Experiences from the Field: How Title X Providers are Offering Substance Use Services
July 28, 2020

Slide 1

Experiences from the Field: How Title X Providers are Offering Substance Use Services

Katie Quimby: Hello, everyone. This is Katie Quimby, from the Title X Family Planning National Training Center. And I am pleased to welcome you all to today's webinar, titled Experiences from the Field: How Title X Providers are Offering Substance Use Services. I have just a few announcements before we begin. First, everyone on the webinar today is muted, given the large number of participants. We do plan to have some time for questions at the end of the webinar today. You can ask your questions using the Q&A pod on the side of your screen at any time. A recording of today's webinar, the slide deck, and a transcript will be available on fpntc.org within the next few days. And finally, this presentation was supported by the Office of Population Affairs. Its contents are solely responsibility of the authors and do not necessarily represent the official views of OPA or HHS. And now I'd like to turn things over to my colleague at the FPNTC, and Training and TA Provider, Caitlin Hungate, to provide some background and introduce today's speakers.

Slide 2

Caitlin Hungate, MDP, is a Project Manager with ten years of domestic and international experience providing training and technical assistance with the Family Planning National Training Center. Ms. Hungate provides T/TA specific to integrating Title X with primary care providers such as community health centers, to improve financial operations and management, and to address substance use in family planning settings. Ms. Hungate led a five-month peer learning group focused on substance use services in Title X settings. We'll first hear from Caitlin and then we'll hear from a panel of peer learning group participants – one grantee and two subrecipients to share their experiences what they are doing or plan to do.

Caitlin Hungate: Thank you, Katie. Today, on our webinar, we are going to describe the importance of screening for substance use in a family planning setting, identify strategies to address the substance use needs of clients, and hopefully by the end of the webinar, you'll be able to identify at least one strategy described by a peer that could be used at your agency or site to implement or enhance your screening for substance use.

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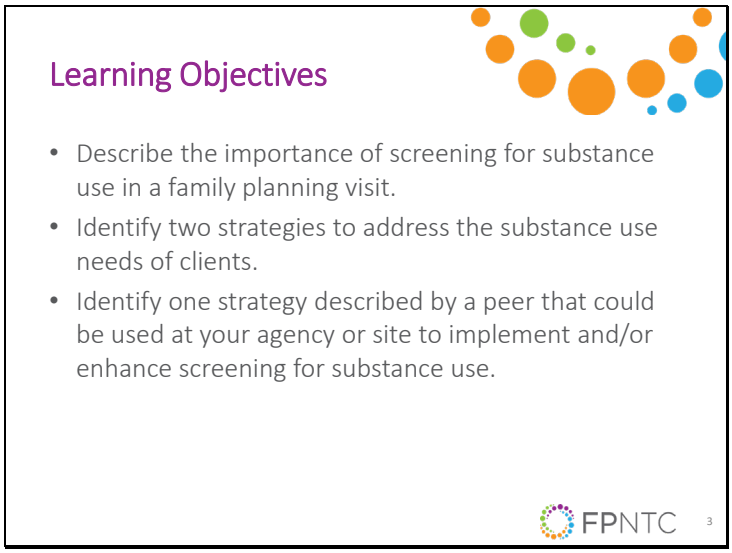
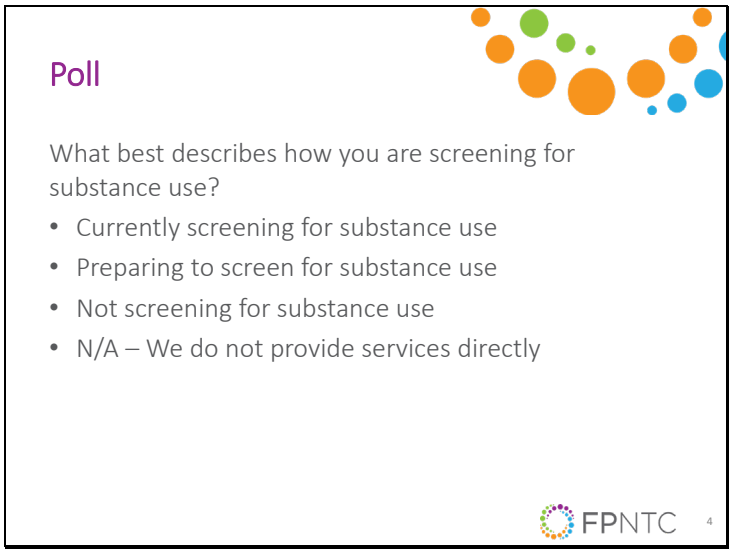


Describe the importance of screening for substance use in a family planning visit. Identify two strategies to address the substance use needs of clients. Identify one strategy described by a peer that could be used at your agency or site to implement and/or enhance screening for substance use.

Slide 4



Before we begin, we wanted to see where folks were at with regards to screening for substance use. Please take a minute to answer this brief poll. Are you: Currently screening for substance use? Preparing to screen for substance use? Not screening for substance use? Or, not applicable, we do not provide services directly

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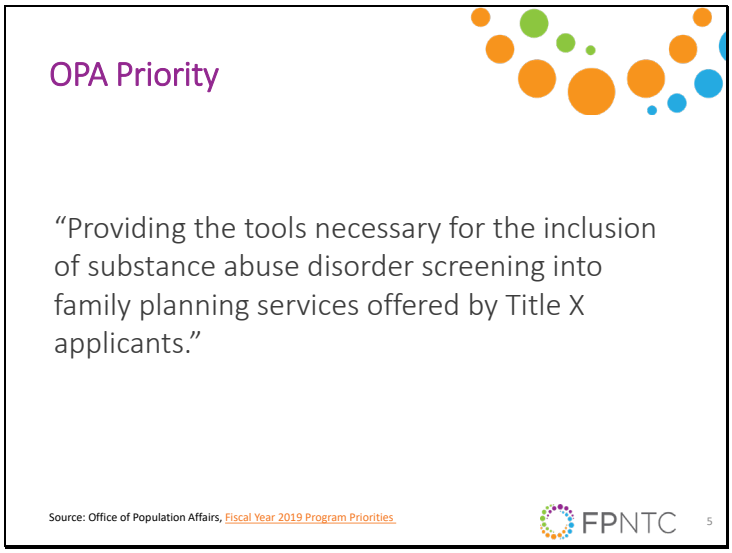

Screening for substance use is a key issue fiscal year 2019. Specifically OPA prioritized screening and applicants in 2019 fiscal year were asked to document how they would address screening. The language about screening is on the slide.

Source:
Office of Population Affairs, Fiscal Year 2019 Program Priorities (https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/program-priorities/index.html#:~:text=The%20FY%202019%20key%20issues,merely%20the%20absence%20of%20disease.)

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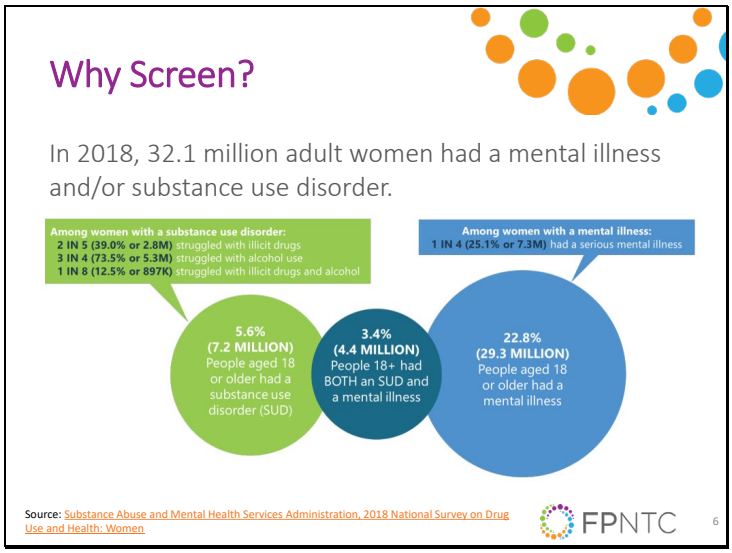

There is a lot of data around the rates of substance use and mental health across the US – substance use and mental health needs are increasing. We've seen increases in opioid use related overdose deaths (prescription and illicit). The data on the slide is from SAMHSA or the Substance Abuse and Mental Health Services Administration from their 2018 National Survey on Drug Use and Health. This data is specific to women. Of note, 32.1 million adult women had a mental health illness (or challenge) and/or substance use disorder. We are also in the midst of a collective trauma and many experts are anticipating a rise of substance use and mental health needs – from the mental health risks due to social isolation and more. Here's a recent Kaiser Family Foundation article about this from April 2020: The Implications of COVID-19 for Mental Health and Substance Use (https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/)

Source:
Substance Abuse and Mental Health Services Administration, 2018 National Survey on Drug Use and Health: Women (https://www.samhsa.gov/data/sites/default/files/reports/rpt23250/5_Women_2020_01_14.pdf)

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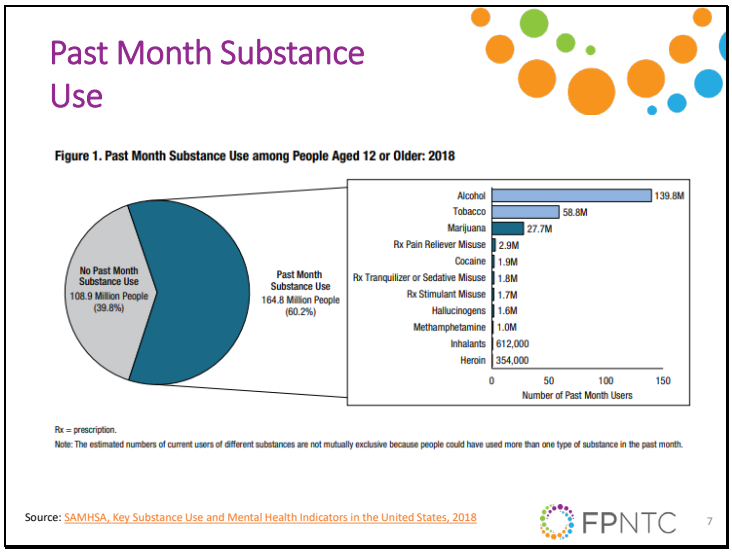

Data on substance use indicates about 60% of Americans aged 12 and older used a substance in the past month. The three most common substances individuals reported using included alcohol, tobacco, and marijuana. Alcohol use in the past month refers to having more than a sip or two from any type of alcoholic drink (e.g. can/bottle of beer, glass of wine or wine cooler, shot of liquor, or mixed drink with liquor). Tobacco includes cigarettes, smokeless tobacco, cigars, and pipe tobacco. Note that the total number of past month users exceeds the 164.8 million people who used substances due to polysubstance use – or using more than one substance. Responses are not mutually exclusive. While these may have been the three most common in 2018, we know that in many communities that Title X serves, including for a couple of our presenters on this webinar, prescription opioid misuse and heroin use are significant issues.

Source:
SAMHSA, Key Substance Use and Mental Health Indicators in the United States, 2018 (https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf)

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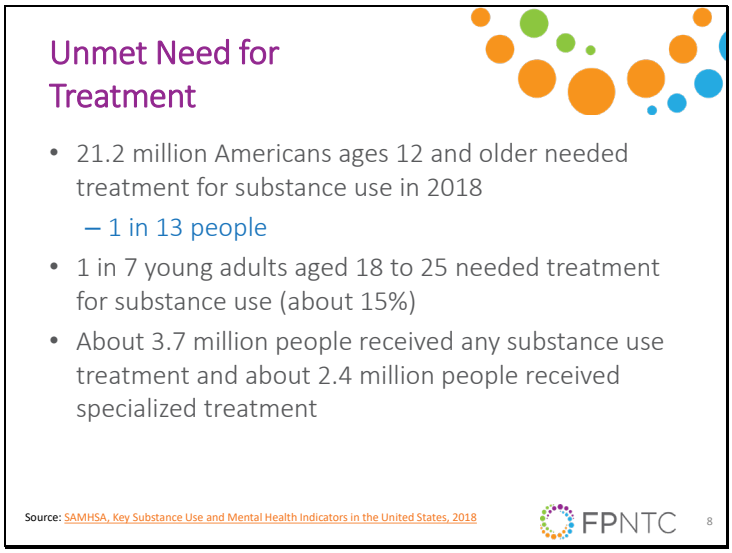

While data is from 2018, the need for treatment is increasing from prior years. Data from 2017 was 20.7 million Americans, in 2018 this was 21.2 million Americans.Screening is important as there is a significant unmet need for treatment across the US. SAMHSA estimates 21.1 million Americans 12 and older needed treatment for substance use in 2018. This is about 1 in 13 people. And for young adults aged 18-28, there is a greater need for treatment – about 1 in 7 young adults or about 15% of the population.

Source:
SAMHSA, Key Substance Use and Mental Health Indicators in the United States, 2018 (https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf)

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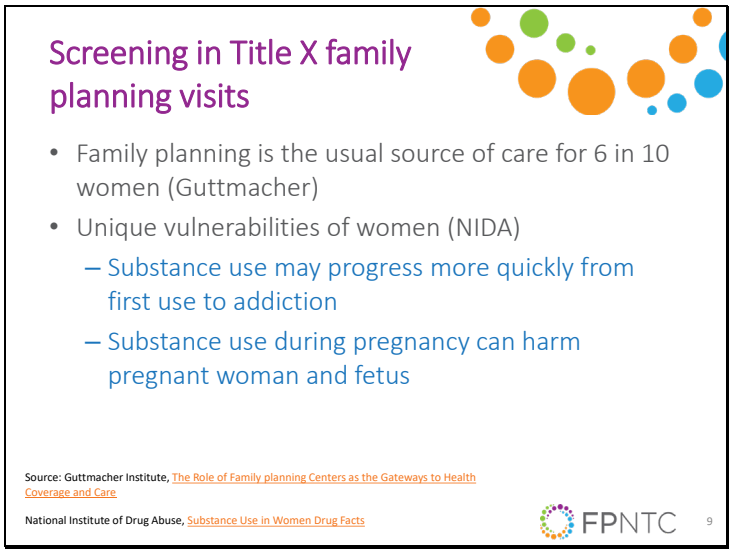
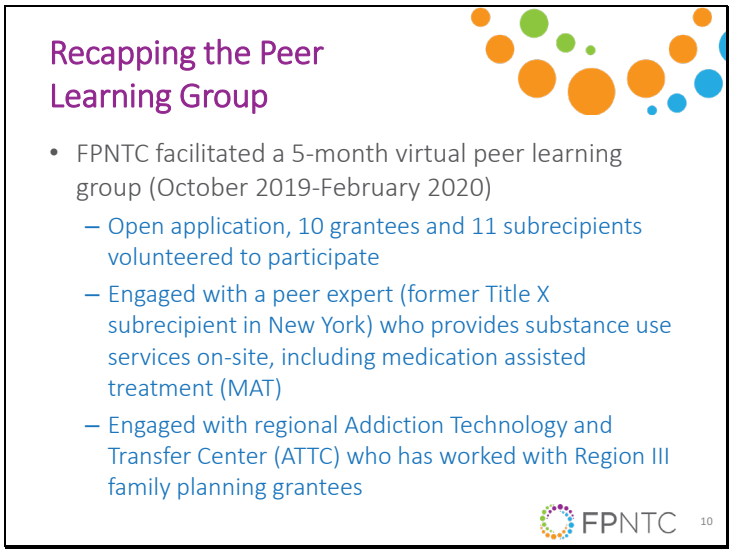


Family planning is the usual source of care for 6 in 10 women (Guttmacher). As many of the folks on this webinar know, Title X agencies are the usual source of care for 6 in 10 women. This may be the only health care clients access. Unique vulnerabilities of women: The National Institute on Drug Abuse and many other scholars note unique issues around substance use specific to sex and gender. These may differ (sex) based on biology or gender (differences based on cultural norms and role). A few things to note: Substance use may progress more quickly; from first use to addiction – while women often use smaller amounts of certain substances to; Substance use during pregnancy can harm pregnant woman and fetus – when a woman uses some drugs during pregnancy, the baby can go through withdrawal after birth. This is called neonatal abstinence syndrome (or NAS) and you will get to hear more about this from a grantee shortly. I want to also mention our sister training center, the National Clinical Training Center for Family Planning hosted a three-part webinar series about substance use and family planning settings. We have linked the series at the end. The webinars go into greater detail on some of the unique sex and gender differences specific to women when it comes to substance use. I encourage you to listen to those great archived webinars.

Sources:
Guttmacher Institute, The Role of Family planning Centers as the Gateways to Health Coverage and Care (https://www.guttmacher.org/gpr/2011/06/role-family-planning-centers-gateways-health-coverage-and-care)

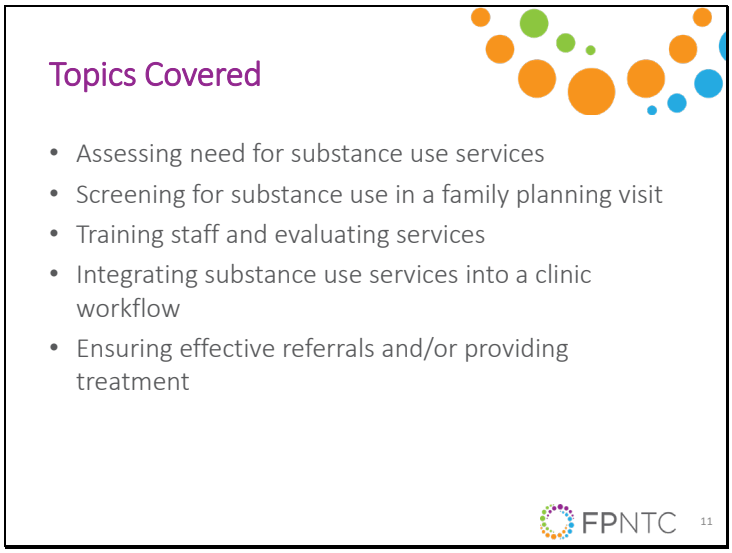
National Institute of Drug Abuse, Substance Use in Women Drug Facts
(https://www.drugabuse.gov/publications/drugfacts/substance-use-in-women)

Slide 10



The FPNTC facilitated a 5-month peer learning group with 10 grantees and 11 subrecipients across the country to discuss and operationalize screening for substance use in family planning visits. We engaged a former Title X subrecipient who is not only screening all clients for substance use but also went through the DEA MAT waiver process and is providing onsite MAT as needed. We also engaged a regional Addiction Technology Transfer Center funded by SAMHSA who has worked with Title X grantees and subrecipients in Region III on integrating screening for substance use.

Slide 11



In the peer learning group, we approached substance use services holistically and acknowledged for many grantees and their network the need for services varies, as you'll hear from some of our panelists today. While our focus was on screening for substance use and the steps needed to take and considerations necessary, we also talked about referring to treatment and providing treatment on-site. We talked about different screening tools, training staff and how to measure or evaluate services, workflow changes, and referrals to treatment.

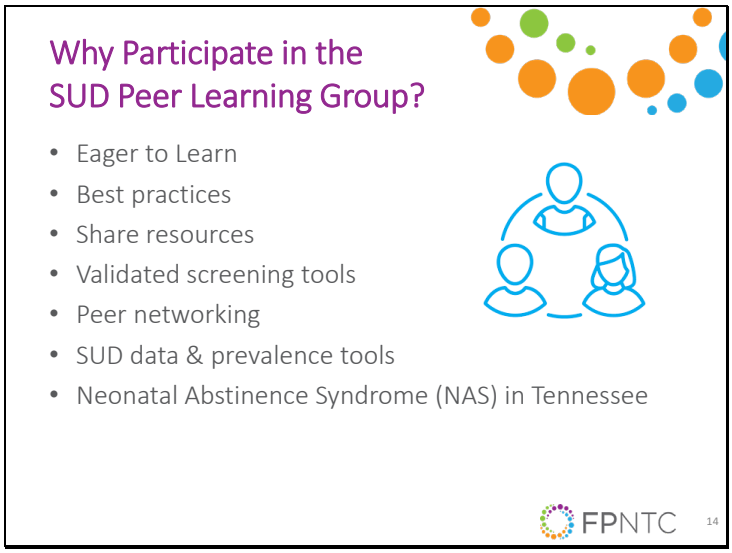
Slide 12

At this time, I want to introduce our first panelist today, the Tennessee Department of Health, where they will talk about the neonatal abstinence syndrome work and how they will take what they learned in the peer learning group and integrate screening for substance use in their network. Let me introduce our speakers from the Tennessee Department of Health.

Slide 13

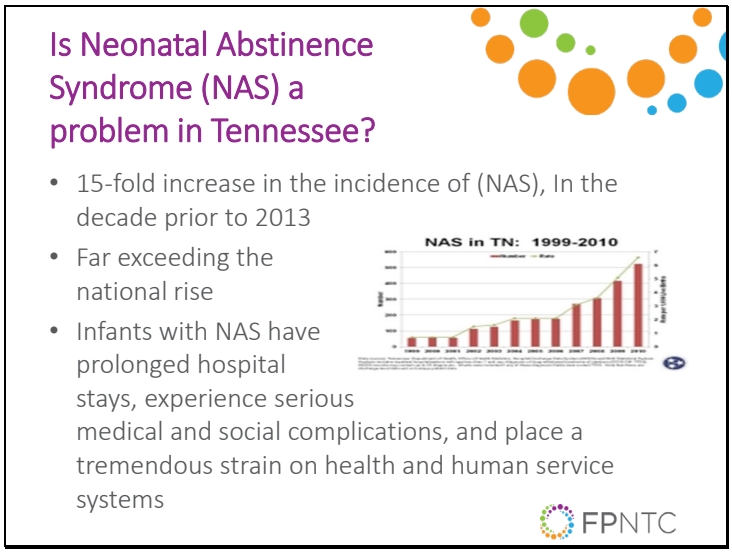
We have Danni Lambert and Sasha Foust on the line, and Danni Lambert is a registered nurse and the Tennessee State family planning director. The Tennessee family planning program consists of 124 Title X sites and has been a grantee for nearly 50 years. Since she began working with the Department of Health in 2006, Danni has taken an active role in working to protect and promote and improve the health and prosperity of people in Tennessee. Danni has always been a strong family planning champion, who believes in and actively supports family planning and adolescent reproductive health. Additionally, Sasha Foust is a registered nurse and family health and wellness director for the East Region at the Tennessee Department of Health. She has a passion for family planning and all programs involved in family health and wellness. She enjoys working with the community to provide these many services in the health departments and community partners. Sasha has been with the Department of Health since 2014. Beginning as a public health nurse in 2014, Sasha knew she had a passion for empowering clients to have an active role in their own reproductive health. Danni and Sasha, it's my pleasure to turn it over to you.

Slide 14



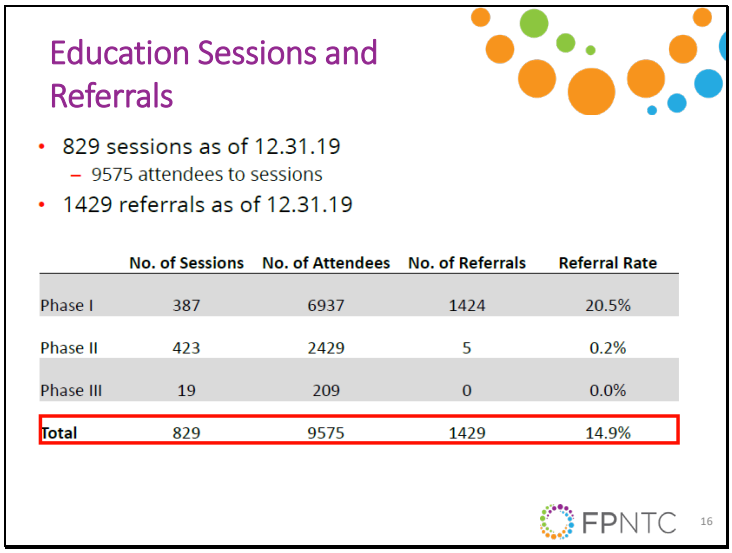
Danni Lambert: In Tennessee, we chose to participate in SUD peer learning group because we were eager to learn what other states were doing to combat substance use and abuse. Like many of you, our numbers have been steadily rising, and anything we could do to help decrease that, even one death, we felt it was worth it. We hope to learn best practices as far as screening and learn about validated tools while we were screening use. It could be cumbersome and referral process really took a lot of time for providers and nurses. What we learned the most about was all the resources that were shared by all of our peers in this learning group. What we found most valuable was just that. Our peers, people in our same roles in other states were able to share what they had learned and what worked and what didn't work. We learned how to find data and tools to help us meet our goals. We were unsure on whether or not we should participate in peer learning group, because we were afraid of the amount of time it would take away from work to participate. But just let me know go off to the side a second. If you get an opportunity to participate in one of these peer learning groups, I highly recommend it. We learned a lot, got a lot of tools, and what I found most valuable was the camaraderie and learning that we weren't out there dangling by ourselves, that the problems we were having, other people were having and you were able to make some really strong connections and networking. One of our major problems was neonatal abstinence syndrome or NAS as I'll refer to it. That's when an infant is born dependent on a drug because mom used while she was pregnant.

Slide 15



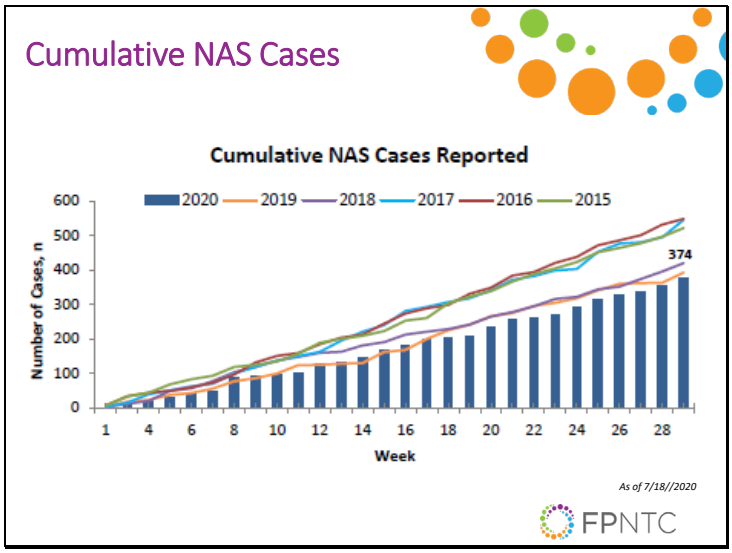
The Tennessee Department of Health (TDH) developed a Primary Prevention program for local health departments to provide education about the risks of Neonatal Abstinence Syndrome (NAS) and family planning options to reduce unintended pregnancies among women who use substances. Subcontractors choosing to implement this activity have an opportunity to provide prevention education and public health services in settings outside of the health department. Subcontractors will use available public health data to identify high-risk populations and develop targeted outreach plans. TDH Family Planning resources and technical assistance are available for localities interested in implementing this initiative.

Slide 16



Sasha Foust: And as you can see on the referral rate, around 20% of the referrals came into our health department for family planning, long-acting contraceptive services. And then while we offer these services, we educate our clients on the many services we do offer, including family planning services, STI screenings, immunization, and tobacco and substance use screenings. And I might add, we don't coerce clients to receive any birth control methods, however we encourage them to think about their reproductive life plan and what that looks like in their life. So working with the criminal justice system and the community partners, it's just opening an a door to empower and to work together in the substance use screening world, and working to decrease NAS cases together.

Slide 17



How we are meeting the substance use needs of our family planning clients. How we have taken what we learned with your NAS work and integrated screening into family planning visits. TN Together https://www.tntogether.com/. The TN Together campaign is a statewide effort to impact the state's opioid crisis through messaging, information, and inspiration. Media Campaign Primary messages: Addiction is a disease, not a moral failing; Addiction is a community issue that affects everyone; Everyone can contribute to help end the crisis; Substance abuse treatment resources are available; People of all walks of life are living in long-term recovery; Television and Digital Video Ads; Count It! Lock It! Drop It!; Family Recovery Stories; Teen PSA Video Competition; Faces of Addiction; NARCAN Trainings The Tennessee REDLINE (1-800-889-9789) is a toll-free information and referral line coordinated by TAADAS and funded by the Tennessee Department of Mental Health Substance Abuse Services. The purpose of the REDLINE is to provide accurate, up-to-date alcohol, drug, problem gambling, and other addiction information and referrals to all citizens of Tennessee at their request. The Redline provides referrals for Co-Occurring A&D disorders that arise along with Mental Health disorders.Laws and Policies: Prescription Guidelines – Graphic Summary; The Need for Opioid Prescription Limits; FAQ for Prescribers and Dispensers; Buprenorphine Treatment Guidelines; Pain Management Guidelines for Medical Practitioners; Naloxone; Public Chapter 1039; Public Chapter 1040. Services: Faith-Based Initiatives; Help for Court Issues; Housing & Homeless Services; Oxford Houses.

Slide 18


FPNTC
FAMILY PLANNING
NATIONAL TRAINING CENTER
Insights from Working in Behavioral Health:
Applications for Title X Agencies
Family Planning Center
of Ocean County, NJ
18

Slide 19

Caitlin Hungate: Our next panelist is from the Family Planning Center of Ocean County, New Jersey, a subrecipient agency in New Jersey. Our speaker today is Gina Polese-Grosso, and she is the CEO and president of the Family Planning Center of Ocean County. She is also a certified school social worker, a licensed clinical social worker, and a certified clinical supervisor in social work. Gina has served and continues to serve on the Central Jersey Family Health Consortium, Ocean County Children's Interagency Coordinating Council, and many other committees and boards throughout the community. She is a board member of Ocean Partnership for Children, serving as the president, HR chairwoman, and member of the executive committee. Gina, it's my pleasure to turn it over to you.

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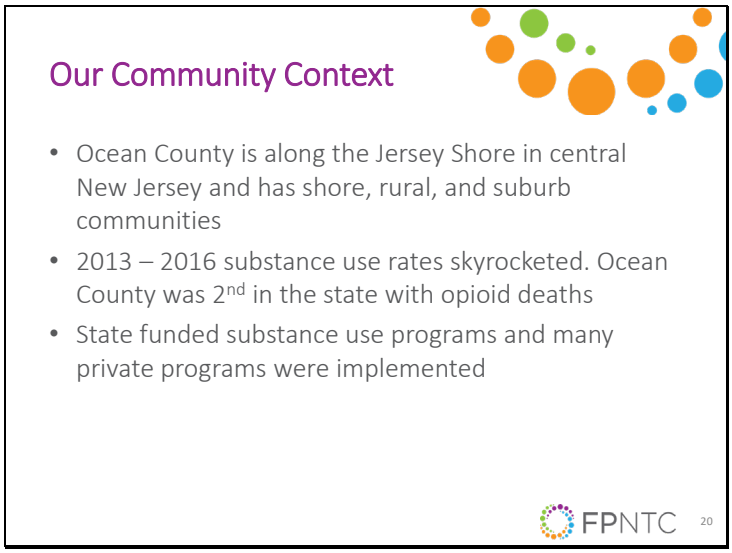
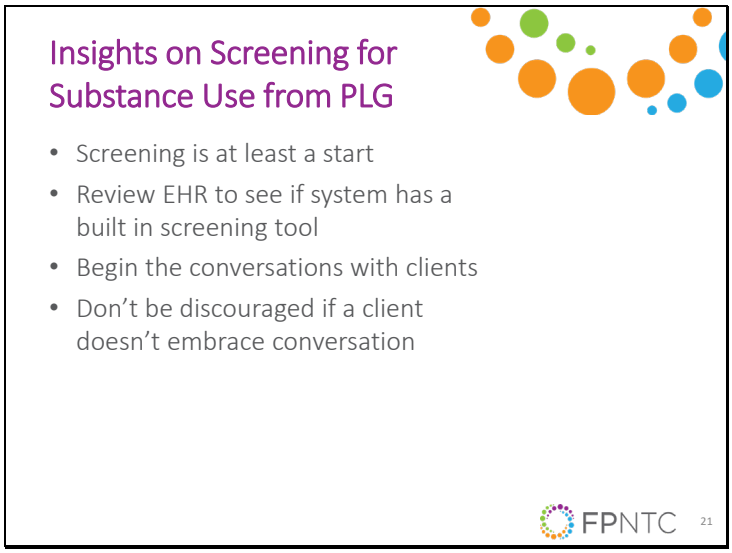


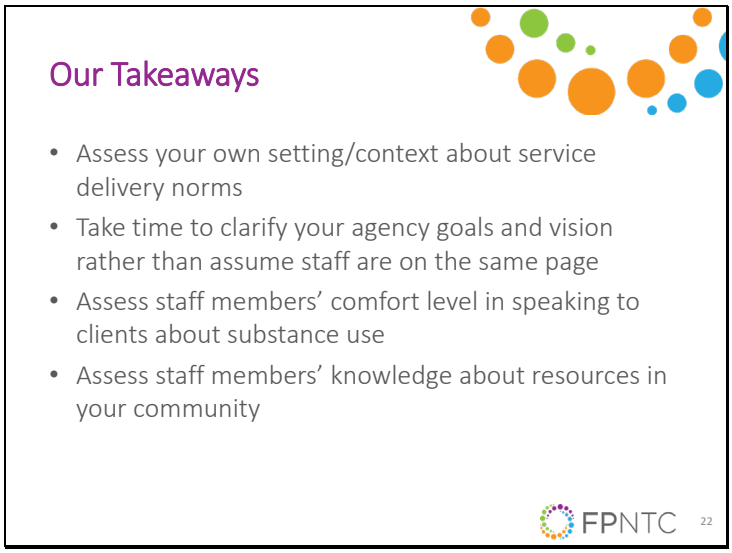
Gina Polese-Grosso: Thank you, Caitlin. And hi, everyone. New Jersey consists of 21 counties, with the urban areas near New York City, which is well north of Ocean County. We're located along the Jersey shore in the central portion of the state. And we're the fastest-growing county in the state. Ocean County consists of shore, rural, and suburb communities, not the stereotypical type that you would think of in the past, being an epicenter for drug use. 2013-2016, substance abuse rates skyrocketed in Ocean County, and Ocean County ranked 2nd in the state with opioid deaths. We were in a real crisis. Due to this, the state funded substance abuse programs and many private substance use programs were immediately implemented to combat this crisis. So for us, meaning us, Family Planning of Ocean County, brief intervention and screening intervention and referrals to treatment with a warrant hand-off when needed, is an appropriate position for our family planning in our county.

Slide 21



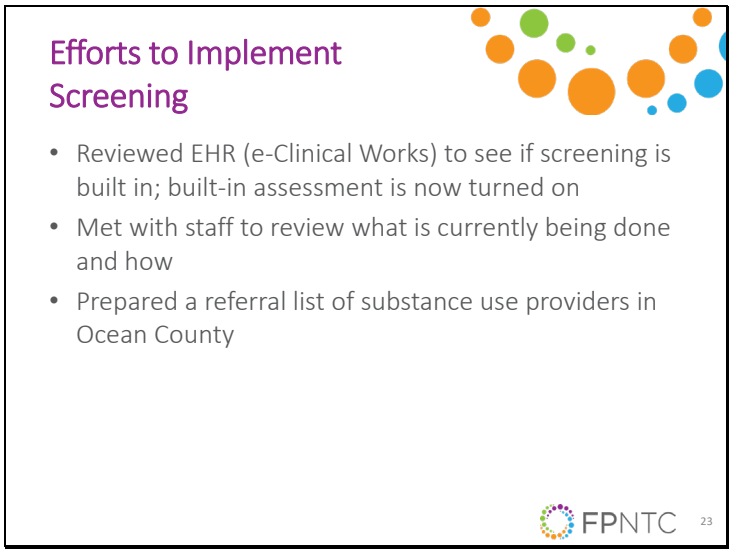
Gina Polese-Grosso: Some insights. Screening is at least a start, even the most basic screening. I personally don't use the EHR, so I needed to review it to see if the system has a built-in screening tool, which it does. You may have one and it may not be turned on, so that's something to look into, which I did then. In beginning the conversation with your clients, with patients, just to see if there's concern. That's really key and first step. Don't be discouraged if the patient doesn't embrace conversation or even admit to an issue. At least introducing the possibility of an issue is a first step. The patient might give some thoughts or be more open to discussion in the future or even the possibility of treatment.

Slide 22



Gina Polese-Grosso: Some takeaways. Assess your own setting, context about service delivery norms. It's important to assess your own paradigms for that service delivery norms. For me, coming from a behavioral health background, I found that what I feel is first nature to me was not first nature for my staff. So take time to clarify your agency's goals and visions, rather than assume staff are on the same page. Assess staff members' comfort levels in speaking to clients about substance use, and assess members' knowledge about resources in your community.

Slide 23



The Family Planning Center of Ocean County uses e-Clinical Works for its electronic health record. This program has a built in assessment that has been turned on. It begins with simple questions and utilizes drop downs when indicated. Every patient is screened with this tool and it is required in order to move forward during the intake. I met with staff and reviewed what they are doing and how they are doing it encompassing the screening tool; their comfort level; how they approach their patient with their findings; and how familiar they were with the resources available in our community. I prepared a list of Ocean County's Substance Use Providers for the patients that will be handed out with other information that is routinely handed out.

Slide 24

Thirty-five years at the same behavioral health organization starting as a mental health aid, went to therapist, to program director, to Vice President of Children's Service, and to Chief Operation Officer of Children's Services. Duties: designed programs with a mental health and substance use focus, proposal/grant writing, implementation and program supervision. Supervised and coordinated the provision of the behavioral health, substance use, social services, childcare centers and in-home services ranging from parenting skill to crisis intervention. In today's environment of comprehensive healthcare, screening is crucial for all health facilities in caring for their patients. From my perspective as a CEO, if considering moving into substance use treatment, assess the community for the need, and any organizations doing at least some of this work. It might be more beneficial to partner rather than competing and starting up a new program. Collaboration and partnerships are key.Participate in as many community boards and committees as you can.Lend your services to other organizations as much as possible.

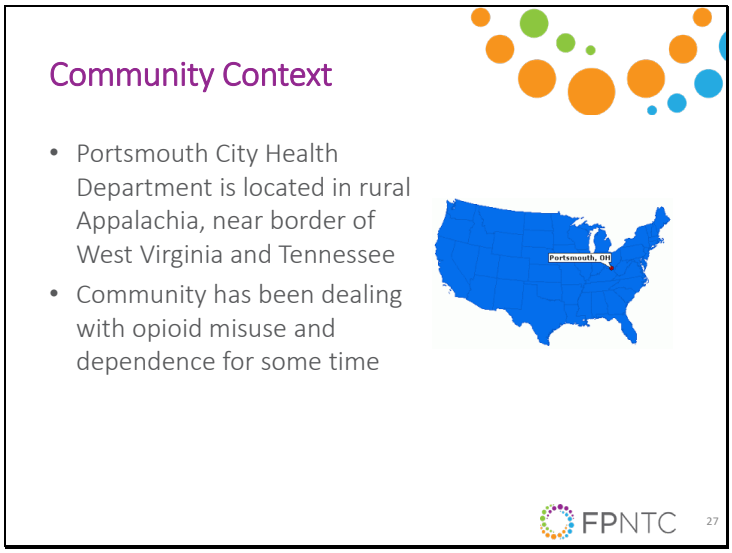
Slide 25

Caitlin Hungate: Thank you so much, Gina. Our third and final panelist is from the Portsmouth City Health Department in Ohio, a subrecipient agency in Ohio. And our speakers today from Portsmouth are Tiffany Wolfe and Elyse Waugh.

Slide 26

Caitlin Hungate: Tiffany Wolfe has a Masters of Science in Nursing from the University of Cincinnati. She has been with Portsmouth City Health Department for eight years now. Elyse Waugh has a Masters of Science in Criminal Justice from the University of Cincinnati. She obtained her Chemical Dependency Counselor Assistant license and has been with the Portsmouth City Health Department for a year. Tiffany and Elyse, it's my pleasure to turn it over to you.

Slide 27



Tiffany Wolfe: Hi. Thank you, Caitlin. I'm just going to go over the first bullet. Portsmouth City Health Department is in rural Appalachia. Located on the Ohio River and directly borders northern Kentucky or South Shore Kentucky. Portsmouth is located in Scioto County, which is one of the 88 counties in Ohio. Our total population is around 77,000 and our median age is around 39. Approximately 71,000 are white and about 2,000 black. Poverty rates in Scioto County is 24%. Nine percent of our population is between the age 18 and 24. Twenty-eight percent of our population is age 25-44, and 22% is around age 45-64. Community has been dealing with opioid misuse and dependence for some time. Approximately 63% of overdose deaths are between ages 25 and 44 years old. The highest growing rate of overdose and opioid abuse disorder is in females across the country and in Scioto County. The most recent statistics reported 80 deaths in the last year, which ranks Scioto County for the most overdose-related deaths in Ohio, followed by Gallia County, Pike County, which is our neighboring counties. The most current threat from 2019 to 2020 fiscal year data suggests that Scioto County's death rate is the highest annual death rate reported by any Ohio county ever, even higher than during the heart of the carfentanyl and overdose surge in 2016 to 2017. The cause of the surge of the 2019 to 2020 is not 100% clear, but out of all the deaths recorded so far, 86% involve fentanyl or fentanyl analogs. The biggest picture of the overdose death toll and opioid abuse epidemic for 2019 shows no evidence how the drug overdose catastrophe is receding. This is the largest and fastest growing number of deaths and addiction rates of our females. Females represent the fastest growing group at risk for fatal prescription overdose across the country. This group also leads the way in the most unintended pregnancies. A recent report by the Children's Defense Fund finds that Scioto County has the highest birth rate of drug-addicted babies in the state. The report also explains that 76 babies out of every 1000 births in the county are born with neonatal abstinence syndrome, as Tennessee went over earlier. Another heartbreaking fact is a

public servant services issue and has reported children born to mothers addicted to opioids accounted for nearly one-third of all children in custody. Those children in custody are also struggling with many health care needs, physically and mentally, which also are very costly. A study from the CDC reports women who use opioids just prior to pregnancy or in the first trimester were twice as likely to have a baby born with a heart deficit. These children are born with major health care issues, mentally and physically, which in turn, causes them to be left behind from their peers. Frequently, these babies also turn to substance abuse due to the situation they were born into. This cycle has continued to rise since the 1980s, and I predict if substantial interventions are not done, we will continue to grow and reach other parts of the country as well, as we have seen in the past few years. Our community has been dealing with opioid misuse, independence for many years. The inventor or founding father of the term "pill mill" was developed by a Dr. David Proctor in 1979, just five minutes south of Portsmouth, which is in South Shore, Kentucky. The term "pill mill" is typically used to describe a doctor clinic, prescribing or dispensing controlled prescription drugs inappropriately. Dr. David Proctor is also well-known for what's called the "Portsmouth cocktail," or a deadly combination of Xanax and Oxycontin. Dr. Proctor treated other physicians over the years and some of them moved to Portsmouth and other cities to open their pill mills. Another doctor, Dr. John Willey, opened a profound pill mill in 1999, which he wrote thousands of opioid pain prescriptions in a period of three years. Dr. John Willey wasn't in practice very long due to other criminal activities, but as soon as his clinic shut down, Dr. Paul Workman relocated from Chicago to open up a pill mill in Scioto County. In 2004, Dr. Workman ordered 457,000 oxycodone pills, the most of any doctor in the nation that year, according to DEA reports. He also made patients sign a form saying that they were not undercover police officers or other informants. More than a dozen of Dr. Workman's patients died, which is why he is now serving four life sentences in the federal penitentiary. One other key physician is Dr. Margaret Temponeras, who wrote 1.7 million opioid prescriptions between 2006 and 2012. These doctors typically made around $350 cash for each patient visit, and this is why despite the ongoing investigations and charges, pill mills continue to open in Portsmouth and surrounding areas. Although there were more than eight major pill mills in or near Scioto County, in the Portsmouth area, today's pill mills are gone but we are still struggling with the aftermath. Now that there is no pill mill, the drug of choice is a mixture of heroin and fentanyl. The consequences have caused great damage to our community, and we continue to strive to correct the situation.

Slide 28

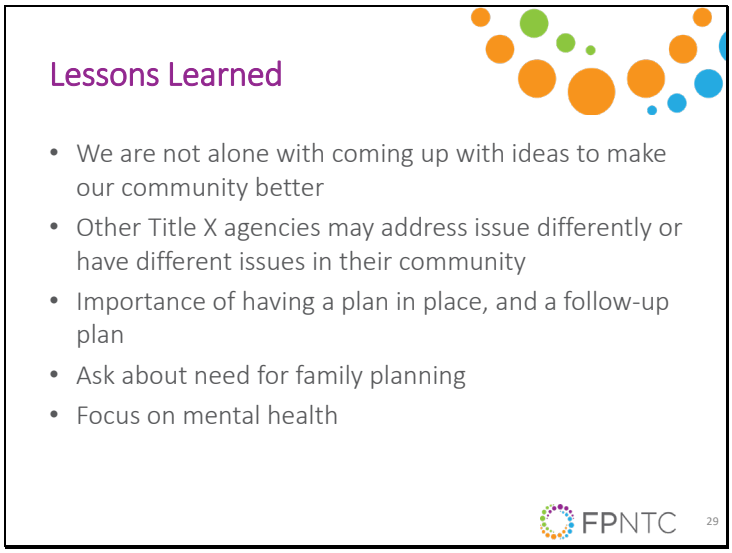
Tiffany Wolfe: We provide family planning services for anyone of reproductive age, including NEXPLANON, IUDs, and all other forms of contraceptives; testing for infectious diseases, including STDs, Hep-type A, B, and C, HIV; PrEP provider for HIV prevention. Prep, as in, pre-exposure prophylaxis program, and provides daily medication to prevent HIV transmission in the high-risk population; and we offer condoms five days a week to our community without the need of an appointment. Many patients are also encouraged to take advantage of our primary care services, Ryan White HIV program, children with medical handicaps, child and adult immunizations, child care seat program, and Project DAWN, a naloxone overdose death prevention program. Each of our family planning patients are screened for substance abuse and we refer them to our Recovery Gateway program for further supplemental treatment needs. Due to the sensitive context of our screening, we try very hard to approach each individual with a non-judgmental, holistic type care. We start off by telling each of our patients that their visit is totally confidential. Explain to the patient that we are a guest in their life, and we are not here to judge them, and we are just here to help. Tell them we are concerned with risky lifestyles and behaviors, but we are not here to reprimand them for those actions or force our views upon them. Help guide them to a healthier lifestyle. Explain that we believe there is no perfect person in the world, and we all make mistakes. We further explain to them our job here is to help them heal with a treatment plan that best meets their needs. We try not to even force our treatment plans upon them. We believe everyone should be treated with respect and dignity, regardless of their past, sexual preference, socio-economical status, or current mistakes or failures. This is how we help develop trust with our patients. Some of our patients may not completely trust us on their very first visit, but most remember our kind words and frequently return for our drug treatment programs, STD treatments, or other services that can sometimes be uncomfortable to obtain care for. I do see a lot of family planning patients who didn't quite admit on their first

visit, or even second, that they had a substance abuse problem return to our clinic for Vivitrol treatment or the use of the Recovery Gateway services. Our Vivitrol treatment is the 28-day opioid or alcohol blocker, in which they cannot use opioids or alcohol on top of, or else it causes severe side effects and is non-addictive and habit-forming. Scioto County is located in what is called the Bible Belt area. Religious views, which are usually associated as a wonderful community aspect, has also involved a culture that has shied away from talking about family planning and substance abuse. Substance abuse problems have a tendency to produce crime and hate in the community, which develops stigmas. These stigmas seem to be changing over the years with multiple organizations in the community striving to change. Many of our local churches have addressed this issue and now reach out to those with substance abuse problems and offer counseling and other programs to them. Outreach programs have been developed in which we attend events such as the county fair, festivals, or other large gatherings. In the past, we were not encouraged or allowed to discuss family planning or substance abuse at these events. Now our community organizes parades, fundraisers, walk/runs, to help educate and fund substance abuse treatments and bringing awareness to this community, not only for that but family planning as well. There are still some people in our community that are outraged by our intent to change the stigma and increase awareness, but we feel education and community awareness will triumph in the end.How do you connect the dots between family planning needs and substance abuse, if at all? We have many programs here at the Portsmouth City Health Department. Because we try to do holistic type care, we noticed that primary care and family planning was highly utilized by our substance abuse patient population. As time went on, and we developed a stronger trust base with our patients, we noticed family planning patients returned for substance abuse treatment. Like I've said before, a large majority of the patients are female, which is the largest growing population in the opioid use disorder and overdose death in our country. In addition, we have an alarming and increasing number of unhealthy babies born to opioid-addicted mothers who did not plan on starting a family. Therefore by combining these programs, we have helped women and men make sober, healthier decisions about their futures and family plans. Furthermore, most of our substance abuse patients, male and female, have multiple mental health care needs. They usually put off treatment due to bad stigma they receive in most health care settings, which is strange to me, honestly, because health care workers should be educated enough, in my mind, to realize that substance abuse is almost always originated from mental health disease. The brain is an organ, just like the heart or kidneys. Why do we treat a cardiac patient any different than somebody with a mental health disease or problem with their brain? Family planning is not about preventing pregnancy, treating STDs. Family planning is overall health of an individual, their family, and preventing disease and negative health care outcomes. With strong family planning, with strong families, we build strong communities.

Elyse Waugh: Recovery Gateway is a public health navigation program here at the Portsmouth City Health Department. It serves as an access point for high-risk individuals seeking help for addiction treatment, harm reduction, or any other medical or social services. Regardless of where an individual may be in their personal recovery, we will guide them in the right direction that we feel is fit for their needs. We assist with applying for medical insurance; we have all of our linkage to care for treatment services; we just started our new program, called the Early

Intervention program. It's with our prosecutor here, and basically it's a way to help individuals extinguish non-violent criminal charges. By completing this program, the individual will have their charge forgiven from their record. We also incorporate the Thinking For a Change, which is a cognitive behavioral curriculum developed by the Nashville Institute of Corrections, and it basically concentrates on changing the criminal thinking of the offender.

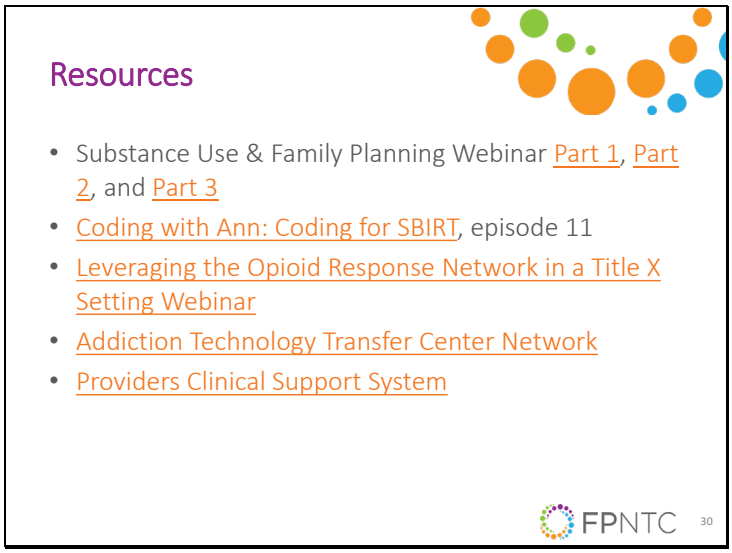
Slide 29



Tiffany Wolfe: We are not alone with coming up with ideas to make our community better. We have made partnerships with almost all the drug detox programs, rehab facilities, and hospitals in our area through our County Health Coalition. The County Health Coalition was developed by our health commissioner, Chris Smith, who developed a community partnership to promote optimal health in our communities. They meet once a month to discuss and plan for ways to meet health care needs in our community. Other Title X agencies may address issues differently or have different issues in the community. We are different than most, or majority, of Title X agencies, in that we have a large population of substance abuse, which is kind of growing across the country. Unintended pregnancies, teen pregnancies, and children in foster care. We learn to adapt to our community needs along with incorporating family planning services, despite this overwhelming health care crisis in our community. Plans are very important, because it helps you identify goals that your team wants you to achieve. Our team develops plans based on our current health care crisis in ways that we thought would best intervene and make an impact. Our views and needs were out of the ordinary, and therefore a lot of our plans changed along the way, where we learned by trial and error. We were sort of like an experimental site for the entire state at the time when we started these programs. We found that the plans may change, but if we focus on our goals and move forward despite our struggles, eventually our goals will be reached along the way. And we just grow and learn. We learned while treating substance abuse patients there was a huge need for family planning. Most of our patients with substance abuse have very dysfunctional families and relationships. Also a majority of our patients had children who were in foster care and who would benefit from future family planning service to prevent some of this from occurring. In addition, patients with substance abuse disorder have very risky lifestyles with multiple partners, sexual partners, and also exchange sex for drugs or money to support the addiction. Most patients made these bad choices while intoxicated or

suffering the effects of substance abuse withdrawal syndrome, which distorts their decision making dramatically. We took note of these issues and started offering family planning services to these patients while they were sober and able to make better decisions for themselves and their family's future. I highly encourage Title X agencies to include mental health screenings for their patients with substance abuse. The majority of the patients who have this disorder, as pointed out previously, have self-treated their mental health disorder. These patients who turn to substance abuse are trying to cope with emotional or mental pain or trauma. And when mental health issues are found, it's best to have a plan in place to assist or refer these patients to mental health care treatment facilities, out-patient, in-patient, whatever. You just need to develop that rapport with the agencies around you. Reach out, email, call, text, whatever you've got to do. Also you need to be prepared for those who may come into your clinic that are suicidal, and what actions are you going to take then? Do you have a suicide prevention in mind? Do they go to their local ER? You've got to have a plan in place or a policy in your clinic. We usually train our peers with on-site training. We allow them to observe and review our policies and procedures to get them started. We're also available to them by phone, email, text, when they encounter any problems that arise. We're happy to guide them and help them in any way we can. And all of our staff is usually trained from billing to the front desk, so we kind of match each person in either the peer clinic or someone in ours, so that everybody's trained from, like I said, billing to front desk to whatever it may be. Our major training success is focused on lowering stigma, and reminding them that addiction treatment is uncomfortable for those patients but the reward from helping someone recover from addiction is beyond comprehension. It not only helps the individual, but the community in the long run, so you have to keep that in mind. We also teach them to treat every single person like they're your child, mother, father, sister, because they are someone's same close family member, and we have to embrace that and treat them as such. Every life is worth saving.

Slide 30

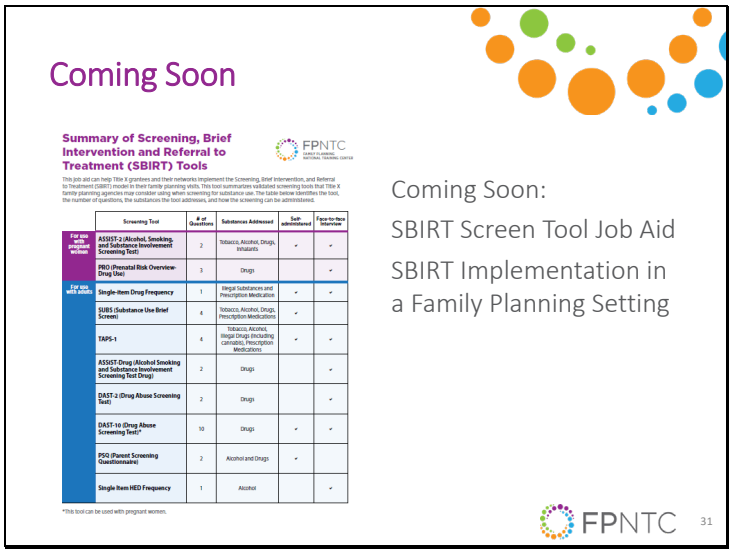


Caitlin Hungate: Thank you to all of our presenters. On the slide we have several resources that are now available to support Title X grantees and their network with integrating screening for substance use. The first is an archived webinar series from the National Clinical Training Center for Family Planning. Second, is a Coding with Ann episode specific to SBIRT. Another resource from the National Clinical Training Center for Family Planning is a virtual coffee break (shorter webinar) discusses the Opioid Response Network, which provides training and technical assistance for addressing substance use disorder in all types of settings, including in family planning settings. The Addiction Technology Transfer Center network, is comprised of a national and regional TA centers. We partnered with the Region III to implement the peer learning group. We recommend looking into the ATTC in your region for events, tools, and resources. Additionally, the Providers Clinical Support System is a resource to inform and educate medical professionals and funded by SAMHSA in response to the opioid overdose epidemic to train primary care providers in evidence-based treatment and prevent of opioid use disorders. There are a lot of great on-demand resources!

Resources:
Substance Use & Family Planning Webinar Part 1 (https://www.fpntc.org/resources/substance-use-family-planning-webinar-part-1), Part 2 (https://www.fpntc.org/resources/substance-use-family-planning-webinar-part-2), and Part 3 (https://www.fpntc.org/resources/substance-use-family-planning-webinar-part-3)
Coding with Ann: Coding for SBIRT, episode 11 (https://www.fpntc.org/resources/coding-ann-coding-sbirt-episode-11)
Leveraging the Opioid Response Network in a Title X Setting Webinar (https://www.fpntc.org/resources/leveraging-opioid-response-network-title-x-setting-webinar)

- Addiction Technology Transfer Center Network (https://attcnetwork.org/)
- Providers Clinical Support System (https://pcssnow.org/)

Slide 31



The FPNTC will soon be posting (or share it has been) a job aid adapted from the Danya Institute Inc., which runs the Region III ATTC. This job aid outlines different validated screening tools for SBIRT. Another resource that is coming soon and should be available during the National Clinical Training Center for Family Planning's virtual National Reproductive Health Conference August 11-12 is an SBIRT Implementation toolkit developed by the Danya Institute.

Slide 32

Caitlin Hungate: And at this point, we want to open it up. We have plenty of time for questions, and we wanted to open it up for questions. So please do. We've got a few in the queue, which we'll address, and then others, please feel free to send them in. The first question that we have in the queue is for Gina. Gina, this person is from the New York State Department of Health. And they're really excited about your work. In regarding partnerships versus providing in-house services, have you faced issues of clients who were lost to a referral? And how do you deal with that? And this person, Gina, for your reference, they work in a drug user health context and she knows a lot of case managers at syringe exchange programs that will refer clients to reproductive health clinics, but through a variety of barriers, the clients, it will keep them from going to the reproductive clinics on time or at all. So again, if you could speak to any issues of clients who are lost to a referral and how do you deal with that?

Gina Polese-Grosso: I'm going to speak both in my past life and in this life, in terms of where I used to work and where I work now. And I personally find it critical to follow up and to do it in the opposite direction also. And I believe that due to the strong relationships that I have with these other programs that everyone's very willing to work together. I live in an incredible county, and all the people on all the committees that I work with, everybody's willing to help each other out. And I've only been in family planning now til this past July. Well, now. Now. Three years. So what I did was, I reached out to all the substance use providers that I had worked with in my past life and offered to do family planning services right in their facilities. And I did that also by reaching out to the private programs also, and they were thrilled to have us come in.

Gina Polese-Grosso: So, for example, First Behavioral Health, where I used to work, we'd go in. We were going in once a week and offering services. So we would do health counseling and we would also offer STI testing, pregnancy testing. So the community providers loved it, and that's how we then also had some of their participants in their program come to us, because they were referring to us, plus they got to know about us. And I hope that answers your question.

Caitlin Hungate: Thanks so much, Gina. The next question we have is for Danni and Sasha. What advice do you have for other grantees who are looking to support their network, who may not provide direct services themselves or who may but are wanting to support their network in implementing screenings?

Danni Lambert: Well... This is Danni. Sorry. I would suggest following up on some of the tools that Caitlin has shared and find one that works best for that provider, and make sure they have a robust referral system in place. Here in Tennessee we have something called Tennessee Together. Please feel free to visit that website. It's tennesseetogether.gov. The patient, you can refer them even to a phone number, because often times, the first time you meet with that patient, they may still be in denial and not ready to progress on the road to recovery. But we have found that the fewer questions, the better when... I'm an old psych nurse too. The patient will come to you when they're ready if you are supportive. In Tennessee, we use the SBIRT model.

Caitlin Hungate: Great. Thanks so much, Danni. This question is to Elyse and Tiffany. As you are further along in the services provided within Portsmouth, what advice would you give for other Title X agencies that are just starting out?

Tiffany Wolfe: What advice would I give for just starting out? Basically to have plan in place and start at the front desk with your questionnaires. Make sure that every staff member is trained on questioning the patient about substance abuse. And have classes on stigma and how to combat that and gain trust from your patients, and encourage them to open up and return to the client and feel comfortable and safe discussing their issues with the staff. That's number one right there, is developing that patient relationship. You have anything, Elyse?

Elyse Waugh: No, you pretty much summed it up.

Caitlin Hungate: Thank you both. The next question, I'll take a shot at answering and then I would welcome the other panelists in answering or adding additionally to this question from a participant.

Caitlin Hungate: So the question is what triggered the change that now sees opioid usage to be a disease in suburban and rural areas, but was seen as a crime, especially during the crack era in the 1970s or 80s in urban areas?

Caitlin Hungate: So I think one of the biggest changes has been the evolving science and understanding addiction and it being an issue of the brain, and so for this user, I would highly

encourage checking out... I jumped back to the resource slide. The Substance Use and Family Planning webinar series covers some of that evolution as the science and understanding of addiction has changed over a period of time. So that's definitely a big component. I know that there's other issues and context that are in address, but that's certainly one of the biggest changes from 2020 to back in the 1970's and 80's. And then I would welcome if anyone from Tennessee or New Jersey or Portsmouth have anything else to add to that question.

Danni Lambert: Hey, it's Danni from Tennessee. For years, we've tried to get over this stigma of mental illness, and I really think that the pendulum is finally swinging the other way. And who amongst us doesn't know someone with a substance abuse problem? As one of my colleagues stated in her presentation, it's rarely just a substance abuse problem. There's usually something, a mental illness specifically, that goes along with that that led to the substance abuse. They're usually self-medicating. And I think the big change is it's so prevalent now. It's hard to say, "Oh, it's them," or "Oh, that only happens in big cities." Where I live in Appalachia, and we have one of the worst substance abuse problems in the United States.

Caitlin Hungate: Thanks, Danni. Gina or Elyse or Tiffany, would you like to weigh in as well?

Gina Polese-Grosso: I agree that it's so prevalent now. And I think that that is key here, because everyone is seeing it.

Caitlin Hungate: Thanks so much, Gina. So the next question is open to anyone. Which screening tools were used? Maybe we can start with Portsmouth, as you're further along in the continuum. Can you talk about which screening tools you used with clients in your health department? (silence) Elyse and Tiffany, if you can unmute your line and talk about the screening tools you used?

Tiffany Wolfe: Sorry.

Caitlin Hungate: That's okay.

Tiffany Wolfe: We were having a problem with our microphone there. Well, we did the brief intervention and referral to treatment, the SBIRT comprehensive screening in the beginning. We also do the clinical opioid screening, the COWS assessment screen test. We screen for anxiety and depression, the generalize anxiety screening test. What else do you do, Elyse?

Elyse Waugh: The harm reduction.

Tiffany Wolfe: The harm reduction, yeah. That's what I was trying to think of. The harm reduction screenings. Most of our patients that come in, especially if they admit to substance abuse in the past or even if the family's involved, close family members, we will have Elyse or one of our counselors go in and talk to them and touch base with them prior to leaving, if it's a family planning appointment. Anything else?

Caitlin Hungate: Great, thank you. And Gina, maybe I can turn it over to you. Can you talk more about the screening tools embedded in your EHR and if it's a specific tool and how many questions and is it validated? If you've been able to look into that.

Gina Polese-Grosso: You know, it is not one of the tools that we had spoken about. What we were doing or a peer learning group. However, when I looked at it, it's very comprehensive. I can't tell you how many questions are on it. As I mentioned before, the screening drops, so the answers... Or for lack of a better way of saying it, positive for possibly having an issue, then the next screen drops. And then if that comes up positive for an issue, then the next screen drops. It seems comprehensive, and it's something that we're using because it's in our EHR ready, and all we have to do is turn it on.

Caitlin Hungate: Thanks, Gina. Danni and Sasha, did you have anything else you wanted to add around a screening tool that you all may be doing or using?

Sasha Foust: I think we do the same as about Tiffany and Elyse. I think we do the SBIRT, we assess anxiety, depression. We use the SBIRT model too.

Caitlin Hungate: That sounds great. And I do want to go back to the previous slide. This coming soon job aid, it includes a variety of validated screening tools, so for those that are interested in a specific validated screening tool, we will have, coming soon, a job aid that outlines those tools that are available. And during the peer learning group, folks often talked about using a shorter screening tool to screen all clients and then using them more in-depth or robust screening tool for someone who's responses indicate or warrant further assessment. So that was another strategy that the peers on the call talked about utilizing, regardless of trying to find a shorter screen first and then doing a more in-depth screen for the clients who indicate a positive screen.

Caitlin Hungate: Thank you, everyone, for weighing in. Let's see. Our next question. And this is for everyone. Gina and everyone can weigh in. How do you all address the health disparities seen in substance abuse treatment once you've referred a patient to a treatment facility? And this question is for everyone, so I don't know, Gina, if you want to start out specifically as you're very clear in what your organization will do that referral that out. But Tiffany and Elyse, I welcome your input as well as Danni and Sasha.

Gina Polese-Grosso: I'm not really clear on the question.

Caitlin Hungate: So this is asking about health disparities. So in addition to the unmet need for treatment, there's definitely some health disparities across different demographics to access substance use treatment. I'm just curious if you have seen any of those disparities yet in your community or even in your historical context, prior to working in a Title X site?

Gina Polese-Grosso: Actually, I'm not. And if there is, I'm on the wrong side of the line to be able to see it.

Caitlin Hungate: Thanks so much, Gina. Is there... Danni or Sasha or Tiffany or Elyse, would you like to weigh in on some of the... How you and your organizations address health disparities seen in terms of accessing treatment once the patient is referred to treatment?

Tiffany Wolfe: Well... This is Tiffany. When I first started here, we didn't have a referral system. We didn't have Elyse or Recovery Gateway. So a majority of my time was spent trying to find patient treatment. In-patient, out-patient across the state. There was many insurance companies that wouldn't accept certain facilities as a payment source, so it was very difficult. And that's a big reason... That's a job in itself. That was a big reason why we had created the Recovery Gateway program. And over time, more treatment facilities opened up in and around our area because of the demand. But when we first started, there was really not very many intervention programs here in Portsmouth. We've had a few Suboxone clinics starting in, but our town really stuck to the idea of Suboxone treatment in the beginning.

Tiffany Wolfe: So it was just a really difficult process for me. In general, I don't know. Elyse, do you have anything to add on that?

Elyse Waugh: So basically what I do is, we do the assessment on the individual and then once the assessment is complete, then we determine if they need in-patient, out-patient, counseling services, or no treatment at all. Whether they are self-referred or court-ordered to be into treatment. Hopefully that answers your question.

Caitlin Hungate: Thanks so much, Tiffany and Elyse, for weighing in. This is a question for everyone. What specific strategies have been used to have medical staff buy-in for initial screening beyond simply asking a few questions? So this individual is from an agency in New York and their family planning agency has been providing behavioral health services since January this year. And integration, for them, has proved to be challenging at times. So for anyone from Tennessee, New Jersey, or Portsmouth, if you have any ideas of specific strategies to get medical staff buy-in?

Gina Polese-Grosso: Hi, this is Gina. When I came into the organization, I viewed what we were doing there and how to do it very differently than the person who was doing it beforehand. And right away... And this is a small organization. So right away, staff knew we were doing things differently. And we slowly but surely changed a lot of how things were being done, and what I find is the best way, in my training with group work, is I included everybody. I wanted input from every staff member. I wanted input from the receptionist, et cetera. And everyone, I think because they felt empowered, they were empowered. Came right along. So we really didn't have any resistance.

Gina Polese-Grosso: When I first came on board, there was some staff that were resistant, and needless to say, within the first year, they left. So I have a great team of people who are willing to look at what's the issue? Let's look at it. Is what we're doing when we should be doing it? And I would say to them, "If this is what we want to do, how do I do it? Let's try this. If this

doesn't work, let's come back to the drawing board." So I feel that everybody's on board, and I think it's due to participation from everyone.

Caitlin Hungate: Thanks, Gina.

Tiffany Wolfe: Sorry, I didn't mean to interrupt. So this is Tiffany. Hi. I'm on the same page as Gina. It's all about participation in everybody. It takes a collaboration. It's the people who... It takes an army to fight drug addiction. It really does. And she's right. We've seen people come and go here. I've been here the longest, out of all the staff. Eight years. Since our substance abuse program started.

Tiffany Wolfe: But I'm really dedicated to it, and I feel like we finally have a group of staff members that are also dedicated just as much as I am. So I think that's what it takes. Everybody has to be on the same page and understand what they're facing when they take on the job.

Elyse Waugh: And with Recovery Gateway and our navigation program, it's when that individual is ready. So if they come in and we tell them about our program and the things that we want to help them do, if that's not something that they're interested right now, we give them our card and we let them know, "You call us when you are ready." It's nothing that we force upon them or we pressure into going into treatment. It's fully 100% their decision.

Danni Lambert: Hey, it's Danni from Tennessee.

Caitlin Hungate: Go ahead, Danni. Thanks.

Danni Lambert: I wanted to share. When we started our NAS outreach, we started in the jail, and many of us, providers and staff were like, "No. I do not want to go in there with a bunch of drug addicts. I'll be afraid in jail." And so we did a big staff training. We got buy-in not only from our staff but from the jail staff because jailers can be hardcore. It takes a special kind of nurse to work in a jail.

Danni Lambert: But once we provided that, the first few times I provided the service, there was not a dry eye in the room. And next thing you know, all the staff was like, "No, it's my turn to go. It's my turn to go." It's one of our best community outreach programs now because of the buy-in. Get the buy-in first, educate. That goes back to the whole stigma thing. If they don't understand mental illness, they're going to want no part of it because people think people with a mental illness are dangerous.

Caitlin Hungate: Thanks so much, Danni. I just want to acknowledge we received a couple comments/questions about some of the change in our country around substance use, crack epidemic, and opioid use, systemic racism and racism. And absolutely, that is a part of the conversation. And this webinar is really focused on OPA's priority and successes from the field as a result of the peer learning group, and that topic of historical racism is a bigger conversation beyond our webinar. And we are thankful for the participants who weighed in on the chat on

that. We hope that we can have further conversations about that, as that is a much bigger conversation that impacts so much of the substance use space and accessing services. So thank you for the participants who have commented and weighed in on that.

Caitlin Hungate: I want to... This is a question for everyone. I know that some of you talked about not having resources when you first started your work either in Tennessee. It's a question of how do you all address the lack of resources? So how do you address the lack of resources to this client's lack of insurance? How do you pay for services? How do you address that and ensure clients have access to services?

Danni Lambert: Hey, it's Danni from Tennessee. Like I said, when we were attached to doing something about NAS, we weren't given a budget. We had people from every job description within the Department of Health on this committee. We had clerical, nursing, provider, billing. We were lucky to have a community partner, a judge who actually had adopted an NAS child, that was all in for our initiative. And he actually sold our program to other judges across the state and then across the United States, and he was recently honored on a national level for his work in NAS prevention. So the community partners don't cost a thing. Get them involved. They bring their own valuable resources with them, like Judge Dwayne Sloan did for us.

Danni Lambert: People want to be needed. We're in public health because we care. We are definitely not in it for the money. So if you have a heart for this, if one of your staff members has a heart for this, get them involved because it’s not about the money. It's about making a difference.

Caitlin Hungate: Thanks so much, Danni. I'll go ahead and open it up to the other panelists, if you have any other ideas about how to ensure access for clients without insurance.

Tiffany Wolfe: Yeah, this is Tiffany from Ohio. Well, we offer discounted services like primary care services all the way down to zero percent. Our major thing was if somebody scheduled an appointment for the substance abuse issues, that we wouldn't decline their care no matter if they couldn't pay or what.

Tiffany Wolfe: Now as far as finding the locations for them, that's been a little bit of a struggle, because we do detox some of these patients, at-home medical detox. And we also do give them Naltrexone, oral tablets, which is not as effective as Vivitrol, but we can get a prescription for that as low as $50 a month, a dollar a day, per pill. And then sometimes we also supply a few days to a week worth of tablets to the patient free of cost. We just feel like it's such a huge community need that we would basically eat the cost of that.

Tiffany Wolfe: But it's like all the other presenters say, you have to have a lot of heart. You've got to have a lot of drive to treat these patients. But the reward is so... For everybody, the community, the patient, us. I can't say enough about how much you feel like you make a difference in medicine, treating substance abuse patients. I mean, their life totally changes 360. And you see it right in front of your eyes. Something that's progressive over years, you see it

within months. And their family, the changes in their relationship, their job, the economy is better. I can't say enough. Do you have anything, Elyse?

Elyse Waugh: And like when we're doing an assessment and they don't have insurance anywhere, we will assist them with applying for medical insurance, but if they need to go into treatment right away for in-patient, we can contact our job and family services and file for an emergency medical card, so then they are able to go right into treatment.

Caitlin Hungate: Thank you for that additional information. This question is for… Oh, yes, Gina, please go ahead.

Gina Polese-Grosso: I would just like to add that we don't really have the problem, because if they don't have insurance... And I would imagine this is across the country, but definitely in New Jersey, we'll do the presumptive eligibility application with them. And we also partner with substance abuse organizations. Some do presumptive eligibility. Some don't. And those that don't, we have offered to do it for their patients, their clients. So what they will do is they'll send their clients to us, and we will do the presumptive eligibility with them. So that would be for Medicaid.

Caitlin Hungate: Thanks, Gina. Thanks for adding that information. And we have time for one final question, and I'm going to open it up to everyone. As a result of the work that you are doing in your state or agency, what are additional topics that come up as a need for training and support within your network or your agency? Either for your providers, your front desk staff, your entire team. What has come up for you all in doing this work?

Gina Polese-Grosso: For us, LGBTQ, which I'm working on right now.

Caitlin Hungate: Gina, can you expand on that? Is that the intersection of care for clients who identify as LGBTQ with a substance use disorder?

Gina Polese-Grosso: Yeah.

Caitlin Hungate: Okay.

Gina Polese-Grosso: Well, not only with substance abuse disorder, but just in general. What we're finding is that that population does not access health services. They feel uncomfortable. I have reached out to a support organization here in actually our county and also in the next county over, and we're planning on doing some things together, as well as speaking with my staff. They feel uncomfortable. They don't know what to do. They don't know how to handle it. Of course we service them, but it's obvious that we don't have the proper training. We don't have enough information and... In fact, before COVID-19 hit, we were trying to put something together to be able to start moving on this, and it's sort of at a stand-still right now. But we're also doing prep and doing what we can to try to assist this population. But we have a long way to go in that area.

Caitlin Hungate: Thanks so much, Gina. Anyone else want to weigh in on what additional topics have come up as a need for training and support within your agency or network?

Danni Lambert: Hey, it's Danni from Tennessee. I just... Since Gina brought it up, I wanted to stress the COVID-19 substance abuse has increased, will continue to increase, so it's very important that our providers across the state and across the United States remember to screen. They may not think so unless you ask that question. They may not even fill it out on their health history. It's a very valid question and very valid screening right now. Even I have been depressed. This is not normal. I have a grandson that's going into the first grade and wearing face masks. Depression and substance abuse go hand-in-hand. Remember that as we go through this pandemic.

Caitlin Hungate: Thanks so much, Danni. You're absolutely right. Tiffany and Elyse, are there any other topics that come to mind for you as you've gone through this work and additional training and support within your agency?

Tiffany Wolfe: You know, over the years, with me, I think our LBGQ was a big topic in the beginning, but our state does a very great job, our state health department, of teaching us about having those conferences and teaching us the stigmas behind that. As far as putting a rainbow sign on our front desk, showing that we're lesbian, gay, transsexual friendly. So we have a lot of training in how to address patients who can't say her/she, that kind of thing. They. So I think that is a growing need across the country, because a lot of us don't understand it. It's just like anything. Substance abuse, we didn't understand that. So there's a stigma behind it. And I agree. I'm sorry. I agree with the COVID thing, as far as... I just wanted to touch base that I have seen an increase in my patient's relapses on opioids, alcohol abuse. It's been very high over this pandemic. So yeah. Screen, screen, screen. Please screen.

Caitlin Hungate: Thank you so much. And I want to thank all of our panelists today for participating and sharing these experiences and answering questions. And with that, I want to turn it over to my colleague, Katie, to wrap us up.

Katie Quimby: Great. Thanks so much, Caitlin. And yes, please join me in thanking all of our speakers today in sharing their experience on this important topic. We, just in closing, have a few announcements. We will have the materials from today's session available on fpntc.org within the next few days. If you do have any additional questions for the FPNTC on this topic, please don't hesitate to email us at fpntc@jsi.com. And our final ask is that you please complete the evaluation today. The link to the evaluation will be emailed to you after the webinar. We really do love getting your feedback and we use your feedback to inform future webinars. Thank you again for joining us today. That concludes today's webinar.

Slide 33

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