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ASAM Practice Pearls Transcript

Enhancing Addiction Care Through Care Touchpoints

Dr. Stephen Taylor: Hello, and welcome to ASAM Practice Pearls, where we turn clinical expertise into everyday addiction care one conversation at a time. I'm your host, Dr. Stephen Taylor, and today we're going to talk about enhancing addiction care through care touchpoints.

If you ask someone whether they support harm reduction, you might get a mixed response. But if you ask people if people deserve clean supplies, a safe place to shower, testing for HIV, or medication that can reverse an overdose, then the answer's going to be a resounding yes, more than likely.

Every day across this country, community programs are doing just those things. According to the Charm City Impact Report, tens of thousands of hygiene kits, thousands of overdose reversal kits, showers, laundry, wound care, and other services were provided to individuals over the past year. For many people, these services are an entry point into care, a foot in the door of treatment. These small human moments build trust, foster connection, create touch points, and meet people where they are.

So, today we're digging into how to enhance addiction care through this kind of community support. And I have the pleasure, the honor, the privilege of having with me today's expert, Dr. Mike Finnerhood, who, among many, many other things, happens to also be the co-author of the third edition of *The ASAM Handbook of Addiction Medicine*. Dr. Mike, please say hello to our listeners.

Dr. Michael Finnerhood: Hey, everybody. I was just going to open up with something I just received a few days ago. I wear a lot of hats, and you'll hear more about work I do at entry points or touchpoints, including Charm City Care Connection—we have a van outside the detention center, I'm at a church. And last week, I had the privilege of taking care of a young woman who had gained insight in that she needed help.

She had received compassionate care at Charm City Care Connection. And then, it was recognized that she needed more as she was using both opioids and benzodiazepines, and she decided to come in the hospital in order to further her journey, in as she put it, "To get my life back." She was very eloquent, and she had interest in tarot cards.

So, I went in, and she had a deck of tarot cards with her, and she proceeded to say, "As I get to know you over the next couple days, I'd like to figure out about you." So on the last day before she was going to leave, she handed me a very long, two-page letter that was really a thank you, but also what she termed her evaluation of me using tarot cards.

And this is what she said: "Getting to the root of someone's ailment takes more than checking physical symptoms. It takes an open heart balanced with a discerning mind. You understand that our medical system hasn't fully caught up with this, and this may make you have doubts at times. But you have all the right tools at your disposal to make a difference and show others what a balanced approach can look like."

So clearly this wasn't just her reading tarot cards. She put herself into this and put me into it, too. But I think that she raises the idea of what our discussion today should be about.

Dr. Stephen Taylor: I couldn't agree more. "An open heart and a discerning mind," is that what she said?

Dr. Michael Fingerhood: "An open heart balanced with a discerning mind" were her words.

Dr. Stephen Taylor: That's beautiful. Well, listen, on that note, I'm going to go ahead and jump in and ask you some questions that I think will give you a chance to expound on that way of thinking. Because when people hear the term harm reduction, they have a lot of different opinions, as I mentioned earlier. Some view harm reduction as itself harmful, right? On the other end of the spectrum, you have people who think that any kind of treatment, any kind of intervention, is harm reduction by definition.

How should our listeners be thinking about this, and how will we be defining it or redefining it today, particularly in light of that profound discussion by your patient?

Dr. Michael Fingerhood: Years ago, I started to just hang out at this place called Charm City Care Connection and just see who came there. And it's clear that, and we know this from all our work in addiction, that loneliness is a key feature of addiction, and eventually people often, unfortunately, wind up drinking or using alone. And I think of what we try to do at community sites is really to start the process of compassion, and I think we also work really hard to undo shame.

I have a cartoon that I've shared with patients where a medical provider says, "The best thing you can do for yourself is not drink." And the patient says back, "I don't deserve the best. What else can I do?"

We need an entry point. We need to undo shame and to help people become people. I'm at a church on Monday morning, and a person sits at a distance from me. They apologize and say, "You know, I haven't showered in a week." That impacts their lives tremendously, so by having a center in which someone can take a shower, we have clothes available, get some food, they can do laundry, and that's a start. We're making someone feel like a person again. That's the beginning of treatment.

So doing those things means that someone has started treatment. And sometimes patients say to me, "What's recovery?" And I say, "Recovery is making today better than yesterday. And if you've come here, taken a shower, washed your clothes, you know, you've started in recovery because today is better than yesterday."

Dr. Stephen Taylor: That's awesome, and that's so true. So basically, identify people's humanity and help them get back in touch with their own humanity. It's potent and scary to think about a person saying, "Well, I don't deserve the best. What else is there?" That's really powerful. Humanizing care means providing different touchpoints, right? Creating different entry points, looking beyond the clinic, providing whole-person care, as you have just described, and access to a lot of the essentials, like taking a shower, like taking care of yourself.

What are some of the low-threshold but high-impact interventions that clinicians should know about and should be offering to their patients?

Dr. Michael Fingerhood: So I think there's a variety. A connection is first. So it's someone who they can always connect with. I've worked with peers for over 15 years now, and I find peers are essential because it's someone that's always available for conversation. Traditionally, within 12-step meetings, we had a mentor or a sponsor, but that's a different type of role, right? Because a sponsor kind of tells you what to do. A peer's there to share their experience and to listen and be available and to humanize care.

Most good peers offer advice, but they don't truly tell you what to do. So it's a little different than I think people are used to, in terms of NA or AA, where a sponsor has more of a mentor-mentee role. I think that's really essential, especially as we're trying to build self-esteem and undo shame, that you want someone who can connect in a role that feels equal.

And then, there's also things that we become aware of, especially these days, is that people who are using may have wounds that they may be ashamed of. I've seen many individuals at Charm City Care or at our van who will say, "Well, I won't go to a hospital because they'll stigmatize me because I have wounds."

So in the middle of summer, it's 90 degrees out, and you see someone wearing pants and long sleeves, asking, "Do you have wounds underneath?" Individuals are embarrassed; they're ashamed. And you want to ask, and you know, you want to be able to say, "Let's see if we can try to help you with those." Addressing what can make you feel better, not necessarily medically or physically, but emotionally. Everybody's different in terms of spiritually, how they feel. I usually don't bring that up at first...

"Do you need naloxone?" As I mentioned, "Do you need wound supplies?" "What are your needs?" And I think that there's no limit on, or way to assess, and say that, by

doing these things, isn't cost-effective. People often say, "Is there any evidence that what peers do is cost-effective?"

So, to me, if a peer helps a single person, which they do, I think every interaction, every person they try to impact is a positive. And it may be a year later that that individual reflects on how a peer made them think or made them feel. So I'm going to propose that, I think, you know, in medical literature, you often look at number needed to treat to say a therapy is useful, that the number needed to treat for providing compassionate touchpoint care is really one. Every single person that we interact with, we have a positive impact.

Dr. Stephen Taylor: That's so true. And yet, I can hear, as you're talking, people sort of in my ear that I've had conversations with before, saying, "You know, Mike, that all sounds great and all, but let's get down to brass tacks here. How does this translate into real clinical outcomes? How does it affect engagement in care, treatment of infectious diseases, starting medications for MOUD, getting people into recovery? To what extent does all this nice-sounding stuff you're talking about translate into real clinical outcomes?"

What do you say to that?

Dr. Michael Fingerhood: Yeah, so there's different measures that you can look at. So my primary care clinic, which I created about 30 years ago now, provides integrated care for people with substance use disorders, with peers and access to a counselor, and compassionate care for sure. Lots of integration of MOUD, HIV treatment, hepatitis C treatment...

I mean, it's hard to believe that in 2026, we have to search for patients to come to us in order to get hep C treatment because people who have come are all treated and cured for hepatitis C. And there's very few things that physicians or healthcare people can cure, and hepatitis C is one of them. So we can have huge impacts. We have lots of data to show that by linking to treatment, that we can cure hepatitis C.

We even participated in a PCORI study in which we treated recent injection drug use. You had to have had injection drug use in the past 90 days, and we have to show 98% cure rates of hepatitis C.

And then, I mentioned primary care practice where we integrate treatment with buprenorphine and primary care, and we were able to show by providing integrated care versus siloed care, where patients did not receive buprenorphine in the same place, for a Medicaid population, that we saved a lot of money to the state Medicaid program here in Maryland.

So it translates into dollars as well.

Dr. Stephen Taylor: That is impressive. So I got to ask, though, there's probably going to be resistance to some of this kind of work from the community, from legal sources, even some ethical resistance. What have you seen work in terms of implementing these kinds of strategies at a local level?

Dr. Michael Fingerhood: That's correct. There can be obstacles, and it always works best to involve the community as best as you can. I'll give you a few examples. For our van outside the detention center, we early on involved the chief warden for the Baltimore Detention Center to make sure he knew we were going to be out there. And he was all for it.

At Charm City Care Connection, we've had close ties with the community associations, as well as the police department. So the police know that they can actually bring someone to Charm City Care Connection if they see they could use food or a shower. And they view it as a place that is helpful. And that the police themselves view it as a positive.

And the other important piece which came about, especially with communities that are leery, is that providing of service of cleaning up alleys. They can call and say, "You know, my alley has, you know, used syringes or other things. Can you come clean up?" And the program will send someone very quickly to clean up that alley. And proactively. There are program employees who actually do that and go through alleys to clean them up.

Dr. Stephen Taylor: That's pretty powerful. So basically, it's about doing things with a community and for a community, not necessarily to a community.

Dr. Michael Fingerhood: Yeah, I think that's an important distinction, because otherwise, the community say, "You're just going to attract people." We've had that problem even with...

You know, there are churches that have food pantries that are ridiculed because you're bringing people to the church that don't live in our community to get food. Believe it or not, there's criticism. And this is outside the realm of what we do.

So yeah, so you have to be aware of what the community thinks.

Dr. Stephen Taylor: Absolutely. Now, all this stuff costs money, right? How do clinicians get funding and support for their patients and folks in the community who use drugs to get access to this great work that you're doing? Where does the money come from? How do we get it?

Dr. Michael Fingerhood: Yeah. So that's a great question. We get funding from a variety of foundations, including, for instance, local CareFirst, which is BlueCross BlueShield.

There are lots of entities that provide healthcare that are interested in helping with what we do. And then, more recently, the opioid restitution funds have played a huge role in being able to fund a lot of these projects. So there's a lot of state funding.

So, I've helped many community organizations become opioid response programs, or ORPs, as their medical "advisor," so they can get naloxone. So we have naloxone distribution at libraries, you know, all over. I just found out there's a naloxone vending machine at a library right near where I am. A lot of it is state funding through the opioid restitution. And then Baltimore went in by itself, which is one of the few municipalities or cities that did it. So there's additional money that has come from the city to places such as Charm City Care Connection with the view of positivity.

At Charm City Care Connection, we also have another van that goes out as well. There's also a checkered van that's available outside that people can bring their substances that they're not sure what they are to see what they are. And we also have a vending machine outside, so even after hours, people can get naloxone and wound care kits.

Dr. Stephen Taylor: Awesome. Now, naloxone distribution has become accepted, in part because of great work like you just described. What should clinicians know about not just expanding access to naloxone as you've already been doing, but also applying the lessons on that same expansion to access other kinds of services? What lessons can be learned? How do you move from the acceptance we finally have for naloxone distribution to maybe accepting, you know, syringe programs or other kinds of services?

Dr. Michael Fingerhood: Yeah, so early on, as you stated, people thought, "Well, naloxone kits, perhaps it's okay to use as long as you have naloxone on hand," right? So there's a large misinterpretation of data.

You know, and then there was a study published up in Massachusetts where different counties had sequential training on naloxone, and the overdose rates went down, no surprise, much more in communities where there was ready access to naloxone. So that gains acceptance. And it's interesting how there's been a change in mindset.

I try to give out naloxone. I always have some in my car or in my pocket. I've administered it multiple times myself. Some people say, "I don't need any." And I say, "Do you have a fire extinguisher in your home? If you say yes, you should have a naloxone in your pocket. You hope you never have to use it." When I see individuals, I often make sure you [tell them], "You need to tell family members where it is, even though I'm giving it to you, because it doesn't work in that way."

So that I think of it as then transferred into a realization that when we give out naloxone, or people use naloxone, then that is the start of compassionate care, right? So you've created that touch point. And then in most settings, there's something

besides just the naloxone that's a possibility, and that we need to do more to reach people.

You mentioned syringe exchange. The data is robust for syringe exchange, preventing new viral infections that are spread through injection, like hepatitis C and HIV. And so, we know that those programs decrease new cases of HIV and hepatitis C. Clearly, they do. And places that do syringe exchange do all those other things as well.

So they promote HIV testing, hepatitis C testing, wound care. And a significant number of individuals who have access to syringe exchange wind up through that touchpoint seeking treatment. So it's really the start of treatment.

It shouldn't be viewed as it's okay to use or sanctioning use. It's really a way of making sure someone's still alive and each time saying, "What can we do?" And getting people ready. It's also giving motivational interviewing.

So we need to change people from "not treatment-seeking." That's the wrong lingo to say someone's not... right? They don't know what treatment is even. A lot of times, you know, we say that person's not ready. But that's on us. That's not on the person. It's on us when we say someone's not ready.

As clinicians, we should be saying, "What can I do?" The term "ready," I think, is not the best term. It's really that you need to move people along a continuum, and recovery starts before you stop using, and I think we have to realize that.

Dr. Stephen Taylor: So, a couple of things that you just highlighted that struck me. One is that syringe exchange is actually the beginning of treatment. Two, that recovery starts before people stop using. When you start thinking about it that way, then you realize that there's a lot of this understanding that far too few people have.

So, for example, I had the privilege on May 6th of this year to visit the White House as they rolled out the National Drug Control Strategy. And there are very many people who have the same desires we all have to try to help people with substance use disorder and substance use issues, who really would not recognize the validity of what you just said about syringe exchange being the beginning of treatment, about recovery starting before people stop using.

And so, part of this makes me think maybe some of it is just the greater and louder and more frequent communication of this needs to happen. What's your view of that? How do we get that word out to more and more people so that they come to understand it? Or is it just going to have to be that we keep doing what we're doing, and they'll figure it out as the improvements continue to happen?

Dr. Michael Fingerhood: Yeah. And I think that's such a tough issue because I think what's really revolutionized the way a lot of clinicians think about addiction is by having peers around them. So I think there's been a dramatic change in the way care

is delivered in emergency departments, because if they have peers and the stigma really diminishes, I think it's really a battle over stigma.

Now, I didn't tell you my background. So I was originally from Brooklyn, New York. And in the early '70s, we had a school trip to Daytop Village in Manhattan, to a recovery center. I was probably 13 or 14, and that was my first entry point. So for me, it was seeing people, I was pretty young, people who seem like regular people.

And I think that's kind of the message. These are regular people. These are people who need compassion. But certainly bringing humanity and compassion to individuals can be pretty universal.

Dr. Stephen Taylor: Yeah, exactly right. And then translating that compassion into strategy and recognizing that there can be a number of different strategies that can help different people.

So yeah, I think that's a powerful message. Earlier, you talked about making sure people have showers. Making sure people have access to HIV testing. There are so many different measures. Another one of them is test strips, so that people have an understanding of what they're using and what they're not using.

Can you speak to that?

Dr. Michael Fingerhood: Yeah, I think the use of test strips is somewhat dynamic, and I think it evolves and changes over time. Couple years ago, certainly xylazine test strips were definitely useful as xylazine entered as an additive to fentanyl. And, you know, there's clear studies that show that people did not necessarily really want xylazine in their drug supply. And we saw just terrible wounds related to xylazine. So in those instances, xylazine test strips were quite useful.

And then, of course, xylazine has started to diminish in many communities. And then in a variety of communities around the United States, we've seen medetomidine as an additive to fentanyl. And in most instances, also not desirable, although in some communities like Philadelphia, it's tough to avoid or to find fentanyl without it.

Clearly, most individuals do not want these additives. So I think that the use of test strips is important because of the fact that the substances the test strips test for, that have their own toxicities that generally aren't wanted. Certainly, they're somewhat sedating, but individuals in surveys say that they would prefer their drugs not to have these additives.

So I think test strips are useful in being available, and I think what we're testing for using test strips is going to be changing year by year.

Dr. Stephen Taylor: Yeah, there's the age-old story of the game of Whack-A-Mole that we always have to play, that, you know, this month we got to worry about xylazine. Next month, we have to worry about medetomidine. The month after that, who knows?

So you're right. There seems to be an evolving need for different kinds of test strips in order for people to just be aware of what it is that they're using.

Let me ask you, what are sort of the main practice pearls or action items that you want to make sure that our listeners take away from our discussion today?

Dr. Michael Fingerhood: Yeah, I think for all of us, the reason we do this is because of what patients say to us. I want to mention another gentleman who I met at also a low-threshold center who was covered with hay, and he was sleeping in a horse stable, and he weighed about 90 pounds. He had untreated HIV, untreated hepatitis C, and we became friends.

And a lot of my patients have nicknames, and I'm going to share his nickname, which is Rabbit. And Rabbit's done really well. He's now normal weight. He's been in recovery for 20 years. Undetectable viral load.

So I think the message really is remember every patient that you've touched, and you don't realize how many patients you touch. And you'd be surprised at how many lives that by doing this that we touch, especially as we reach people who have complex social needs, who have tremendous obstacles in their lives. And every single person is worth our effort.

Dr. Stephen Taylor: On that note, I want to thank our expert, Dr. Mike Fingerhood, for sharing his expertise in meeting individuals where they are in terms of their addiction care needs.

Dr. Fingerhood, he is the co-author of the third edition of *The ASAM Handbook of Addiction Medicine*. And you can understand why this guy is a professor at John Hopkins and why he is teaching people about how to take care of folks with addiction disorders. Because when you have this kind of approach, you need to be teaching other people about how to do this work.

For more comprehensive information on addiction care, check out that handbook. Again, *ASAM Handbook of Addiction Medicine, Third Edition*. Chapter 14 actually explores medical care for patients with substance use disorders, which continues to delve more into what we've discussed today. So don't forget to visit ASAM's e-learning center to claim your CE credits for this episode.

Also, make sure to subscribe and share this episode with colleagues who may find this information helpful. Thanks for listening, and we'll see you next time on ASAM

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