It's Hard, But It's Worth It: Lessons from Implementation of a Community-Based Nursing-Led MOUD Program

CATHOLIC COMMUNITY SERVICES OF WESTERN WASHINGTON

Agenda

- Introductions
- Relevant Terms
- Getting Your Organization Started
- Finding Your Clients
- How does MOUD work?
- Lessons Learned

Introductions

About your presenters

Casey Wishart, LICSW

Regional Director of Behavioral Health

She/her

18 years' experience of community behavioral health

Hired at CCS in 2013 to get CReW started

Primary role now: administrator, spreadsheet whisperer

Kerry Browder, RN, BSN

Registered Nurse

She/Her

3 years of nursing experience; over 10 years in healthcare

2 years of inpatient psychiatric experience and 1 years of community base mental health and substance use disorder treatment

What I do at CReW: I mostly talk to people and sometimes I give shots!

Janine Torres, PMHNP-BC, ARNP

Psychiatric Nurse Practitioner

She/her

10+ years as a psychiatric provider in Community Mental Health

What I do at CReW:

- Leadership: Development of clinical processes for the MOUD program.
- Clinical care: provide education and treatment choices, try to rebuild/develop trust in medical providers
- Personal: Focus on unexpected outcomes as learning opportunities

CReW: Counseling, Recovery & Wellness Program

- Brief program overview and history
- Current overall staffing
- Volume of services provided
- Primary funding source – King County BHRD

CReW Philosophies of care

- Meet people where they are: literally, figuratively
- Integrated, collaborative treatment
- Respect for the autonomy and individuality of persons served
- Flexible, dynamic, responsive to community needs
- Belief that recovery is possible for everyone

Relevant Terms

USING TRAUMA-INFORMED LANGUAGE

Language Matters

- The way that we talk about people impacts access to services and treatment relationships.
- Important to use Trauma-Informed, Person-first language
  - Consider the role and setting
  - How people refer to themselves may not be how they prefer to be addressed/described
- We may use some terms interchangeably: people, clients, patients, residents, guests

Language Matters: Opioid Use and Treatment

- Opioid Use Disorder (OUD)
  - Progression of diagnostic language to describe a person's relationship with substance use:
  - "Addiction" (1953) -> "Abuse/Dependence" (1980) -> "Use Disorder" (2013)
  - *Acknowledgement that a "diagnosis" in itself can stigmatizing*
    - *Assurance that documentation includes person-first language*

- MOUD (Medication Opioid Use Disorder) vs MAT (Medication Assisted Treatment)
  - Preferred term = MOUD; acknowledges the role of medication as first line treatment, in combination with psyhco-social support (National Practice Guidelines – ASAM 2020)
  - Helps reduce the stigma people may be concerned about in taking medication for treatment

Language Matters: Terms specific to treatment

Instead of...	Use...	Because...
"Former Addict"		
"Dirty" urine drug screen "Failing a drug test"		
"Drug abuse" (for both illicit drugs and prescribed medication)		
"Opioid Substitution" "Replacement therapy"		
"Clean"		

Language Matters: Terms specific to treatment

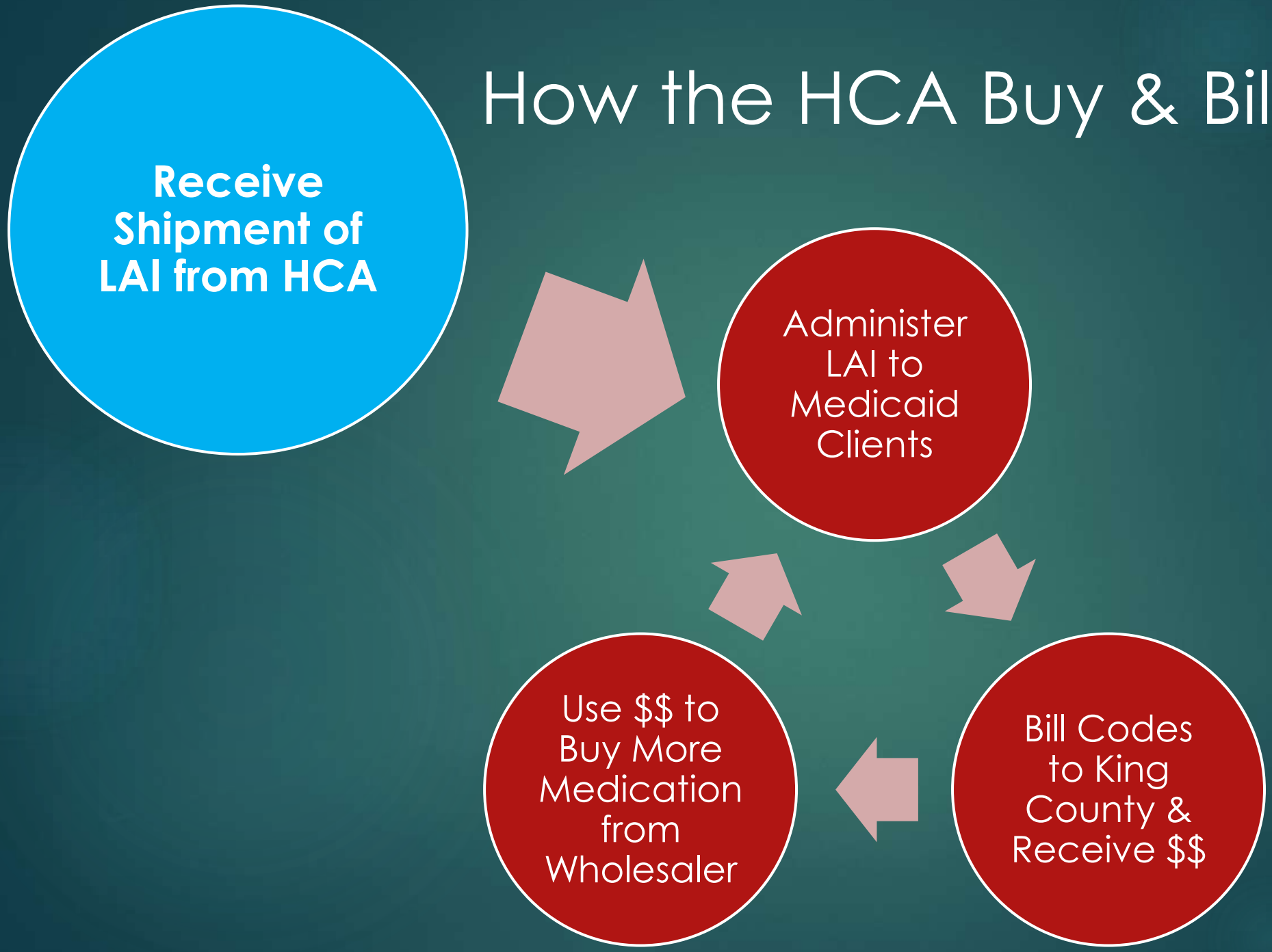
Instead of...	Use...	Because...
"Former Addict"	**-Person in recovery/long-term recovery** **-Person who previously used drugs**	Person *has* a problem, they are not *the* problem
"Dirty" urine drug screen "Failing a drug test"	**-Testing positive (on a urine toxicology screen)**	Use medically accurate terminology; these terms may decrease self-efficacy
"Drug abuse" (for both illicit drugs and prescribed medication)	**-Drug use (illicit drugs)** **-Drug/medication misuse (using prescription medications other than prescribed**	"Abuse" has a high association with negative judgments and punishment Using not as prescribed *is* "misuse"
"Opioid Substitution" "Replacement therapy"	**-Medications for OUD** **-Opioid agonist therapy** **-Pharmacotherapy**	MOUD aligns with the way other medication are understood – as being essential to treatment
"Clean"	**-Being in remission/recovery** **-Abstinent from drug** **-Testing negative (on a urine toxicology screen)**	Medical terminology (like you would use for other illness) reduces stigma

Getting Your Organization Started

Securing Funding

- KC BHRD fee-for-service MOUD payment structure for in-network BH providers
  - E&M Codes allow add-on qualifiers for MOUD services
- Seattle King County Public Health RFPs
  - Grant funding has broad scope of goals and deliverables
  - Competitive process to apply for and receive awards
  - Time-limited – need an off-ramp
  - Crucial to help pay for what Medicaid does not
- WA Health Care Authority's Buy & Bill LAIB program for small/mid-size providers – more detail next slide

How the HCA Buy & Bill Works



Opiate Overdose & Response Projects

- Expand services for people who use opioids that otherwise would not receive services in traditional outpatient services.
- Address quality of life issues for people who use opioids.
- Support community-based organizations to sustain or expand harm reduction services.
- Provide overdose prevention, naloxone distribution
- Support connection to services for people who use drugs from communities disproportionately impacted by overdose including people who are unhoused, people who live in permanent supportive housing programs

Deciding where to start

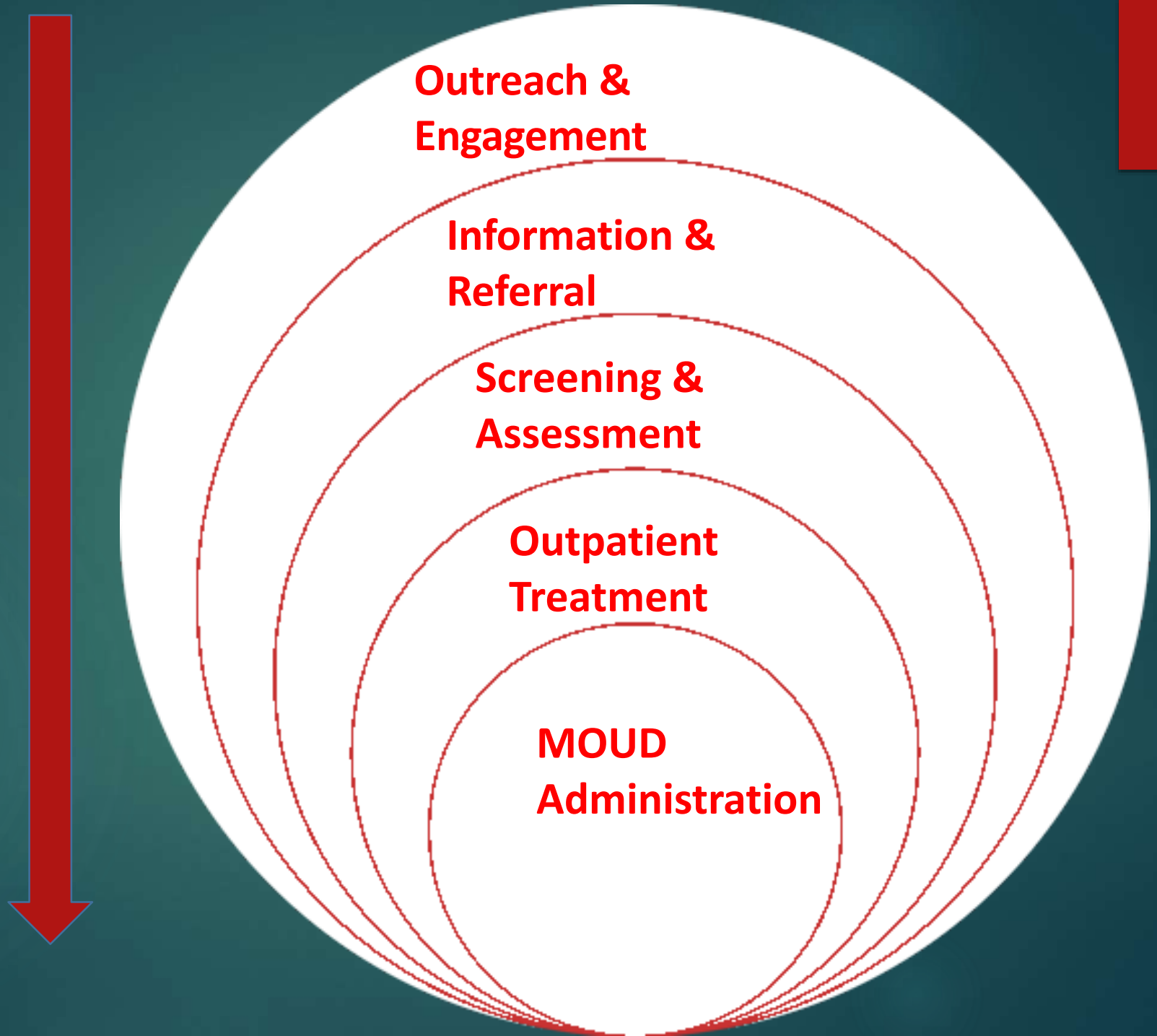
- Site selection: One emergency shelter and one PSH location
- Data-informed decision-making
- Consultation with housing and shelter staff across the local agency

Getting Qualitative Input

- Community Based Opioid Treatment (CBOT) study with University of Washington
- Researchers conducted qualitative interviews with shelter residents

Setting up the team

Services Flow



Pathway to Induction

Outreach & Engagement (relationship building, planning for addressing barriers to treatment engagement)

Nurse (RN intake including health history, vitals, medication trial history, gathering collateral medical history, education round I)

Provider (evaluation and diagnosis, education round II, medications orders placed); Note: to increase speed of induction, support meds may be ordered before this appt, based on info from RN intake

MOUD initiation (injection administration and/or review of dispensed oral medications); plan for next appointment

Defining interdisciplinary roles in the process – there is some overlap!

Outreach CM

Assertive outreach & engagement

Information & Referral

Health Education & promotion

Overdose prevention & response

Linkage to treatment (MH, SUD, MOUD, PCP)

Ongoing case management support

Care coordination with site staff and treatment teams

Nurse

Assertive outreach & engagement

Health Education & promotion

Overdose prevention & response

Nurse Screening for OUD

Facilitate appts with Practitioner

LAIB Administration

Care coordination with health care providers and treatment team

Practitioner

Screen for and diagnose OUD

Provide individuals with info re: treatment options for OUD

Prescribe medications, monitor for side effects

Training and education for staff

Provide follow up care, address MOUD side effects

Assertive outreach and engagement at the site (less frequent)

Finding your clients…or letting them find you

Outreach and Engagement

- This is the first contact with your organization so be thoughtful
- Speak to them without expectations
- Have a conversation with sensitivity
- Let the client lead – treatment is not always linear or fast paced
- Asking about client goals from treatment

The what and the when

- Be a familiar face!
- Consider putting up a table
- Have engagement items to start the conversation:
- What do you see on the table --->
- -Catchy sign
- -Snacks
- -Pamphlets
- -Narcan and fentanyl test strips

HOW to start the conversation:

- Start by identifying yourself – act natural

"Hi, I'm Kerry a nurse from CREW. What's your name?"

- Be friendly – open to talking about anything

"How is your day going?" Or *"Do you have any plans today?"*

- Give out items regardless of whether they're willing to talk to you

"You can take anything you want or need off the table."

You do not need to talk about MOUD the first time you talk to them

Words of wisdom from our outreach experts

How do you do client-centered outreach?

“There is not one approach. Don’t be about just fixing the problem, you need to listen to the client and respect their autonomy. You should approach with curiosity. You can't go in there and be a know it all because that will make them run off.” -Jennifer Philip

"For a lot of clients, their priorities aren’t what we expect. Having respect for those priorities and trying your best to see from the client’s point of view can help connect with clients as well as getting overall needs met."
-Morgan Paine

Consider your client from the beginning of the process

- Use Motivational Interviewing
- Remembering informed consent about the process – at all points
- Education needs to be suited to the client's education and attention level
- Flexibility and understanding -In active substance use can cause disorganization
- They are doing something very hard since they probably have trauma and anxiety around withdrawal

Consider your client continued

- Social context
  - Where do they live?
  - Do their friends/ neighbors use substances?
  - Do they have other services for mental health?
  - Do they have chronic pain?
  - Are they in a place where they can mentally and physically go through some withdrawal?
  - Couples or friends who want to do MOUD together
    - Consider pair dynamics

More words from the MOUD case managers

How do you support a client when they are not coming to their appointments?

"I make sure my presence is there and they know they are supported. I am figuring out what the barriers are. Is there something that I can do to break down a barrier? Is it physical, time management, or fear – a lot of time is it fear. Do they need something different from us? A different appointment day, extra reminders, or walking with someone to where they need to go?" -Jennifer Philip

"Keeping the process transparent with clients and trying to keep conversations as honest as possible can help strengthen the trust between the team and the client leading to more personalized care and higher retention." -Morgan Paine

Considering Individual Goals

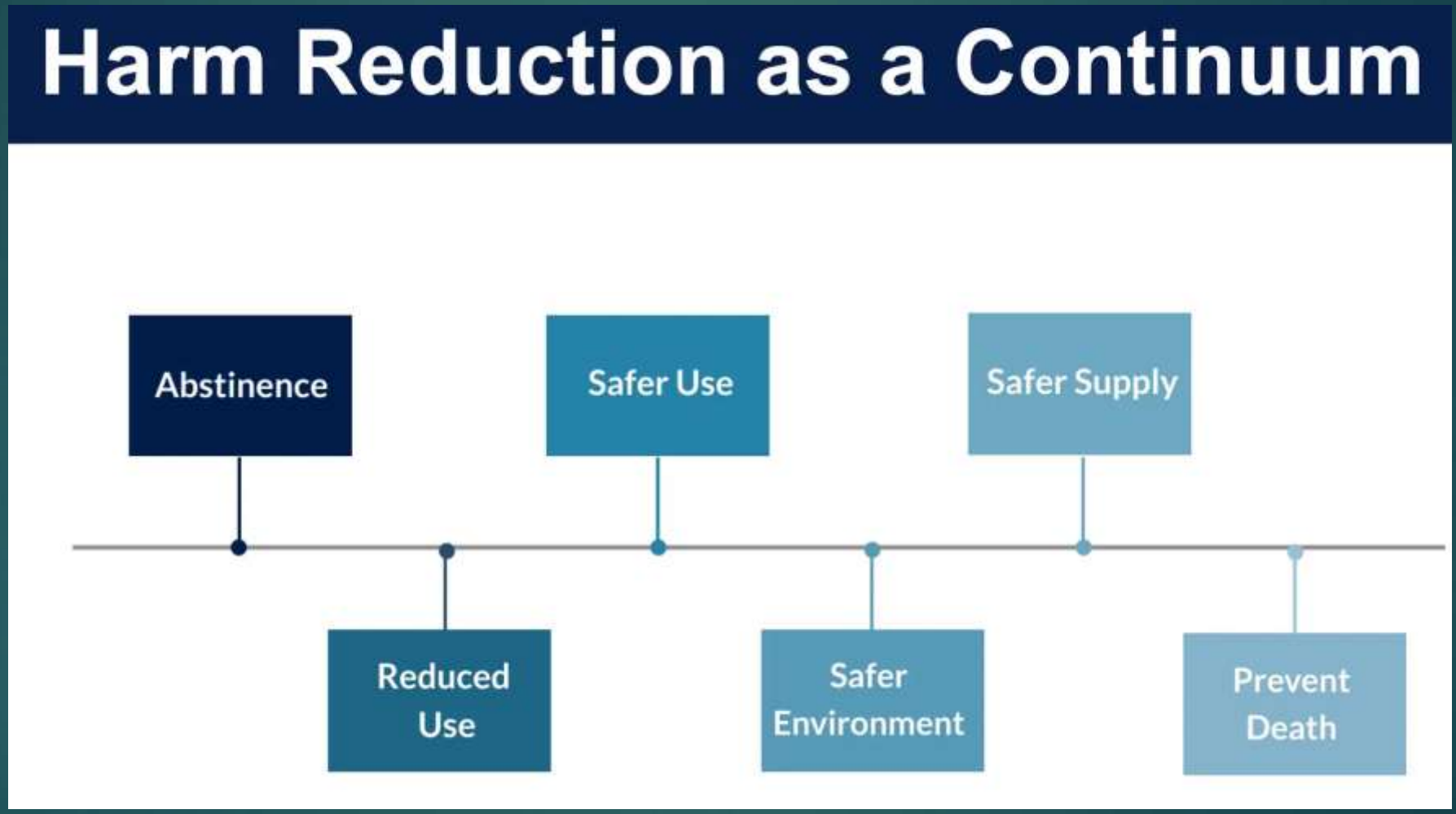
What do they want and why do they want it!

Collaborative goals

Incremental goals

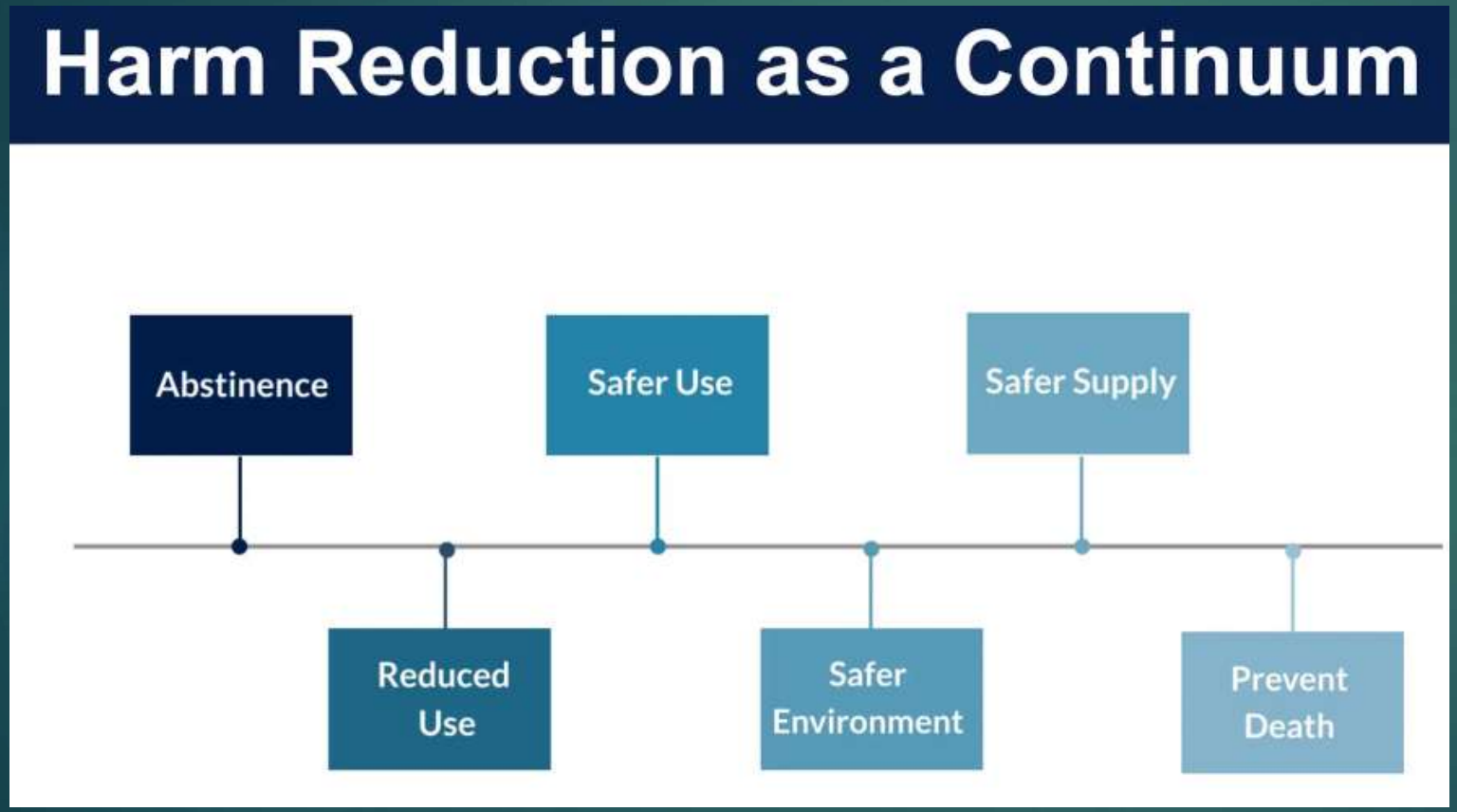
Consider different philosophies of treating substance use

Meeting the client where they are at



Absence based recovery

Example of this philosophy in action

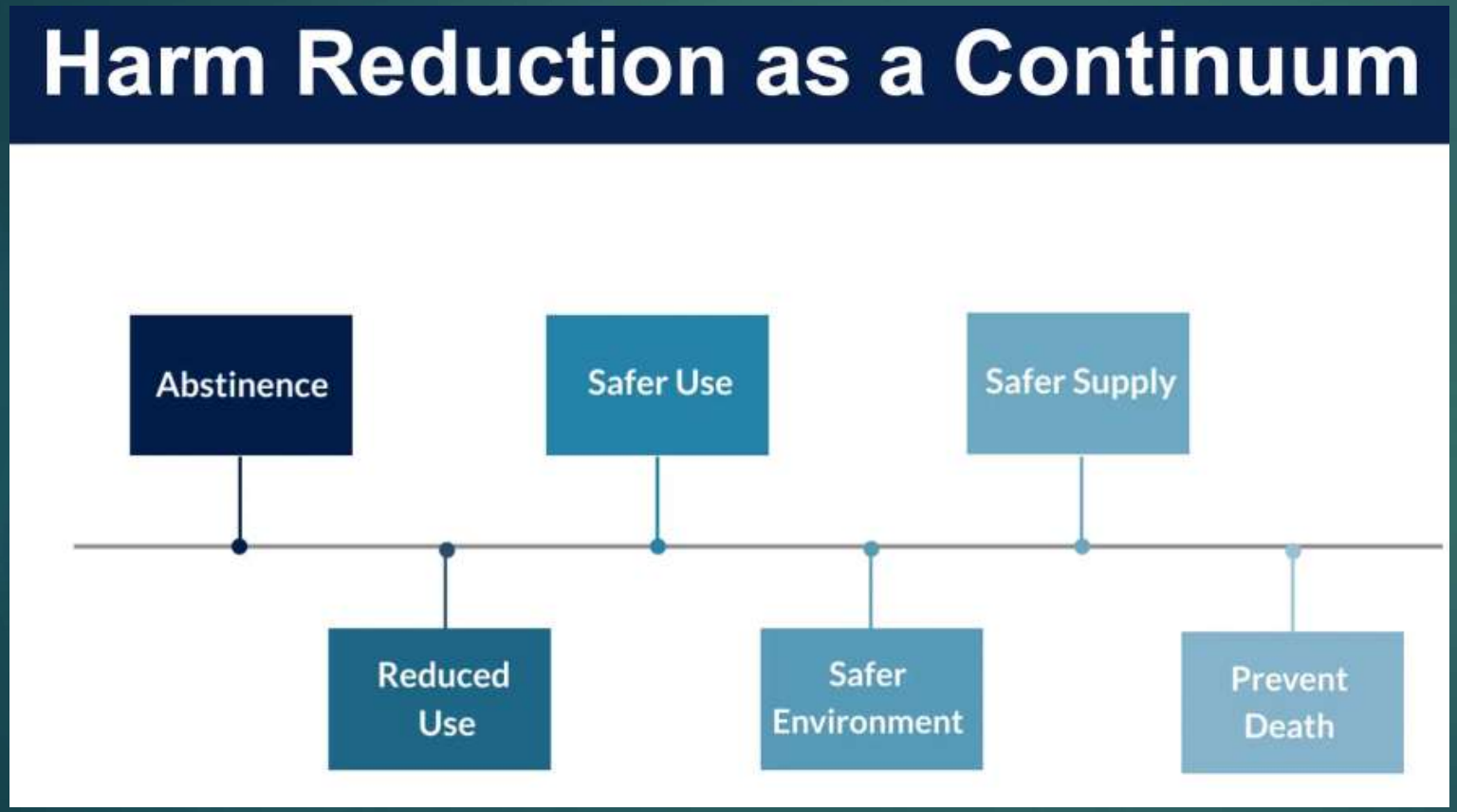


SAMHSA Principles of Harm Reduction

SAMHSA Principles of Harm Reduction	Existing Best Practices
Assist, not direct	Patient Centered Care
Provide support without judgement	
Provide many pathways to well-being across the continuum of health and social care	
Connect with community	
Value practice-based evidence and on-the-ground experience	Trauma-informed care
Practice acceptance and hospitality	
Cultivate relationships	
Promote safety	
Engage first	Motivational Interviewing
Prioritize listening	
Respect autonomy	
Work toward systems change	Advocacy

SAMHSA Harm Reduction Framework. Accessed: https://www.samhsa.gov/sites/default/files/harm-reduction-framework.pdf

Example of this philosophy in action



Safer Use

- Not using stigmatizing language
- Overdose prevention education
- Body maintenance health education
- Safer use strategies and education (Never use alone)
- Carry Narcan
- Test strips
- Safer use supplies

How does MOUD work?

LET'S GET INTO THE BIOLOGY

All opiates are opioids…

…not all opioids are opiates

Natural opioids (opiates)

Derived from opium poppy:

Morphine

codeine

heroin

(plus **endogenous opioids** – more to come!)

Semisynthetic opioids

Chemically modified from natural opioids:

oxycodone,

hydrocodone,

buprenorphine

Fully synthetic opioids

Entirely laboratory-made:

tramadol

fentanyl (rx)

methadone

ILLICIT FENTANYL

Contains additional synthetic "unknowns"

Brain and Body Communication

Messages sent via hormone, neurotransmitter or neuropeptide connect with "receptors" which, when activated, send additional message or start new processes. The messenger must fit the receptor for it to activate the next process.

Neurotransmitter / Neuropeptide = "Key"

Receptor = "Lock"

Endogenous (**internally produced**) opioid activity:

BRAIN:

- Impacts mood and emotional regulation
- Engages with dopamine in the "reward center" of the brain – affects reward and motivation
- Support recovery from stress, but prolonged stress can increase endogenous opioids increasing aversion to stressors/tasks
- Protective against social rejection and reinforcing social reward

BRAINSTEM: Respiratory regulation through opioid receptors in the brainstem

SPINAL CORD and **PERIPHERAL NEURONS**: During acute stress - pain relief through signaling in spinal cord sand neurons extending all over the body

INTESTINES: Regulates gastrointestinal functioning (movement, pain, health of mucosa/intestinal skin)

ALSO: Plays a role in regulating inflammation and immune system

Exogenous (**externally sourced**) opioid activity:

BRAIN: Mood – euphoria (dopamine system disinhibition/increase), over time brain stress systems are recruited, causing a negative emotional state.

BRAINSTEM: Overdose deaths caused by higher levels of opioid increasing "slow" signals and decreasing "activating" signals in the brainstem, causing breathing to slow or stop.

SPINAL CORD and **PERIPEHERAL NEURONS**: When opioids receptors are activated for too long, it can cause hyperalgesia (a heightened sensitivity to pain)

INTESTINES: can slow intestinal functioning - constipation

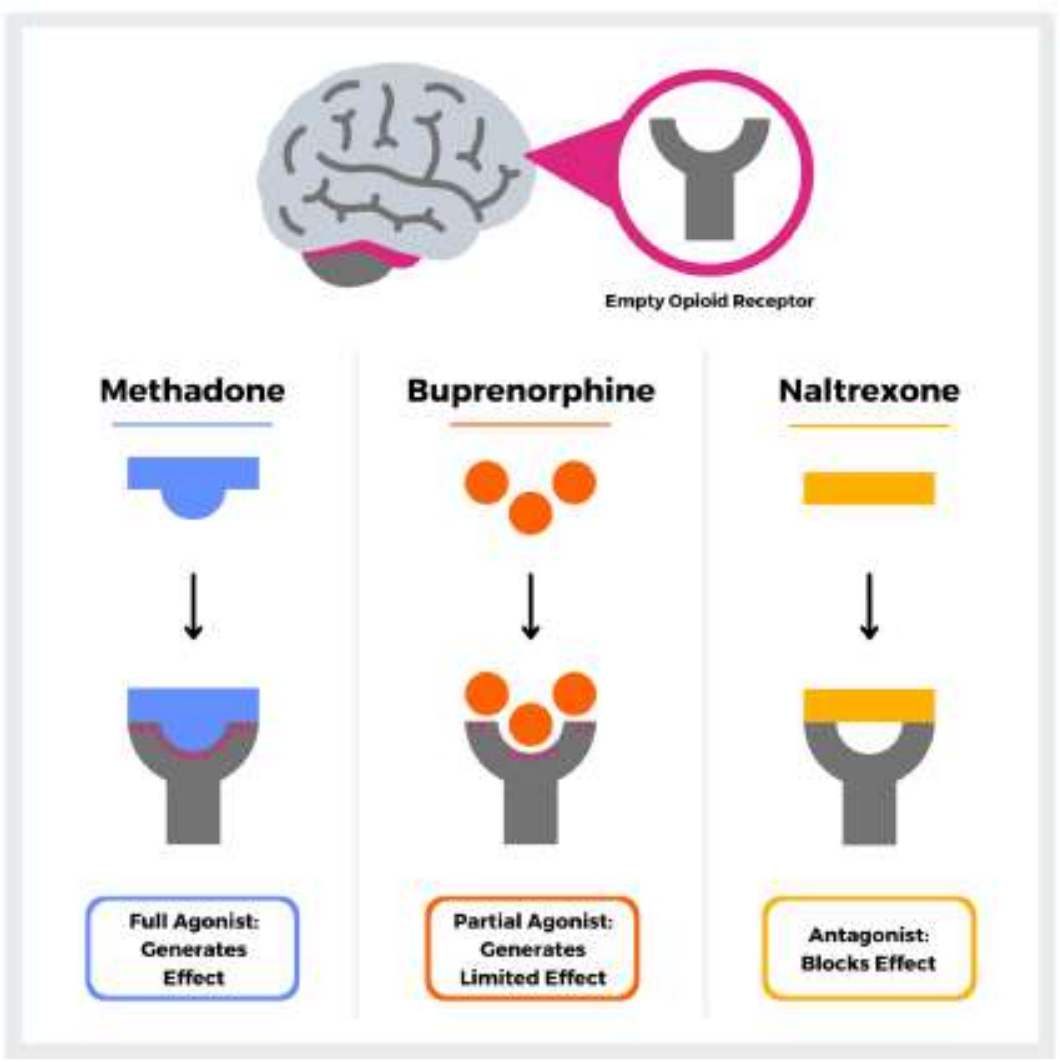
NOTE: Long term and/or high levels of opioid receptor activation causes brain changes to accommodate the increase "slow" signaling. When opioid levels decrease, the "slow" signal is removed, "activation" signaling increases and a **Withdrawal Syndrome** emerges which can last days to weeks.

Symptoms include:

Anxiety / Irritability	Abdominal pain / Diarrhea
Insomnia	Nausea / Vomiting
Craving	Fever / Sweating / "goosebumps"
Heart racing / High blood pressure / Fast breathing	Muscle and bone pain

Medication Options for the Treatment of Opioid Use Disorder

Opioids and Medication for Opioid Use Disorder (MOUD)



AGONIST ("GO!!!") - A messenger that fits into the receptor snugly and **initiates full activity (methadone, heroin, fentanyl)**

PARTIAL AGONIST ("GO! …but only halfway") – a messenger that fits in the receptor snugly but provides only **partial activity (buprenorphine – Suboxone, Subutex, Sublocade, Brixadi)**

ANTAGONIST ("NO GO!!!") - a messenger that fits into the lock snugly but **blocks all activity (naltrexone, vivitrol, naloxone/Narcan)**

Extended-Release injectable naltrexone

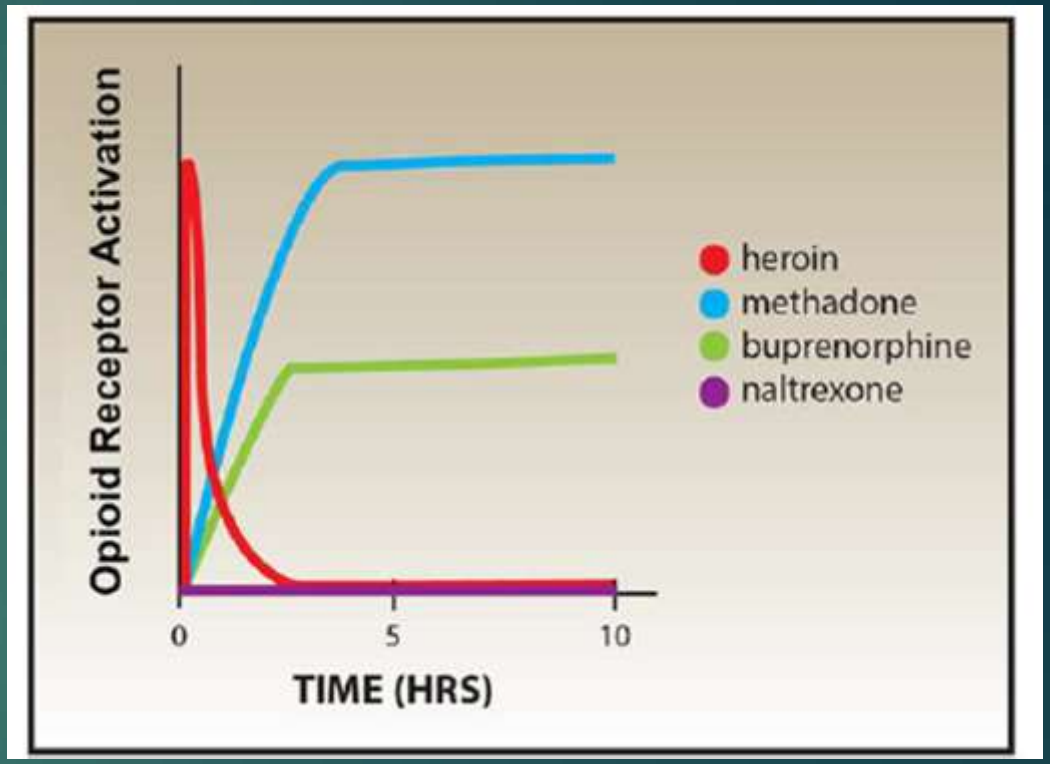
- **Opioid Antagonist – 0/10 activity**

Benefits for treatment:

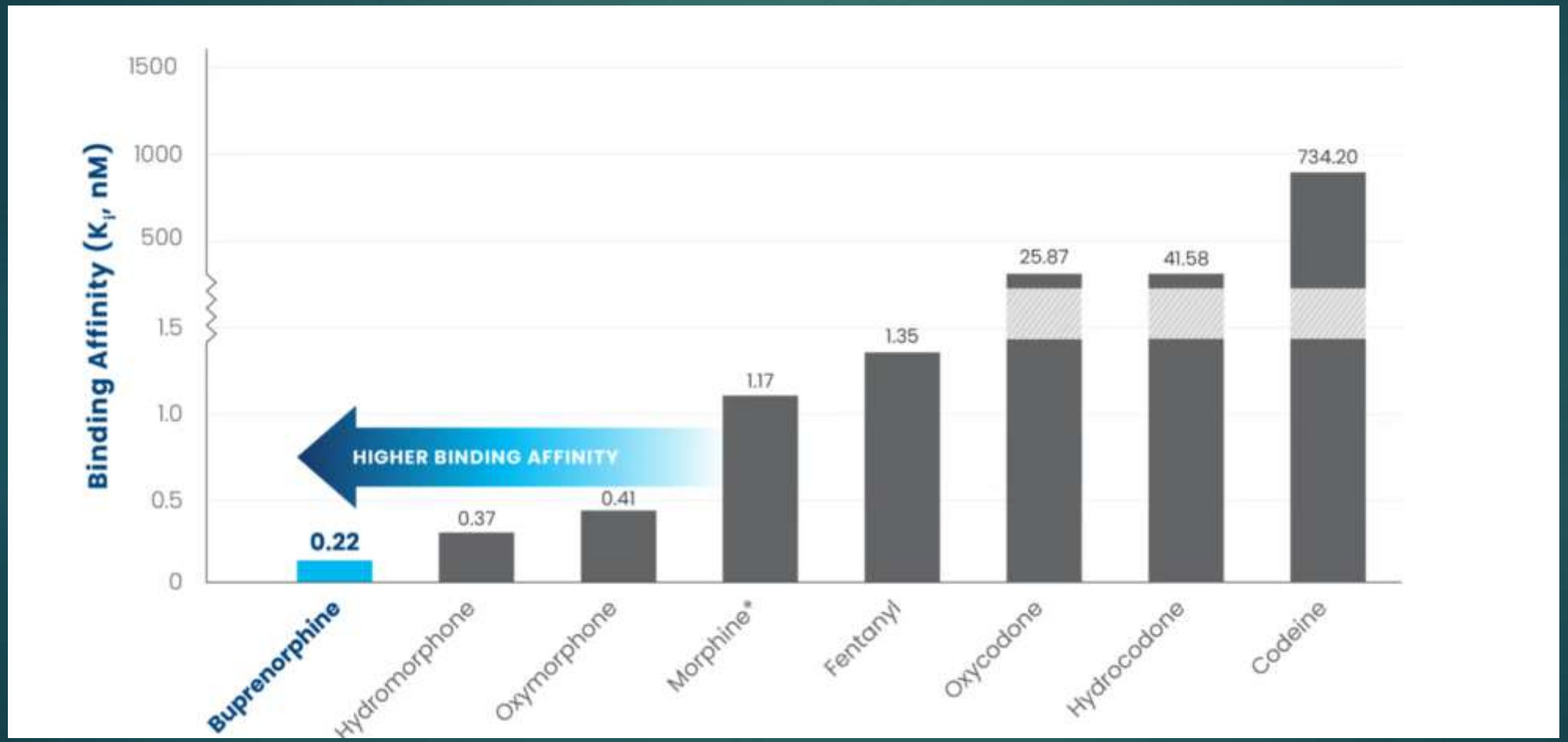
- Once-monthly dosing (improved adherence over oral naltexone)
- Reduction of opioid use versus placebo
- **No physiological effects (no withdrawal with discontinuation, no opioid-like effects**)
- Great option for people who do not want to take a medication that activates the opioid receptors (high level of concern for medication being "substitution" for opioid use)
- **No risk of misuse** (no opioid activation – no euphoric effects

Drawbacks to treatment:

- **Requires full withdrawal from opioids for 7-14 days** before initiation
- No evidence for reduction in mortality (unlike methadone/ bupe)
- **Overdose risk after discontinuation** is high (tolerance to opioids lost
- Adherence in community is low (10.5% at 6 months) and tail coverage (duration opioid receptors are covered) drops quickly



Binding Affinity matters! Who can hold onto their "seat" the tightest and who will bump others off of their seats and lock down their spot?



Methadone

(Requires specialty state-regulated clinic – not CREW)

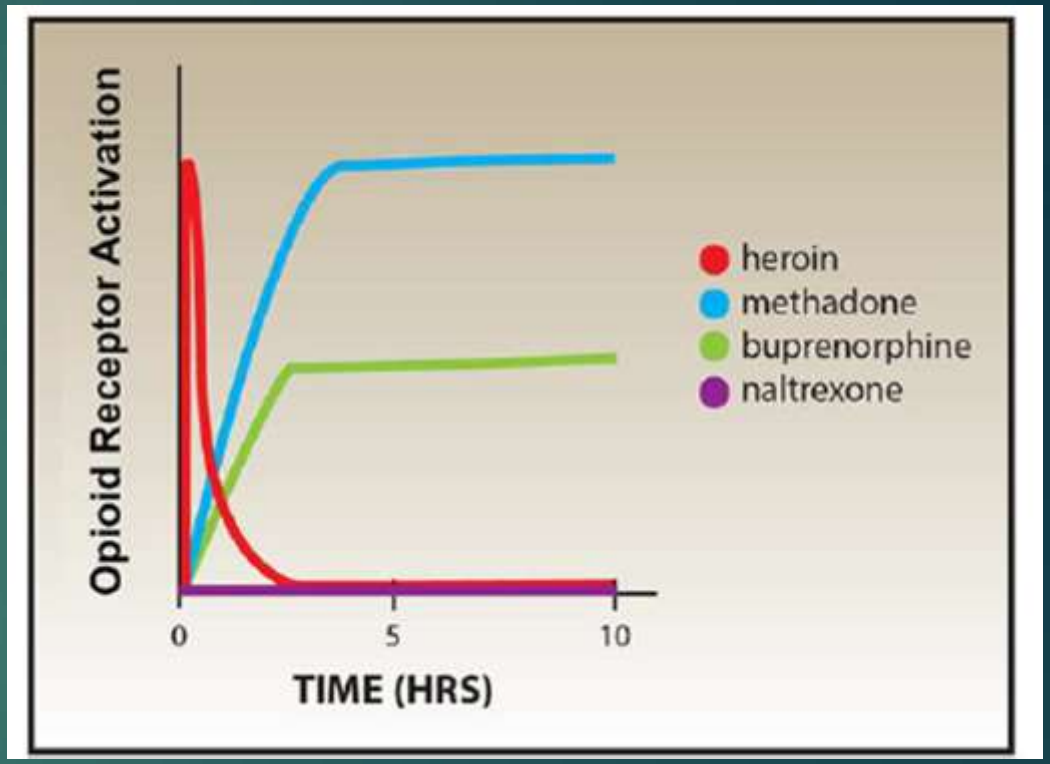
- **Full Opioid Agonist – 10/10 activity**

Benefits for treatment:

- Long half life - with daily dosing, people can get to a "steady state" where they do not experience withdrawal symptoms from opioids and they feel well
- Can prevent opioid cravings
- Start without experiencing withdrawal from illicit or community sourced opioids
- Don't need to be in active withdrawal to start treatment
- Prevents illness/disease associated with use of illicit opioids (if no longer using pipes, needles less infection risk)
- You know what is in your medication – no additives

Drawbacks to treatment:

- No protection from overdose - no ceiling for receptor activity (can cause respiratory depression / overdose with medication only, can use fentanyl on top of methadone)
- Weakly binds to the Mu opioid receptor – can be bumped off of the receptor by other drugs that bind tighter (i.e. buprenorphine start may cause withdrawal)
- Requires multiple trips week/month to clinic for dosing

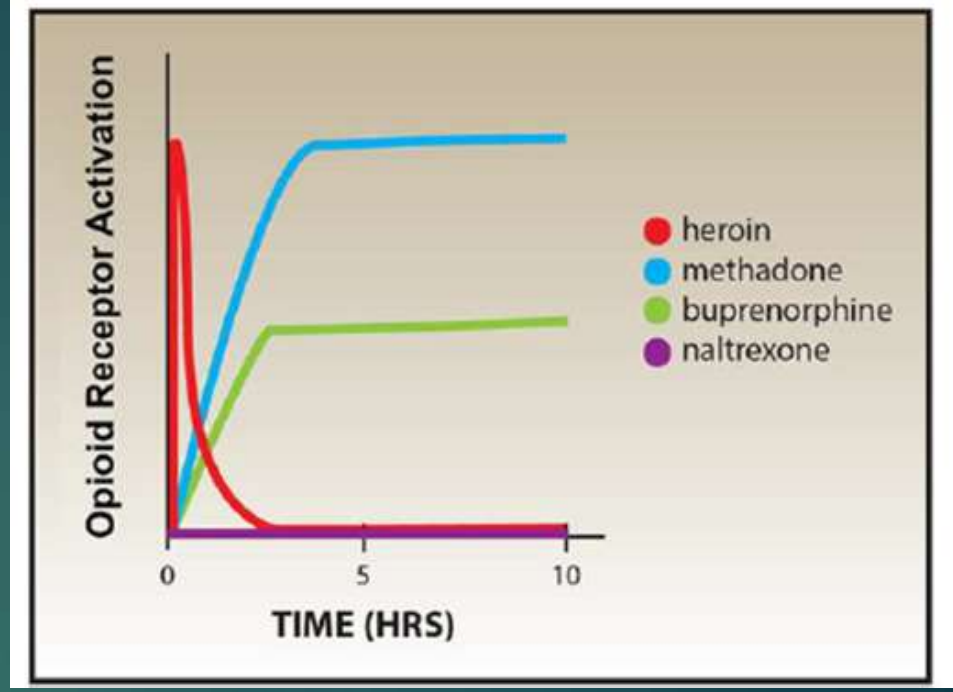


Buprenorphine

-Partial Opioid Agonist – 5/10 activity

Benefits from treatment:

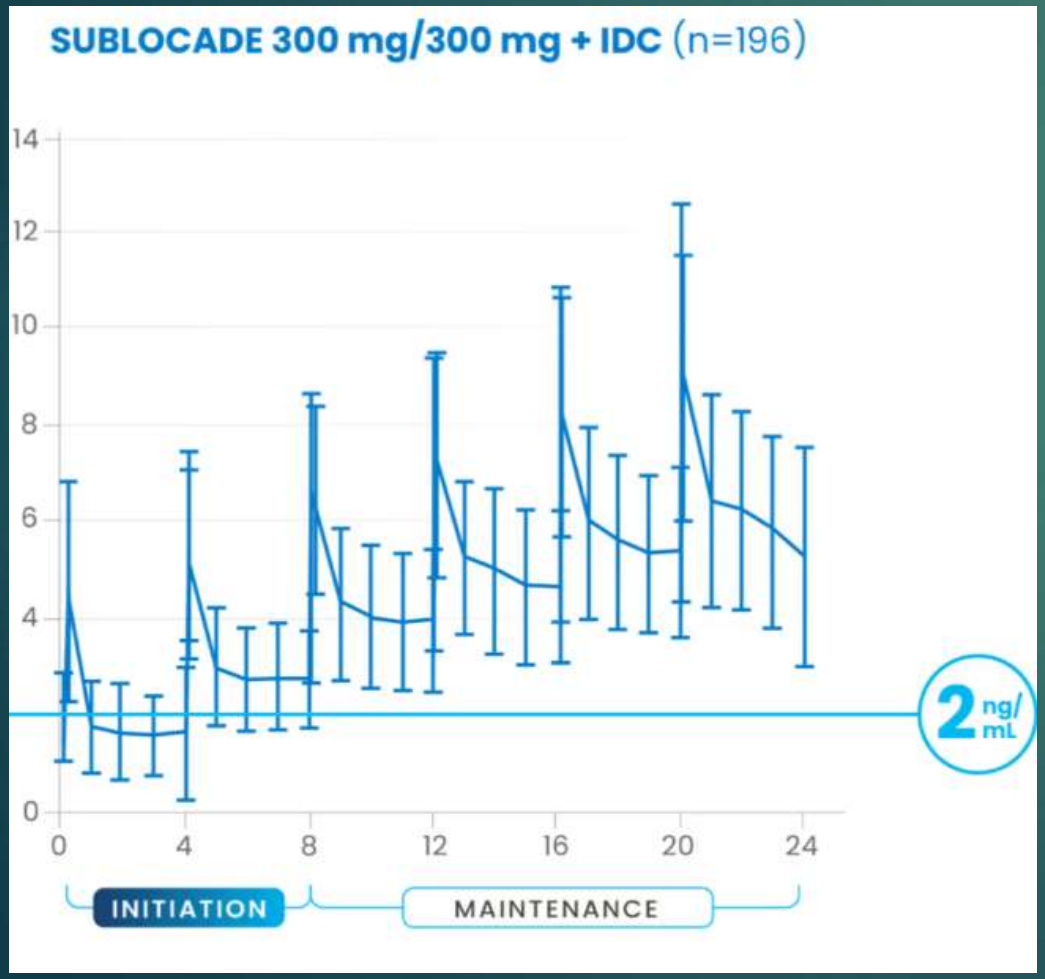
- **Protection from overdose** – binds tightly to the receptor – cannot be shoved off by other opioids. T
- **There is a "ceiling" of 5/10 activation** on the mu opioid receptor. More drug covers more receptors, it does NOT increase the activity at the receptors.
- With consistent dosing, can also achieve a "steady state" where they are no dips in coverage. For injections, this is 5 monthly injections.
- Long half life for injections provides "tail coverage" protection against overdose AND supports gradual metabolism of buprenorphine – lower risk of withdrawal with rx cessation
- Reduction in cravings AND not feeling "medicated"
- Can receive monthly scripts and/or monthly injections – no trips to clinic (more time for school, work, family)
- Prevents illness/disease associated with use of illicit opioids (if no longer using pipes, needles less infection risk)
- You know what is in your medication – no additives

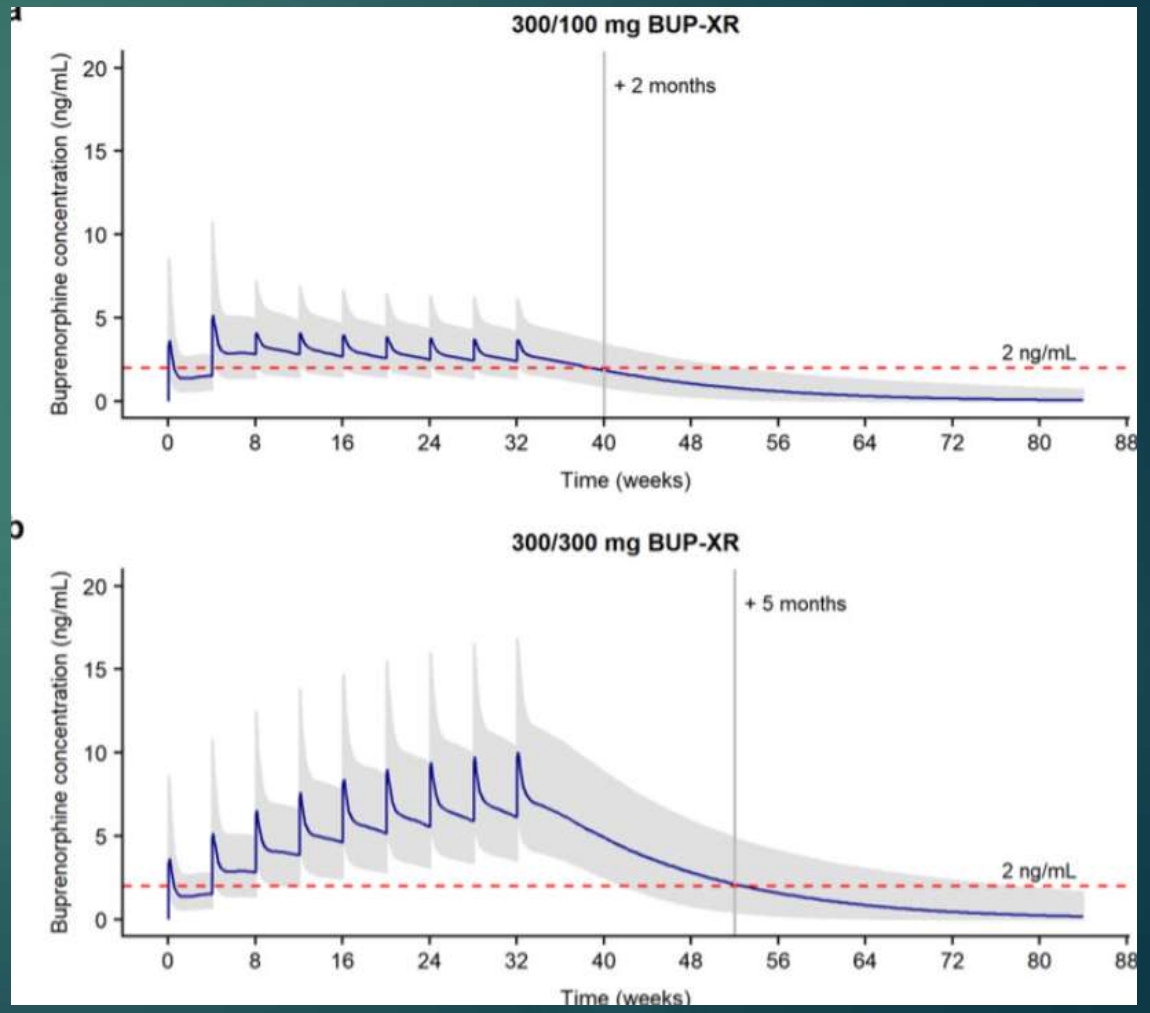


Drawbacks to treatment:

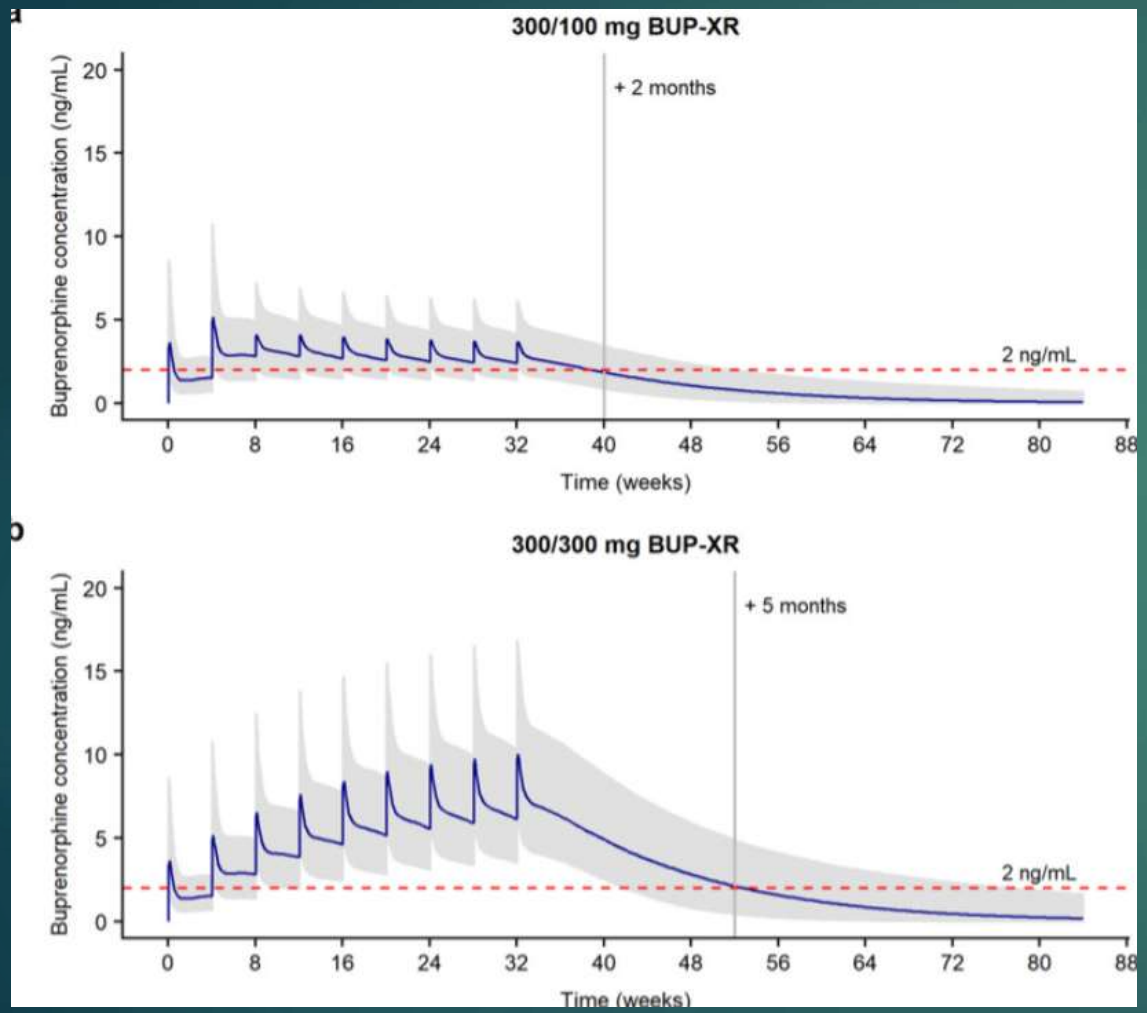
- **Some level of withdrawal symptoms expected,** depending on person, duration of use, type of opioid and induction method. Can be mitigated with support medication(!)
- Many clients have experienced precipitated withdrawal from bupe products – acceptability can be questionable
- Injections can be very painful, but lidocaine may help

Plasma levels about 2ng support reduction/remission of cravings and protection from overdose





Tail of Extended Release Buprenorphine / Duration of therapeutic benefit



Time After Last Injection	Estimated % of Steady-State Concentration Remaining	Clinical Significance
1 month	~60–70%	Fully therapeutic; opioid blockade maintained
2 months	~35–50%	Likely still therapeutic (especially after 300 mg)
3 months	~20–35%	May remain above therapeutic threshold at 300 mg dose
4–5 months	~10–20%	Approaching sub-therapeutic; withdrawal monitoring recommended
6–12 months	10%	Sub-therapeutic but still detectable
12–38 months	Trace levels	Detectable on drug testing; not clinically active

Oral Buprenorphine Induction

Table 2. A Comparison of Buprenorphine Induction Approaches

	Standard	Low-dose	High-dose	Micro-dose with cross taper
Post-agonist washout duration	16h (short acting) 48→72h (long acting)	24 - 36h	16→24h	No washout Usual dose of agonist continued
First dose of buprenorphine	2 mg	0.5 - 1 mg	2→16 mg	0.25→0.5 mg
First day total dose of buprenorphine	8→12 mg	8 mg	16→32 mg	0.5→1 mg
Adjuntive medications	As needed	Standing doses up to maximum tolerability	As needed	None

FDA-approved injection induction methods:

Brixadi: oral buprenorphine followed by weekly then monthly injectable

Sublocade:
- ≥7 days of stable dose of oral buprenorphine dose, then monthly injection
- Single 4 mg sublingual buprenorphine dose followed by the first Sublocade injection

Clinically informed induction:

3 day injection series - community developed practice; informed by emerging clinical research

3-Day Buprenorphine Induction

Community developed induction protocol

Dr. Richard Waters and colleagues at Seattle's Downtown Emergency Services Center (DESC) developed a 3 day long-acting buprenorphine induction protocol with results published in August 2025:

Benefits:

- Minimizes withdrawal during induction
- Outpatient/mobile services can provide
- Less confusion regarding medication instructions (versus oral buprenorphine)
- High retention rate

However:

- Cost/insurance may limit access
- Withdrawal symptoms may occur even after first month
- Staffing resource use is high (3-4 RN visits and 2-4 provider visits to get through induction period)

Waters RC, Hoog J, Bell C, et al. Injectable-Only OverlappingBuprenorphine Starting Protocol in a Low-Threshold Setting. JAMANetw Open. 2025;8(8):e2527016. Published 2025 Aug 1.doi:10.1001/jamanetworkopen.2025.27016

Day 1:
- Weekly Brixadi 8mg
  - Lidocaine injection offer(?)
- Opioid agonist

Day 2:
- Weekly Brixadi 16mg
  - Lidocaine injection offer(?)
- Opioid agonist

Day 3:
- Monthly Brixadi 128mg or Monthly Sublocade 300mg
  - Lidocaine injection (encourage if available)
- Stop opioid agonist (if patient is comfortable)
- Use support medication

3 day Long-Acting Injectable Buprenorphine

Day 1: Brixadi 8mg + continued use of Full Opioid Agonist + open receptors

3 day Long-Acting Injectable Buprenorphine

Day 1: Brixadi 16mg + continued use of Full Opioid Agonist + open receptors

3 day Long-Acting Injectable Buprenorphine

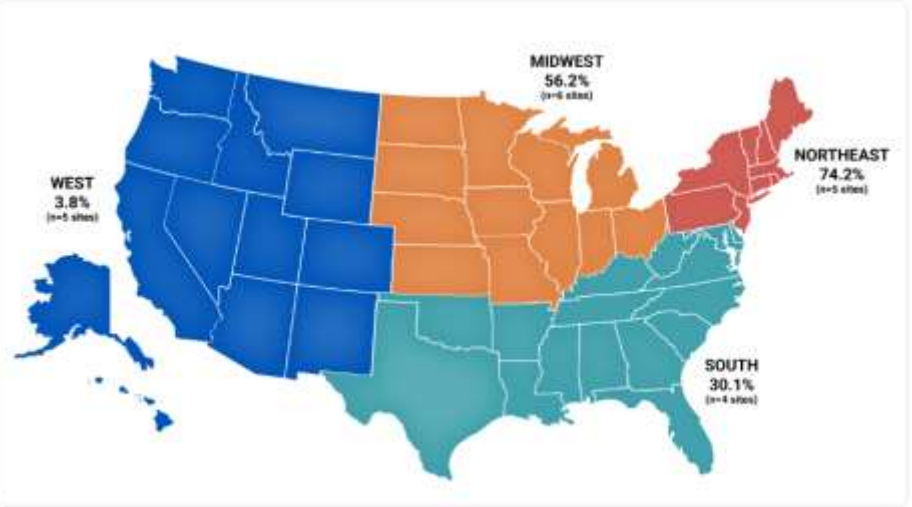
Day 3: Sublocade 300mg + open receptors (STOP opioid agonist)

Additional Considerations

- **FOLLOW-UP** (booster needed?)

- **ORDERING MEDICATIONS:**
  - **Support Medications** – ensure access BEFORE induction
  - **Lidocaine** – not covered by insurance – can the cost be covered?
  - **Order Narcan** (and ASK before doing this)
  - **Oral buprenorphine** likely needed (even if client is also on injection)

- **CONSIDER CHANGING DRUG SUPPLY**
  - Drug trends tend to move from east to west
  - Xylazine remains a concern but reduced presence
  - Medetomidine - complicated withdrawal
    - sedation remains even after Narcan
    - cardiac risk/emergency, generally requires inpatient support)

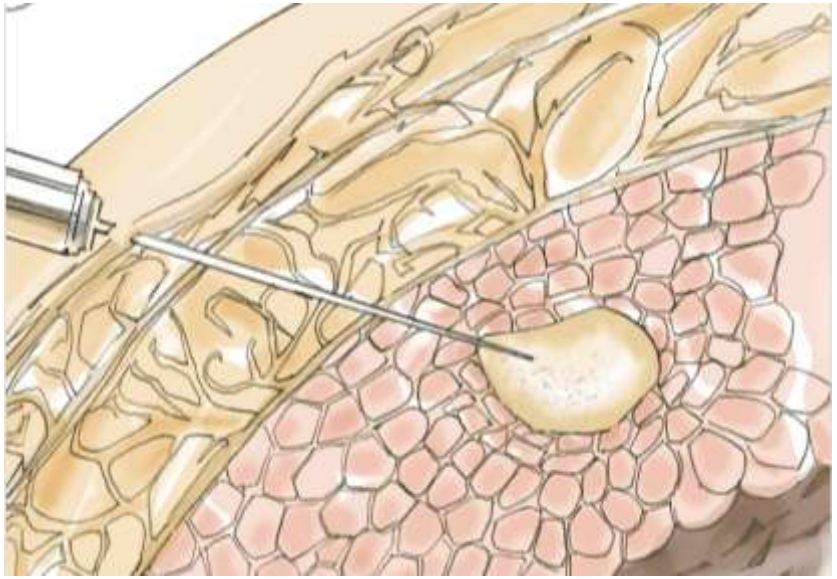


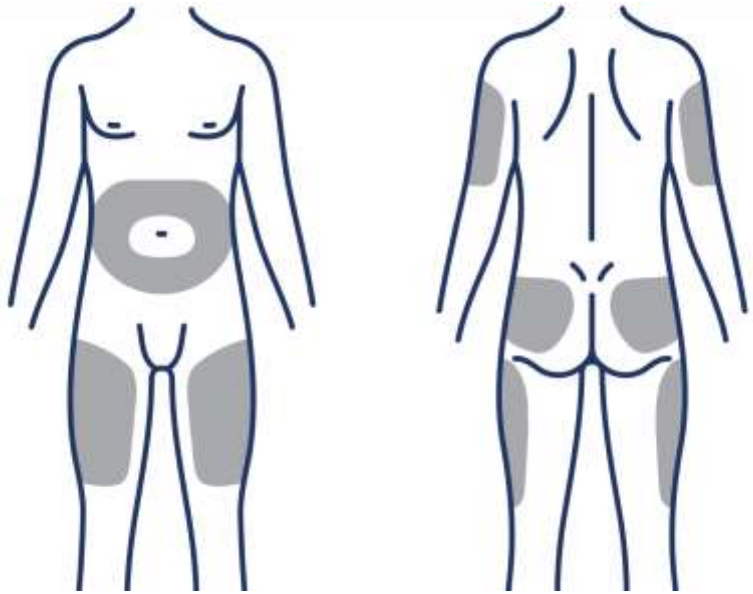
What is the injection like?

Subcutaneous shot (in the fat layer)

Will create a bump we call a "depot"

Burns during the injection and afterwards





Administration Considerations

- Injection sites; body composition; privacy
- Medical trauma
- Trauma informed care
- Respecting the client pain and anxiety
- They are allowed to not like getting the shot

Planning on Pain interventions

Non-pharmacological

- Ice
- Music
- Lighting
- Breathing
- Stress ball / fidget
- Shot blocker
- Compassion

Lessons Learned

… IT WAS HARD… AND IT WAS WORTH IT

Expect the unexpected

- Rarely do things go as planned
  - Unexpected leadership departures
  - Unanticipated shelter closure
- Flexibility and collaborative decision-making are essential
- Some amount of structure will help keep staff
- Co-occurring treatment has pros/cons

Be clear on your capacity

- Quick turnaround between notification of award and start of funding
- Grant funding will only pay for so much clinical time – but too little provider time will limit enrollments
- Need high-level support and involvement from leadership
- Wide range of decision-making requires staffing that may not be reflected in project proposals or design

Be prepared for policy and credentialing hurdles

- Pharmacy and DEA barriers prevent the intended rapid response using stock supply
- REMS Enrollments required for the related medications
- Consider your provider size and risk tolerance: Individual vs clinic DEA registrations
  - Agency registration as Health Care Entity:
    - Sizeable administrative lift
    - Need an identified Pharmacy Manager

Find the right staff trainings

- Motivational Interviewing
- Trauma-Informed Care
- Local Drug Trends
- Harm Reduction Treatment, Training and Technical Solutions (HaRT3S)
- Overdose prevention & response
- Naloxone Administration (link for video/training)

Make friends with your local pharmacy

- Quick turnarounds on medication orders
- Courier services and scheduling deliveries
- Need a source for lidocaine and other OTC

Build solid external partnerships

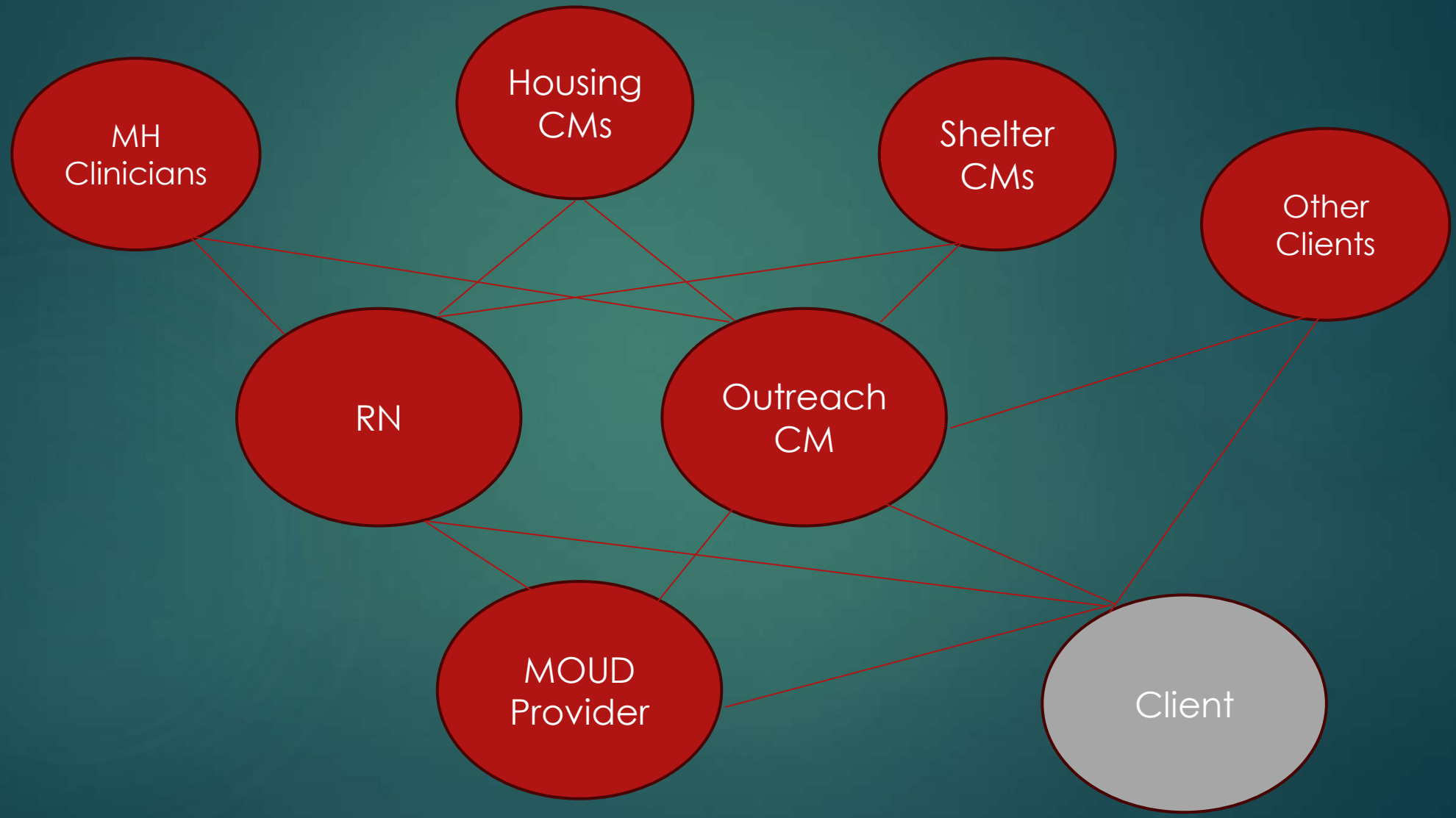
- Other local MOUD providers
- Hepatitis & HIV testing
- Drug checking
- Primary Care
- Intensive Outpatient Treatment
- Local Communities of Practice

Know where to turn when you need help!

Community-based services are trickier than in-clinic

- Space for clinical work is always a hot commodity
- Establish regular communication pathways:
  - Care team chats
  - Weekly "huddles"
  - Programmatic leadership meetings
- Role clarification is needed
- Safety considerations
- High-level support from leadership

Start small with referral sources



Set realistic outcomes

Set goals in line with funder deliverables

Make them easy to measure within existing tracking and reporting systems

Help staff delineate their time between different funding streams

Balance your strengths with your opportunities

- Integrated services
  - Mental Health (provider can see both, clinicians may be co-occurring)
  - Opportunity – SUD IOP
- Have a plan to increase capacity
- Relationship building allows:
  - Authentic encouragement
  - Highlighting and recognizing client strengths – hold up a mirror for them to see their progress and courage
- Expanding team to include peers and support people with lived experience in discussing the program/their journey:
  - "Interviewee: I think you can be successful by going out to different places and having someone to talk to a group of people about it. Like we had a lot of people that's using drugs. A person that was successful, have them talk to them about it. And when you talk to people, as myself, using drugs for so many years, you have to be real. You can't come with no BS, you know, you have to just keep it real. A person will tell if you're real or not that's on the drugs. They can tell if it's book or if it's lived, you know? That's two separate things."

Think about long-term individual goals

- How to help people sustain motivation for change
- What should folks do with their new-found free time
- Creativity is needed for long term engagement

Dynamic response to client needs:

Review and support plans to discontinue / switch treatment

- Treatment is voluntary and it is staff responsibility to listen to client's words, social context, and nonverbal communication (and decision-making)
  - "Client E" got through 2 shots of the induction – then wanted to stop
    - Be prepared for them to disengage at any point in the process
    - If you can engage to help them know alternate resources – bupe resources somewhere else or methadone
    - Explicitly leave the door open to restart
  - "Client F" routinely declined the shot when offered and asked for the RN to return another day
    - Adjust factors you can control in the process such as day and time of appointments
    - Investigate the resistance versus labeling it as disengagement or disinterest

Power dynamic, interpersonal relationship considerations

- Pick the right person for the conversation about where the sticking points are
  - Different staff member may get different information from client

What's been the impact in numbers?

- 640 services provided to 89 people
- 33 MOUD enrollments
- 12 of inductions
- 118 LAIB administrations

Let's hear from the clients

Question: What are some changes you have noticed in your life since you started MOUD?

- Client H 
- Client P 

Personal Success Stories

- Client "A" presenting for 3 day induction, history of fentanyl use for >5 years, using 2 grams daily bumpy 2 months with induction and follow-up
  - Outreach CM making frequent contact, RN flexibility
  - Attendance to primary care -> treatment of hypertension -> denture success(!)
  - Engaged with caretaking of grandchildren on weekend
  - Engaging with mental health care with provider for assessment of hallucinations

- Client "B" presenting for 3 day induction, history of fentanyl use now at 1 gram/daily, unhoused. Significant trauma history, parents/siblings using opioid as well. Use of grant money for shelter for induction; providing safe/comfortable space to cope with symptoms
- "I didn't know how many hours were in a day!"
- We believe that their parent has initiated contact for services in our other CReW location

Contact us!

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Citation Links – provide in downloadable handout as resource?

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Q & A