Transcript:

Overdose Disparities Series, HHS Region 5: Contactless Overdose Prevention Strategies in Wisconsin and Indiana During COVID-19

Presenter: Chuck Klevgaard, Christine Niemuth, & Cassidy McNamee
Recorded on March 24, 2021

PRESENTER: Hello, everyone. We're going to get started in just about a minute. We're just going to give some people some time to get in and get settled, but we're happy to have you all join us. All right. I think we're just going to get started. Again, welcome everyone to our webinar this afternoon, Disparities in Overdose in Region 5. This is part 3, and our speakers today are Chuck Klevgaard, Christy Niemuth, and Cassidy McNamee.

This webinar today is brought to you by the Great Lakes PTTC and SAMHSA. The Great Lakes ATTC, MHTTC, and PTTC are funded by the following cooperative agreements. The opinions expressed in this webinar today are the views of the speakers, and do not necessarily reflect the official position of DHHS or SAMHSA. The PTTC network believes in the use of affirming language. Words matter. The PTTC uses affirming language to promote the application of evidence-based and culturally-informed practices in all of our trainings,

We have some housekeeping details for you today. If you are having technical issues, please individually message Kristina Spannbauer or Stephanie Behlman in the chat section, and they'll be happy to help you. Kristina will be on early today, and then Stephanie will join us later. So if you have questions right away, check with Kristina. Please put any questions that you have for the speakers, or comments in the Q&A section that is at the bottom of your screen. The speakers will address questions at the end of either their section or at the end of the presentation today.

We will be using automated transcriptions for today's webinar. You'll be directed to a link at the end of the presentation to a very short survey, and we would really appreciate it if you could take it. It takes about three minutes, and it's how we report back to SAMHSA. We are recording this session, and it will be available on our website in a couple of weeks. And certificates of attendance will be sent out to all who attended the full session, and those take about two weeks as well.

If you would like to follow us on social media, please do so. Again, our speakers today are Chuck Klevgaard, Christy Niemuth, and Cassidy

McNamee. And I am going to turn it over to our first speaker for the day, Chuck Klevgaard.

CHUCK KLEVGAARD: All, right thank you, Anne. As we get started, I just want to remind everybody, this is part three of the Disparities in Overdose in Region 5. We started and kicked off this series and heard from Ohio. We later heard from Illinois and Michigan as they talked about rural and urban differences with regard to some of the disparities folks experienced around overdoses. We heard from many of you that you wanted to spend some time talking about sort of contactless overdose prevention, and addressing disparities in the context of COVID-19. So that's the objective for today.

We are going to hear from two more states. We're going to hear from Wisconsin and Indiana, who are going to share a little bit about their disparities. Their overall overdose prevention, naloxone efforts, as well as some specific ways that they've been impacted by COVID-19 and some response in terms of what they're doing to deal with that.

Some quick context-- we know that there's been an acceleration of death during the pandemic. In fact, the CDC says 81,000 drug overdose deaths in the 12 month period ending in May. The highest number of overdose deaths ever recorded in a 12 month period from that provisional data set at the CDC. We certainly know that, while that was increasing prior to the onset of this pandemic, we were seeing increases being led by synthetic opioid cocaine psychostimulant. So we already talked some about that, but know that that's certainly also a significant driver in addition to COVID of what's been happening here in the Midwest.

So, likely contributors. The reason we're talking about this is, as a result of shutdown orders and the pandemic itself, we saw treatment center closures. We saw physical isolation, that in some cases prevented bystander rescue. We saw mental health stressors, financial instability, and then changes to drug supply network all showing some evidence that they contributed to that spike in death. And as always, we want to spend some time in this region looking at populations that are disproportionately affected by that.

So the conversations we have today, we'll be talking about all of those issues. We're pleased to say that we've seen a very united front from the current administration with regard to the secretary of HHS, the surgeon general, and the CDC director all being really clear that they understand and recognize and made a priority to deal with what's happened with regard to this number of overdose deaths in the last year. Certainly looking at the issues of what happened with regard to social supports and disruptions. And again, a unified, committed plan.

So one of the very earliest things that they did through the Biden administration through that joint statement was to come up with recommendations. You can see the full list of these expanded discussions

around these recommendations for addressing overdose during COVID in the CDC's emergency preparedness and response site. I'll provide that link a little later in today's webinar. Certainly, we know expanding distribution and overdose prevention education in whatever way we can. Finding ways and using innovation to do that is certainly part of what they expand on in these recommendations.

Looking at awareness about, and access availability treatment. Finding, again, sort of innovative ways to meet the needs. Dealing with folks that are at the highest risk, improving detection of outbreaks, all significant recommendations with lots of good content in that report. We think that really sets the stage in a nice way. So we want to engage you right away, before we move into our two speakers today. And remind us, what are some of the most significant disparities in mental health and substance misuse experienced by racial and ethnic minority groups where you live? We think that's still the foundation of what we've been talking about with regard to overdose or some of the disparities.

Is that, in your part of town, something to deal with access to care? Is it about psychosocial stress? Are you most concerned about social determinants of health? You can pick as many that apply, and that will kind of give us a sense of what you all see and are concerned about with regard to some of these issues. With regard to race and ethnicity, in terms of, we know that is some of what we're going to talk about, of course, today.

So again, go ahead and vote. Take a moment. Check as many as apply. All right. And go ahead and show our results. What are we seeing? Lots of social determinants of health. Spot on. Some of the same determinants, socioeconomic, that we worried about prior to the pandemic that were creating and driving disparities, were hit much harder in the same way. So very cool.

Psychosocial access to care, all issues you're going to hear about today, with regard to what our presenters are going to share with you. So at this point, we'll go ahead and begin, hearing first from Wisconsin. Christy Niemuth is the Opioid Harm Reduction Prevention Coordinator. She's also the Overdose Data to Action Grant Coordinator for the State of Wisconsin Department of Health Services, Bureau of Community Health Promotion. I will turn you over, at this point, directly to Christy.

CHRISTY NIEMUTH: Great. Thanks so much, Chuck, and I'm happy to be here today. Again, as Chuck said, I'm Christy Niemuth and I work on the Overdose Data to Action Grant as our Harm Prevention Coordinator. Really, today, I'm going to be focusing a lot on our NARCAN distribution efforts. Obviously, we have many efforts at the Wisconsin Department of Health Service. Again, addressing access to care and harm reduction as well as prevention and treatment and recovery support services.

But what we're going to focus a little bit today on is some of our naloxone distribution efforts. And I want to just quickly mention that I don't do this alone. So my background has been in primary prevention. I've worked for the Division of Care and Treatment Services at DHS for many, many years. And I just recently switched over to the Division of Public Health, also housed in the Wisconsin Department of Health Services.

And one of the great things about kind of switching jobs, is that it really gave me the opportunity. I've worked both from kind of a SAMHSA side, working under the State Opioid Response Grant Funding. But now, working more on CDC funding related to Overdose Data to Action. And what that has allowed us to do is have a really, really coordinated effort between two divisions that, at times, sometimes did work together. Sometimes didn't.

But when it comes to this harm reduction piece, and working together on naloxone distribution efforts, that's been a really positive experience. And so I would be remiss if I didn't mention that I'm not the only person doing this work. My colleague in the Division of Care and Treatment Services, Dennis Radloff, is a staunch advocate for harm reduction services and reducing stigma. And is a wonderful, wonderful partner in leading these efforts in our state. So we form a two person team to try and push some of these projects forward in the state.

So I will just mention, kind of give you a lay of the land on when we were starting off. Thank you. I say 2018 was kind of the beginning of some action around moving beyond just kind of single little projects that allowed us to distribute naloxone.

So one of the big things we had in the state at the time was we have a syringe access program through what was at the time AIDS Resource Center of Wisconsin. And they were really a statewide organization that had syringe access services, HIV/Hep-C testing, and also naloxone distribution. And they have several satellite offices in the state at the time. They still do. And that was kind of our one stop shop.

So a lot of our community based prevention efforts through the State Opioid Response Funding supported local substance abuse coalitions with funding for prevention activities, such as take back events, or placing permanent drop boxes. Or distributing personal medication lockboxes and disposal units, and raising an awareness around media and community events.

We knew we wanted to increase naloxone access in the community through this effort. However, most of our coalitions we support did not have a medical director who could sign off on a standing order, or even a central office for storing their naloxone, because many of these are volunteer groups. So at that time, we decided to support the coalitions with some funding through the State Opioid Response Grant, to hold naloxone administration events. So the coalition was funded to organize the logistical details.

But then additional substance abuse prevention and treatment block grant funding was awarded to the AIDS Resource Center to actually provide the training and the naloxone. And what we found through this, is that with one agency doing it, even though they had many locations or several locations throughout the state, it quickly became a really big nasty burden on their staffing to be addressing this in so many communities. And we needed to find a way to expand that. We also have a statewide standing order for naloxone in pharmacies that was written in 2017, and it allows the participating pharmacies to dispense naloxone without a prescription to anyone who asks for it.

And that's the map here on the top right, is those participating pharmacies. Which is great. It increases access a little bit, but the grant was really-- but you have to pay for it, right? So unless you have a certain insurance, or depending on what your insurance is, you might pay anywhere from anywhere from a $5 copay for that naloxone through a pharmacy to upwards of $160, right? So while it did expand services, and was a good step forward, it wasn't getting out there as much as we hoped.

And then finally, we had a five year prescription drug overdose grant from SAMHSA that began in 2016, and allowed us to prioritize three high need communities, and fund them to purchase, train, and distribute naloxone. And those three counties are highlighted in the map on the bottom right there. This grant was really a catalyst for what we developed moving forward, in terms of really expanding what they had learned, and taking some of the lessons they had learned from that funding, And trying to offer that to other folks in the state.

It's important to note that while there may have been other local efforts to distribute naloxone or increase access happening regionally or locally, these are the only real programs that we had at a state level that were supporting any sort of-- at least, the AIDS Resource Center and the statewide standing order were really our one stop shop for how we were getting naloxone out across the state. And we can go to the next slide.

So in the summer of 2019, we began with 14 pilot agencies to develop the NARCAN direct program. And so while we recognize the need to prioritize high risk areas, or even high risk population, we also know that opioid use is an epidemic. And with fentanyl laced in other substances, we needed to do a more concerted effort of distributing naloxone and getting it more far reaching in the state. And so that in that sense, anybody could benefit from an increased access to naloxone.

So the initial program started with a pilot with agencies who had shown interest and some readiness to begin distributing naloxone, but they just needed funding to purchase it. And after the initial pilot, we wanted to make sure that it was more available throughout the state, so we expanded the

program to allow any public health department, tribal health department, or syringe access program to be participating. And this was fun because every county and tribe had at least one health department, and so we really saw this as an opportunity for those health departments to serve as local hubs for naloxone distribution.

So instead of funding every law enforcement agency, or sober living home, or library, et cetera, individually, we encouraged the health departments to partner with those types of agencies, to provide the naloxone they needed by participating in the NARCAN direct program. This also allowed local tribal health departments to do some heat mapping of their own, to find out what are the areas in their community themselves? Either heat mapping, or even just high risk populations. So they know the best about what's happening locally, so they could target their naloxone distribution efforts where it was going to have the greatest impact.

In 2020, in April, shortly after we started with the stay at home orders, we further expanded eligible agencies to include opioid treatment programs in the state. And this was because of COVID. With COVID and stay at home orders, they were providing larger take-home doses of methadone. And we wanted to make sure that they were providing naloxone with those individuals as well. So we expanded the program.

This program is an annual application. We ask people to re-up or reapply for it every year, so then we had a new application process this past fall in 2020. And we now have 75 agencies participating, and it's still growing. And so based on lessons learned from year one, we also expanded some of the eligible agencies to include some certain recovery organizations, such as those that provide recovery coaching.

I wanted the next slide, and this is just intended as a quick snapshot. These are those initial NARCAN direct agencies. The circle represents a 30 mile drive time radius around those agencies. And so, as you can see, there are still some pretty big gap areas in the state where naloxone access is not necessarily really easy to find.

So in the next slide, we will talk a little bit about our naloxone training in conjunction with NARCAN direct program, or getting naloxone into the hands of folks. We knew we needed to address how to train other people in using naloxone, so many agencies expressed concerns about developing a training mechanism for their programs. We heard some people say, I'm a certified naloxone administration. But when we pressed them a little bit about it, it turned out they had taken some online something something, or they had been trained to administer naloxone, but not necessarily trained to train others to administer naloxone.

So we wanted to ensure that agencies who were distributing naloxone through the program were training others on how to recognize an overdose,

how to respond to an overdose, and how to use naloxone. So we developed a naloxone training of trainers, and required that all NARCAN direct agencies have at least one staff member attend. Why we only distribute the NARCAN nasal spray through NARCAN direct, we still train all the formulations of naloxone, in case an agency has other resources they're using for their distribution, such as IM, for example.

So this began as a three hour in-person training, which we shifted to a virtual setting after April. So far, we've trained over 300 people as certified naloxone trainers, so now we have the state certificate that really shows, it kind of legitimizes, I guess, the fact that this person is authorized to train other people on how to use NARCAN or naloxone. And then it goes beyond just training on Naloxone. It helps provide resources in terms of developing business resources or local standing orders or memorandums of understanding with other agencies who may support their naloxone efforts.

So as we move to next slide, we'll just touch a little bit about some of this. We certainly saw this on the national level, in terms of the impact COVID had, or just an increase overall in overdoses in 2020. So we saw after stay at home orders were in place, that there was a definite increase in overdose deaths compared to the same months in previous years. We know that there's some seasonality related to when opioid overdoses are occurring. And so we wanted to make sure to compare that by month.

And we definitely saw-- I think it's the orange line here, is the top line, and that's 2020-- it was certainly higher in 2020 than in previous years. And particularly in May and June, and at the same time, we found that many of our NARCAN direct agencies were not ordering NARCAN from us. So we see overdoses going up, but we also see the agencies people were relying on getting naloxone into the community, their use going down. Or their access to naloxone going down.

And much of this was because of the way we had the program set up. We had the program set up to go to local health departments. But when another event, like a global pandemic comes along, and health departments need to go, and their priorities are shifted into another area, it's very difficult to continue programs that are not as prioritized at that time. So other agencies recognizing the impact of-- I just lost my spot completely, but I'm going to get on track, people.

So they reached out, asking, what are other people doing? How can we promote this? We don't have access to people. We can't get out in front of people. And so what do we do? So they started reaching out at that time. And on the next slide, I'll just underscore the point. This is a slide showing the number of naloxone trainings that our NARCAN direct agencies had provided, and then the number of people who had trained. So the orange line is the number of people who had trained, and the blue line, the lower line, is the number of naloxone trainings. And so we did see that the number of naloxone

trainings offered, and the number of people trained by NARCAN direct agencies, sharply declined in March and April.

And they rose a little bit, again, in June. But you see the number of people, that orange line, trained. The orange line was much higher distribution, in terms of the number of trainings held, and how many people they were training. And so this was a big difference in the way we were training people, or the agencies who were training people. They had to go from doing group trainings, where they could maybe get 30 people in the room or 20 people in the room to train them, to really doing one on one trainings.

And then we started seeing that separation again by August or September, where people were maybe doing a little bit more in-person training. So it's also a function of the fact that some of these agencies were able to start offering trainings later in the year, or later in 2020. You can also see that in April and June, there were a lot more of these one on one trainings, as I said, because those lines are really close together. And so one training equaled basically one person trained.

So on the next slide, let's talk a little bit about what we started to do in terms of remote training and access. So because of COVID-19, obviously, health departments-- and in particular, smaller rural health departments with small staff-- really struggled to continue providing naloxone training and distribution. So we had to, obviously, switch from in-person to virtual training. Agencies began using virtual meeting platforms such as Zoom, Skype, Teams, et cetera, as well as social media platforms to reach more people in the community.

And some agencies were holding socially distanced in-person trainings as well, on a one on one basis, or maybe through a Plexiglas barrier. And some agencies provided people with a link to a video demonstration on how to distribute naloxone. On the state level, it took us a few months to transition our training of trainers from in person to virtual. We had to cancel three trainings in March, and we were kind of holding out hope that after March, we'd be able to get those back up and running in June. And that when it was clear that wasn't going to happen, we had to kind of regroup and get those trainings up virtually.

And so we began doing that by September. And we really had to condense our three hour in-person training to two hours. And so that's something I would say to think about, as you're doing trainings. It's like, how can we condense this? How can we give people resources online that they might be able to use?

For example, we had our folks watch a training video that really went through all the signs and symptoms of an overdose, of a different formulation, so that in the training of trainers, we could really focus on some of the other material that we wanted to make sure trainers understood. Like reducing stigma,

modeling person-first language, things like that. So that we have a good training workforce.

And then we also, obviously, switched from in-person training to also contactless distribution. And so this was a real challenge. This was one of the first challenges we started hearing about. We can train people, we can do it virtually, but how are we going to get them the naloxone? So some state agencies were able to mail naloxone. Although I will say that we had an agency reach out saying that she had gone to the post office, and the postmaster wouldn't mail that for them, because they said it was medication, and you can't mail that.

So we started encouraging people to make sure that was in a package before they brought it to their postmaster. But some were able to provide delivery directly to people's homes. So this, obviously, is a challenge when health departments are feeling taxed, is personal one on one home delivery. But we did certainly see some agencies doing that. Or doing a pick up at the agency's office.

One of the things that we're really excited about, and we're really looking to start expanding in the state, especially in light of what we've learned this year, is the NaloxBox Project. And so one of our agencies, it's called Nalox-ZONE, and they're using naloxone boxes, and they're installing them in community settings where there are reported overdoses happening, or these really high need areas of the community. Or perhaps marginalized population community centers, where they're installing these boxes.

So these are boxes that have naloxone in them, instructions on how to use it, and then a breathing shield as well. So for example, they have one installed at a Hy-Vee, where the Hy-Vee had called them for support, because they were seeing that there were overdoses happening in their parking lot. These have gone in at hotels, treatment centers, gas stations, or other recovery organizations. And we really see this as a really exciting opportunity that we're looking to expand into some of those gap areas you saw on the map.

The box is placed in a community setting, and the staff are trained in administration, as well as protocols for administering the supply that's in the box. And then the agency itself, the agencies that's coordinating this particular effort, is also training people virtually. So when they train people virtually, they can actually now refer the person they train to one of these box locations, so they could go there. So it's another opportunity for them to pick it up after receiving training.

And then one of the unique things that they have done with this box is they installed the sensor on the box, so that when the box is open, it lets them know that it's been opened. They can contact the location and ask, has the naloxone been taken? And if it has, they replenish it and get it closed back up,

so that they're not going to visit the agency time and time again to check in, to see if it's full or not.

So, finally, on the next slide, if I can get to it on mine, I just want to talk about some lessons learned we've had over the years. And so really diversifying distribution locations. So while the intention of having public health or tribal health agencies serve as our distribution hubs really made a lot of sense to us, and it really felt like we could get more traction in the state and more widespread coverage, we quickly learned that, again, when another public health crisis arises, such as this global pandemic, health departments quickly get pulled in other directions. And this was particularly true for our smaller rural health departments, who maybe only have one or two permanent staff members. Right?

And so when you're spending your entire day doing contact tracing, there's not a lot of time left to be training on naloxone. And so for the second year of the program, we really expanded the eligible agencies, so that the areas without public health departments participating would have an opportunity to have an agency that could serve in that role. The other thing we really learned, and really support, is building strong partnerships. And so while many of our agencies were not able to train or distribute naloxone directly because of their competing priorities of COVID, they still saw the need for the effort to continue.

They knew the risk factors. They saw the trends happening already with overdose deaths in the communities. But because they've established some strong partnerships with other agencies in the community, they were able to really regroup and supply those agencies with the naloxone for distribution. And partner agencies were very willing to step up and help. In some cases, this improved the partnership. And in others, new partnerships were formed in order to allow for distribution to continue.

So for example, in one community, they began providing a recovery agency and a sober living facility with naloxone, and had them provide the training and the naloxone to community members. Because the local health department staff was just overburdened at that point. The other thing I would say is know your audience. Where are you going to get the best bang for your buck? Who do we need to get this out to? Who do you really want to target with distribution?

And this gets back to some of those populations that are being disproportionately impacted. Many of our agencies focused on general community training, or focus their partnerships on law enforcement agencies to ensure that first responders have access to naloxone. But we know that the biggest bang for our buck when distributing naloxone is to get it in the hands of people who are using substances, or people who are likely to witness an overdose. Yet many of our public health departments or tribal health departments are not currently working in a concerted way with this population.

And then on the other side, many individuals who use substances are unlikely to reach out to the public health department for help. So what we learned through this is leave your pride at the door, and know when you may be not the right person or the right agency to reach the people most in need, and actively seek out others which could have greater impact. So for example, you might be the agency receiving NARCAN through our program, but seek out those recovery community organizations or other organizations that are working-- syringe access programs-- that are working directly with the population most impacted. And let them run the show, and you provide the naloxone to them.

And then finally, I will just close-- I think I ran a little over-- but I will just close with, just be nimble and meet people where they're at. We are always going to face challenges. And we may have the best plan or program in place, and then someone says, no, I can't do it like that, or it doesn't work for me. So more options we can offer, the better. Can you use Zoom? Can you use Facebook Live, as well as providing some in-person training?

Can you record the training and provide it online later using something like Adobe Connect, where you can even ask questions or have people respond with answers to make sure that they're understanding the content that you're providing? Can you ask people to pick up the naloxone? If that's your plan for your agency, have them pick it up, and they can't, what are your alternatives? So, OK, we're not going to offer that to everybody, but when somebody says that's a problem, we can shift and we can be flexible, and we can move and we can get it to them another way.

COVID has actually opened a lot of avenues for us to get creative about how we are interacting and engaging with those who are impacted by this life-threatening disease. And we need to use what we learned, and apply that. Not just to contact tracing, and not just to vaccination sites, not just to testing sites, but to overdose safety as well. And so, really, what I've learned through this-- and this is certainly not the stance of my department-- but leave bureaucracy at the door. It's something we need to get through, and we need to break down our bureaucracy doors.

But we are helping save lives, and keep people safe, healthy, and alive through the darkest seasons of their life, as my wonderful partner Dennis usually says. And so we need to do whatever we can to continue to knock down these barriers to keep them alive, especially in a time when we're seeing such an increase. So those are some of the things we've learned, and ways to overcome some of our barriers. And with that, I'll turn it back over to Chuck, and really appreciate everybody listening today and your time.

CHUCK KLEVGAARD: Awesome. Thank you so much, Christy. I see some of you already putting your questions in the Q&A. So as you do that, take a moment now. If you have a question for Christy, go ahead and open that Q&A. Click that bullet, and again, say question for Christy, question for

Wisconsin, however you want to do that. Or if it's just a general question for either panelist today, you can type those in.

At the same time, we're also interested in hearing from you right now, before we transition to Indiana, is hearing a little bit about the biggest disruptions to access that you've experienced where you are. So you just heard Christy talk a lot about disruption with regard to access, and some things that were unanticipated. And some things that were difficult to change gears in terms of how you provide both harm reduction and naloxone directly. So go ahead and type that in the chat.

What are some of the disruptions you all experienced? What are some of the biggest challenges, you think, dealing with overdose in particular, harm reduction, and naloxone during COVID? What's been the hardest part about this for you?

Lots of great stuff. Again, thanks, everybody for jumping into the chat. Getting people to respond, absolutely. Continuing to deal with stigma. Hearing lots of that around our region in terms of folks feeling that stigma has presented itself in lots of very frustrating ways. In some cases, new ways. Money and transportation. Lots of stuff.

And again, we're ready to move into this next part of our presentation. So I want to tell you, you're now going to hear from Indiana. So you're going to hear Cassidy McNamee, who's going to talk about-- she's the Naloxone Program Manager. She works with the COVID Vaccine Deployment Team. She's been part of the Indiana State Department of Health, in the Division of Trauma and Injury. So without further ado, I'll turn this over to Cassidy.

CASSIDY MCNAMEE: Hi, Thanks Chuck. You can go ahead and go to the next slide. So this here is just the Indiana Department of Health mission and vision statement. It's to promote, protect, and improve the health and safety of all Hoosiers. And our promise to the state of Indiana is that every Hoosier reaches optimal health, regardless of where they live, learn, work, or play.

Next slide.

So a little bit more about me. My name is Cassidy McNamee. I am the Naloxone Program Manager, housed within the Division of Trauma and Injury Prevention at the Indiana Department of Health. I specifically work on the Drug Overdose Prevention Team. There's about eight of us that work on drug overdose prevention efforts throughout the state of Indiana. We are funded by a few different funding sources.

I manage to, specifically, I manage the First Responder Comprehensive Addiction and Recovery Act, or FRCARA Grant. That is through SAMHSA. And I don't house the State Opioid Response Grant, but I do some work through that as well, or the SOR Grant. Next slide.

So Indiana, when thinking about combating overdose disparities, we had a couple of questions back when a lot of this all started a few years ago. Kind of in what we're looking for, and how to combat those disparities, and what barriers we may have. A big one is naloxone access. So where is naloxone access limited in our state? We started our very first naloxone program back in late 2016, early 2017. We currently do have a standing order in our state where anyone is able to get naloxone without a prescription, which has really helped a lot of the barriers that we had initially.

Previously, due to Indiana legislature, only first responders and hospitals, Medicare, medical settings, could carry naloxone. And what that new standing order, where naloxone can be delivered to the public, that has really helped break down some of those walls and barriers that we had previously. Stigma is another big one that we look at. Kind of who and how people are affected by stigma, and how we can get education out there around stigma.

SSP access and harm reduction supplies are another program that we have. So we understand that not all communities are ready for an SSP, so we also have a harm reduction program that supplies harm reduction supplies. And we try to figure out what type of services work best in our communities. Because we know every community, with being such a large state, some things might work better for others.

And we also have a lot of community programming and partnership that we do with some of our funding. And we want to make sure with the community programming, that the appropriate stakeholders are at the table. So I'll talk about a little bit about those projects a little bit later. Next slide.

So our response to those different disparities, we have a couple of different projects. Like I mentioned, we have our Project ECHO, which is a community based program planning project. We have our Know the Facts campaign, which is a stigma related campaign that is through the Family and Social Services Administration, another state agency in Indiana. We have our naloxone programs, as well as our SSP programs that are housed within IDOH itself. Next slide.

So the first two programs that we have are our naloxone programs. Like I mentioned, I am the Naloxone Program Manager, so this is kind of my wheelhouse. We have two different naloxone grants that cover two different populations. The first one is our First Responder Agency Grant, so this is the one, the FRCARA Grant funded through SAMHSA. This is available to 49 of the 92 Indiana counties. So you do have to be a rural county first responder agency to apply for this grant, as you can tell.

Over half of Indiana is rural. This provides naloxone to a first responder to use while on active duty. So what we see in a lot of these is being those rural communities, is they don't have the funding to pay for naloxone on their own.

So this program really kind of minimizes that gap between our rural communities and naloxone access.

With this program, we also have a evaluation program. Where after a dose of naloxone is used on a patient, each first responder agency gets one prepaid postage card per dose of naloxone that they receive. And after the overdose event, they do fill out the postcard. It's non-identifiable information, and that is automatically sent back in to IPY, a University in Indianapolis that does all of our evaluation program. So we get some really cool data out of that program, and we can kind of see who and where naloxone is used throughout the state of Indiana through that grant specifically.

We also have our second grant, which is funded through SOR funds. Most recently, it was, back in 2017, funded through state dollars. And state dollars, unfortunately, is limited, as most of us know. So now we are able to receive federal dollars for this grant specifically. This is available to all 92 counties. So there's 92 two counties in Indiana. Some counties have two health departments. Most of them only have one, but they are all eligible in the state of Indiana, currently, for the 2021 grant.

We have, I believe, around 48 agencies participating. Last year, in 2020, we had 52 counties participating. And through this program, the doses are sent directly to the health department, and then the community health departments can distribute to other agencies, such as schools, jails, universities, other non-profits. Kind of similar to Wisconsin's program. The health department's really that middle man in getting those doses from the state to the community.
We also have some SSP and non-insurance service programs that aid in naloxone as well. So Indiana currently has eight active SSPs, and through previous funding, we have been able to give naloxone to SSP participants through that program. And we also have some counties who may not have a full-fledged SSP, but they do receive non-syringe harm reduction supplies. So this would include band-aids, cookers, condoms, straws, and hand sanitizers.
A couple of other things through a separate grant opportunity. Our SSP and non-syringe service programs are run through our HIV division at the state. So I'm not the expert on those. I have included my colleagues' information on there. If you do have any questions following the program, she would be your go-to. Next slide?

Two other programs that we have that focus on overdose disparities are our Project ECHO. So our Project ECHO is funded through the Overdose Data to Action Grant. This is, if any of you are familiar, so ECHO originally, when it came about, was focused on doctors and medical staff. And training rural, or across the state, one doctor would be able to train 10, 20 other doctors on a particular topic through these ECHO modules.

So the very first community-based ECHO was out on the East Coast. I believe it was Massachusetts. Don't quote me on that one. But Indiana heard about their program. We thought it was super awesome. So when we applied for the

OD2A Grant a couple of years ago, that is when we decided we wanted to implement something similar in Indiana. So in our first year of the grant, we had 16 participating counties.

Once a month, we had the community-based ECHO screening, so this is a webinar of sorts. And each county would get a different opportunity to be the case presentation and talk about some success stories, some barriers, that they've had around a certain program in their community. And then the other participating communities would be able to ask questions and get advice from that county to see if they could implement something similar in their area.
So with that Project ECHO, funding could pay for any sort of realm of projects. Our funding has covered anti-stigma promotion campaigns, implementing overdose fatality review teams, or OFR teams. Conducting naloxone trainings, purchasing NaloxBoxes for communities, providing school-based overdose education, and expanding peer recovery support in certain counties. And we do have our program director over Project ECHO. Her name is Claudia, so if you have any questions, or email is also right there, so you can send her a follow up.

Our Know the Facts campaign is our statewide anti-stigma campaign. This is actually funded through FSSA, our Family and Social Services Administration, which is a separate state agency in Indiana. This includes billboards, commercials. We have advertisements at our Indianapolis Colts games, at our Pacer games. We have radio ads, as well as other virtual advertising.
The campaign itself, actually, previously was Know the O Facts, the opioid facts. But as we know, growing trends, that unfortunately, opioids are not the only thing that we're seeing in our overdoses throughout the state. And so we kind of dropped the O and just went with Know the Facts. But it's still a really great program, a really great campaign, and it does focus on three separate facts.

That addiction is a disease, there is treatment, and recovery is possible. And like I mentioned, that is through FSSA. It is headed by Tony Toomer. He's actually a part of this group as well, and there is his contact information if you have anything specific. Next slide.

So like many other states, we have seen a very large COVID-19 impact on our different programs that we have. As we saw, our local health departments were closed multiple times during 2020. During the spring of 2020, we saw they were closed due to state-wide closures, and things like that where they were sort of forced to close down. I've also had some more smaller county health departments that closed throughout the year, because they had an outbreak in their very small staff, and so they were unable to operate for a week or two.

So due to a multitude of reasons, we've seen health departments really hit hard throughout this 2020 year. There was also a lot of misinformation around COVID-19 and naloxone use. So this was a lot of questions stirred up by our

first responders. And kind of, if there was a risk of contracting COVID-19 when giving someone naloxone. And there was a lot of back and forth around that that we saw throughout our state.

A lot of naloxone trains were canceled, same as Wisconsin. We had our health departments conduct trainings, and then I, myself, also am a certified naloxone trainer, and I travel around the state and do trainings as well. In 2019, I believe I trained a little over 900 people on naloxone administration throughout trainings at universities, private businesses, nonprofits, all across the state. And I think in 2020, I only trained about 200 people. So a very large decrease in the number of people trained in the state of Indiana just because previously, most trainings were conducted in person.

We also saw some issues in our in-person treatment services, so our OTPs and things like that had some barriers when things were closed, and due to limited contact and limited crowds, our MAT programs, those daily dosage appointments, became tricky. And finding out a way to accommodate all of their patients became a really big barrier last March and April.

With our Community ECHO, even though Community ECHO is a virtual-based platform, the community partners within that participating county would usually all gather together monthly to meet, and talk about, and program, and plan, and attend the ECHO together. So with COVID and limited capacity restrictions, those community partners were unable to do that. And with the lack of collaborating in person, sometimes, I personally am someone that I prefer to be in person. I prefer to talk to someone face to face. I'm not a huge fan of the computer, even though I am younger. I feel a little awkward talking to my computer all day. So that's been a struggle as well.

Indiana, as you saw earlier, is also a very rural state. Over half of our counties are considered rural by HRSA, the federal organization, which has multiple barriers on its own. And then when you throw in COVID and technology, I know a lot of things went from in person to technology based. But in rural communities, they might not have the best Wi-Fi. They might not have a computer, or a laptop. Families might have to travel to the library to access a computer. So things like that we already were kind of seeing before in a lot of our rural areas has just exemplified during COVID. Next slide.

So in response to COVID, we tried to be creative as we can. One county in particular, I kind of want to highlight, because they do a really great job with their naloxone program. They had a community drive-through naloxone training in Clark County, Indiana, which is in Southern Indiana near Kentucky. That is a little video clip there where you can watch, and it shows some live footage of the drive-through training.

It was really cool. And it was kind of inspired by the drive-through testing sites for COVID that we have throughout Indiana. So they were like, well, if we can do that, then we should be able to train and distribute naloxone in a drive-

through setting as well. So that's been a really great option. The first one I kind of heard about and worked with is through Clark County, and we've had a couple of others as well.

Telehealth services became options for individual and group counseling sessions. So Indiana kind of got quick on our toes. A lot of our treatment options and services are through FSSA, so FSSA worked really hard on getting a lot of those treatment and counseling and MAT sessions to be on a virtual platform when available. With our MAT programs, like I just mentioned, curbside dosing also became available for MAT patients.

We saw curbside naloxone pickup, so agencies or individuals that have already been trained on naloxone could pick up their naloxone curbside, instead of having to go into the agency. We had a lot of virtual naloxone trainings. Even though a lot of my trainings over 2020 were canceled, I did have quite a few virtual trainings as well. I still do prefer the in-person training, but virtual trainings are a great way to reach people during a pandemic. As well as people who might not have access or driving ability to one in the meantime.

We also had the implementation of more NaloxBoxes. So FSSA, our Family and Social Services Administration, actually funded a not-for-profit that's local here in Indianapolis, for the implementation of more NaloxBoxes. So they have a current program, the non-profit called Overdose Lifeline. They are currently installing NaloxBoxes all across the state of Indiana, and are trying to have a tracking service where people can go online and find a NaloxBox in their area.

I believe their goal is to have one NaloxBox per county. Like I said, that is through a not-for-profit that's local here in Indianapolis. I don't have a ton of information on the program. I know it's really great, and they're working on it. That funding and that project came about a few months ago. So I can get contact information for that as well, if anyone has questions. Kind of like how Wisconsin mentioned earlier, I know I'm the one speaking, but there's an army behind me helping with all of these programming, and we have a really great infrastructure here in Indiana.

So with our ECHO project, our original goal when funding the project, was that we were going to have the counties that were awarded a select amount each year. They would have funding for one year, and we would have the ECHO sessions, and then the second year of funding, we would have a brand new set of counties. So to kind of help build infrastructure in the first year, and in the second, find new counties to help, and fill gaps in those new counties as well.

Unfortunately, due to COVID-19, a lot of our echo counties were not able to continue all of their programs during 2020. So thankfully, with approval through CDC, we were able to give any currently participating counties

additional funding to continue in 2021. So like I said, that wasn't our initial thought when having the program, but we have been able to extend those counties for another year. So they will have two years of help from the state, and two years of services due to all the pauses and barriers that we had in 2020.

Another thing that was really helpful that we had is Indiana's Department of Homeland Security came out with a couple of different infographics, educational materials, around naloxone and COVID-19 guidelines. And talking about how it's safe to still use naloxone on an individual, as long as you're using your normal safety precautions and sanitary procedures. This was widely distributed through the health department, through the Department of Homeland Security. I distributed it to all of my first responder agencies that participate in my grant. And we made sure we get that information out there, because we do not want anyone to not be given naloxone due to a fear of COVID-19 infection. Next slide.

Next slide, please. Thank you. Running a little bit out of time here. So our naloxone programs at the state level through 2020. Thankfully, on my end, like I said, I do manage both of these grants. I was able to continue business as usual throughout most of 2020, even though I've been working from home. I do go into the office every so often to distribute and ship out our naloxone that we receive. So in 2020, over 3,000 doses of naloxone were distributed to our different grantees, and we do accept applications for naloxone on a rolling basis.

So throughout the entire grant year. It is on the federal year. So from October through September, we were able to accept applications all year round, and get that naloxone shipped out. On the local health department side, like I said, on my end, thankfully, it was business as usual. The state did not see too many barriers in carrying out the naloxone program. I have been heavily working in the vaccine response as well, these past few months, so that's taken up a lot of my time too. But I've been able to continue with the naloxone program, with some help of my awesome coworkers as well.

In 2020, I was still able to ship out over 23,000 doses of naloxone to our county health departments. The LHDs were still able to distribute these doses to community partners. Some had to make some changes to their original distribution plans, but after those changes were made, most of the 23,000 doses were still distributed. And we do understand that some LHDs were more negatively affected than others.

A lot of Indiana is rural. I know I keep saying that. But a lot of these rural counties only have a few people on their staff, and we understand that those counties were more negatively affected than others. I tried to provide additional support, and they've had to make some changes, but they still stayed strong and were able to distribute a lot of their naloxone.

Same with the first responder grant. We do accept applications all year on a rolling basis. We don't want anyone to miss out on the program, and especially with COVID now, I had kind of a slow start of applicants at the beginning of the year. Applications started coming in January, but I've had a really big uptick in applications recently, due to the health departments. They're getting a little bit more in the swing of things with the vaccine.

I know in Indiana, the health departments are leading the vaccine deployment right now. I'm not sure about in other states. But they have still been able to apply for naloxone, and I will be sending out more, hopefully in the next week or so, to a lot of agencies. So, yeah, we've been really lucky in that aspect, and our health departments have been really great throughout this last year. Next slide.

So some lessons learned, other outcomes after COVID-19. So COVID-19 pandemic kind of exemplified some of our current barriers and gaps in services. So like I said, being rural, a more rural state has really had its ups and downs throughout the years. And then during COVID-19, you've kind of seen how that's really been a barrier, and just an extra barrier in a lot of those communities.

It also showed when things were closing down and things were offline, kind of where we had gaps. I mean, I guess it's the silver lining. We might not have seen those gaps before COVID-19, but due to COVID-19, we have seen those and tried to work towards filling some of those gaps and barriers that we wouldn't have seen otherwise. Some of the positives, though, is that community organizations were able to find creative ways to go virtual, and have now voiced that they will continue these adaptable services post-pandemic.

So like I said, the drive-through naloxone training was a really awesome thing that Clark County did, and you know, they've mentioned that they want to do that again in the future. And I personally would love to host some of those through the state in the future, once we get the clearance from our state government that we're able to do this sort of things. So I think that creativity during COVID-19 has really brought about some great ideas that we can use, hopefully once COVID is behind us.

And education around addiction and mental health became a really important and forefront topic during the pandemic. Not that it wasn't important before, but I think due to the pandemic, it was more of a table conversation in families and at the state level that it might not have been as much before. But it's great to bring to light, and show the importance of it as well. So I think that is it. A few minutes left.

CHUCK KLEVGAARD: Awesome, thank you so much, Cassidy, for that great overview of Indiana. We do have some time to take a few questions, so Anne is going to share with us some of what showed up in the Q&A.

PRESENTER: Great, thank you. And I agree. Both of the speakers, really good information. The first question is, where can I find more information on the NaloxBoxes?

CHRISTY NIEMUTH: So I will chime in, and Cassidy, you can certainly chime in as well, because I know you have a NaloxBox program as well. You can certainly-- this is a terrible answer-- but you can Google it. You can Google NaloxBoxes to see the price of them. I think the ones we get are around $275 per box, and then they have additional things that you can buy, additional cards to go in them. But they do come with basically everything you need in one box, except for the Narcan, or the naloxone you're going to put in there. We also put additional training materials in there, so local resources might go in there, or card for our addiction recovery helpline. Things like that also go in the box. But they really do come with everything you need, except for the NARCAN. And if you want some more information about-- Anne, I think you might be getting to this-- there was a question I think I saw in the Q&A about the sensors that we—

PRESENTER: Right. I was going to ask that next.

CHRISTY NIEMUTH: Yeah. So the agencies that's been leading the charge on this in Wisconsin is called Wisconsin Voices for Recovery. And to my knowledge, they really developed this themselves. This isn't something that comes with the box. And they didn't manufacture and create the sensor. They found some other sensor, I guess, that they buy on Amazon or something, and then install in the boxes. So I can certainly get some contact information from them, or get that out to folks.

Or if you contact me, I can get you in touch with them. Because they've gotten a lot of press about this, and they have been reached out to from a lot of people. And so I'd be happy to connect you with them to find out a little bit more how they do that. Because I've heard from a lot of folks that that's kind of one of those barriers to putting in the NaloxBoxes, is that you're constantly going to check them, or you don't know when they've been accessed, and things like that. And so it's a really innovative way to make that a little bit more seamless of a process.

PRESENTER: Great, thank you. Our next question is, are challenges getting sites to accept a NARCAN box for individuals to access? How do you get buy-in? And actually, the next question we had, too, was how do you get sites on board for NARCAN distribution, such as gas stations and hotels?

CHRISTY NIEMUTH: I'll jump in again. This is Christy. I guess I could take it again. I'll put my camera back on. But certainly, Cassidy, please step in as you know more about what's going on in your state as well. But what we have seen, or what our agency that has started this movement has done, is that the boxes that they've placed so far have been both a combination of them

reaching out to agencies that they know are in locations that have a high overdose rate. They're a very well-respected agency in the community. But they've also had people reaching out to them. So for example, I give the example of the Hy-Vee that they were having overdoses in their parking lots, or had had several overdoses. That agency actually reached out to Voices for Recovery, saying, what can we do? We need to do something. We need you to train our staff. And then they offered the opportunity.

So if you're not as lucky that people are reaching directly out to you, wanting that opportunity, I think oftentimes it's just pounding the pavement and looking for places in the community that really have those high rates, or would really benefit from them. We work with hotels. The majority of the boxes that have been placed have been in hotels. Gas stations. Like I said, the Hy-Vee. There might be a library or two. I think that would be a good location as well.

But really, those congregate places, open to the public, easy to access, where people are going to be. And so I think it's really a combination of educating people about the issue, and kind of working that. It's a delicate situation sometimes. But I think as it takes off, and people see that people who have come to their agencies are being impacted by this, they're getting more and more on board.

CASSIDY MCNAMEE: Yeah. Very similar to what Christy was saying. So I think a lot of, I mean, I guess more in the placement spectrum, is making sure the boxes are placed in a place where people feel comfortable. We had some discussions about-- which, understandably, is a great idea-- placing NaloxBoxes near police stations or fire stations, emergency response areas. Where that might be great on the surface, just, unfortunately, due to stigma a lot of the times, and people might not feel comfortable in those situations, that those locations might actually not be the best place for a NaloxBox.

So definitely finding places where people feel comfortable is going to be a big one. And unfortunately, sometimes it just takes experience in an area to get people on board. So they don't have a NaloxBox, but I did a naloxone training at four different lumber company. Well, it was one lumber company. They had four different locations throughout Indiana. I did a training at each of their locations, because they, unfortunately, had an overdose on the site during the workday in their lumber yard.

So due to that, they were really proactive-- or they were really retroactive-- and they said, we need this training. We need to have naloxone on hand. So I did travel to those locations and provide training, and they were able to get doses to keep at the company, in case the event happened again. So that, sometimes, unfortunately, buy-in comes from experience, which has pros and cons. But definitely, for the NaloxBoxes, having places where people do feel safe and comfortable going up and actually getting the naloxone.

PRESENTER: Great. Thank you. I want to be very aware of the time. We want to respect everybody's time. And so if there are some questions that we're not able to get to, we can certainly talk with the speakers and get some information out to people. Chuck has put a slide up with all of the resources. This will be included in the slide deck that you get online.

Again, all of those things will be online, probably within a week to 10 days, along with certificates of attendance will also be sent out. So I just want to, again, thank all of our speakers. Chuck and Christy and Cassidy, this was a really great presentation, and a lot of really good information. If you have any questions, you can let us know. But I want to thank all of you for your time. And we will, I'm sure, see you again soon.