it was highly highly effective people stayed with the medication. Their risk of dying of an overdose dropped their um

Benjamin Nordstrom: uh their uh use of illicit opioids dropped. They stayed in the programs longer. Uh they uh people who were criminally active, committed less crime.

Benjamin Nordstrom: Um! There were lots of these benefits. Later on it was shown Um, that it reduces behaviors that lead to the transmission of pledborn uh pathogens getting transmitted. So it produces injecting behaviors and things like that. So it was found to be really really super effective, but it just didn't get any mainstream acceptance,

Benjamin Nordstrom: right? That people still, you know, policymakers were saying like this is just replacing one drug with another drug. Um, you know Bill W. Who uh um

Benjamin Nordstrom: No, no, i'm sorry it wasn't built up. He was The guy started narcotics. Anonymous said very famously. When asked what he thought about it, he said, Oh, yeah, well, I think it's a great idea, and we should just give bank robbers money so that they don't rob backs, you know, very dismissive of it. Just did not get any traction.

Benjamin Nordstrom: It wasn't until one thousand nine hundred and seventy-four, though that the Government really started paying attention. And the reason um was basically because in Vietnam, at the time about thirty to forty of our service members who were there. Uh, we're using heroin have used, or we're using heroin. Heroin was abundant over there. Um, there's a lot of reasons for it we could get into if people are interested,

Benjamin Nordstrom: why Harold was so abundant there, but very pure, very cheap, and American service members were using it, and there was a huge concern that these service members were going to come back to the United States with heroin habits, and not only did they have heroin habits now they had combat experience, and that there is going to be this on this crime wave the like the likes of which the country had never seen. A huge piece of This, too, was fueled by racism that they were very concerned.

Benjamin Nordstrom: Uh about um. What was going to happen there was, you know, in this very frequently happens, driving a Us. Drug policy is just racist Fears get tangled up with uh scientific kind of uh uh misstatements and overstatements. And uh bad things can happen

Benjamin Nordstrom: in this case it led to something that I think on balance was good, which was the passage of the I, their coticatic treatment act of one thousand nine hundred and seventy-four. They did not do this to help people. They did this to to try to stop crime, that's kind of the the the falls from the the you know the full stop of that. The

Benjamin Nordstrom: so at it's a moment of inception. When Methadone went mainstream. In this country

Benjamin Nordstrom: there was attention because the people working in the clinics were there because they're trying to save people's lives that they are working with. People. See them as valuable human beings. We want to restore them to functioning, get them into recovery. Help them out.

Benjamin Nordstrom: That's their reason for being there. The reason why the system wanted them. There was to uh address uh social control and as kind of an agent of social control. So from the beginning there's been this tension between what the purpose of these uh of these clinics is for

Benjamin Nordstrom: um, and that has a kind of long-standing implications.

Benjamin Nordstrom: So

Benjamin Nordstrom: the laws that essentially make this legal are under um

Benjamin Nordstrom: the forty-two Cfr part eight uh. So you can Google this and you can. You can read it. It doesn't take long um But what it lays out is the licensing requirements for what is now called an opioid treatment program. Right? So it is the one place where it is legal in this country to give a schedule to narcotic to somebody for the purposes of treating opioid use disorder.

Benjamin Nordstrom: It's the only place you can do. It is through one of these things. They lay out. What the licensing requirements are. They lay out um the admission criteria who can come in? Um! They spell out what services are to be offered there. They spell out the staff positions that have to be filled at a minimum. Um!

Benjamin Nordstrom: They specify the maximum that you can give as a first dose um, and they uh they lay out how,

Benjamin Nordstrom: you know, because traditionally people would come to the clinic you'd give them the medication. They go home. They come back the next day you give them the medication, and then over time as they stabilize, you could give them some. Take home doses and say, Okay, you can have a dose to take at home.

Benjamin Nordstrom: They do. Well. Now, you can have two doses to take at home and three, and so on until people can take up to a month's worth at home at any one time but those uh the criteria, both time and treatment and then stability criteria, are laid out in Federal law. It's just kind of interesting that there's kind of two

Benjamin Nordstrom: broad buckets where legislators like to put on the white coat and and play treatment professional. Um! It's in addiction medicine

Benjamin Nordstrom: and in reproductive medicine. That's where they all of a sudden they feel like they they can just kind of come in and tell uh professionals how to do their job. They don't tell them how to do brain surgery. They don't tell them how to do endoscopy, but they tell us how to do our jobs, and this is one of the ways that they do it. Now

Benjamin Nordstrom: some municipalities, if you go to the next slide, Samson.

Benjamin Nordstrom: So a lot of States add to this on top of it. So the Federal is the thing that everybody has to do, and then a lot of States. Add on to that

Benjamin Nordstrom: beyond what this, what? The Federal Government regulates. Some States really limit the number of opioid treatment programs or otps that can that can exist in the State.

Benjamin Nordstrom: Um! A number of States limit where they can operate. They don't want them near schools. They don't want them in. You know various locations like that.

Benjamin Nordstrom: A number of States in force piece of patient to counselor Ratios Um! Not paying any attention to whether the patient is stable where the patient is unstable. They just say you, you've got to have this many counselors to this many um

Benjamin Nordstrom: you know, to To this many patients. Some States mandate the frequency of counseling.

Benjamin Nordstrom: Some States tell us, uh how frequently um the urine drug screens have to be done. Some States even mandate in their State law that we have to observe every urine screen that's done in these uh settings. Some States mandate um,

Benjamin Nordstrom: you know they they put additional limitations on How take home Those are given.

Benjamin Nordstrom: Um! They make them, uh, you know, either by saying people have to be a treatment longer, or they specify additional uh criteria to to to to, to to be given a Take home, for example, Missouri. You have to be looking for a job or have a job.

Benjamin Nordstrom: Um states also uh mandates that that uh programs discharge, that we discharge people that they continue to use drugs.

Benjamin Nordstrom: Um and other States again, without without real evidence, force discussions about a program, discontinuation, and send the message that people should not be on these medications long term, and they forces to have discussions about getting people off of it. So you can see, then, that that that the social control piece of this um exists at the Federal level. But then it can

be much tighter at the State level.

Benjamin Nordstrom: So

Benjamin Nordstrom: there is Federal Uh, there's lots of oversight of what we do, for at the Federal level. Um, There's the substance, abuse and animal service administration, and specifically the center for substance abuse treatment That, uh regulates uh Us. Issues licenses um the drug enforcement administration also. Um, because uh, these clinics have um

Benjamin Nordstrom: supplies of medication on hand. So the dea is very, very involved, and does a lot of auditing and oversight

Benjamin Nordstrom: at the State level. Um, Every State has a State opioid treatment authority uh that oversees the um. The use of uh, you know the the administration of these clinics, and then, in additionally, uh addition, their State licensing, you know, either through the department of Substance, abuse, services, department of Behavioral health, et cetera, that um oversee what Otps do, and in a lot of States the Board of Pharmacy is also involved where we happen that there has to be a pharmacist that has to be following pharmacy uh

Benjamin Nordstrom: regulations as well

Benjamin Nordstrom: from a professional standpoint. Uh, by uh, you know, in order to have a Federal license, yet there has to be accreditation

Benjamin Nordstrom: um, either through the Joint Commission or the Council on Accreditation of Rehabilitation facilities. So these this is a highly highly regulated space, right. So one of the ways that um uh one of the things that has happened as a result, um is uh

Benjamin Nordstrom: back in two thousand and at was past called Data two thousand. The Drug Added Treatment Act of two thousand, and what that allowed was for Buprenorphine um to be given outside of

Benjamin Nordstrom: this kind of federally licensed Otp, and so what they were trying to do is get around the stigma that was associated with coming to an Otp and also to increase geographic access, so that you know you didn't have to have one of these clinics. Any doctor who took a training could prescribe

Benjamin Nordstrom: Buprenorphine to anyone who needed it for opioid use. Disorder

Benjamin Nordstrom: um

Benjamin Nordstrom: they uh, and that became known as robot or office based opioid treatment.

Benjamin Nordstrom: Um the uh um.

Benjamin Nordstrom: The whole point there was to increase access, get more people on it, and uh make it easier for people to get the uh to get the medication.

Benjamin Nordstrom: Um! It has not been as successful as people hoped when they started it, even though we've got, you know, of the about thirteen percent of people in the country who have an opioid use disorder or automatic pond medication. About sixty of them are on Pupil orphan. About forty percent of them are on Methadone, but still only thirteen of people who have an opioid use disorder on medication.

Benjamin Nordstrom: So you know the um, the

Benjamin Nordstrom: the

Benjamin Nordstrom: the end of this, though the Otps are playing a very, very critical role treating a lot of people who um, you know, for whatever reason Don't have access to, or don't want to be at Buprenorphine, and we get to questions and answers. We can kind of talk about how Fentanyl's complicating all of this. So at the end of the day, though the otps are uh have a lot of different conflicting messages from different stakeholders from the public health sector. Um, there's a a huge push

Benjamin Nordstrom: about access to these medications, you know, and anyone who's kind of reading what's coming out of Oh, and Dcp. And coming out of the White House, sees that access as a as as their number. One concern. Um!

Benjamin Nordstrom: A lot of people in the public health world Look at regulations as barriers. They think that uh everything that um every one of these regulations just creates a higher step into this kind of treatment.

Benjamin Nordstrom: Um. Frequently the public health voices are in different, or even how possible the counseling

Benjamin Nordstrom: that they say these medications um are important, and saying that somebody has to have counseling at the same time, or any of the rest of this. Uh it just lowers the chance that people will go in and get on these medications. Um, The just this past summer the Federal Government uh weakened the the data, two thousand uh stipulation that people that doctors had to say that they could connect the patient to counseling if they wanted it. In order to prescribe buprenorphine. They don't even have to say that any

Benjamin Nordstrom: um that they can just be on the medication. You know it's initially described as medication assisted treatment where the medication supposed to assist the treatment. There's been a push to replace that at for medications for opioid use disorder, and to just say it's a medication like any other medication counseling. It's not important.

Benjamin Nordstrom: Okay, From the recovery community we get a really different message from them because their cut, the recovery community wants to see people get into recovery. They want to see people making process, and you know progress in their treatment that they're progressing towards goals, and that they're getting somewhere from this now. The

Benjamin Nordstrom: other kind of big stakeholder group that um influences Otps or the the Social Control people, and they see otps as a necessary evil.

Benjamin Nordstrom: Basically They they don't like them. They don't want them there, but they say it. You know It's better than just having people on the street using drugs. But we want really strong regulations to ensure that your patients don't hurt the rest of the community.

Benjamin Nordstrom: So if you go to the next slide.

Benjamin Nordstrom: The net result of this is that nobody is very satisfied. Right? The public health people are telling us, you know. You're too punitive. You're killing people by preventing them from getting into your program or by kicking them out of your programs. Recovery Community complaints come at us. You know where it's people saying things like you don't get people better. Yeah, you keep them, change your medication. You keep them change to your clinic,

Benjamin Nordstrom: you know it's it's liquid handcuffs. Um, and you're just replacing one thing for another, and the social control people are kind of constantly saying you're not being punitive enough. You're letting people get away with too much, and the Otps have to kind of figure out a way to navigate this space, where all of these stakeholders are saying kind of mutually exclusive things.

Benjamin Nordstrom: So if you go to the next slide, the you know the the truth is, they've all got a

point. They they they they've all got, you know something reasonable at the heart of what they're saying. From a public health perspective, we should be doing everything we can to lower barriers uh into treatment and to help retain patients.

Benjamin Nordstrom: Um from a public health perspective. We do have a vital role to play in preventing overdoses. People on medication are fifty to eighty percent less likely to die of an overdose than people not on medication.

Benjamin Nordstrom: Um! The recovery community.

Benjamin Nordstrom: You're right. There should be a clear path to recovery for people.

Benjamin Nordstrom: Um, this shouldn't just be a gas and go operations, I mean, where else? What other uh addiction do we say to people? I you don't need counseling. Just take a pill. You'll be fine, you know um that there has to be more to it than than that to really get people to recovery, because, look, the medications are great at keeping people from using opioids, stopping them from dying of overdose deaths, reducing the chance that they're going to engage in. You know, behaviors that transmit bloodboarding factions reduce crime.

Benjamin Nordstrom: They're very, very good at all that kind of stuff, but the medications don't teach you how to handle frustration.

Benjamin Nordstrom: Um. The medication still teach you how to identify and avoid traders. High risk environments. They don't, teach coping with craving the medications. Don't teach a lot of things, and all of these things are routinely um kind of imparted to people, for with other substance use disorders. Um, and you know that that otps should make those same skills and that same information available to to their patients

Benjamin Nordstrom: and from a social control perspective. Um,

Benjamin Nordstrom: you know, we should be careful to make sure that our patients Aren't harming other people, we should make sure that our patients are just taking a month's worth of Methadone, and taking it out to the parking lot and selling it, you know, for a dollar a milligram to whoever wants to buy it like we, we we should be careful, Methadone. It can be very dangerous in the wrong hands, and we don't want things to go back to the battle days One hundred years ago,

Benjamin Nordstrom: uh when doctors were drug pushers. Hell! We don't want to go back to the battle days of one thousand nine hundred and ninety-six when doctors were drug pushers and the pill mills were getting schooled up in in Florida and places like that. So you know that the social control people have a point to. Even

Benjamin Nordstrom: So at the end of this, you know,

Benjamin Nordstrom: since and I, you know we work for a company called Behavioral Health Group.

Benjamin Nordstrom: Um, we're a big nationwide uh provider of both Otp and robot services. Um and uh, you know, we've got a we our board and our Ceo kind of said like, Okay, we need figure this out, you know. And so what we came up with we need a new clinical model,

Benjamin Nordstrom: because the historical model is really kind of a one. Size fits none, And if you have a programmatic approach that's designed to satisfy a stakeholder Um, you're not going to be able to address really what the patients need right. If you put the stakeholders at the center of your solution, you're not going to have the patient there,

Benjamin Nordstrom: and so we need to think differently about the model in its entirety. You know. We've got to move from programmatic thinking where, you know, we may keep a stakeholder happy and a patient at that to us

Benjamin Nordstrom: we got to move to individualized thinking where the program adapts to the patient. Okay, and the patient and not the stakeholder, should be the program should be at the center of the program. Um, and and that's where our focus has to be. So i'm going to turn it over to Sam.

Samson Teklemariam: Thank you so much. Ben: Um: Yeah. So like, like, you know, Ben said this in the beginning and kind of touched on it just recently. We have done this before right, when thinking through the environment of care that we currently work in and and the provision of services we provide. It's important to start with that entry point.

Samson Teklemariam: Most of the people we care for what's their entry? Point

Samson Teklemariam: the intake, admission assessment,

Samson Teklemariam: or a quick eligibility call. If you have a call center. Um, Most of us currently use, or we we. We at some point learned how to use the assem levels of care right? We use that to conceptualize what placement fits best for the patient who's sitting in front of us. In addiction treatment we've always wrestled with program driven versus individualized treatment. This is a part of our history in every level of care. Now the cycle that you see right here that that cycle is is a part of the len

Samson Teklemariam: of the A. Sam. It was designed. Excuse me. It was designed to illustrate

Samson Teklemariam: how the patient goes through this more individualized, person-centered, clinically driven model of treatment. It should be familiar to you, right? There's the biocycle social assessment. Usually there's multiple dimensions, not just one factor. You, you you kind of assess the presenting problems, their highest priorities. Somewhere in there. There's the you know the snap. If you ever use that the strengths needs abilities and preferences, there's what intensity of surface, or, you know, service. So the acm calls that what's the the least intensive but

Samson Teklemariam: most safe level of care for that patient. Now, this is in the Acm. Training, so i'm not going to. I'm going to dive too deep here. But I want you to see the example that we've gone through saying to ourselves, Okay, we've got someone in a level of care.

Samson Teklemariam: But there's more to it, you know, to unpack what individualized treatment really means. It doesn't mean. Oh, they belong in this box. Um, you know, because that's what a level of care Assessment says. You know they should go to inpatient. They should go to intensive, outpatient, you know, outpatient personal hospitalization, Otp:

Samson Teklemariam: But once someone's a level of care is assessed. They're in treatment with you. We have these these additional opportunities

Samson Teklemariam: for individualized care. Sometimes, if we're honest, and if we're in a rush, those are missed opportunities

Samson Teklemariam: and sometimes within those opportunities we sometimes revert back to a program-driven model

Samson Teklemariam: where we say they fit here,

Samson Teklemariam: and then we, you know, kind of give them what we've got. You. Know. Now we may fail to properly reassess or re-review the person's treatment plan, whether or not it's working sometimes we do things in just a checklist, you know. Fashion Well, they got a ua doesn't. Have

Samson Teklemariam: you know, several substances in it? Yes, um! Is it unfavorable to the person's recovery journey? Yes, um! Are we doing anything about it

Samson Teklemariam: sometimes. Um. And so we have to ask ourselves, Are we really meeting the patient's primary presenting needs that were identified at the point of of intake?

Samson Teklemariam: And again, you know, like I said, we've done it before right. So two examples of how we've kind of evolved from there is. There's the chronic care model you're familiar with. It came out of research about ten years ago, when seeing addiction as a chronic medical problem, researchers looked at how multidisciplinary teams work together to help people with

Samson Teklemariam: diabetes, and it was very um outcome focused right or outcome driven. So it was all about how we improving treatment outcomes for these patients. Now some of us recall, maybe about ten years ago, we said, Oh, okay, addiction treatment is becoming the medical model, you know, and we started. You know, kind of saying that statement, but but really what they've essentially used is the same model that that was used in the chronic care model where there's

Samson Teklemariam: and understanding that a person is on a continuum of care, and hits episodes of care in their journey. That's the same model that we've adopted here in addiction treatment.

Samson Teklemariam: There's also the male clinic model of care. They they have this long time mission that it's been there for a really long time, and and really what it says. In In some ways it talks about that. There's cooperative teamwork through a structured, integrated care setting that expert that expands, not restricts the person's understanding of how to treat the patient and the patients understanding of who can help them.

Samson Teklemariam: And the key I want you to remember, is expanding, not restricting. We want to expand a patient's understanding of how they can be cared for, especially when they're in a crisis. Right? I I want a patient that's working with me to say

Samson Teklemariam: I can get help from there. There, there! They're not. Recovery can only happen in this lane, you know, and and we we've hit those walls. Sometimes we we slide back down the mountain to program driven, or even we slide back down the mountain of of voicing increased stigma to someone getting recovery in a way that may differ from how we got recovery.

Samson Teklemariam: Now, i'm going to turn this back over to Ben to to unpack a little bit more about what this means and how we kind of unfolded the Idcm, the integrated dynamic care model. Then.

Benjamin Nordstrom: Okay, thanks, Samson. So really um

Benjamin Nordstrom: in a nutshell. All that we're saying that this is is. If a patient needs more, then we're going to offer them more.

Benjamin Nordstrom: They're stabilizing, or they're stable. Then we fall back, and we just kind of make less available to them when they don't need it.

Benjamin Nordstrom: If they were stable, and they destabilize, we step back in and offer more services, and if a patient doesn't want recovery, that's not what they're there for, then we're going to meet them where they are, and then kind of gradually work with them and move them along uh the the stages of change.

Benjamin Nordstrom: Because one thing that's kind of important for us to recognize is that not everybody who comes to one of our programs? They're not all the same. Right? Um!

Benjamin Nordstrom: This is the old apples and oranges, you know. They, they they they are both that come through uh our our doors.

Benjamin Nordstrom: Different patients have very, very different goals for for the treatment for what they're looking for some people are really looking for a recovery.

Benjamin Nordstrom: Okay, some people um

Benjamin Nordstrom: really do want to get back everything that their disease took from them and get more. Um, However, some patients just kind of want to reduce their opioid use or or stop their opioid use that they they don't want to stop using cocaine, or methamphetamine, or whatever else they might be doing,

Benjamin Nordstrom: and because their goals are different, our approach has to be different for engaging with them.

Benjamin Nordstrom: So why make this distinction right? So if we look at a recovery patient, and we just kind of adopt a stakeholder model, or what we're trying to do is just make a make the public health people happy, right? If we re ah under react um

Benjamin Nordstrom: to their their distress. Right? I mean if they're struggling, they're continuing to use um. We're just gonna say, Oh, they don't really want to change. They want to keep using these other things. Well, we're We're failing that person. We're not helping them. If their goal is to get into recovery. We're not doing that. If we don't, offer it more services to get them there,

Benjamin Nordstrom: we're going to fail to teach them the skills and the information that they need to really be to be successful in a recovery process.

Benjamin Nordstrom: Further,

Benjamin Nordstrom: if we don't give them credit for the progress that they've made by liberalizing things around them and giving them more opportunity to go out and get gain, lived experience in recovery. They're going to get frustrated with us if we tell them. No, you gotta be here every day you got to come every day, and they're getting.

Benjamin Nordstrom: You know they're they're getting more and more stable and getting more and more uh kind of power behind their recovery, and we don't recognize that they're going to get frustrated. They're going to drop out.

Benjamin Nordstrom: Now, what happens if we make the mistake and think that a harm reduction patient is a recovery patient, right. So if we just go and try to make um uh the recovery stakeholders happy by saying, Well, we're going to push everybody to get into recovery, no matter what they want. Well, first off we're imposing our values and our goals on the patient. We're not listening to them,

Benjamin Nordstrom: you know. Uh

Benjamin Nordstrom: secondly, we really miss an opportunity to meet them where they are.

Benjamin Nordstrom: Um, and build a a relationship with them where we we earn their trust right that we we show them that we respect them as consenting adults, and that you know we, even if we don't, agree with the decisions that they they make, that we accept the fact that they they're capable of making them, and that we still think that we can help right. We still think that there's something there. Um! We're going to blow that opportunity to build that kind of relationship that's really necessary to to help somebody change

Benjamin Nordstrom: and then, lastly, if we press them to do something they don't want to do.

Benjamin Nordstrom: They're gonna quit, you know, and then they're no safer. They're they're no better off. If if we make them so frustrated, and we demoralize them,

Benjamin Nordstrom: and we keep trying to cram stuff in it down their throats or hammer a squared P. Through a round hole. They're just gonna go. And then now they're back, and they're just using street fentanyl, and they they are no better off than if they hadn't come to us in the first place.

Benjamin Nordstrom: So

Benjamin Nordstrom: when we think about the harm reduction patients, you know. So just oranges. Let's take the apples out of the out of the equation for a second.

Benjamin Nordstrom: So these are people who just aren't motivated for recovery right now.

Benjamin Nordstrom: There, uh,

Benjamin Nordstrom: you know Frequently they want to continue using other things, whether that's cocaine, whether that's method. But I mean some states we uh by law have to take Cannabis seriously. Um, it. It's not one that I think that we think uh makes sense for us to to to uh, to lump in with cocaine, or methamphetamine, or or pcp, or anything like that. But some, you know some states they they we don't have any room to maneuver there. Uh um! But if people want to continue to use those other illicit substance,

this is,

Benjamin Nordstrom: you know we can still help them right if they are not using

Benjamin Nordstrom: Fentanyl, or they're using less fentanyl on the street.

Benjamin Nordstrom: Um, they're safer if they have a high enough dose of that medication that they're We've induced a tolerance where, if they do use, it, puts them at a lower risk of dying of an overdose. We've really helped. If we're helping them not commit crimes that they need to buy. You know, one hundred dollars with the heroin every day, and they're no longer at at risk of getting arrested, incarcerated, and everything else we've helped, you know, so there's still things that we can do. We can still play an important role, and we can still connect them to other resources. We can connect

Benjamin Nordstrom: them to mental health. We can connect them to housing, we can. You know there's lots of stuff that we can do, but it's predicated. We have to have that relationship with them, so there's still something useful that we can do for these folks

Benjamin Nordstrom: if we think about the recovery patients, even the recovery patients Aren't. All the same, you'll notice that you know. So now not apples and orange is just apples, but some apples are red apples, and some apples are green apples, you know, because all of these patients are going to differ from each other in terms of the acuity of their illness. Um! What their needs are, and what their level of motivation is.

Benjamin Nordstrom: And, moreover,

Benjamin Nordstrom: if you follow the same person over time. What they need is going to rise and fall, based on how stable they are, because we know that people go out and they bump their heads. People learn through lived experience, you know. Somebody could be doing well, and they could be stabilized for a while, and then we can restabilize them and get them back where they were. And that's just part of this process. So, even for the recovery patients, we have to have some way of

Benjamin Nordstrom: uh sensing and responding to what their needs are.

Benjamin Nordstrom: So that kind of takes us to the three pathways of the integrated dynamic care model.

Benjamin Nordstrom: The first pathway is what we call the cop pathway. So it's. It's an iop level of care where we have uh kind of a step down kind of an extended uh um, you know less than nine hours a week, but more than one hour a week. Basically Um, in some States don't allow us by regs to do that. But where we can, we step people down?

Benjamin Nordstrom: Um, It's really kind of for people who come in with high motivation higher needs.

Benjamin Nordstrom: Um. It's also for people who, if they don't if if they can't get stabilized at um less intensive interventions, then they would get they would find their way into this code pathway, and while it's obviously kind of individual and everything like that, this is kind of a rough rule of thumb, it's about it like a ninety day process.

Benjamin Nordstrom: The second pathway is what we call standard programming. So that's just kind of for our new patients. Um! Who either are, you know they might be criteria to go to, an uh a sam two point one level of care. But when you float it to them there's like,

Benjamin Nordstrom: I don't want to do that. I don't have time Doesn't work for me. Okay, fine. You come into the just standard programming or people who are just lower clinical acuity.

Benjamin Nordstrom: They don't be criteria for two point. One. There are kind of three phases to this. There's the induction phase, which is day one to day ninety.

Benjamin Nordstrom: Um! There's a stabilization phase which is day ninety-one to day, one hundred and eighty, and then maintenance which is kind of everything. After the those first six months.

Benjamin Nordstrom: Um, this um! We've got an engagement model. Um! Where people are coming for counseling on a weekly basis for this first ninety days every Other week for the next ninety days, and then monthly. Thereafter. Some States make us do more counseling than that for a longer period of time. But what in general.

Benjamin Nordstrom: This is the the model that we follow where wherever we can.

Benjamin Nordstrom: Um, If somebody starts out in the co-face, and they do their first ninety days, and then they step right in here to stabilization on day on day ninety-one.

Benjamin Nordstrom: So those are kind of the two uh the kind of the two uh pathways for people who are really motivated for recovery. But we do have a very defined pathway for people who are just looking for harm Reduction, right? So these are for people who don't have recovery, or even abstinence as a goal. Um! We still think that we can benefit them from being on medication.

Benjamin Nordstrom: Um. The counseling focus is motivated. Uh is really focused on motivation enhancement and connecting people to other services and and really trying to build, report and build trust.

Benjamin Nordstrom: Um. This is something that we would do, really. Uh, generally speaking, only at the otps right? Because if you've got somebody who's using uh methamphetamine regularly

Benjamin Nordstrom: giving them a week's worth, say, of Buprenorphine. Um could could be problematic right? Because they could just sell that buprenorphine and use it to buy more. Um methamphetamine. You know how people get when they get into a using cycle. They'll kind of burn through whatever resources they have on hand. Um, and the bing ends when the money ends.

Benjamin Nordstrom: If we give them something that is essentially as good as money, like a supply of medication, then they can chew through that medication. Now they don't have the medication. So now what are they going to do? They're going to use whatever they can get on the street,

Benjamin Nordstrom: and that puts them into a harms way. So the nice thing about an otp is at an otp. They can be seen on a daily basis. They get assessed by a nurse.

Benjamin Nordstrom: They're given one day's worth of medication that is in their bloodstream by the time they walk out of our program and we don't have to worry about um. We don't have to worry about

whether or not we've inadvertently contributed to somebody's risks. So we would do this really, for you know, a high risk person like that, you know. We would try to treat them at the At at an Otp level of care.

Benjamin Nordstrom: So wh Why do we call it the integrated and dynamic care model. Right? Well, it's integrated because these pathways are connected to each other. These are things that happen in the same center. Um, but they can also be integrated between our facilities. So you know, if we've got an intensive outpatient program running in Minneapolis, Minnesota. And then we've got a uh program up, and Brainer will bring. It might not be big enough to support an Ip and have an iop level of care running. Well, we can either send the patient down to uh the Minneapolis program

Benjamin Nordstrom: or tell them in, and they can participate between centers. So we're integrating the the otps, we're integrating our robots with our otps on this

Benjamin Nordstrom: and these pathways are also integrated in that there is different levels of intensity within the pathways, and it's dynamic because the patient's pathway can change as their goals change, or as their stability changes. So um when treatment intensity um it, it. It rises, um,

Benjamin Nordstrom: you know, because their acuity is high, and then it falls when acuity is low. Um! And the the pathways change. Um depending on the patient's level of motivation. So I think if we go to the next slide,

Benjamin Nordstrom: Yeah, this kind of shows this right? So

Benjamin Nordstrom: what we always encourage people to think about is think of our program as essentially a public pool. Right? Just a public swimming pool.

Benjamin Nordstrom: Now, if you go to the public pool, you'll see that there's a lane that is marked off, that is, for people who are there to exercise right or to to to swim laps. So the people who are serious and are swimming their laps are in one part of the pool.

Benjamin Nordstrom: Then there's another part of the cool that's marked off where you've got um

Benjamin Nordstrom: People who are, um, you know, doing aquatic exercises. They're doing water, or aerobics, or what have you?

Benjamin Nordstrom: And then there's a part of the pool that's marked off. That's you know for people who are there for recreational purposes, or, you know, just kind of want to be left alone and do their own thing.

Benjamin Nordstrom: Now it's all one pool. It's all the same water. It's the same Life Guards the same staff. It's just the there's kind of demarcations based on what you're there for. And that's how we think of these pathways. So let's take patient one. This is a person comes in. They're assessed kind of high needs high motivation. So we put them in the code pathway,

Benjamin Nordstrom: and we keep them in the code pathway for those you know. Let's call it eighty, ninety days. This person stabilizes great. Then we step them into that standard programming. Let's say, this person's going along in standard programming, and all of a sudden they start to use again. Well, okay, So we increase the frequency of the counseling,

Benjamin Nordstrom: and they're still struggling, and they're still using, you know, um with that, and they're at a kind of a one level of care. They're not getting stabilized. Well, then, we might bump them back into the Co. Program for a short stay, just to increase the structure and the support around them

Benjamin Nordstrom: in order for them to stabilize. Then, when they restabilize, we put them back into standard programming, and then this person does. Well. Thereafter,

Benjamin Nordstrom: you know. Patient, too. This is just kind of our bread and butter. Normal person that comes in just meets a level one level of care great. We put them in level one we follow them, have them do counseling at the beginning we step down to less frequent counseling,

Benjamin Nordstrom: and then they're in kind of monthly counseling, and this person does fine through the whole time great. So then they're just standard programming, and they stay in standard programming throughout.

Benjamin Nordstrom: Now, this person might come in, and they seem like they're going to be a bread and butter patient. They seem like they're going to be simple. They seem like it's going to be fairly straightforward. Um!

Benjamin Nordstrom: And then all of a sudden they stop coming to the counseling appoint right. They're they're giving on therapeutic urine screens showing cocaine, we're saying, Hey, look, man, we think we need more counseling. We got to help you get this stopped, they say No, thanks. All right. Then we put them into that harm reduction pathway,

Benjamin Nordstrom: and we keep them there,

Benjamin Nordstrom: and we keep them there, and we just work with them, you know. Again, we're trying to get them connected to other services. We're doing motivation enhancement. Counseling is whatever the regulatory minimum. If there is a regulatory minimum in the State, we'll check in with them as frequently as we need to.

Benjamin Nordstrom: But then

Benjamin Nordstrom: let's say something happens. Maybe they get picked up on a charge, and their uh lawyer says, uh, they say I need to really be in treatment in order to to try to stay out of jail, or maybe they want to get their kids back. They want to get custody their kids back.

Benjamin Nordstrom: Something happens, Something changes. And all of a sudden they want treatment. Well, then, we can move them into standard programming. We can start working with them on counseling, and if they stabilize and they do well, great.

Benjamin Nordstrom: If this person needed to come up into cope for a while in order to stabilize. Then that's what we do to help them stabilize, because if they're if all of a sudden their motivation changes, and now they want recovery. Well, then, we're going to respond and deliver the right intensity of services to help them get the the recovery that they need.

Benjamin Nordstrom: Okay. So So who's right for kind of that code pathway? Again, it's new patients who, when we assess them, need a two point, one Ots level of care.

Benjamin Nordstrom: Um! The new patients in standard programming who don't stabilize, we would put them into code or patients who are in standard programming, who are doing fine, but then destabilize and need more than just kind of that weekly counseling in order to uh in order to get back on on path.

Benjamin Nordstrom: So who's right for the standard programming pathway. Well, any new patient who, when we're assassin, only needs a one point zero opioid treatments to both of your treatment services, you know. Apparently we're going to move to a new format here, where this is going to be called one point five, I guess I don't know

Benjamin Nordstrom: um new patients a A. Also who are referred to Co. On admission. But don't want it. We're not going to tell them it's our way to the highway. We're gonna

Benjamin Nordstrom: We're going to listen to the patient. What I always tell people is Look, I think you need to go to an Ip, but maybe you don't, and I I would love it for you to prove me wrong. You know I I

would love it for you to be successful in this level of care. Let's see how it goes.

Benjamin Nordstrom: If it doesn't work, then we have that discussion like, Look, do you think that maybe you know, to to really catch you what you say you want? Do we need to do more for you, and then move them into kind of a that two point, one level of care in order to for them to stabilize

Benjamin Nordstrom: um. And then also people who complete cope, They come right back, standard programming.

Benjamin Nordstrom: Now, who's right for the harm? Reduction pathway.

Benjamin Nordstrom: Well, these are the people who are persistently giving us non therapeutic care and drug screens. Um, We want to start motivating to accept referrals to higher levels of care right? And then that higher level of care that can be within our program, or that could be without our program. And sometimes we know we've got people who are like, you know they're doing really scary stuff like using benzos. And uh, you know, Federal and our opioids at the same time, and they don't want to stop. And we say, look, we think you need to go residential, and they say it ain't happening. We operate in some areas where that's just

Benjamin Nordstrom: it kind of doesn't exist for all intents and purposes. It just doesn't exist, and they, you know they they don't want to do the Ip. They don't want to do anything else. They just kind of want to be left alone. Okay, fine. We will continue to work with you here. We're going to see you assess you every day. Make sure it's safe to give you that dose before we give you that those we're not going to give you enough to go home and hurt yourself with. You know those are the people that we would put into harm Reduction?

Benjamin Nordstrom: Um, One important thing, and This is what we tell our staff a lot.

Benjamin Nordstrom: The patients who are always giving us therapeutic care and drug screens who are just refusing counseling,

Benjamin Nordstrom: but otherwise they're making, you know, meeting the Federal criteria to get Take home criteria. We shouldn't force them into harm reduction right If somebody is succeeding without counseling.

Benjamin Nordstrom: Oh, Yahtzi. They they somehow they figured it out. You're doing well, that's great. We're not going to punish them by making them come to the clinic every day just because they don't want to do counseling. If they are being successful, they are making progress towards their goals. They are the you know they are not using illicit substances, and and are successful without additional help. Well, we're not going to be a stumbling lock and get in their way and make it harder for them to live there.

Benjamin Nordstrom: Our lives, you know, so we're not going to push those people into harm reduction, you know, and we tell them, like Don't, punish people just for not coming to counseling if they're not coming to counseling, and they're giving us non therapeutic parents Very different story, you know. Um, the goal here is,

Benjamin Nordstrom: you know. Let's figure out what we need to do to support this person

Benjamin Nordstrom: A and their way to their goals. You know we we obviously have to check the regulatory boxes. We have to stay in the good graces of all of those agencies that we went over that regulate us, you know. But like, let's not put any additional burden on the patients, or make it harder for them to get the care they need and and the support they need to to be successful.

Benjamin Nordstrom: So ultimately, you know, some of this stuff, you know, especially for people who never work in kind of the Otp space. You're gonna think like this is really kind of basic stuff like this Doesn't seem that that. Uh,

Benjamin Nordstrom: you know that revolutionary. But this is this is really a transformation. Right? This is this is very different. The traditional Otp model, the traditional Otp model is looked at. You know the the very program uh program centered the very programmatic

Benjamin Nordstrom: Um. Regulatory minimums drive the standard of care.

Benjamin Nordstrom: Um. The counselors are very frequently um functioning as kind of case managers and traditional otps, um, and and, moreover, the and this is kind of my biggest. My biggest pet is. They confuse an administrative designation with a level of care,

Benjamin Nordstrom: and Otp is a license that allows us to legally give a schedule to narcotic to somebody for the purposes of treating opioid use disorder. That's all. An otp. Is it is not a level of care in and of itself. It doesn't stand separate and apart from the rest of the Asam spectrum, the Assem levels of care. It is a license that you could apply at different levels, you know, and that what we need to be able to do is again sense and respond

Benjamin Nordstrom: what that patient needs, and deliver the services that they need, and then use that license to deliver medication when it appropriate, uh, based on what that patients goals are

Benjamin Nordstrom: where we're moving to with the Idcm. I'll go back up one. Thanks. Um. This is a very patient-centered as opposed to program centered The regulatory minimums are just that

Benjamin Nordstrom: their minimum. So let me say this to this great staff as well, you know. Would you want to go? Get your chest cracked open, and your heart operated on at a place that said, Well, we we just do the Federal minimums for what we have to do to have an operating suite, you know. Would you want to go? And um, you know, get intensive care at an intensive care unit that just said, Well, you know, hey? We meet the minimums good enough. No, the minimums are the

Benjamin Nordstrom: that's the ticket to the dance. You know what you we've got to exceed those, you know and and that mindset around that we're shipping the mindset from the counselor as case worker to counselor as an addiction treatment, professional delivering evidence-based counseling um that that we know is going to help people stay in treatment and help them help them recover.

Benjamin Nordstrom: Um the case management part's important to, but that's not all you do, you? You know we did. We do these act additional services on top of it.

Benjamin Nordstrom: And then, lastly, the big differences Here we're clarifying that multiple levels of care can occur under that administrative designation under that Federal license. Um, but it again, the the license for how we deliver medicine is different from the intensity of the services we deliver, and they're not to be confused.

Benjamin Nordstrom: Okay. So

Benjamin Nordstrom: in summary, we're we're fundamentally trying to shift how uh oed care is being delivered in this country, and we're we're We're building a a new culture and a new kind of program.

Benjamin Nordstrom: Um,

Benjamin Nordstrom: Um, None of this stuff is conceptually that difficult right? But change is hard. And you, anyone on this call knows this right, that it that um cultural change, attitudinal change that takes time, and it takes effort, and it takes dedication. So what we've

Benjamin Nordstrom: done is really tried to build uh, you know, we think of as a drive train right? We're trying to get the power to the rear wheels. How do we drive? Change from leadership? You know It's Samson's level. My level to the level of the individual contributor. Um uh, you know,

Benjamin Nordstrom: and get each of the counselors engaged on this. So that's That's kind of the work that we're in now. I'll turn it back over to Samson.

Samson Teklemariam: Yeah, um, if you if I i'm sorry if you work in an area where you haven't heard a doc and addiction psychiatrist.

Samson Teklemariam: Um tell you how important you are as a counselor, because that I think that's what we've had for a long time is is in B on the opioid epidemic. We didn't have a model that really said, Okay, now that you know the level of care. Now that you know that this patient fits here,

Samson Teklemariam: you know. Now here's your roadmap of what to do with that patient, and how to address the the cycles, the ups and downs right. And so That's what we've worked on and building the Idcm. And i'll tell you i'll I'll say the same thing about otps that you know. I used to say about residential treatment programs and think Oh, my God! You know confrontation, you know, in counter groups. Um, you know they're they're going to try to keep you there forever, you know, because they're making money off your you laying in their bed. And and there was all all of these

Samson Teklemariam: types of stigmas which which wasn't true, just like the patients retreat.

Samson Teklemariam: Those settings are not all the same. Right um in in similar with otps, you know they're not all the same.

Samson Teklemariam: You may live in a city or a town where you're hearing a lot of things of where there's an otp or an obot doctor, or something where it's not being done right,

Samson Teklemariam: and and I would say, advocate, push for for safety and and patient care right, but also dig deeper and learn where it is being done right, because this is a fully integrated care program that we're working on. This is, we're we're we're trying to individualize treatment at the point of need, right where the patients are at that moment. And so so, yeah, it really does take everyone, but it also takes providers and referral sources who are who are wondering. Wow! This patient is on Mit. How does this fit with my own philosophy?

Samson Teklemariam: And how do I handle harm? Reduction, You know, Have I, you know, kind of evolved or done my research on my perspective of recovery that may fall outside of what i'm, you know, educated in or or um experience in my own lived experience right? Um. So there's there's a lot more to the I Dcm: so we're going to take your questions in a minute. But what I wanted to share this with you also. I'm going to try to drop it in the chat box a link. There's a white paper with additional research research and some references. There's a link in the chat box. I think you may also be able to hover your mouth

Samson Teklemariam: and click on this, but I may be dreaming. You can put your phone up, you know, and get the Qr. Coder will just take you straight to it.

Samson Teklemariam: Oregon hit the link in the chat box. Um, but this white paper helps you learn a lot more about the Idcm model, and really about the opioid epidemic, and how we're treating it in otp settings.

Samson Teklemariam: Um! So I will leave this on screen, and then um invite Nadak back up to see if we have any questions. Um, but uh, um, need that. Thank you guys so much for letting us um have a moment to share this with with the profession and with um. You know this incredible group here?

Haley Hartle, NAADAC: Absolutely. No, that was great. Thank you both so much for everything. I know we really appreciate you. There was a lot of engagement in the chat, and we do have quite a few um questions that have come up, so I will go ahead and just read those and get us started.

Haley Hartle, NAADAC: Arrange them by uploads. There we go. So our first question is, can patients eventually discontinue Methadone or other drugs assisting with Oed?

Benjamin Nordstrom: You want to take that, or you want me to take it.

Benjamin Nordstrom: Um! You you take it, and i'll follow up. I I i'll go first, so not planned. Um,

Samson Teklemariam: I I want. I just want to brag real quick on. You know, one of the many otps that is doing it right? Okay. So we have an Otp. In Higgerstown, Maryland, where the program director has started two innovative groups that can kind of address your question. I'll let Ben speak to it on maybe more of the medical side, but on the clinical side she has a group that is a method uh introduction to Mit or Methadone Maintenance support group,

Samson Teklemariam: which is really for folks who are on Methadone or on people on Ref for the first time, and they're trying to figure out how to navigate that in a supportive way how to communicate it with their family; How to kind of bat down the doubters and the folks who are saying what you're still addicted. You know you're not doing anything, you know, and you know so how how that individual can back that down in that same program there's a titration support group.

Samson Teklemariam: And that group is for those patients who are really interested in learning how to titrate or they're hearing about it from another provider, or they're hearing about from a counselor, and they just want to learn more about what that looks like, and how to titrate either. All for tightrate down. Then i'll let you speak a little more to that from, I guess the medical side. Yeah. So um. The short answer is, Yeah, people come off these medications right? And um

Benjamin Nordstrom: The The long answer is, nobody really knows how long it should be on it, or what the

Benjamin Nordstrom: the titration down should look like. I mean, This is just kind of an embarrassing thing to admit. But you know um! In the sixty years that Methadone has been around, nobody's really um been able to establish what the right level of care is now in tip forty-three. Um,

Benjamin Nordstrom: they uh said it should be at least two years um that that I mean I they

Benjamin Nordstrom: the treatment improvement protocols that the Samhsa puts out specifically around different topics, and this one was on um otps, and it said at least two years that people should be on these medications, and you know, and kind of you know you what your finger and stick in there. It kind of makes sense, because you think about how long it takes to get people to a point where they they've made new social networks. They've rebuilt bridges with their families. They've learned new skills. Put them into practice, you know all all the rest of that kind of stuff like the concrete is really hard and not

Benjamin Nordstrom: of recovery. Now you can kind of take away the the support that their medication was good. It's really, you know, the data behind that are

Benjamin Nordstrom: really weak. Um! It was a case control study from like one thousand nine hundred and seventy-seven that you know where they looked at people who came off medication. And Then they looked at who did well off medication? Who didn't? And what they found was the people who were on the tree, you know. Program at least two years did better than people who were on last. You know they were more likely to be successful than people on less than that. That's about the strength of the data. Um, you know the uh

Benjamin Nordstrom: further tip that came out um sixty one or sixty-three basically said people should be on the medication as long as they're driving benefit from it. And that's kind of our perspective right that that there's not an in in the absence of good scientific evidence, saying, this is how long it should be it. It should really be up to the patient,

Benjamin Nordstrom: and they tell us, and when they want to come down, no matter when they come down, you know, if they want to come down to soon, say like Holy Gee! You know that doesn't seem

like quite enough time. But you know what. What's the rush, you know like. Let's not jeopardize everything you've built so far, but at the end of the day they're the boss. If they said it's their body, and if they take it in the office we're going to get them off of it.

Benjamin Nordstrom: The coming down process. I always tell people it's kind of like jumping out of an airplane and pulling a parachute. Now you pull the parachute as soon as you jump out of the plane. You're going to be floating for a long time,

Benjamin Nordstrom: but you're going to touch down nice and soft.

Benjamin Nordstrom: If you jump out of the plane and you fall for a long time first, and you pull the parachute out at the last second. Well, the canopy is going to deploy. It's going to slow you down. You're going to land. You're going to live, but you know

Benjamin Nordstrom: your knees and your back are going to feel it, you know, and by the same to, so you can come down off of these medications very quickly. Um, but that's like opening the parachute real late. Um, but you'll be off fast, but it's going to be uncomfortable.

Benjamin Nordstrom: We also come down super slow, and then it's going to take a long time, but it's going to be a lot more comfortable, so it's really up to the person you know. It's kind of a pick. Your poison situation, you know what. What?

Benjamin Nordstrom: How do you want it to go. Um, and it's a very individualized process. Now we we also um offer uh to counseling only services. So people who just want counseling,

Benjamin Nordstrom: we offer that to and with, you know. And and you know, we really trying to get people to change their thinking on this, that that in the same way that if you have diabetes or you have heart failure. Your uh clinic never says, Oh, congratulations! You've graduated treatment. You're done.

Benjamin Nordstrom: They say, okay, you know, Maybe if you get you? You know you're on insulin, and then you start exercising and watching what you eat, and all of a sudden you don't require insulin anymore. They don't say, well see you next lifetime.

Benjamin Nordstrom: Say, we'll see in six months. Let's see how this is going. Let's you know, and keep a conversation going, so that if somebody does need something, there's not this whole process of re-establishing a car relationship all the rest of that kind of stuff starting from scratch. Um! It's not hard to come in and admit. Oh, uh,

Benjamin Nordstrom: uh! You know this one badly. You just have an ongoing conversation with the person, So, no matter what we think that it's best time to think about treatment, discharge or treatment completion and just thinking about just like the the those check-in visits get farther and farther apart, but not to separate the relationship with them entirely, because it's since the wrong message, you know, like the treatment, it it's not graduation, you know I mean It's not you this this wasn't because you didn't know enough. You know It's not like. Now you got your degree, and you walk. You've got a chronic condition that we know is

Benjamin Nordstrom: we relapses and remains. Um, let's keep a conversation going and keep a relationship going.

Haley Hartle, NAADAC: That's great. Thank you both so much um our next one his Methadone maintenance safe for pregnant women. Will the newborn experience any withdrawal symptoms?

Benjamin Nordstrom: I'll i'll take that one Samson um the the short answer is, Yes, it's safe. Um

Benjamin Nordstrom: uh. The Both Methanone and Buprenorphine are safe to give a pregnancy. The American College of obstetricians and gynecologists recommends that any pregnant women who's got an opioid sort of beyond these medications. Um, better fetal outcomes better maternal outcomes,

obviously. Um, And uh, you know that that they're very, very important medications. They're safe, not associated with uh birth defects and things like that. Um. Further breastfeeding after delivery is also safe uh only

Benjamin Nordstrom: about one of the medication dose that ends up in the breast milk. It's safe for babies. Um, and they and the American College of Upstate uh situations and kind of colleges recommend breastfeeding, even when you're on these medications after delivery. Now, as the question about um, the babies having withdrawal that that can sometimes happen

Benjamin Nordstrom: right? Um! It's a little less likely to happen with people working than it is with method out. Um,

Benjamin Nordstrom: but uh it it's not us uh it. It's not a significant problem that uh, sometimes babies just need to be monitored for neonatal abstinence syndrome.

Benjamin Nordstrom: Um, and they can be. They can be treated and and very frequently all they really kind of need is comfort. Um, reassurance, comfort, and things like that. Uh, and they can get through it without anything and more a additional to that.

Benjamin Nordstrom: Um. So the the risk of that neonatal abstinence syndrome is much less of these medications than it is. If somebody is using elicits. So, no matter what you know, our we encourage people,

Benjamin Nordstrom: you know pregnant patients to be on these medications. Um,

Benjamin Nordstrom: whichever one it makes the most sense to them. That's the right one.

Benjamin Nordstrom: Breastfeed their baby afterwards.

Haley Hartle, NAADAC: Awesome. Thank you very much. Our next one. Can you provide more of an explanation about the dropout prevention plan.

Samson Teklemariam: So I was. I was tracking the chat box. I think someone mentioned that it's not in our presentation, but but I think someone mentioned in the chat box. So that's from Dr. David Mealy. Um, and it's It's mainly about um.

Samson Teklemariam: It's a training that he provides. I think that is, that is for mandated uh court. Um patients. Um! So there's like recovery, I think he calls it recovery. Relapsing Prevention versus dropout prevention for us that we have our code pathway, standard pathway with those you know kind of three sub pathways, and the harm reduction pathway and and I think it's all done in the spirit of how do we meet the patient where they're at? And how do we accept that harm? Reduction is a reality for some patients, and and harm reduction? I feel like sometimes as a misunderstood

Samson Teklemariam: statement, because it's got so much, you know publicity to it. Um, but it's about safety promotion. I mean. It's about elevating safety right? It's about focusing on. No, no one's going to judge somebody for putting a seat out on right. We've gotten past that hopefully, you know. But but um, for some reason harm reduction models. Get,

Samson Teklemariam: you know, a little bit of a negative stigma sometimes, and um if the patient is safe, if you're tracking them. You're meeting your needs, and even kind of speaking as a counselor for one of the earlier questions about titration.

Samson Teklemariam: Make sure they speak to the doctor, you know um make sure they speak to the person for who's prescribing it right like I As a counselor, I try not to speak to that I always had patients that would say, Hey, Samson, something's happened. I'm biting my nails, i'm taking well, but Trin and i'll be like well, you know It's really important to talk to your doctor about that. But I do want to point out that over the last six months you've told me you haven't had suicidal thoughts, right? And

so so it's like I as accounts, so I can speak to how their progress is going, and treatment, and especially highlight the positive aspect that they're still here with me.

Samson Teklemariam: Um! And then I want to refer them to the expert to make sure they're speaking to someone who's in their scope or practice. Um.

Samson Teklemariam: But unfortunately, I can't speak too much of the dropout prevention plan other than find David Meeley. Um, he's the man, you know. Yeah,

Haley Hartle, NAADAC: awesome. Thank you. Um. Our next one. You talked about telehealth and tell a video how well do you think that works for patients? Honestly, in your honest opinion.

Benjamin Nordstrom: Um, well, I I I'll take a crack at this, and then you can um clean up what I say, Samson. Uh as usual. Um, you know what we found is it's it's really variable.

Benjamin Nordstrom: Um, Obviously, with Covid. Uh we got shoved into the telehealth world without a whole lot of warning, and a whole lot of preparation, and kinda had to, you know, build the airplane um around us as we were in flight.

Benjamin Nordstrom: Um, we we've got some patients who really really uh like to tell us stuff Um, that that you know whether that's because they live in very rural remote areas have unreliable vehicles. You know it, You know

Benjamin Nordstrom: that's one one group of people that it seems to really be helpful for the other group is There's um

Benjamin Nordstrom: some patients who said that they they just prefer. Actually, it's almost like being in a confessional booth. You know that that it's not as intense as that one on one interaction. And um

Benjamin Nordstrom: um!

Benjamin Nordstrom: You know that that they feel like they could speak more freely. Um, I mean I just in my own life. When I was I spent a number of years working during the work week away from my family. It would come back and see him on the weekends, and my daughters were teenagers then

Benjamin Nordstrom: and on the phone with me because I could call him every night and talk with him every night. Um! They would talk to me for an hour on on the phone, and my wife, who was right there. They'd hardly say anything to her, you know, but it was somehow like easier to talk to me

Benjamin Nordstrom: on the other end of a phone and open up and things it's, you know, so I I I can see how this works for for some of the patients as well. Other patients have told us to hate it. They wanted to get back to in person, counseling as quickly as possible, so I mean again, I think it's just kind of being flexible and listening to what the patient in front of you is telling you, and doing what makes the most sense for that person rather than just like building something and saying, All right. Now. Everybody's going to get crammed into this one care model.

Samson Teklemariam: What's that? I'll let you? It's no intelligent, you know. I was gonna say It's a It's just a different environment. You know. It's like you know. I don't. I don't know if I could say how well do. I think it works right, because every patient is different, and, like Ben, said, some patients at work some. It doesn't. I think it's about creating connection

Samson Teklemariam: and getting them connected to treatment connected to recovery. And if it's a virtual platform that's doing it awesome. You know. I could care less bus train automobile plane, right, like whatever it takes to connect them to treatment and and and connect them to recovery. Leverage that technology learn about it. Use the skills and strategies, you know. There's a lot of great folks out there teaching and researching on it now, but I think it's still very.

Samson Teklemariam: It's still too soon to say. You know statistically what works right. I and I don't know if we'll get to that point. I think it's about using the environment, using the tools we have to connect with our patients.

Haley Hartle, NAADAC: That's awesome. Thank you. Um, Our next one. I think we're gonna have time to get through all of them attendees if you have any final questions now, the time to put them in there. Um! And whatever we don't get to. We'll send those to you both, and you can answer them. We'll post them on the web page.

Haley Hartle, NAADAC: Um, so the next one. What is the success rate of patients tapering off of Methadone successfully and continuing in sobriety.

Benjamin Nordstrom: So that's that's a really tricky question to answer. Because even in research settings when people do that. Um! Once somebody is off the medication, they they

Benjamin Nordstrom: they're kind of lost to follow up right, because now there's not really a way to get them to um. They're not coming in for assessments, you know, because they're kind of off the medication.

Benjamin Nordstrom: What we know from the literature is that whenever people stop their their chance of going back to using basically doubles uh as soon as they they stop it, whatever that kind of time point is. And so it is one of those things where that it comes with. Um,

Benjamin Nordstrom: uh it. It comes with some risk when people stop, which is why we're not in our big hurry to push people off of this for programmatic reasons, and why, you know, we're working with those States where they force us to have those conversations with people every six months saying, like Don't, you think you should come off like we want to change those laws, because there's just not good evidence that that that it's the right thing to do um, and really prefer to have it. Be kind of patient centered. And again, because there is that risk of relapse once people.

Benjamin Nordstrom: Um, we want to continue to have that that relationship that we're just starting normalizing the expectation that even when you're off this medication.

Benjamin Nordstrom: You still have a home here. There's, you know. Let's keep a conversation going. Let's keep this relationship going and keep talking about it, so that if something does happen, it's just easy to just talk them back in um and and get them back to where they were.

Benjamin Nordstrom: The other thing I would say is, we've got good data. Um, we measure um

uh, We've got the brief addiction monitor, the bam

Benjamin Nordstrom: that we uh monitor over time with people, and What we can see is that the longer people are in treatment their bam scores continue to fall even beyond five years in treatment with us, you know, so that the longer people are in treatment, the more progress they they seem to make in terms of both. Um accumulating recovery. Capital and um

uh, thank you,

Benjamin Nordstrom: you know, reducing their use, but also in a trusting risk. Factors? Um, as well.

Haley Hartle, NAADAC: Awesome. Thank you. And then I think we have time for one more. Um! There is another question that just topped up. But again we'll get any remaining ones over to you both. Um! So are you prescribing in harm reduction if they are using

Benjamin Nordstrom: prescribing. So I mean, this is to kind of the a technical. And i'm not sure if you're if you're asking this technical question. But typically in an otp you're You're ordering medicine because you're dispensing it out of our supply. So it's not a prescription per se in the overt world. We

write prescriptions, they go to a pharmacy, and then the pharmacy fills it. So in general we try to keep harm reduction at the level of the Otp once in a while, you know our backs are into the wall. We operate some obes in some

Benjamin Nordstrom: places where you know where there isn't an otp around for hours, you know we might do harm reduction out of those obots, and would prescribe in those robots. But in either event, you know we um, the goal would be

Benjamin Nordstrom: even in harm reduction to make medication available to somebody, you know, as long as the benefits of the medication are outweighing the risks. Um! That we can. We continue uh to to provide medication to people,

Benjamin Nordstrom: and it's in it in an otp setting. It's very, very rare that you are in a situation where they are better off using Fentanyl than um being on on on medication,

Benjamin Nordstrom: because that that's really what the decision is these days it's fentanyl, or what we have

Haley Hartle, NAADAC: awesome. Well, thank you both so much for all the valuable information continued to get lots of great feedback in the chat. So. Um! We'll wrap up, and then we will have you be on your way. So

Haley Hartle, NAADAC: um everyone we're going to go over the Ce reminders and questions again really quick. Um as we finish up. If you do have questions, you can still post them in that Q. A. Box, and then we'll be able to collect those um. So this is the web page where you'll go to for the ce quiz um, as you can see on my screen next to yellow arrow. That's where that link will be. And then right beneath, that is the access to the online C Quiz and certificate instruction. So

Haley Hartle, NAADAC: um be sure to follow along with that. If you do have any issues, you can email us at Ce at Needacc Org. See, as in continuing as an education at nedac org a reminder that if you need your certificate after this Webinar to stay, live on it, be sure to take and pass the quiz within twenty-four hours, and then download that certificate as well.

Haley Hartle, NAADAC: We just have a couple more webinars up before we are wrapped up with the two thousand and twenty-two year. So we have one on Wednesday, December seventh. Um. Switching the deck chairs on the Titanic eating disorders as a growing phenomenon of cross addiction, and then we have our final one for two thousand and twenty-two on December fourteenth,

Haley Hartle, NAADAC: developing performance measurement and management plans that make sense.

Haley Hartle, NAADAC: Um! And then we will be announcing that two thousand and twenty-three calendar very soon to be on the lookout for that. A reminder of all of our specialty online Training series series consists of six to seven webinars on a particular topic.

Haley Hartle, NAADAC: Upon completion of all the Webinars in each respective training series you can apply for that respective certificate evidencing your accomplishment. We have specialty series on technology in the addiction, profession, wellness and recovery, ethics and practice, clinical supervision and addiction, treatment and military and veteran culture.

Haley Hartle, NAADAC: We also just completed our adolescent treatment and recovery. Specialty Online Training series. Um Part two was rescheduled. We just recorded that one last week. So be sure to check those out, and we do have our women in recovery specialty online training series available on demand from this past year as well.

Haley Hartle, NAADAC: A few reminders about the benefits of joining May Needac Um by joining as a member with needac. You have immediate access to over three hundred and twenty Ce. And that

number is climbing each week. Um! And then you can also instantly become part of our national edition initiative for advocacy, for the addiction profession as a whole, and those that we serve.

Haley Hartle, NAADAC: Um. So for more information you can email us at Nedac. You can also go to Nadac or forward slash. Join for some more information on that, and we don't have time for the social worker video. But if you have any questions about getting your license number on that certificate, be sure to reach out to us, and we can help you with that. So thank you, everyone, and have a wonderful day.