Transcript: Engaging Emergency Medical Services in Naloxone Distribution

Presenter: Erin Russell, Anthony Pantaleo, Stephanie Busch, Becca Scharf, & David Sabat
Recorded on January, 12, 2022

JEN: Welcome, everyone. We're going to give folks a few minutes to log in and then we'll begin. Oh wait.

Welcome, everyone, to today's webinar, engaging emergency medical services and naloxone distribution with our presenter Erin Russell. Today's presentation is sponsored by the Great Lakes PTTC and SAMHSA. The Great Lakes ATTC, MHTTC, and PTTC are funded by SAMHSA under the following cooperative agreements.

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Please put any questions or comments for the speaker in the Q&A section, also at the bottom of the screen. We will respond to questions during the presentation. Certificates of attendance will be sent out to all who attended the full session. They will take about two weeks.

The recording of this training and the PowerPoints will be available on our website. It normally takes 7 to 10 days for it to be posted. You'll be sent a link after the presentation to a very short survey. We would really appreciate if you could fill it out. It takes about three minutes. If you'd like to know more about what we are doing or information on upcoming events, please see our social media pages.

Our speaker today is Erin Russell. Erin serves as Chief of the Center for Harm Reduction Services at the Maryland Department of Health. The center

envisions a Maryland where health and social service systems meet the needs of people who use drugs in a comprehensive, community-based manner.

Her portfolio includes coordination of statewide naloxone distribution, syringe service programs, a harm reduction grant program, and local capacity building initiatives. She has been at the forefront of integrating harm reduction into larger behavioral health, opioid response and infectious disease prevention programming at the Department since 2013.

Erin obtained a BA in sociology and a master in public health from the University of Pittsburgh graduate school of Public Health and is currently pursuing a doctorate in public health with the Johns Hopkins Bloomberg School of Public Health as a Bloomberg American Health Initiative Fellow.

Erin is joined by our panelists, Anthony Pantaleo, Stephanie Busch, Becca Scharf, and David Sabat. And I'll turn it over to you, Erin.

ERIN RUSSELL: Thank you so much, Jen. Hi, everyone. Good afternoon or good morning or good evening from wherever you're tuning in. Really great to be here with you. I am going to pull up my slides up for you and we will get started.

Thank you for the introduction, Jen. I will also add that I am a technical advisor to the EDC. And in that role, I assembled the policy brief that we'll be discussing as well as this webinar.

As was mentioned, I'm joined by four amazing panelists. They were instrumental in creating the policy brief that you have all joined us today to learn more about. Each will give an introduction and share about their experience establishing EMS leave-behind naloxone programs in their states. So you'll hear from them shortly.

The goal of this webinar is for you to leave with an understanding of the role of EMS in overdose prevention. EMS is for typically treated health issues, and we're talking about their role in prevention. We'll identify the core elements of successful programs in three states. As I mentioned, you'll hear directly from individuals in those states who were key to establishing those programs.

And we will highlight how you can set up a program in your state. The key components of a program being policies that support EMS in the activity of

providing a naloxone kit, evaluating your naloxone access laws, and identifying the important partnerships that are needed to have a successful launch.

And really, why we're all here, I believe is to make manifest this quote that Becca, one of our panelists, said. As the severity of the opioid epidemic escalates, it's essential, it's critical that we find innovative methods to reduce morbidity and mortality. And that those interventions have cascading positive impacts to mitigate those negative consequences that we're seeing on families and communities. So that's why we're all here. And so I hope you leave with a new tool and a new approach to accomplish that.

So this is the policy brief that I mentioned. It's engaging emergency medical services in naloxone distribution. It was published on October 21, 2021. So just a few months ago by the Great Lakes PTTC. All of you should have received a link to the policy brief. And I believe it's also being added to the chat box. It was created in response to interest from a number of states.

Leave-behind programs by EMS have been sweeping the country over the last five years. And so many are getting on board and it felt time to create some to pull together some best practices and create a publication that could communicate that to those interested.

So to accomplish that, I was fortunate to connect with three successful state programs. All of our panelists. So I conducted interviews with them to inform the brief. Also did background research on existing leave-behind programs. And focused in on targeted naloxone, which is something that we'll really talk about as a justification for this program in the next few slides.

I also did a literature review of the role of EMS in overdose prevention. And another thing that we'll highlight in the coming slides is how naloxone leave-behind-- naloxone distribution is connected to other overdose prevention initiatives. And in fact, can bolster those initiatives and help connect people to further care that they need.

All right, so level setting. We're here to talk about naloxone. We all, I'm sure, know what it is by now. But it quickly and effectively reverses an opioid overdose. Emergency medical services have used it for decades to stop overdose deaths. It's approved by the FDA for community distribution. Lay individuals can be trained to use naloxone-- can use naloxone when they witness an overdose. And it has over the last, probably, decade or more-- in 20 years has been distributed to community members as a public health effort for preventing and reducing overdose mortality.

We've come to learn through research that the greatest impact naloxone can have is when it is as available as possible to people who are most likely to witness an overdose.

And this concept of targeted naloxone has even been mentioned by the US Office of the Surgeon General. That increasing availability of naloxone-- targeted distribution of naloxone is a critical component of efforts to reduce opioid related overdose deaths. It's part of a comprehensive plan to respond to the overdose crisis in the US.

When it's combined with the availability of effective treatment, it can be-- it's instrumental to ending the opioid epidemic. So again, we'll talk about how handing a naloxone kit to someone has led to a greater likelihood that person is willing to talk to a peer recovery specialist. A greater likelihood that they are going to ask about treatment resources and connect with the broader network of care that has become available to support someone through their addiction and into recovery.

And so I want to talk about what I mean by targeted naloxone. It means reaching individuals who are identified as a priority because of their history, experience, lifestyle, or a community because of its geographic location. So perhaps, there's an increase or a spike of overdoses in a geographic area, a zip code, a neighborhood. So we want to target naloxone distribution to that neighborhood.

And so we can identify what a targeted population looks like based on research. And what is most relevant to our conversation today about EMS leave-behind of naloxone is that people who experience an overdose and survive and overdose are very likely, unfortunately, to overdose again. Some research even says people overdose an average of 11 times when they're in active addiction and heavy substance use.

So overdose is very common for people. Fortunately, we have tools for them. We have naloxone and we have emergency medical services responding to those overdoses. But it's likely that people will continue to use an overdose again. So that is why reaching people who have survived an overdose is very important, and why that is a targeted population for naloxone and why EMS is so well positioned to support this priority population.

So what is the naloxone leave-behind? All of our panelists can explain it better than I can. They've all been doing it themselves. But in brief, it is a naloxone

kit-- a take home naloxone kit that is provided to an individual who has been revived after an overdose at the scene of the overdose. The naloxone kit can also be provided, depending on your state's naloxone access laws, to friends and family who are at the scene of an overdose.

So it's having that intervention of giving a naloxone kit, perhaps a brief training, going over the education materials that are in your naloxone kit-- at the immediate moment after the person is revived and stabilized. But in the moment, at the scene, not at a later point, not during a follow-up. But giving them a naloxone kit as soon as possible-- offering it to them on the spot.

And again, how that's done looks very different among different EMS agencies who are doing this program. And so you'll hear a little bit more from our panelists about how they've taken a unique approach to this in their states or jurisdictions.

The naloxone kit that's provided is-- also may vary by state or jurisdiction or EMS agency. But when I say naloxone kit, I'm talking about that typical kit that is handed out by naloxone distribution programs. It's a kit that would include two doses of Narcan nasal spray or injectable naloxone with the necessary intramuscular syringes.

A kit can include a rescue breathing shields, gloves to use throughout the administration of naloxone and recovery, and then, any educational materials. And those, again, vary widely can fit into a naloxone kit.

So after speaking with all of our panelists and doing my research, I identified five key elements of a successful naloxone leave-behind program. First, there needs to be the authority for emergency medical services providers to provide a kit to someone at the scene.

If any of you-- as you would know, if you are an EMS provider yourself. But for those who are not, EMS providers must operate under certain protocols. And they have a scope of practice. And so, often, and typically, that scope of practice does not include giving a medication to someone when they're not currently being treated. So this is a bit of a change in the type of work that EMS providers do. So looking at those policies and procedures and identifying what needs to be adapted to allow for the provision of the kit is a first step.

Secondly, each state has different naloxone access laws. Pretty much all states now have passed laws that allow for community distribution of naloxone. But naloxone, being a prescription medication, that typically has to

happen in the context of, say, an overdose response program through a statewide standing order or through some other delegated authority-- from a physician to allow that naloxone to be given out in the community.

So if you aren't already connected to those who are responsible for overseeing a state naloxone distribution. Learning more about your state's access laws would be a key piece of information that you need as well. Because it might determine what information you have to collect and report. Who is going to be the standing order authority? Is it statewide, or does it have to be local? Things like that to help you set up your program.

Thirdly, you obtain kit supplies. Many state health departments are purchasing and providing kit supplies. I know, in some states, the local health department will purchase kits and provide them to their EMS providers. Or an EMS agency themselves may need to purchase and buy all the kit supplies. So figuring out how you're going to obtain those kits supplies and if you-- and package them together into the kit is a next step.

And fourth, having a point person for who's going to coordinate, who's going to figure out training, who's going to make sure that data is collected and reported out to the right and stakeholders. That seems to have been a key component of many successful programs.

And finally, working partnerships. Getting buy-in for a leave-behind program is critical. Steps one and steps two are both related to policy change. Changing scope of practice. That takes a lot of conversations. I'll quote Anthony, one of our panelists, it takes patience and persistence. So continue talking to your partners. Make sure you've got buy-in from the right stakeholders locally and at the state level.

And use that to your advantage, especially if you are not in the world of EMS. If you're a prevention provider or a harm reduction provider. You'll need partnerships. You'll need to build relationships in order to make this happen. So it's very important.

So in summary, the purpose of an EMS leave-behind is, from a public health perspective, to get as much naloxone as possible into the hands of people at highest risk of overdose because that is what is going to reduce overdose mortality. This program is not just a-- checking that box. It is, I think, building on the incredibly inspiring role that EMS plays in improving the health and well-being of communities.

EMS, they're the first on the scene often. They're the first point of contact into a health care system for overdose survivors. And have the opportunity to really change the trajectory of someone's experience in the health care system.

Positive interaction with patients with people who survive an overdose can affect not only that individual's decision making post overdose, but the likelihood that they'll call 9-1-1 when there is an overdose in the future. And we want people to call 9-1-1. We want emergency medical services to be alerted so that people can get connected to further care. Get transported to a hospital. Get referred to treatment.

And naloxone is an opportunity to bring all of that together. To start that conversation. To show the patient that they're cared for, and in a way that maybe they haven't experienced before. So the purpose goes beyond just a public health intervention. I think this is one of the most phenomenal things we can do to address the overdose crisis and reach people who are in really high need of services.

So I've provided an overview of what you'll find in the policy brief and how we got there. And now, you'll hear from our panelists. So first, I'll turn it over to Anthony Pantaleo who's a paramedic and works in the Bureau of EMS Trauma and Preparedness for the Michigan Department of Health and Human Services.

ANTHONY PANTALEO: Thank you, Erin, and good afternoon, everybody. I thank everybody for attending today and I appreciate the opportunity to speak with everybody about our program that we have here in Michigan that we got kicked off just over a year ago now.

In the brief that they have published it goes over our program. And basically, Michigan is set up a little different than a lot of other states. It is similar to some, obviously. But in Michigan, our 83 counties are covered by different medical control authorities.

And with each individual medical control authority, we have a medical director and their advisory group that approves their local protocols. As the state we provide state model protocols for them. And one of the protocols that we've offered to them for adoption is the leave-behind naloxone.

It is not a mandatory protocol for them to adopt. It is optional. And at this point, we've got 24 of our medical controls that have adopted it. And what's

really nice is Michigan being very diverse and urban to very rural settings with the upper peninsula, the leave-behind program is available to a little over 60% of our state's population by those MCAs that have adopted it, which for a year into it, I'm very pleased with, to be honest.

Overall, we have just over 800 agencies in this state with nearly 30,000 providers. So it was a pretty big task when we got this program launched and off the ground. And that's why we made it an optional protocol because we needed to do this and steps, basically.

So as a medical control adopts their protocol, we developed an online or in-person or virtual, however it works best for them, education program that's about one hour that not only talks about the leave-behind naloxone, but it talks about stigma reduction. It talks about harm reduction. We talk about motivational interviewing in that.

And try to get EMS more involved than just a reactionary-- I'm going to a 9-1-1 call for an overdose. It's about community and public health now. And I think, throughout COVID, we've seen EMS evolve very well across the country to more than just a reactionary state and taking care of our patients.

Another key part that Erin mentioned was partnerships. I have been blessed here in Michigan with some great partners that are also SAMSHA grant recipients that have developed some regional response because-- Opioid Response Consortiums in our rural areas of the state. And they have truly been champions and worked with the local medical directors to get this protocol adopted. And helped with education on the EMS providers on multiple levels on not just the leave-behind, but about stigma opioid use disorder and substance use disorders.

Another group we have here in Michigan, Families Against Narcotics. I am talking with them regularly that they're looking to involve EMS more and more across the state on follow-up programs that would also include the leave-behind naloxone programs.

As Erin mentioned, it's patience and persistence. It's not about talking to a medical director or EMS providers one time and walking away going, well, that didn't work. Let's try this again. We're going to come back and we're going to come back and we're going to come back and we're going to revisit this conversation.

And understanding, I have been in EMS for over 25 years now. And what I learned through paramedic school has definitely changed. I go back to before we did 12 leads as paramedics. And I had to learn about doing 12 leads. This is something new. It is innovative. It is a different concept for EMS. We all understand that.

But we also have shown it to be very effective in reducing the number, not only of overdoses, but particularly, overdose deaths in our communities. And as an EMS provider, our number one goal is to help people. And this is one way that we're able to help these individuals in a slightly new concept.

Our kits do include the naloxone. Face shields are an optional piece of equipment that the MCA puts in there. Kits are ordered through an online portal that our O-ROSC office through grant funds provides the kits and naloxone at no cost to the MCA for them to put on the rigs for the crews to provide.

We also have a great partnership with the Michigan Veterans Affairs Agency, which is a little bit different than the VA. Their resource card goes in all the kits. Whether they or a family member is a veteran, there are resources available for them. An instructional card on how to use the naloxone and what to do in the case of an overdose. And then, lastly, is a local resource card.

Our protocol says all of those things go in the kit. So it's not only the Veterans Resource card, but it's whatever county that they might be in, whatever their local resource is. So that's kind of an overview of where we're at with Michigan. And I will turn it back over to Erin for now.

ERIN RUSSELL: Thank you so much, Anthony. Up next is Stephanie Busch who's the injury prevention manager with the Vermont Department of Health.

STEPHANIE BUSCH: Thank you, Erin. And I also want to say I really appreciate everyone's time coming to this webinar. And I really hope that people take away at least one either fact or way that they might be able to advance this kind of work in their own state. So as Anthony kind of said already that EMS is critical in both the opioid crisis and COVID and whatnot.

But I also want to-- I would want to take a step further and say that EMS is a critical public health partner. And I think that through both the opioid crisis and then also, really, some of the work around COVID, which is not the point of this conversation today, has really highlighted how EMS is a critical partner

when it comes to public health. And I'll talk a little bit more about how we've done it in Vermont.

So providing a little bit of context. I'm sure people realize that Michigan and Maryland are very different places than Vermont. So in Vermont, our EMS system is about 180 EMS agencies, both transporting and non-transporting. And so the way that looks is a non-transporting agency might show up to a 9-1-1 call and provide some care until an ambulance comes. And then, that ambulance would transport.

So we have two different structures within our system. We have about 3,000 EMS providers, a bit fewer than Anthony's state. Just a little bit. Some of the other kind of key differences around our state is that we have statewide protocols where-- so one thing that's very fortunate with all of our EMS agencies as well as our EMS providers, depending on what level of certification they are, a paramedic is going to be providing the same level of care, same type of care, same skills, following the exact same protocols, whether it's in the northern part of Vermont or southern part of Vermont. So that can be a little bit different.

It made it much easier for us when we were implementing this protocol because we said, starting July 2020, you shall do this as an EMS agency where different states have different levels of medical authority. So that was one of our key differences. And I'll talk about how that kind of relates to some of our partners.

EMS in the state of Vermont has been administering-- responding to Narcan-- or responding to overdoses and administering naloxone and Narcan to a suspected opiate overdoses since around 2016. So EMS has been responding, as Aaron said, for many decades to overdoses. Narcan has been around for a number of years.

And then, really, for us, as we were continuing to see opiate overdoses, both 9-1-1 calls and then also deaths, we were really trying to figure out how can we ensure we're getting Narcan out into the community. And then, also, as Aaron said, people who have experienced an overdose are more likely to experience another overdose. So really making sure that regardless if people are going to the emergency department or able to go to a harm reduction service area or organization that they were actually getting Narcan.

So that was one of our big things. So we launched our program in the middle of COVID, which I think has resulted in a slightly slower uptake. But it has

really kind of kicked off since that summer of 2020. And so we implemented statewide protocols. Basically, every EMS agency shall utilize this protocol.

We really leave it up to the providers on our calls to identify, one, if someone is experiencing an opiate overdose. And then, our other kind of criteria for being able to give naloxone or a Narcan kit would be if someone has symptoms or signs of an opiate use disorder. So really, the idea was low barrier. Even if you're going to a call for an asthma attack and you suspect that that person might have an OUD, you can just document that and put that and offer a naloxone kit to someone.

We've seen most of our kits have gone out to people who've experienced overdoses. But also, wanting to make sure, again, that we're getting it into the hands of people that need it. And some of our key partners include our ADAP program. So I'm blanking on the name right now.

It's the Drug and Alcohol Abuse Program and they're in the process of changing their name. So our department, we have a regionalized-- so we have statewide protocols, but we have regional EMS districts. And so engaging our EMS district leadership was really key in understanding the needs and challenges and barriers to our EMS agencies and our providers. Like working through training and figuring out what they would need.

And then, one of the things that-- which we haven't talked about yet is really engaging other states that have these programs. So New Jersey and Pennsylvania were really key to saying, what are you all doing with your states? What's worked out well? If you could go back and do it again, what do you wish you had known in the beginning? And that was really amazing to be able to leverage other states and other programs to learn their lessons before we had to go through that process alone.

With our-- as I said, with our protocols, it's really about getting it into the hands of people who might be in a position to help. So whether it's someone who-- a patient who had overdosed and then they might need it later in the future, or friends and family. And really, what's allowed that to happen is our standing order that we've had in place since 2016.

So with our kits, we have Narcan. We have a statewide Helplink Hotline that allows people to be able to get whatever resources from recovery treatment, harm reduction, SSPs, et cetera. And then, we had also had an idea around the rescue breath barrier. COVID's kind of screwed all of that up.

And so we're kind of re-evaluating how can we help people safely perform chest compressions and rescue breathing in a time of COVID and what training is needed or are we going to scrap that for a little bit and just help provide resources to the best of people's ability. We'll see about that.

One of the things I do want to highlight as well, specifically, in Vermont, because we're relatively rural, most of our overdoses are actually in private homes where-- and not so much kind of like in the street or in common public places. Trying to figure out, how can we get those resources into private homes into the community. And then, help people feel comfortable that they can actually call 9-1-1. So we have some good Samaritan laws that help to reduce the stigma of calling 9-1-1, which has helped. We have a lot of work to do on that. But that's been one of the key things.

And then, the one other thing I'll also add around, specifically, overdoses and engaging EMS, as I said, they're key public health partners in this work is really, one, working to address first responder mental health and wellness or compassion fatigue.

I know when we were really developing this program, one of the challenges that a lot of EMS providers and first responders, in general, really had spoken to is they're going to the same patient on a somewhat regular basis, whether it's weekly or monthly or annually. They know that people need help. And they just don't have the resources. They didn't have the resources to help that person other than providing excellent medical care. And then, taking them to the emergency department.

And so the naloxone leave-behind kits really were one step of-- yes, you're responding to an overdose. This person is having a hard time. Yes, we can take them to the emergency department. Connect them with recovery coaches and whatnot if they're interested. But having a leave-behind kit allows for that conversation to start. As I like to say often, EMS are gatekeepers to health care.

Historically, we're the one-- we'll bring an ambulance to you. With emergency departments, you have to come to an emergency department to receive care. And so empowering EMS providers and first responders with that one prevention tip, that initial conversation around getting access to services can really mean life or death. And also, as Tony said, in EMS, we want to help people. We want to help them have better lives. And this is just one piece that can work to empower people.

And then, the other thing I'd also say too, so with Vermont, that was slightly different is we actually have a website around mental health for EMS providers and first responders. Just understanding the ongoing opioid crisis. And then, also COVID and whatnot. The mental health and wellness stress that a lot of first responders are experiencing. And so working to bolster those resources to help people as well.

That's a lot of information. The one other thing I should also say-- sorry, Erin-- is for our next steps, one of the things that's kind of cool. We're actually working to extend this program into law enforcement, which will be really exciting. Through our social autopsy reporting, we have found out that more than half of people who die by-- or die from an opioid overdose have been touched by law enforcement. And specifically, a couple of different law enforcement agencies.

And so being able to extend our EMS program into law enforcement and engaging those partners will be a good opportunity to further increase the community access to naloxone. Looking forward to hearing anyone's questions. And if somebody wants to reach out to me to talk more individually about what Vermont did, I would love to. And there's my email. And I will turn it back over to Erin.

ERIN RUSSELL: Thank you, Stephanie. Thank you for building on some of the themes that Anthony highlighted such as the differences in protocols and the way that's approached in your states. And that there is a need for partnership at different levels. You both mentioned state level partnerships, local municipality, coalitions. So at all different levels, there's people that need to be engaged.

And highlight in leveraging other overdose prevention interventions, such as the good Samaritan law. So thank you. And finally, I'll turn it over to our representatives from Maryland. Becca Scharf is the data and performance analyst at the Howard County Department of Fire and Rescue Services. And David Sabat is a Battalion Chief of EMS operations with the Howard County Department of Fire and Rescue Services.

DAVID SABAT: Thank you, Erin. Thanks for the opportunity to speak today. So this was an interesting venture here in Howard County. Around 2018, I was reassigned from the field to come up to the headquarters to work with the EMS operations. And it was-- around that time, the state had released what we'd call an optional protocol for leave-behind naloxone kits. And it was pretty quickly put out. Hey Dave, this is a great opportunity. Me and Becca worked together. Take it and go forth.

And we had some opportunities to build from, but this was a very interesting venture. So in Maryland, there are 23 counties and one major jurisdiction, which is Baltimore City. Our state protocols are just that. They're statewide, but there are specific optional protocols, similar that Anthony had mentioned.

So in Maryland, 14 counties have adopted this optional protocol, the leave-behind naloxone kits. So like I said, in March in 2018, the state had released the protocol. And in June of 2018, we were able to successfully get this program up off the ground and running.

Now, what made this successful in the beginning for us-- what made it a little bit of an easier lift was that in Howard County, specifically, we already had peer recovery specialist to work with, our local health department. And the police would try and get a contact phone number from overdose patients.

Now, as you can imagine, a lot of people were resistant to give accurate phone numbers. So they only had about a 40% accuracy rate with the phone numbers they got. So not many people got in contact with peer support specialists.

So this was an opportunity for us to be that bridge to bridge that gap to get to connect them. So the take home naloxone kits, really, provided two opportunities. One, a set of resources for this patient. How to contact peer support. We actually had some additional resource information there for them as well and the naloxone.

And we had a little pink piece of paper on the outside of the kit. And we had our EMS crews break down the patient's name and a phone number. And then, we would send that up so that we would actually be able to submit that phone number. And we had a much higher success rate with gaining a valid phone number.

Now, one of our big concerns-- and Stephanie touched on this was compassion fatigue. We also were running in the same situation where crews were running to the same patient multiple times. And our main concern was, look, people have their own personal biases for whether or not we should be giving Narcan to someone that has just overdosed. Some people felt that maybe we were encouraging that activity.

So we really felt like our biggest challenge was to get buy-in from our EMS crews. And we did that in a number of ways. One is, we made a video. We

made a short video. We provided a virtual platform for all of our crews to watch-- all of our personnel to watch that encouraged the most articulate and the most compassionate person on the scene to provide this kit to the patient or their family or cohabitant on the scene.

That may not always be the paramedic and that may not always be the officer. But nonetheless, we felt it was important that somebody provide that kit in a most compassionate way possible and articulate way.

One of the things that we found out early on was that we actually tried to avoid the paramedic directly in charge of patient care with providing that kit. They had enough going on and we felt like it just got bogged down in the process. At this point, since June 2018, we've distributed over 360 leave-behind kits to patients or cohabitants or family or friends on the scene.

The other way we've tried to get buy-in is from feedback from our health care partners. So working with our local health department, which provides the kits as well as the naloxone. We try and get feedback on the patients and the clients that we've referred to them for their peer recovery specialist so that we can let the crews know that, look, your efforts are not in vain. There's actually real benefit-- real tangible results of what you're trying to do.

So from that, in June 2020, Becca and I were part of a small group that actually looked at the data and said, how are we doing and what do we find to be most successful? And what we found was, actually, contrary to when the protocol came out, which really tried to deter people from giving it to patients.

Actually, we found that if we give the leave-behind kit and all the things that come with it. If we were to give that kit to a family member on the scene, that patient was five times more likely to be contacted and make contact with a peer recovery specialist than if no kit was given at all. And if we could give it to a friend or a cohabitant that they lived with at the scene, they were nearly four times as more likely to be contacted by a peer recovery specialist.

And then, if we give it directly to a patient, it was about 2 and 1/2 times more likely. So what we've done is go back to the crews and say, look, this is great. You're doing great work. These are the tangible results that we're seeing. Please keep in mind that these are the people. Focus on these efforts specifically to be successful.

Now, from that, we continue to look for ways to improve upon the program. So in Howard County, all of our police vehicles-- all our police officers are

equipped with naloxone to administer overdose patients. As well in all of our county buildings, we have AEDs and bleeding control kits and all of them also contain naloxone as well.

We've recently misstated fentanyl test strips to our leave-behind kits. And just a couple of months ago, we partnered with a crisis stabilization center here in the county to have patients-- overdose patients actually stable-- as long as they're stable meet specific criteria, to be transported directly to that stabilization center as a bridge to get them to recovery. This stabilization center has had a nearly 75% success rate with getting clients from their center to recovery placement within 72 hours. So we're hoping to build upon that opportunity.

Lastly, what I'll say is you've got three great examples here. Maryland Vermont, and Michigan. All of us a little unique in how the constraints we have, but also how we've implemented. What I'd say is if one of us, I think, reflect the challenges or the model that you work within, please feel free to reach out to any of us to see how we can assist you and provide you some guidance. So with that, I appreciate the opportunity. Look forward to your questions. Thank you.

BECCA SCHARF: David about covered everything really, really well. So we will-- very ready for your questions. Definitely.

ERIN RUSSELL: All right, thank you so much to all of our panelists. And now, we'll move into discussion and Q&A. So we have a few questions coming in through the chat. And we ask if you do put a question into the chat box, please actually copy and paste that into the Q&A box. Because it'll be much easier-- it'll highlight it, then, for us as a question to answer.

So first, I have a couple clarifying questions that I want to make sure I get addressed before we go into some more bigger picture questions. There was a question about, can you repeat the how many times more likely statements just so people can jot down those numbers? That's also reflected-- and we should also make sure people know it's in the article that we shared.

BECCA SCHARF: Yeah sure, absolutely. So within the article, we were looking at the association and the odds of connecting to peer recovery support based on who received the kits on scene, right? So when the kits were provided directly to a family member on the scene, which was a mother, father, grandmother, direct family member, they were 5.16 times higher odds of being connected to peer recovery support specialists.

When it was given to a friend or a cohabitant, it was 3.69 times higher odds. And when it was given directly to the patient, it was 2.38 times higher odds. And all of these are as compared to not receiving a kit.

ERIN RUSSELL: Thank you, Becca. And David, can you elaborate a bit more on the stabilization center?

DAVID SABAT: Yeah, absolutely. So it's really a multi-resource center available to help anyone considering suicide as well as our-- address any kind of homeless considerations. Anyone that is having trouble getting food or paying for their bills.

But also, with that, able to handle any patient that has an overdose or would like to reach out for recovery options or treatment options. That program is already in place. We just sort of built that bridge where now we can transport patients directly from an EMS scene to that facility.

ERIN RUSSELL: Thank you. And Anthony, you had mentioned follow-up programs. Can you elaborate on that a bit?

ANTHONY PANTALEO: Absolutely. In various areas of our state, we have EMS partnered and they've created their local partnerships with peer recovery coaches and QRT programs, which are the quick response team or the overdose follow-up programs.

So basically, what the EMS crews do or their quality improvement staff within the EMS agency, they're referring these overdose calls and making a referral to these folks to follow-up with the individuals that overdosed, ideally, 48 to 72 hours after they have experienced the overdose itself.

And they reach out. They try to schedule a visit. The visits can include EMS. Sometimes it includes non-uniformed law enforcement with the Families Against Narcotics group. Typically, a peer recovery coach. Sometimes, there are local pastors or ministers that might be involved in this.

And basically, they reach out to these individuals with the understanding that patience and persistence, again, they may not want recovery. They may not want to seek treatment at this time. But we're offering it to them, whether they accept it this time or not. It might be the sixth, eighth, tenth time we have dealt with this individual. We're still going to follow-up with these folks. Offer them

naloxone and talk with them and see if we can help get them into some type of treatment for their addiction.

ERIN RUSSELL: Thank you. And I think this is such an important point that there are existing resources. States are investing a lot in building up infrastructure to support people with addiction right now. And EMS and naloxone leave-behind programs is an opportunity to, like David said, bridge the gap between get the patients and these existing services. Thank you both for highlighting that.

STEPHANIE BUSCH: Erin, I want to add real quick. And I'm not sure about Michigan and Maryland as far as paid systems versus volunteer systems. But I know one of our big challenges is that a majority of our EMS agencies are predominantly volunteer-based.

And so understanding funding mechanisms and how-- it's one thing if someone's already doing certain work and saying, hey, can you do this other added component for either little to no funding versus having a peer recovery coach in an EMS agency that's predominantly volunteer. So understanding some funding mechanisms can also be a barrier for a lot of agencies. And that's different across the state, but something to consider.

ERIN RUSSELL: Wonderful. That's a really great point, Stephanie. And actually, leads me to the next-- another question. We have a question about stigma associated with naloxone and how buy-in was obtained when you have the barriers of stigma and the barriers of volunteers being overworked and the demands on them. So everyone consistently-- all panelists consistently mentioned compassion fatigue. That is real and very serious.

So can anyone speak to what worked? What might have-- what tipped the scale and got people to open up to the idea of a leave-behind program?

STEPHANIE BUSCH: I can start. Oh, sorry. And then, I can pass to Maryland because I know you guys have done specific work. So specifically with Vermont, our-- one of the things that really helped is that within our office or in the department-- or the office that I work within, we are all EMS providers. Most of us are volunteer EMS providers. So we're known throughout our community, which can really help some of our conversations around-- and also we've experienced. We've been on overdose calls. We've been to repeat patients where we're going to often. So we really understand that kind of work.

And one of our biggest barriers, actually, so I'll jump on the funding component is even just-- when we were starting to talk about leave-behind programs, a lot of agencies or departments can get really anxious about just the potential cost of-- OK, we're going to do this for a year, but what happens after that?

And so us being able to have, specifically, SAMHSA funding to say, this is-- a funded mandate has actually made it a lot easier and removed some of those barriers. In addition, we have training that we've done with all of our providers around compassion fatigue. And then, also with opioid overdoses. And really, shifting that stigma around drug use and the challenges. And some of it's resonating.

So I remember one time I was in the middle of the state and I was talking about the leave-behind programs. And people were-- I was getting so much anger and frustration and barriers from the people I was training. And so one, as an EMS provider, engaging in that conversation. And what it was is they felt helpless. There were like, we have this one specific person who we go to, literally, every single week for overdoses and we can't do anything for it. We can't do anything about them. And this was before the leave-behind programs.

And so it's like, OK, let's have that conversation. Let's engage with your local recovery centers and treatment centers and harm reduction programs to help that person. That person is calling you for help. And it's super frustrating to not be able to help them in a way that you want. So how can we work to address that? And that agency is one of our most engaged agencies for the entire state because of that. Unfortunately, I think part of it is-- it's some bad areas. Areas that are just really suffering from a lot of opioid use disorder.

But their frustration or their aggression against me originally was just because they were throwing their hands up. So that was getting-- getting at the root problem was one of the big things. And then, I know that David in Maryland has really awesome stuff that they've done. So I won't take any more of that. But I want to hear you guys talk about your stuff.

DAVID SABAT: No, thank you, Stephanie. Actually, just to build upon what you said. Yeah, I think, from our perspective, let's take it from our crew's perspective first. We were already handing out information for smoke detectors or other resources that the county had available to our patients or people that called 9-1-1.

So I don't think it was much of a bridge to say, look, now, there's this other resource. Look, I know you don't want to run to the same person consistently. Let's actually get them to the treatment they need. And then, I think for the patients know. We try to emphasize that they engage them-- either the patient or the family confidentiality and in a most professional manner that they could possibly. And no, we've never had any problems with that being a challenge for us.

BECCA SCHARF: Yeah, I will say that I do think that compassion fatigue is still an issue. It's still a barrier within our program. It's something that we combat, I think, pretty constantly. And the emphasis operationally to really focus on the most compassionate person on the scene who isn't totally burnt out or hasn't run three overdose calls overnight is a really important aspect because it puts that power and that responsibility in someone's hands who can actually compassionately talk to this individual who's just had this fairly traumatic experience or their family, right?

So I think that is also a really important aspect of combating that field and provider level stigma and getting that buy-in.

ERIN RUSSELL: Excellent. So I'm hearing that the messenger is important for who's doing the training and having conversations with EMS. And in the situations you highlighted, both Stephanie and David are EMS-- you can speak from experience and can relate on that level. So that sounds very-- a very important component of the training and bringing on board of others.

And then, that's a good point that just to echo and reiterate and reiterate that. To be thoughtful about who's going to be, actually, asked-- tasked with doing this on the scene. And so it doesn't have to be someone who's completely burnt out. It can be-- that their-- you can be thoughtful about who takes that on and flexible as well.

BECCA SCHARF: Yeah, exactly. And I also think that it-- coming at this from both a public health and an EMS standpoint, right? As a manager and somebody implementing this program, I think it's important to also understand that our EMS providers don't come from a public health background. They don't necessarily know what harm reduction is or understand why it is such an important approach and theory to the opioid epidemic and to addressing addiction.

A lot of people come from a background where abstinence only treatment is the only option, right? And that's very-- goes very against what harm reduction does. And all of these programs and these innovations that are distributing

naloxone are inherently harm reduction programs. So it's also coming at it from-- trying to educate people on what harm reduction is at an operational level as well as those individuals that you are treating for their overdoses, right?

ANTHONY PANTALEO: Becca, that's a great point. And as an EMS provider, it is difficult. As a long time EMS provider and other EMS providers, it is a challenge for some people to accept that there is opioid and substance use disorders. This is a recognized medical issue that people suffer from. It's not just a lifestyle choice. And oh, I'm going to choose to use heroin today. It doesn't work that way.

And changing that mindset can be very difficult and takes multiple conversations and multiple levels of education.

ERIN RUSSELL: Thank you, Anthony. Stephanie, did you want to add to the stigma conversation?

STEPHANIE BUSCH: The only other thing I was going to add-- and for my Vermont might be a little bit unique to this is when we were developing our protocol, we kind of-- it was originally the conversation of someone overdoses and so we can get them leave-behind kits post-overdose, right? If they're not going to the emergency department and whatnot.

And one of the things that we wanted to make sure to highlight early on was having as a low barrier. I don't want to make my EMS providers justify-- have to list the five different reasons why they're giving someone a leave-behind kit. And so how we made it was kind of like, if they have signs of an opioid use disorder. And it's kind of like, just-- and it's like a-- it's a way that I think we're going to talk about data at some point.

Just explain that you offered, was there any challenges or questions, so we can continually improve our program. But really making sure that it's like, if you think that this person could benefit from a leave-behind kit, give it to them. I'm not going to be like, why did you get five of them out at one overdose? Because if there's five people that want them, we're getting it out to the community and the hands of people that could potentially save a life.

And so really emphasizing that and where it's not like, oh, I'm going to get harassed from my-- our EMS office if I give out five of them to one overdose call. But they're really trying to make that low barrier, which I think is-- it's

making it less of a deal, I guess, to try and reduce that stigma. That's not a nice way to say that at all. But normalizing--

ERIN RUSSELL: Trying to get as much naloxone in the community as possible. If naloxone is at the scene of every overdose, then people have a higher chance of surviving and that's what contributes to a decrease in morbidity.

STEPHANIE BUSCH: And we reason seen that some in-- with our overdose-- I read the narrative of our overdoses. And I've seen some recently where it's like, the people had Narcan, they used it, and the person was still experiencing symptoms or whatnot. Boyfriends and girlfriends overdosing together. And being able to read that they had it on scene already is-- and then, they called my 9-1-1 is amazing. That's not what we saw in 2016.

BECCA SCHARF: So that's actually interesting, Stephanie. What we recently-- I would say COVID has made everything a little bit more difficult. But one thing that we were finding on our field providers we're finding is that they would go to the scene of an overdose. And then, they would-- people would already have a kit on scene but from another county. From one of our neighboring jurisdictions who had already given a kit or they would have maybe multiple kits on scene. So we're kind of seeing that.

We'll offer it, but they'll be like, nope, I'm good. I have one from Baltimore County or from-- so we're reaching a point where we are not quite saturating, I don't know that I would say that. But it is reaching those, I think, that we are intending them to reach.

ERIN RUSSELL: Can I clarify-- so then when you respond to an overdose-- if 9-1-1 is called and you respond and someone has a naloxone kit already on scene, is it that they're already revived? And so it means your job is easier, in a way? What is that like?

BECCA SCHARF: That's a good question for Dave.

DAVID SABAT: Yeah, nice hand off, Becca. Yeah, absolutely. So what's interesting is, I think, exactly like Stephanie said. The more you can normalize it, the better. So even on those scenes-- maybe some of our transient patients that will run-- there's a kit already on the scene. We will still give them a leave behind kit from us.

Because look, one component is Narcan. The larger component that we're trying to get out there is the connection to resources. So you may have one, just like Becca said, from a surrounding jurisdiction, which may have other things in them. There are other counties that even have-- that may provide STD information or condoms in their leave behind kits.

Ours has a different set of resource information. We want that in the hands of the patients, regardless of whether or not they have a kit already.

ERIN RUSSELL: Excellent. Thank you. So we do have a few questions in our Q&A box about evaluation, outcomes, data collection. Just wonder if we could pivot and speak briefly about what information is collected and how does that contribute to evaluation of your efforts?

ANTHONY PANTALEO: So I'll jump in first here. So our EMS providers, when they leave a naloxone kit, it is documented in their EPCR. For Michigan, we have dropped it into the procedure section. We talked with a lot of different folks in EMS across the state. Do we put it under medications? Do we put it just into the narrative? Do we put it-- where do we put it?

And where we've landed is in the procedure section. And there is a code for Nemesis. It is a code that anybody in the country should be able to use for Nemesis data information. And it moves into our state database. And it's a procedure code for a general education leave-behind naloxone for opiate intervention.

And basically, what that allows us to do is track when kids are left behind. It puts it in with a PCR. We can see if naloxone was administered during that overdose or not as well. And again, our kits are available not only to those that have overdosed, but any patient that tells our crew that they have opiate use and they suffer from addiction. We can leave it with them or family as well.

So the next part is the evaluation. And we are starting that evaluation process, actually, the first quarter here of 2022. We've worked with Vital Strategies on an evaluation tool that we're going to start looking at the number of overdose responses to the number of kits that are left behind. De-identified demographic information as well. Age brackets, sex, gender backgrounds, and racial demographics.

And we're going to start to look at, do we see more kits being offered in various areas of the state? Does this rural county offer it more often than this

urban county? And we're going to start looking at those comparisons and identifying what we can do better to help promote this program across the state.

ERIN RUSSELL: That's amazing. Racial health disparities are coming to the forefront as-- are finally having light shed upon them because of COVID and overdose. I know, in many states, there are overdoses disproportionately affecting people of color. So I am very happy to hear that you're looking at demographic breakdowns of who's receiving it. And then, trying to address any gaps. That's a great point.

STEPHANIE BUSCH: I'll add a little bit. But I think Becca-- we're also just starting to do our evaluation. So I'm sure that Maryland has a much more extensive information around their evaluation. So because we have a statewide protocol, all of our EMS agencies report into Siren, which is our electronic health care record.

So we actually-- we looked at adding them as procedural questions. But I think we just added them as supplemental. It's actually listed-- you can see in the protocol at the bottom of how it's being documented. So the nice thing about having it in our electronic health care records is that we can-- we have the entire rest of the call demographic, why they were called, what they do, what the narrative says for us to be able to-- for our program to dig through those questions. And I know that will be involved in our evaluation.

One of the things we also had because we knew this was going to be an iterative process and some agencies were really going to jump on really quickly and then other ones were going to be a little bit less so is having a-- if it was offer-- so this kind of an open narrative response of, if it was offered and you didn't leave behind or if there were any challenges, please just document in that question what happened, basically, to understand that we were going to be going through an iterative process and going to be improving it.

So we'll take that information and actually look at, how can we make our training better? How can we provide more motivational training or et cetera to better equip our providers? And then, the other thing I'll also add on to is because Vermont is a small but mighty state, we really like to push statewide resources.

So we have-- one of the things that our [INAUDIBLE] partners have done is we have VP Helplink, which is kind of like a one stop shop, which makes it much easier than, oh, this county has this resource and this county has this

resource. It's also a much smaller state and less densely populated than a lot of my counterparts.

BECCA SCHARF: Yeah, that's great. So in Maryland, we also have integrated a supplemental question into our EPCRs. And I mean, it's a very simple yes or no, did you leave a kit on scene? And then, it's followed with a contact number-- follow-up number.

One of the early challenges in the program-- because our program was designed to integrate with our health department was finding a way to adequately share-- have-- first of all, have the necessary legal documents in place to be able to share data between our two entities. And then, the actual mechanisms in place to be able to share our patient data. And then, also receive the information about peer recovery support follow-up, right?

So our systems that the health department used and that we use were never designed to really speak to each other or to share data across each other. So we had to come up with an entirely new system, which we could-- a HIPAA compliant database to be able to share with the health department.

And that worked for probably about the-- actually, really, probably until about COVID hit and everyone kind of got pulled in lots of different directions. So we simplified that to regular reporting from us to the health department of how many kits we distribute. And then, demographic information on the patients. How many overdose calls we went to within that-- I think it's a-- we do biweekly reporting with the health department now.

And then, for-- I personally track our-- whether or not we transport the individual. I think that that's actually really important information to track because one of the risks of somebody who overdoses and then is revived on scene and refuses transport or is the potential for them to-- for the naloxone to wear off and them to overdose again while nobody else is on scene from the same incident.

So transport to the hospital, even if the individual is well revived, is still really important. And so I think that's a really important metric to particularly look at as far as the impact of the program.

I think that-- and then, yeah, number of kits delivered is always-- that's kind of an obvious one, right? Do that monthly, quarterly, yearly and out from there

STEPHANIE BUSCH: We have that same thing we like to promote around even if someone overdoses and is revived that they're still transporting. Because there are other reasons that-- the way that I like to say is there are other reasons that people are not breathing and not waking up. They hit their head when they passed out or they're diabetic.

And so getting them to be seen by medical providers is good. But then, also, for a lot of our emergency departments, they have recovery coaches so we can get them into other levels of care or other-- it's a constant struggle.

BECCA SCHARF: Yeah. Oh, one thing I did want-- a future goal of mine is to be able to somehow track the number of repeat kits, right? So the number of individuals who we've given a kit to. They have maybe used that kit or they have-- and then, we are responding again and also providing an additional kit. So how many times are we providing kits to the same individual? And how often are they then being followed up with?

That's a future goal to figure out how to do with the data. But it could be useful for anybody else.

ERIN RUSSELL: Thank you all so much. There is a lot to measure. And then, a lot of opportunities for evaluation. And so thank you for highlighting what has worked for you and how the information is collected.

There's one more clarifying question that I'd like to get to in our Q&A, and it's about obtaining patient phone numbers and considerations of confidentiality when connecting-- when bridging the gap. And so can someone speak to-- are you-- do patients opt in to provide their phone number? Or are there-- what is the, I guess, precedent for being able to do that? Go ahead, David. You want to kick us off?

DAVID SABAT: Yeah, so we'll ask-- we'll let the patient, look, we can connect you to someone that can help you-- connect you to resources. Can we get a phone number? And the majority of the time, we're able to get a contact phone number from that patient. We handle that phone number the same as we would with any other PHI with how it's routed through. And just like Becca said, we have a HIPAA compliant database that will share that information with our health department who manages the peer recovery specialist.

As well as, like Becca said, in our patient care reports, we'll track every time a leave-behind kit is left and the phone number will be in the PCR as well that we'll follow-up with.

BECCA SCHARF: Our naloxone program is also included in a overarching MOU that we have with the health department to be able to share data for a few of our other community health programs. So this one is also included for our mobile integrated health program and the program that we use to put all of the AEDs in county buildings. And so this is also included under that. So it covers us, in that sense, as well.

ERIN RUSSELL: Wonderful.

ANTHONY PANTALEO: Just to add here in Michigan. It's very similar. Our PHI shared with our hospitals and public health departments and so on and so forth. I mean, we follow all those regulations. But a lot of times between agency-- EMS agency and some of our other follow-up programs, they have developed business associate agreements or some type of data sharing agreement between the two entities that does allow them to share that information back and forth for follow-up visits or connecting them with a peer recovery coach.

So a lot of times, that's how we're doing it here in Michigan. But we're also looking at incorporating that EMS team member from the agency with that follow-up program. So it's an internal referral within the agency to that individual to go out and do the visit as well.

ERIN RUSSELL: Thank you. That's great. So yeah, I do-- I know an important tenant of harm reduction is self-determination is we're not forcing anyone into anything. People make decisions about their own care. And so I very much appreciate hearing about the opt in aspect of this and the offering of information. Which it sounds that you're all doing it in such a way that people are accepting it.

And so it's-- what I always say about harm reduction, it's not-- harm reduction isn't just the intervention. It's not just a naloxone kit or a sterile syringe. It is how you do the intervention. It's how you give someone naloxone kit. It's how you give somebody a sterile syringe.

And so thank you all for highlighting so much that this needs to be done in a compassionate manner and with a non-judgmental approach that engages the patient in the next steps of their care.

I'm so inspired by all of you. This is really amazing. Thank you for sharing such detailed aspects of your programs and the impact that it's had already,

not just on patients, but on EMS providers and the approach and that your state and your jurisdiction is taking to respond to the overdose crisis.

JEN: Oh, sorry. I didn't know if we had any more questions left. But go ahead if we're going to take more questions.

ERIN RUSSELL: Yeah, I was just taking a final peek at our Q&A. A lot of the questions remaining are related to some-- sharing specific forms-- data collection forms. I'd like to emphasize that all of our presenters generously offered to-- they asked me to put their email addresses in the slides.

So I will go slowly back through those slides if you didn't have a chance while they were speaking to write down their contact information. Please do that now. So this is Maryland. We can share this through the chat, perhaps, as well. Vermont. You won't hear back from Stephanie for a couple of weeks because she's on vacation. But she will get back to you.

And then, there's Anthony's email address. So I know we covered so much information. This is probably a lot to take in. I want to thank you all for your openness and patience and wish you all of the participants patience and persistence as you move forward. And thank you, Anthony, for that new quote of mine.

We are available, again, going to flip back through these email addresses so that you can see. We're available for follow-up questions. And we have a quick poll that we'd love to do to see where you all are at after this presentation. Because it will help guide us on next steps for the resources that you might need.

So we started with a policy brief. We put together this webinar so you could hear directly and get a bunch of your questions answered. So what's next? What more do you need? This is really fun to see live. So many of you are already on it. All right, we're still getting EMS on board, OK? There were a lot of questions about buy-in, about who the right partners are to speak to. And the policy brief does share specific partners that you should look to get started.

This is great. Well, thank you all so much. I want to give a big thank you to our panelists who made this happen and have generously shared so much of their experience and knowledge. And I look forward to following where you go next with your programs. Yeah, have an excellent rest of your day. I'll turn it back over to Christina for-- to close this out.

BECCA SCHARF: Thanks so much, Erin.

CHRISTINA: Yeah, thank you all so much for this excellent presentation as well as bringing all your research and experience on this important topic to us today. Let me pull up here-- we actually wanted to continue the conversation on social media.

So we invite everyone who attended to go to the Great Lakes PTTC Facebook page. And you can like and follow to find out more stuff that we're doing as well as we have transitions, OK?

[LAUGHS]

We have-- actually, we also have a drawing. So we have posted a-- we've put a post on the Facebook page that says, have you pursued an EMS naloxone leave-behind program in your community? If so, what challenges and/or successes have you experienced? And anyone that comments on that and that is also from the Great Lakes region will be entered to get a registration for our ethics and prevention course.

I know that, typically, if you-- you have to pay to take the ethics course and also to receive the continuing education credit. So you obviously don't need to pay for any of the Great Lakes PTTC training. So if you are interested in that and if you are part of the Great Lakes region, we kindly ask you to go and like our Facebook page and also comment on that post.

And then, as we close out, you will be redirected to a very brief survey. It's only about two to three minutes long. If everyone could take a few minutes to complete that for us, that's how we report back to SAMHSA, who is our funding agent. And it also allows us to continue providing trainings like this in the future to everyone. So thank you, once again, to everyone. Thank you for spending your morning and afternoon with us today. And have a wonderful day.