Identifying and Lifting Barriers to Integrating MAT with 12 Step Modalities

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Learning Objectives

Participants will:

• Increase their knowledge of MAT financing and explore MAT financing barriers in their area
• Explore relationship between stigma of addiction and stigma of medications used to treat Opioid Use Disorders specifically
• Understand clinical and leadership training needs related to implementing recovery-oriented MAT
• Explore tools to assess organizational readiness for MAT implementation
• Learn strategies to help MAT patients interface with peer support programs, 12 Step fellowships, and other mutual aid groups
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“We have highly effective medications, when combined with other behavioral supports, that are the standard of care for the treatment of opiate addiction.” - Dr. Michael Botticelli, Former Director, ONDCP
Medications for Addiction Treatment

**Alcohol**
- Naltrexone – oral
- Naltrexone (Vivitrol) – long-acting, injectable
- Acamprosate
- Disulfram (Antabuse)

**Opioids**
- Methadone
- Buprenorphine
- (pill and implant)
- Naltrexone – oral
- Naltrexone (Vivitrol) – Long-acting, injectable

**Smoking Cessation**
- Varenicline (Chantix)
- Bupropion (Wellbutrin,)
- NRT’s
Current Financing Landscape

• Among those who recognized a need for treatment and made an effort to get it, lack of health coverage was the most frequently reported reason for not receiving treatment (38.2 percent).*

• Most states cover some form of opioid dependency treatment through their Medicaid drug formulary.

• However, as of 2013, only 13 Medicaid programs included all available medications for treating alcohol and opioid use disorders in their Medicaid PDLs.

*Substance Abuse and Mental Health Services Administration, Medicaid Coverage and Financing of Medications to Treat Alcohol and Opioid Use Disorders. HHS Publication No. SMA-14-4854. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
Current Challenges

**Prior authorization** - Getting an agreement from the payer to cover specific services before the service is performed.

**Step-therapy** - Benefit design that requires patients to try a first-line medication, such as a generic medication, before they can receive a second-line treatment, such as a branded medication.

**Lifetime limit** - Insurers place a dollar limit on what they would spend for your covered benefits during the entire time you were enrolled in that plan (banned under current law)
Organizational Benefit Silos

One challenge to establishing a benefit design for medications to treat alcohol and opioid use disorders is that the medications can involve four different Medicaid operations:

- opioid treatment programs
- pharmacy benefits
- medical benefits
- pharmacy contracting

These areas often function independently in their decision systems, staffing, and approval process (ASAM, 2013).
Some Change is Happening

• Aetna, starting in March 2017, will stop requiring doctors to seek approval from the insurance company before they prescribe particular medications such as Suboxone.
• Anthem and Cigna also recently dropped prior authorization requirements. – These companies took the step after the New York AG investigated coverage practices that unfairly barred patients from needed treatment. The insurers adjusted their prescribing requirements as part of larger settlements.
As coverage and policies may change over time, it is important to stay informed about your state’s policies and private insurance options to find out where reimbursement is possible.

✓ What do you know about the financing and reimbursement landscape in your area?
✓ Have you accessed the financial landscape in your community?
Getting Ready to Implement MAT

Key areas of consideration before engaging in efforts to increase access to medication assisted treatment (MAT)

- Economic Environment
- Treatment Environment
- Workforce
- Regulatory Barriers
- Cultural Environment (Attitudes, Stigma)

MAT Implementation Check List
Key Questions to Consider

- What do Medicaid and commercial insurers require for the use of MAT in your state?
- Are there limitations on who can prescribe MAT, the length of time patients can use MAT, and/or the type of formulations patients may receive?
- Do Medicaid formularies include all MAT formulations (e.g., injectable naltrexone, sublingual buprenorphine)?
  - If not, who specifically will provide the leadership to get these medications on the Medicaid formulary?
  - Who specifically will talk with health plans and pharmacy benefit managers to get these medications on their formularies?
Key Questions to Consider (Cont.)

- Does the state view the use of MAT as an evidence-based practice? (Some states require that clinicians follow evidence-based practices to be reimbursed under Medicaid and private insurance.)?
- Are clinicians eligible to receive Medicaid or commercial insurance reimbursement?
- Are they on preferred provider lists for commercial insurers and Medicaid managed care programs?
Will clinicians be reimbursed for clinical services required for MAT, such as physical examinations and laboratory tests?

Are you aware of the typical out-of-pocket cost for the medications, and are your patients able to afford these costs?
  ➢ If not, are you aware of ways you may be able to offset these costs for patients who need assistance?

Are these medications available through the 340B program administered through HRSA and the health centers in your state? (This is particularly important for individuals without insurance)
States are using a variety of innovative approaches to finance and deliver medications for alcohol and opioid use disorders.

**Vermont: Hub and Spoke Model**

_The Hub_, serves a geographic area and provides comprehensive addictions and co-occurring mental health treatment services to Vermont residents with opioid dependence.

_The Spoke_ is composed of a designated provider (the prescribing physician) and a team of collaborating health and addictions professionals who monitor adherence to treatment, coordinate access to recovery supports, and provide counseling, contingency management, and case management services.
Case Example Continued

The Baltimore Buprenorphine Initiative

• Start Buprenorphine in a Substance Abuse Treatment Program
• Patient Transitions to the Medical System
• Patient Continues to Receive Buprenorphine from His or Her Physician.
Other Suggestions

• Developing Partnerships
• Sharing MAT providers
• Use data to make your case
• Create MAT workflows
The **Medication Assisted Treatment Implementation Checklist**, from CIHS, outlines the key questions to consider before engaging in efforts to increase access to medication assisted treatment for addictions.

**Medicaid Coverage and Financing of Medications to Treat Alcohol and Opioid Use Disorders** The primary purpose of this report is to present information about Medicaid coverage of medications used to treat alcohol and opioid use disorders.

**Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans**

This report highlights the coverage gaps that remain in health plans across the US and provides suggestions for how to resolve them.
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No relevant conflicts of interest to declare.
Exploring the Relationship Between Stigma of Addiction and Stigma of Medications Used to Treat It

- Stigma involves processes of labeling, stereotyping, social rejection, exclusion, and extrusion as well as the internalization of community attitudes in the form of shame by the person/family being discredited.

- Social stigma attached to addiction is influenced by perceptions of the role of choice versus compulsion in addiction.

- The social stigma attached to addiction is greatest for those experiencing combinations of addiction, psychiatric illness, HIV/AIDS, minority status, and poverty.

1 White, W. L. Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Philadelphia (With Particular Reference to Medication-Assisted Treatment/Recovery).
Stigma Related to addiction
Stigma related to co-occurring issues
Stigma related to cultural prejudice, racism, heteronormativism, ableism, moral construct around drug use, views of “criminal” behavior etc.
Stigma related to Opioid Use Disorder
Stigma related to methadone
Stigma related to buprenorphine

98% of MAT patients surveyed reported that “Stigma is an essential feature of methadone maintenance treatment.”

Exploring the Relationship Between Stigma of Addiction and Stigma of Medications Used to Treat It

These core beliefs inform the following “mythical assumptions”:

- Compulsive drug use is a choice
- Methadone or other opioid agonist/partial agonist treatment is a “crutch”
- These approaches simply replace one drug for another
- Low doses of these medications and short duration of use result in better rates of long-term recovery
- People using these medications should be encouraged to discontinue their use as soon as possible

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These fallacies have the power to harm those most at risk.

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Cultural Symbols and semantics related to methadone
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Cultural Symbols and semantics related to methadone
Lifting Barriers and Reducing Stigma with COR-12

- Hazelden Betty Ford’s journey to utilizing MAT, specifically buprenorphine
  - External research demanded change
  - Our internal outcome measures demanded change
    - Poor treatment retention
    - Poor outcomes treating Opioid Use Disorder, including overdose deaths
- Our organizational commitment to evidence-based practice, and our fundamental belief in the dignity and respect of all people regardless of where they are in their relationship with chemicals required us to address our internal culture and stigma related to MAT
- Due to our position as a leader in the abstinence-based and 12-Step communities, and our previous position of refusing this treatment to those suffering from OUD, we have a responsibility and a unique ability to address the misinformation and stigma surround MAT
Hazelden Betty Ford’s treatment of OUD involves coupling our traditional multidisciplinary approach with the utilization of medications like Naltrexone (Vivitrol IM, oral) and buprenorphine or bup/naloxone (Subutex, Suboxone) all under an umbrella of a recovery-oriented system of care.

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**COR-12 Overview**

- Recovery Orientation
- Substance Use Disorder and Mental Health Therapy
- Medical care, including medications in support of recovery
- Peer Support Involvement

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\(^2\)Operational Definition - The Centre for Substance Abuse Treatment (CSAT, 2009)
Lifting Barriers and Reducing Stigma with COR-12

The 5-Point Plan

1. MOBILIZE
2. PLAN
3. ASSESS
4. TRAIN
5. SUPPORT

Our goal when training is to help establish or strengthen a community where “people with a history of alcohol or drug problems, people in recovery, and people at risk for these problems are valued and treated with dignity, and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated.”

Lifting Barriers and Reducing Stigma with COR-12

COR-12 Goals

• Enhance public and professional perceptions of the value of medication-assisted treatment
• Offer a recovery orientation and treatment modality that supports concurrent use of medications and participation in 12-Step recovery
• Put a face and voice on medication-assisted recovery and portray the contributions of people in medication-assisted recovery to their communities
• Increase the participation of medication-assisted treatment providers within local recovery community activities
• Facilitate cooperation between historically-opposed harm-reduction and abstinence-based advocates and professionals

Adapted from: ¹White, W. L. Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Philadelphia (With Particular Reference to Medication-Assisted Treatment/Recovery).
Lifting Barriers and Reducing Stigma with COR-12

COR-12 Strategies

• Community mobilization events
  • Draw from a broadly-based coalition of stakeholders to support all pathways to recovery from OUD for individuals and families
• Program assessment and implementation of evidence-based practices
• Leadership training
  • Implementation-specific workshops lay the groundwork for a functional, integrated, best-practices based MAT program
• Clinical training
  • Clinicians practice and improve skillsets specific to practicing in an MAT, person-centered, recovery-oriented, non-punitive environment
• Fidelity of implementation measures

Adapted from: ¹White, W. L. Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Philadelphia (With Particular Reference to Medication-Assisted Treatment/Recovery).
Are We Ready to Implement COR-12 or MAT?

Levels of collaboration/integration

MAT implementation checklist

AIMS person-centered care scale

SAMHSA Partnership checklist

SAMHSA Customer Orientation

SAMHSA Admin Readiness tool

SAMHSA COMPASS Self-Assessment tool
Are We Ready to Implement COR-12 or MAT?

MAT Implementation Checklist sample

<table>
<thead>
<tr>
<th>Assess Regulatory Issues</th>
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</thead>
<tbody>
<tr>
<td>What is the strength of regulatory efforts at the state level related to distribution and use of medications in addiction treatment?</td>
</tr>
<tr>
<td>Is the state legislature educated about the use of medications in addiction treatment? Has the legislature in your state intervened in any way to regulate the use of medications (in statute or otherwise)? If so, how does state regulatory action affect the availability and utilization of medications as part of comprehensive addiction treatment?</td>
</tr>
<tr>
<td>What are the attitudes of state legislators about increased spending on addiction treatment related to the introduction of medications? How will you inform legislators about advances in addictions treatment? How will you work with legislators to improve the financing and regulatory environment for implementation of medication-assisted treatments?</td>
</tr>
</tbody>
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<tr>
<th>Assess Attitudes</th>
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<tr>
<td>How will you identify the specific groups outside of the addictions treatment field in your state that may oppose the use of medications in treatment? What is your plan for working with these groups to reduce potential barriers to implementation?</td>
</tr>
<tr>
<td>How will you work with consumer groups and advocates to increase demand for MAT?</td>
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</table>
Are We Ready to Implement COR-12 or MAT?

Our trainings begin with a consultation and proprietary assessment looking at each organization’s community, their resources, and their current/desired state in each of the following areas.

- Recovery Orientation
- Substance Use Disorder and Mental Health Therapy
- Medical care, including medications in support of recovery
- Peer Support Involvement

\(^2\text{Operational Definition - The Centre for Substance Abuse Treatment (CSAT, 2009)}\)
“At the last trustee meeting (of AA) that we (Vincent Dole and Bill Wilson) both attended, he (Bill Wilson) spoke to me of his deep concern for the alcoholics who are not reached by AA, and for those who enter and drop out and never return. Always the good shepherd, he was thinking about the many lost sheep who are lost in the dark world of alcoholism. He suggested that in my future research I should look for an analogue of methadone, a medication that would relieve the alcoholic’s sometimes irresistible craving and enable him to progress in AA toward social and emotional recovery, following the Twelve Steps.”

- Vincent Dole

Participation in Twelve Step Facilitation therapy supported by the TSF manual:

Many opinions on the topic are formed out of misinformation. Reasons for prescribing medication in treatment and recovery vary. Some medications assist with withdrawal, others change the way addictive substances affect people, and still others help manage co-occurring mental health disorders, such as depression or anxiety. Medications may play a role in a treatment and recovery plan, and ultimately that is the decision of the participant, with help from his or her doctor, therapist, and Higher Power.

Lifting Barriers to 12-Step Participation

• TSF is on the National Registry of Evidence-based Programs and Practices (NREPP)
• Twelve-Step fellowships are non-professional mutual aid societies

• Position of Narcotics Anonymous on agonist/partial agonist medications
  • World Service Board of Trustees Bulletin #29
    Regarding Methadone and Other Drug Replacement Programs

  • People using medications like methadone or buprenorphine are welcome to attend, but “we believe that group autonomy does not justify allowing someone who is using to lead a meeting, be a speaker, or serve as a trusted servant.”

• Due to the nature of 12-Step fellowships, these restrictions are applied unevenly
• This bias has the potential to harm consumers of treatment services
Lifting Barriers to 12-Step Participation

• Recommendations for mutual aid groups
  • When possible, it is recommended to have peer-support specialists, staff in recovery, or allies within your local recovery communities “vet” meetings for their friendliness to MAT
  • Medication-Assisted Recovery Services (MARS) has online meetings and is a terrific resource for peer-initiated and peer-based recovery supports
  • On-site recovery meetings can be very helpful. An explicit preamble informing the participants that they are welcome regardless of what medications they are taking helps to establish the tone of the meeting
  • Other peer-support meetings, like All Pathways Recovery Meetings, LifeRing, SMART Recovery, Women for Sobriety, Methadone Anonymous, etc. can be helpful if available
  • If possible, identify and partner with members in your local recovery community to develop allies for all recovery pathways
Lifting Barriers to 12-Step Participation

Recommendations for individuals using medications in support of recovery:

- Provide in-depth, consistent, evidence-based education to individuals, friends and family members regarding MAT
- Discuss the realities regarding stigma around MAT within various subcultures, including the 12-Step recovery culture
- Role-play discussions of MAT-status with consumers, working with them to reveal as much or as little of their private health information as they are comfortable disclosing
- Recruit and connect with peers in a formal or informal way, use peer-support trainings if available
- Maintain a person-centered expectation for all staff, including this language in job descriptions and formal policies
- Make advocacy for MAT the job of all staff members: Staff tend to feel limited in their ability to advocate publically and anecdotally, many have responded enthusiastically to this invitation
No relevant conflicts of interest to declare.
St. Elizabeth Response to the OPIOID Crisis

Ashel Kruetzkamp, MSN, RN, SANE
Heroin Overdoses

St. Elizabeth Emergency Departments
(Covington, Edgewood, Florence, Ft. Thomas, Grant and Owen)

Data provided by: Ashel Kruetzkamp, MSN, RN St. Elizabeth Healthcare
2016 Emergency Department Visits

**Edgewood, Covington, Grant, Ft. Thomas, Florence, & Owen**

<table>
<thead>
<tr>
<th></th>
<th>Heroin Overdoses</th>
<th>Opiate Overdoses*</th>
<th>Opiate Use**</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Visits</td>
<td>1584</td>
<td>350</td>
<td>1031</td>
</tr>
</tbody>
</table>

*Opiate Overdose (Fentanyl, Methadone, Percocet, Norco): denied heroin use, responded to Narcan

**Opiate Use ED Visit (complications related to use of opiates): withdrawal, suicidal, abscess, request detox/treatment, and other medical related issues).
2016 Emergency Department Visits

Edgewood, Covington, Grant, Ft. Thomas, Florence, & Owen

Heroin Overdose
- Male: 1002
- Female: 582

Opiate Overdose
- Male: 144
- Female: 206

Opiate Use
- Male: 513
- Female: 518
In 2015, Northern Kentucky, on average, lost a person to a drug overdose every 40 hours.

- 2011: 252
- 2012: 447
- 2013: 545
- 2014: 745
- 2015: 1,168
- 2016: 1,584

NKY’s Hep. C rates are 19 times greater than the average rate in the United States.
Naloxone (Narcan) Rescue Kits

The kits contents
- 4mg Narcan Nasal Spray
- Instructions for use
- Rescue Mask
- Data Collection Card
Treatment Response and Community Network Development
Physicians Engaged:

Created an addiction clinic with new area providers

1 Board Certified Addictionologist
4 Part-time Physicians
1 Mid-level Provider

6 existing SEP physicians have been trained and are now prescribing medically assisted treatment in their offices.

Provided education to all SEP physicians on prescribing guidelines to prevent addiction.
SEP Addiction Medicine and Recovery Center

Current State
- Opened July 15, 2015
- Serviced 759 patients at least once
- Current active patients: 272 SEP
  - 208 Addiction Medicine Practice
  - 69 Varies SEP Practice
- 1 Full-Time Addictionologist
- 4 Moonlighters\Part-Time Physicians
- 1 Advanced Practice Practitioner
- 6 MDs from other practices
- 3 Drug Counselors
- 6 MAT groups + pregnancy group

Future Practice Plan
- 12,000 square foot suite
- 850-1,000 active patients
- 2 Addictionologists
- 2 Advanced Practice Practitioners
- 10 Moonlighters\PT MDs
- 10 Drug Counselors
- Behavioral Health Professionals for co-occurring conditions
- 20 MAT groups
- Intensive Outpatient Program
- 10 Case Managers
- Crisis rooms for urgent referrals from ER
- PCP office support services
- Life style skills education
- Inpatient addiction support referral team
Community Relationship Building

- Intensive Outpatient Programs
  - 8 throughout Kentucky, Ohio & Indiana
- Residential Program Patient Referrals
  - 14 programs throughout Kentucky, Ohio
- Detox Services
  - 3 programs
- Inpatient
  - SUN Behavioral Health
    - Falmouth census 24
    - SUN may exceed 45
- Life Skills Programs
  - 3 agencies
- Provided Medical Systems Assistance on Program Development
  - 3 groups
- Community Education
  - 4 programs
- Prescriber Education
  - 2 programs
- Speaking Engagement
  - Numerous
- State Wide Pharmacy Narcan Protocol Development and Authorization
  - 4 major pharmacy chains
- Screening programs for potential referral and substance use education
  - 3 current programs
- Emergency Department Overdose Referral to Treatment Project
  - 1 program
# Opiate Use Disorder in Pregnancy

## 2015
- **4345 Deliveries**
- **481 Positive Urine Drug Screens**
- **24% False Positives**
  - (i.e., Zantac, Albuterol, Fioricet)
- **219 Opiate Exposed Newborns**
- **106 diagnosed with NAS**
  - (pharmacologically treated)

## 2016
- **4457 Deliveries**
- **535 Positive Urine Drug Screens**
- **30% False Positives**
  - (i.e., Zantac, Labetalol, Adderall, Ritalin)
- **217 Opiate Exposed Newborns**
- **84 diagnosed with NAS**
  - (pharmacologically treated)
Opiate Use Disorder in Pregnancy

**METHADONE**
- Must go to clinic daily
- $15/per day cost to patient
- 1 clinic in NKY
- Full agonist/no ceiling effect
- Long track record of safety in pregnancy/evidence of less risk of relapse in pregnancy from studies
- Do not have to be in withdrawal to begin methadone treatment
- Fetal monitoring suggest > severe fetal cardiac and movement suppression than does buprenorphine
- More prolonged withdrawal for newborn if NAS

**BUPRENORPHINE**
- Can be prescribed take home doses
- Medicaid covers cost
- Limited providers available
- Partial agonist/ceiling effect
- Limited data, but benefits outweigh risks and reduces risk of relapse and continued use in pregnancy
- Must be in mild-moderate withdrawal (24-48 hours since last use)
- May be more difficult to treat post operative pain after a cesarean section
Effect on Newborns

St Elizabeth Data 2015-2016

Length of stay

- 2015: 16 Days
- 2016: 12 Days

Opiate Tx

- 2015: 11 Days
- 2016: 7 Days

106 babies with NAS in 2015
84 babies with NAS in 2016
Disposition of NAS Babies

2015
• 61% to Parents
  – 48% Parent
  – 16% MOB supervised
• 23% to other family members
• 18% to Foster / adoptive
  – (1 baby to CHMC)

2016
• 76% to parents
  – 64% parent
  – 36% MOB supervised
• 13% to other family members
• 11% to Foster / adoptive/ CPS
  – (1 baby to UC due to bed crisis)
Services for pregnant and parenting women with opiate use disorder

$321K Grant received to address NAS
Baby Steps Program

- 2 RN Clinical Liaisons
- 1 Community Health RN/Home Visitor
- Assist women in coordination of treatment/detox for opioid use disorder and to establish OB care
- Provide specialized education, support and care for the pregnant and parenting women with opiate use disorder
  - Individual meetings to evaluate necessary support & resources
  - Group meetings/educational sessions
  - 12 Step Meetings
  - NAS/Newborn withdrawal education
- OB Quality Subcommittee
  - Developing inpatient buprenorphine induction program
Baby Steps 1st Quarter 2017 Data

• 107 referrals
  • 61 Prenatal and 46 Postnatal
  • 21 patients assisted to treatment
  • 35 received education about newborn withdrawal & NAS
  • 64 of the referrals received other education and support
• 31 Patients currently consented to participation in grant program
• 11 receiving home visits by our Community Health RN
Community/Regional Impact
Working with the Community:

• Advocated for comprehensive change in legislation to expand treatment funding and strengthen law enforcement.

• Created a Vivitrol delivery option with Kenton County jail system.

• Advocated for syringe exchange programs to stop the spread of infectious diseases. Program is up and operational in Grant County. Resolutions passed in Kenton County, Covington and Campbell County to establish programs.

  • Funded a hotline in partnership with the Fiscal Courts.

• Educated the community through schools or organizations using the Hazeldon Betty Ford approach.
Ashel Kruetzkamp, MSN, RN, SANE
Questions?