PRESENTER: And I'd first like to say back in earlier January, February, earlier in the year, we were looking for excellent examples of the use of OUD services in emergency departments, and had several folks refer the work that's happening at Mass General to us. And so we reached out to Sarah and Martha and had a couple of really good conversations. And thankfully, they agreed to share some of the things they're doing with us today. And so we're really excited about that.

And to say a little bit more about each of the speakers, Dr. Sarah Wakeman is a medical director of the substance use disorder initiative and the addiction consult team at Massachusetts General Hospital. She's also co-chair of the Mass General opioid task force and clinical lead for the partners healthcare substance use disorder initiative.

And to say a little also about Dr. Martha Kane. Dr. Martha Kane is a licensed clinical psychologist who has held numerous positions in her various MGH, Mass General Hospital, substance use disorder programs and in the ambulatory psychiatry division at Mass General over the last two decades. Please join me in welcoming Dr. Sarah Wakeman and Dr. Martha Kane. And Sarah and Martha, the floor is yours. And if you are--

SARAH WAKEMAN: Great. Good afternoon, everyone. This is Sarah Wakeman, and I'm here with Marty Kane.

MARTHA KANE: Good afternoon.

SARAH WAKEMAN: I'm going to be starting off, and then, pass over to Marty for the middle portion. And then, I'll come back for the end. We're thrilled to be here with you today. We co-lead the substance use disorder initiative at MGH. I'm the onsite medical director. I'm an addiction medicine physician. with background in internist, as well. And then, Marty is a clinical psychologist and our clinical director of the substance use disorder We have no disclosure.

So we hope in the time that we have with you today, over the next 40 minutes or so, I'm hopefully leaving time for discussion and questions at the end, to give you an overview of our substance use disorder initiative history here at Mass General Hospital, to detail how we got to where we are, some of the details of the initiative, to discuss some of our outcomes from early evaluation attempts of our initiative, and then to end with lessons learned, and hopefully to hear from all of you about any questions that may come up.

So obviously, why we're having this webinar and why we as a hospital system have invested so deeply in substance use disorder is because we're in the midst of a public health crisis. I'm sure you all are aware that more people now die from drug overdose than from any other cause of death under age 50, and more people are now dying from drug overdose than from the peak number of deaths from motor vehicle accidents, from HIV, or from gun death.

And while, of course, death is the worst possible outcome, sitting in a general hospital, where we work, we're also seeing rising rates of opioid-related inpatient hospitalizations and emergency department visits. And this is true across the country, but particularly true in Massachusetts. This graph here shows the national rate, and you can see the national rate of emergency department visits for opioid related causes is 177 per 100,000 people. In Massachusetts, we're actually about four times that. We actually have the highest rate of emergency department room visits for an opioid-related cause at higher than 400 per 100,000 people.

In addition to the rising rate of hospitalization ED visits, the level of acuity of patients coming in has increased dramatically. We've seen an increase in ICU admissions of people who have survived an overdose, with a 34% increase across the country between 2009 and 2015. And while the in-hospital mortality rate is low, meaning when people survive long enough to get here, they generally do live through the hospital stay, there's an incredibly high mortality rate after discharge, with an additional 25% of people dead at a median of 31 months of follow up.

And this is a very young population. And so while we may be doing interventions in the hospital to treat their acute medical consequences, unfortunately, too often, patients are leaving the hospital without care for their underlying addiction, or the reason why they're often ending up in ICU in the first place. And we see that play out in terrible consequences, including post-hospital mortality.

In Massachusetts, where we live and practice, there's been a rising rate of deaths, as we've seen across the country. We're in the top 10, I believe, for opioid-related overdose death across the nation. This year, we've seen a slight improvement for the first time in many years. But when we started this initiative, which was really in 2014, we were on the rise and upswing of the curve of that. So you can see that from 2012 and onward, there's a dramatic increase in opioid-related death across the state of Massachusetts.

And so if we were thinking as a health system about how to begin to tackle opioid use disorder

and all substance use disorders more effectively, we of course look to what the evidence shows is effective treatment. And so when we think about effective treatment for opiate use disorder, we really thought about it in three bucks.

So, of course, immediate access to medication. And we'll touch briefly on the evidence to that, although I'm sure many of you are familiar with our three FDA approved medications-- methadone, buprenorphine, and naltrexone. Access to evidence-based psychosocial interventions that are really tailored to the individual and based on patient preference. So thinking about interventions like cognitive behavioral therapy, motivational enhancement therapy, and contingency management.

And then, although not formal treatment, ensuring that recovery supports are available on a component of care when patients want that. So here at Mass General, we use recovery coaching robustly, and we'll talk a lot about our recovery coaching program. But obviously, mutual health organizations are probably the best known example of recovery support in the community.

And when we think about access to effective treatment, particularly pharmacotherapy for opioid use disorder-- and the older model of care was often to have patients either self-refer or have to navigate pretty complex systems to try to access medication. Medication was often used as sort of the reward for getting through a complicated series of hoops and very rarely was offered within the hospital setting. And yet, there's been increasing research over the past five or 10 years that's shown that if you actually make treatment easy to access, particularly for hospitalized patients, that you improve outcomes dramatically.

The two studies done at Boston Medical Center, our colleagues in Massachusetts-- the first looked at all comers to the general medical service and looked at offering individuals who were not treatment seeking the opportunity to start methadone in the hospital and then link it to methadone treatment in the community. And in that sample of medically fit patients who didn't come in necessarily looking for treatment, those who started methadone in hospital, 82% of them would actually present for follow up care in a methadone treatment program in the community.

A group at Boston Medical Center then took that a step further and did a randomized controlled trial where they again took all comers to the medical service and randomly assigned them to either start buprenorphine in the hospital and then be bridged seamlessly into

community based care, or to go through a buprenorphine detox in the hospital and then get an appointment after discharge at a buprenorphine clinic. And they found that those that started the medication and continued it in a continuous bridge after discharge, that 72% of them would enter into treatment, compared to only 12% of folks that were detoxed and given an appointment.

Colleagues at Yale went step even further and looked at the emergency department population and did a three armed randomized controlled trial looking at starting buprenorphine in the emergency department with a three day bridging prescription into community based care versus either a motivational intervention with a referral to treatment or simply a referral to treatment, and found that just that three day bridge of medication was incredibly important, that 78% of people were still engaged 30 days later who got the medication started in the emergency room, compared to only 37% of the people that had to wait about three days and connected the care from there.

And so these sort of studies really informed our processes. We were thinking about, what can we as a health system do to address this crisis, and how can we begin to translate what we know works in clinical trials into the actual practice that our patients receive when they're in the hospital?

A couple of important things happened long before our substance use disorder initiative took place. In 2007, the Mass General Hospital changed its mission statement, which ended up being crucial in terms of the genesis of the substance use disorder initiative. Like many hospitals and academic medical centers, we had a three part mission for a long time that included clinical care, education, and research. And in 2007, we changed the mission statement to explicitly make service to community a fourth pillar of the mission, so a key component of everything that we do here at Mass General.

And that was incredibly important because our hospital, like many, undergoes a strategic planning process every 10 years or so where the hospital leadership decides what areas to focus resources and new clinical services on in the coming decades. And so when that process came about in around 2012, for the first time, there was a specific committee focused on the needs of the community at the table when they were thinking about what areas of focus the strategic plan should be guided by.

And that community committee looked at the needs of our community as it began thinking

about recommendations to make to the hospital. Our hospital does a community health needs assessment every three years. That's a pretty in-depth survey process-- both in-person and paper surveys and focus groups of community members in the main communities where we have health centers.

And you can see that in both 2012 and even more so in 2015, substance use was by far the number one priority to our community members. So remember, 2012 was long before we saw any newspaper headlines about the so-called opioid crisis. And yet, the people who live in our communities and work in our communities and get health care in our communities knew that this was a huge priority and the number one issue to them, more than crime and violence, obesity, mental health, education, housing, or any other issue.

In addition to that, our hospital, again, like many others, is beginning to think differently about how we deliver care to patients and particularly the populations of patients. And we're in the process of becoming an accountable care organizations and have begun that transformation, meaning that our system is incentivized to really keep patients well and keep them out of the hospital, rather than thinking simply about a sort of fee for service model of health care. And so we were also able to make a financial case, in addition to the compelling community case.

When we looked at about 2,500 medical and surgical patients who were admitted over the span of a one year period, we looked at patients who had various common medical conditions as a reason for admission and those with a substance use disorder, either in the medical services only or in the medical and surgical services. And we were able to show that the cost of delivering care to patients with a substance use disorder were astronomically higher than for patients with other medical conditions.

On top of that, patients with a substance use disorder stayed longer than expected, and they had a higher readmission rate. That all really painted a picture that was the opposite of value in health care. We were delivering incredibly costly care, and yet, people were continuing to come back to the hospital sicker than before. It's really the opposite of how we wanted to be thinking about health care as a system.

And so that combination that the community prioritized in substance use disorder is the main issue that it valued, and the ability to make a financial case to the hospital leadership. That really not only is this the right thing to do to focus on substance use disorder treatment, but it's also the financially smart thing to do to think about how we can redesign our care as a system

led the institution to support substance use disorder as its number one clinical priority, both from the community subcommittee and the population health subcommittee, leading to the overall strategic plan focusing on substance use disorder as its main clinical priority.

And our focus was really on improving the quality and outcomes for patients with substance use disorder, reducing costs, but also reducing unnecessary markers of poor clinical care. So reducing emergency department visits and inpatient readmission, and increasing effective engagement and outpatient treatment. So with that, I'm going to turn it over to Marty to tell you a little bit more about our process, and then, the details of the initiative.

MARTHA KANE: So thanks, Sarah. So as you can see, on the slide in front of you, we began with an initial state that was less than ideal. We had patients with very high acuity. We were dealing with the fact that the system was not particularly well-integrated. Then, that treatment that was offered was frequently neutral, if not ineffective, that there were tremendous coordination gaps and problems for patients trying to navigate from one care setting to the next. Kind of a giant crevasse they fell into, and without much help across that.

They, in addition to that, had many unmet social needs, which were a little bit beyond the scope of what the hospital could really provide, and yet, had a dramatic impact on their outcome, on their likelihood of establishing any kind of stable recovery. And in general, we weren't seeing much progress in terms of treatment outcomes. So we sort of had an endlessly revolving cycle.

So we decided we needed to interrupt that cycle in a number of ways. As you can see, our mission was to improve the quality and clinical outcomes. We improved the value of the addiction treatment for all patients with SUD. We decided all of our patients needed to have access to evidence-based treatment that was readily available and generally standardized so that there was some expectation of quality across the entire system.

And we rooted that in several core principles. One, this is really a chronic disease, and we needed to apply a chronic care model to the care of our patients with substance use disorder. Most care was offered in generally acute episodic care rather than chronic long-term care with gradual step down And patients needed to be able to move across that continuum.

Because this is a chronically relapsing disease, they need to be able to access higher levels of care, and then reduce to lower levels of care, and then back to higher levels as they needed it without a lot of interference in that movement. And we needed to really adopt a patient-

centered approach, as recommended by the national treatment organizations SAMHSA and NIDA, et cetera, that all care needed to be essentially rooted in the patient from the patient's point of view, that we needed to use evidence-based care in all of our efforts.

Too much of what's done, as we observed in our local system, was not really evidence-based, but more based on tradition. We wanted to change that. And that treatment needed to be available on demand. Same day. Next day. Certainly within the window of a few days once someone was ready for care. And that quality had to be present in every setting.

Sorry about that. Little pilot error there. So just to expand a little bit on our chronic care model, we decided we needed to really work at building a system that allowed for treatment on demand that was integrated into current and existing care. So wherever the patient connected, they needed to be able to find out about an access treatment right away from that.

Patient care was really at the heart of this, so care needed to be a patient-centered. Patient needed to be informed about their process. As they were going through it, they needed to understand what it was that they needed. And people needed to be listening to them. They understand as well as anybody what they needed next or what they were able to do next.

That our treatment models need to be based on outcomes measurement and on continuous feedback to improve outcomes. That we needed to stop saying, well, the patients failed treatment, and rather sort of look at how did the treatment maybe fail the patient. How could we modify the treatments so that it actually resulted in a better outcome? So that was essentially the heart of our work, how we began our work.

So as you can see, we've done a number of things. I'm going to walk you through this sort of in a chronological order because we did not begin all of this on the same day and kind of work through this. But essentially, we developed inpatient services, outpatient services, ED-based services. We added a couple of clinics that were specific to, say, pregnant women, and we added recovery coaches throughout the system. And we're going to talk more about each of these in detail.

Our inpatient addiction consult team essentially serves at the bedside. It's a consulting group that is comprised of a 1.0 FTE addiction psychiatrist, also a full time addiction internist, a 2.25 FTE nurse practitioners who support that work, about 4 and 1/2 full time social workers who support that work. We've also got a very part time clinical pharmacist who helps us out and a full time staff assistant.

And essentially, the process is that they attend at the bedside. They provide-- doctors in first. They sort of make a medical assessment, decide if there's medication needs, pain needs, et cetera. And then, they're followed by social work, whose job is to come in and evaluate sort of what the outcome process-- I'm sorry, the aftercare plan-- is going to be and start to implement that work in the system. Basically, they attend at the bedside every day, so it's not a one and done kind of thing. with recommendation is actually an ongoing interaction and conversation with the patient and with the team attending to the patient.

So to review outcomes a bit, our active consults we've seen over 5,000 patients since we initiated in October of 2014. The vast majority are still with alcohol. About 30% involve opioids. Most are male, with a mean age in the late 40s.

Patients who are seen by ACT is from our outcome studies. Sarah's going to review more outcome studies in more detail later. But basically, we see a 25% lower 30 day readmission rate, compared to patients who have substance use disorder, but are not seen by ACT So essentially, compared with peers, it does appear that we're able to reduce their readmission rates simply with an intervention in the inpatient setting.

In addition to that, we see from our providers-- so from those folks who are actually providing the care-- that we have provided a broad-based education and an interaction with ACT that has really helped increase their comfort in taking care of these patients and increased their willingness to treat patients with SUD.

So we did-- then, we went to our primary care settings. So we started in our inpatient setting, and then moved to our primary care setting, and that-- obviously, we're beginning to try to work at creating services that allow for both acute care and for long-term chronic care.

And in our outpatient primary care setting, we essentially came at it from two different directions. First, we created addiction champions teams in every setting. So these are multidisciplinary teams created from primary care service providers, including internal medicine docs, nursing, if there's a behavioral health service available, behavioral health services, people in the administrative role, and security personnel as needed. So it was really a working group that came together twice a month to really think about what it is that the patients needed.

We integrated also into our community coalitions. So wherever there was a group of people in

the community who were working together to try to deal with substance use disorders in their community, we invited them to participate, creating that bridge between medical care and the broader psychosocial needs of the patients.

And there really were a couple of purposes of these champions teams. One, to address and resolve all of those policy, procedural, functional issues that come up whenever you're adapting care and modifying care and bringing in a new patient population, particularly one that can have behavioral issues or can have other kinds of concerns that maybe are outside the bounds of what we normally do.

And then, and probably more importantly, we brought in-- everybody participates in clinical rounds where we actually talk about the patients who are not doing well from a multidisciplinary, multisystemic point of view, and try to figure out what we can do. Again, bearing in mind that notion that we're providing chronic care and we're providing care for people. Even if they're not doing well, we're re-evaluating and trying a different strategy. And that's really the team where that happens.

In addition to that-- and so just as our general successes, we now have 38 physicians wavered-- new physicians wavered-- over the last few years. And they're prescribing now to 546 patients across our outpatient settings. And in every setting, that champions team still exists, still operates twice a month. It's still a very robust vehicle for managing those patients.

So the other arm of our primary care approach was really to bring recovery coaches and peer-based services into every health center. So we now-- and they work in collaboration with those champions teams. They work directly with our primary care setting. Typically, recovery coaches, at least here in Massachusetts, are attached to behavioral health settings.

We opted to attach them to primary care settings because our belief was, you know, you always have your primary care doctor. You can't ever get fired from primary care, or basically can't. So no matter what happened, no matter whether you're doing well or doing poorly, no matter whether you're active or in stable recovery, you're still attached-- you still have a connection to your primary care doctor, and that meant you'd still have attachment or a relationship with a recovery coach. And we thought that was really very, very important.

We now have 10-- and they've done over 11,000 contacts with over 1,200 patients. They're all pretty much embedded still in primary care. We have added now one in each of two behavioral health settings. We have now hired a manager, who supervises the team. And they have

become a critical part of these teams, and they're relied on universally through these centers-- through these health centers.

When someone is linked to a recovery coach, we see that they've got 25% fewer inpatient admissions. Their number of outpatient appointments that they keep is up over 40%. And when someone is on medication treatment and is involved with a coach, after 12 months of coaching, about 90% of those folks are still involved.

So then, we decided to add a link between the inpatient and the outpatient. As I'm sure you're well aware, people come into the inpatient setting, get their care. They go to the outpatient setting. And somehow in the middle of all that, they get lost to care. So we've created this Bridge Clinic, which was an approach that's essentially low threshold, on demand. A multidisciplinary approach.

It's open seven days a week. You don't need an appointment. Over half of our visits are not scheduled. You can just walk in and get an appointment. So we will give you a scheduled appointment, if you like. It's run by an internal medicine doc, and she is supported by an NP, an MA, a resource specialist, and appear in recovery. And we're soon to add psychology time and psychiatry time, as well, to help her kind of manage that manage that for the patient.

The first priority is engagement. We'll offer medical treatments the same day. The idea is to help you stabilize and then transition off into your outpatient care, where we hope you'll be able to remain stable and benefit from care. And we find that of those our average length of stay is about 76 days, and that unfortunately, about 25%-- a little bit more than 25%-- are staying more than a year. We're now beginning to look at that population and try to understand them better.

The ED was our next collaboration that worked out. As Sarah mentioned, we knew that ED initiated care worked. And so we worked with our own ED, and they really developed a whole program called the get waivered campaign. And they got almost all of their docs wavered, and they're now essentially prescribing medication from the ED. 41 out of 46 physicians are now trained to prescribe.

This was the first emergency department in the state of Massachusetts to really take this on, and maybe the first in the nation. They actually do prescribe buprenorphine, and patients then can receive in the emergency room a take home pack that includes two days and includes

some naloxone. And the idea there is that the Bridge Clinic then provides the follow up care. So they're given the medicine, told how to get to the Bridge Clinic, walked over to the Bridge Clinic if need be, so that there's a warm handoff whenever possible.

And finally, our most recent efforts have been to create a program similar to the bridge model, but now, for pregnant women, their partners, and their children from conception through the first two years of life, integrated one stop-- one stop shopping, essentially, for pregnant parenting women. It was a collaboration between a number of different generally siloed providers here in the hospital, so it's been a very interesting integrated effort.

We have OB, neonatal medicine, primary care, psychiatry, social work, and nursing all collaborating. It is directed by a family medicine physician, who's got her addiction credential, and supported by all the other disciplines. We opened in April. We are currently serving 22 families. And it really is the Bridge Clinic presence that allows us to sort of feel comfortable managing this.

It's not open every day. We can only afford to be open one day a week right now. But patients can then-- those patients can then work in the Bridge-- can come to the Bridge Clinic if they need more support. And our addiction family medicine clinician actually also works in the Bridge Clinic, so there's some nice linking. We are working closely right now to work with our community-based providers, both legal and child protection providers in the state, to create ongoing, organized, and coordinated care.

In addition to that, just very quickly, we keep extending to new settings. We're now working in pediatrics, developing champions teams there, trying to work on embedding behavioral health care into the pediatric setting with developing family services. We've been running a tumor board for our oncology colleagues, and we'll continue to do that, trying to enhance their access to psych services, as well. And we're expanding that model to new primary care settings, including the multidisciplinary rounds and the recovery coaches.

And last but not least, we continue to try to train and mentor everybody who's interested, we repeatedly do the training and mentoring for the buprenorphine waiver. We've just started an addiction medicine fellowship. They've been here three weeks now. Very exciting to have them integrated into all of our teams.

And our nursing colleagues have developed a training program for the nursing license, the CAR the addiction nursing license. And they have graduated, I believe, two classes now, and

are continuing to develop that program. So we're beginning to have more and more addiction trained nurses, as well. So I'm going to turn it back over to Sarah to review our outcome.

SARAH WAKEMAN: Great. Thank you, Marty. So I'm going to cover some of the outcomes to date. And then, again, we'll end with some Brief lessons learned, and then, some time for questions. And I see lots of great questions coming in, so keep them coming.

So in terms of pieces of the model that we've evaluated, the first evaluation we did was of our inpatient addiction consult team. So as Marty mentioned, this is a multidisciplinary and interdisciplinary team that sees hospitalized patients. So the goal is initiating treatment in the hospital and then linking into ongoing care in the community.

And so we developed a quasi experimental process of evaluation to try to determine whether inpatient addiction consultation improved substance use outcomes at both one and three months after discharge. So this was, again, a prospective quasi experimental evaluation. Our primary outcome was a change in the addiction severity index composite score for alcohol and drug use and self-reported days of abstinence in the past 30 days. Although our primary endpoint was 30 days after discharge, we did a follow-up to 90 days after hospital discharge.

So a couple of key points to highlight here from table 1 showing you the demographics of our patient population. The first, as Marty mentioned, are-- our number one type of consult on the inpatient setting is still alcohol use disorder, but opioids is a close second. So drug use disorder accounted for 36% of the type of substance use disorder amongst participants. And when we look at primary drugs that someone had for their drug use disorder, heroin was most common, followed by other opioids and cocaine and multiple drugs.

Importantly, the group that got an addiction consult-- again, because this was a randomized controlled trial-- not surprisingly was much bigger than the group that didn't get a consult. So the group that had a consult had a higher baseline addiction severity index for alcohol and also for drugs, and so we had to control for that in our analysis. And we did mass patients on their baseline and utilization, and also their baseline severity and their primary type of substance use disorder.

And what we found was that even though patients with-- I don't know why that keeps jumping. Apologies. Patients started out with a higher addiction severity index score in the group that got a consult, there was a greater magnitude of reduction compared to a control group. So this is uncontrolled for baseline ASI differences, but you can see that there's a far greater

decrease in terms of ASI in the 30 days after the consultation. For drug use, similarly, we saw that patients started at a more severe level, the folks that got a consult, and they saw a greater decrease compared to controls who did not get a consult.

In terms of days absent, similarly, the group that got the consult started out much sicker. They were able to stay sober for fewer days in the past 30, reporting about 12 and 1/2 days of abstinence in the past 30, compared to 19 for the control group. And they saw a greater increase in the 30 days after discharge. In the 30 days after being seen by the consult team, on average, individuals were able to stay sober for 25 days out of the past 30.

In terms of secondary outcomes, we looked at a number of things, ranging from mutual help attendance to treatment engagement to utilization or the possible admission and emergency department use. And I'll just draw your attention to the hospital admission and ER use data, where we saw a greater decrease in folks who got the addiction consult, both in a decrease in hospital admission and also a decrease in emergency department use compared to folks that didn't see a consult. And I should say that all of the findings that I showed you on the graph remain significant after we controlled for differences in terms of baseline severity, differences in demographics, and differences in baseline utilization.

Another evaluation we did was really around trying to determine what has been the impact of the initiative on providers' opinions and perspectives and their willingness and ability to treat patients with substance use disorder. It will not surprise anyone who's on this webinar to know that stigma continues to be a huge challenge for patients dealing with substance use disorder, and that that stigma occurs frequently in the health care setting.

And we did a baseline evaluation of our general internists prior to the launch of this initiative and found that many physicians actually hold very stigmatizing views of addiction. And despite caring for many patients with substance use disorder, very few feel prepared to take care of those patients, and even fewer actually offer services. And so the goal of this evaluation was to evaluate whether this initiative across the hospital has had an impact on general internists' attitude, their clinical practices, and their preparedness to care for patients with substance use disorder.

And so what we found was that, in terms of 2014 and 2015, there are really no significant differences across the board looking at all comers. There was a slight trend towards an increase in the frequency with which patients asked for help for substance use disorder. But in

general, providers frequently saw patients in clinical practices with a substance use disorder. So 60% of providers in 2015. But no differences overall.

But when we look specifically at physicians who've had an interaction of the substance use disorder initiative, meaning that they had a patient actually receive clinical services from one of the components of the initiative that you heard Marty describe, we saw significant difference between those physicians and physicians who hadn't interacted with the initiative.

The physicians who had an interaction with the initiative were more likely to report that they found caring for patients with substance use disorder satisfying. They were also less likely to report negative use of medication for addiction treatment. They were more likely to report that they didn't view medication treatments as a quote unquote "replacement addiction."

They were also much more likely to say they felt very prepared to screen patients for a substance use disorder, to diagnose patients for a substance use disorder, to provide a brief intervention, to refer patients to treatment, to discuss medication treatments, discuss overdose education, or discuss harm reduction services. That was true across the board, compared to physicians who had had no interactions with the initiative.

And they were also more likely to actually provide clinical services themselves. So again, the blue is the physicians with interactions with the initiative, and they are much more likely to frequently or sometimes prescribe naloxone to a patient at risk for overdose. And you can see that physicians who haven't interacted with the initiative, none actually frequently prescribed naloxone to someone at risk for an overdose.

They're also more likely to frequently or sometimes prescribe pharmacotherapy. And again, physicians who hadn't interacted with the initiative, very few-- only 2% overall-- ever prescribed pharmacotherapy to a patient with a substance use disorder.

So in addition to looking at the impact in terms of our physician colleagues, we also wanted to evaluate critically the role of the recovery coaching program. This is something that really hasn't been evaluated much in the research literature. We anecdotally feel like our recovery coaching program is sort of the lifeblood of our substance use disorder initiative, or the human glue that holds it all together.

When we did this evaluation, we at that point had five recovery coaches. We now have 10 recovery coaching positions, as you heard from Marty. And so this is a qualitative evaluation

that really, its goal was to try to better understand the role of the recovery coach, particularly in a primary care setting, and to understand the impact on patients. And so our qualitative research team was exploring perceptions of the ways recovery coaches affect client recovery and wellness.

We did this through semi-structured qualitative interviews. We interviewed all five recovery coaches, and then, an exhaustive sample of 16 patients that showed a wide range of diversity in terms of age, type of substance, gender, and engagement with the coach. And then, we did qualitative method using constant comparative method to guide the coding with two coders.

And so first, what we found about the recovery coach role-- the themes that emerged were really around four key activities. The first was around system navigation, so helping the patient access treatment, assisting with concrete social service needs-- so applications for housing, for transportation, for IDs, for food assistance-- and accompanying patients to appointments, be that medical appointments, or frequently, appointments in the legal system, like court hearings.

Another activity was around behavioral modification. And so this is really some of the motivational work that recovery coaches do around eliciting and sustaining discussions with patients about changing behaviors in multiple wellness domains that included substance use, but weren't limited to substance use.

Harm reduction was another important activity. Coaches providing patients with access to syringe exchange programs, access to naloxone, helping patients experiencing homelessness get clothing or food if they were staying outside and were not engaged in the shelter system. So really concrete harm reduction needs.

And then, the fourth, and perhaps the most important, was really around relationship building. And this boiled down often to just spending time with a patient in an unstructured-- I don't know why this keeps jumping. Spending time with a patient without a specific agenda. So often, meeting with a patient outside of the health care setting for food, for a coffee, for a cigarette, and to really just build that relationship around the patient coach track.

The strengths of the recovery coach role. And I'll use quotes to highlight some of these strengths. The first is accessibility. So coaches are available in a way that other health care providers really aren't. And so this patient describes, if you think you're having a bad day, the best thing is to try to get in touch with your coach first. And then, say, look, I'm having a bad

day. Is it possible you could come and sit with me?

Coaches can text with our patients. We have a HIPAA approved way of coaches being able to text message with patients. And so they're accessible in a way that often circumvents the many barriers in the health care system of trying to access your health care provider team.

The other key strength will be around shared experiences. So that was certainly something that we envisioned when starting this role and hiring for this role, but really hiring people who had walked in the shoes of our patients and had the shared experience of being in recovery from a substance use disorder.

And as you'll see from this quote, patients didn't always know what that shared experience was. So the patient says, I guess she has family who's gone through it, who had endocarditis so I felt a sense of relations that opened the door that I don't feel with doctors. But that sense of the coach really understanding where they were coming from.

The third strength was around the ability of the coach to motivate behavior change. And so one patient reflected on wanting to leave against medical advice from the hospital and having the coach remind the patient of what might happen, sort of playing the tape forward of what would happen if the patient did do that.

And then, the last was, again, around the activity of really concrete social service needs and linking to those, and about how coaches often know a lot about-- so sorry-- food stamps, about finding housing, about disability, that anything that the patient felt like they needed in terms of social services, the coaches were often experts. And often, there are things that the patients didn't feel comfortable asking their doctor.

There were some challenges to the recovery coach role that came out in the studies. The first is that even with a person with shared experience and someone who perhaps is more relatable than the health care provider, some patients just shared that they had this comfort with asking for help. And so, as one patient said, it's hard for me to ask for help. It is. I just-- I don't know. Maybe it makes me feel weak or something.

Other patients-- actually, a coach highlighted some lack of clarity in the coach role. And again, this is early on in their program, and it's definitely been really important to learn from both the coach and patient perspective and other health care team members about the coach role.

One challenge in particular was around patients who had very severe psychiatric illness. As this coach highlighted, I'm dealing with a patient who is suicidal and really not knowing what to do, feeling like he or she didn't know what to do in that moment and not being trained for that, and so needing to be clear about really the role of the coach.

And then, the last of the tension between the recovery coach and the care team. And so, as one coach said, what happens is the medical degree is kind of overshadow practical experience. Another coach mentioned, the medical team, they don't know what to do. They looked at me like, well, that's why we hired you. Let's figure it out. And so that's certainly something that we've had to learn about over the years, is preparing teams to be ready for a coach and how to utilize a coach, and really trying to focus on building teams where every voice and every perspective has value.

And then, lastly, we recently looked at buprenorphine treatment outcomes among patients who were linked to a recovery coach. And so we did a retrospective evaluation of patients who were on buprenorphine treatment and received recovery coaching and found that among those prescribed buprenorphine, abstinence rates actually significantly increased following coach contact.

So for all coaches-- for all patients prior to coaching, the average duration of absence is one month, and that increased to four months after coaching. But for patients who were able to engage with a coach for 12 months, we actually found that 90% of those were totally abstinent after 12 months of coaching. So in terms of lessons learned, and then, we'll end here, and Marty and I will both take questions.

I think the first piece is just the incredible importance and value of stakeholder engagement. Mass General Hospital is a huge system, and as Marty mentioned, it's not just our system, but our relationship with our community partners, with our community coalitions. And so getting engagement from all of those sectors, ranging from the emergency department to the OB providers to our community coalitions to our primary care doctors was long and time consuming, and also probably the most important and valuable thing we did in getting this initiative launched.

MARTHA KANE: and it's something we continue to do every month. We still-- Sarah or I go out and staff these meetings. We talk to people constantly. It's a continuous process of maintaining and understanding what stakeholders' needs are as they change.

SARAH WAKEMAN: Marty and I often joke that what we're doing is really motivational interviewing for systems, that when we've come in and told a set of providers or a system what we think it is they should do, that generally doesn't go very well, much like when you tell a patient what they should do, it doesn't go very well. And that it's really been a process of us figuring out what motivates our colleagues. What are the things-- what are the goals that they have, and how can we align with them in terms of moving forward on those goals?

We are increasingly recognizing the heterogeneity of the patients that we serve, that there's a wide spectrum of need and severity. Marty alluded to this a bit with our Bridge Clinic, that although we designed it as a transitional clinic, about a quarter of our patients have been with us for longer than a year. And when we look at those patients, those are patients that tend to also be dealing with severe psychiatric illness, with housing instability or homelessness, and with many other competing priorities.

And same on our addiction consult team. When we look at patients who are readmitted frequently, they're often the patients who have many other co-occurring medical and psychiatric illnesses and often dealing with homelessness. And so figuring out how do we tailor these interventions to the incredible range of patients that we're caring for.

And then, the last piece is that what's been really useful to us is what I'll call a top down and a bottom up approach. So what I mean by that is that having hospital leadership from the president of our hospital and beyond saying that this is the number one priority of our institution gave us sort of the umph or the clout, the accountability, to really make this happen. But I think if you have leadership say something matters without actually providing the people in the front line with the tools to do the work, it just leads to people feeling like they can't possibly do it.

And so in addition to that sort of leadership voice of saying that this matters to our health system, really on the ground work of-- as Marty said, twice a month every month, we're sitting with each team in all of these different diverse settings to talk to them about what they need, how it's going, talk about cases, provide whatever resources they need.

And so that combination of kind of skill building and almost handholding, really being there in the trenches with them, and at the same time, having the support of leadership has been really important. So I think at that, we are really excited to take some questions. And I think maybe Cindy is going to moderate questions.

CINDY: Yes. I'm going to turn it over to Maureen Fitzgerald. She'll be reading the questions out loud so everyone can hear.

MAUREEN FITZGERALD: Yes, I'll do that. And thank you so much, Cindy, for your excellent webinar production today. I just want to let everyone know that we received a lot of questions, and I'll be reading them in the order that we received them. So we may not get to all of your questions today, but we'll do our best. First question coming in is, "I'm wondering, are there specific programs happening in Massachusetts to engage first responders in ED treatment, and would that potentially be adding to the increase in opioid ED visits in a good way?"

SARAH WAKEMAN: Yeah, it's a good question. That's sort of why, when we looked at that early slide of Massachusetts having the highest rate of emergency department visits for opioid related causes, why is that. I don't think there's a perfect answer. I think Massachusetts certainly has a high rate of opioid related overdose, both non-fatal and fatal, although not the highest across the country. But we do also have great access to medical services.

And so I think you may be right that there's some component of patients actually being able to come into care and access care, and a lot of focus on overdose across the state that may influence those results. And we also have, essentially, universal health coverage, and we're pretty unique in that. So thanks to our MassHealth system, the vast majority of people across our state have health insurance. And so that, I think, also allows people to access services in a different way.

MAUREEN FITZGERALD: Thank you, Dr. Wakeman. Our next question-- "We're going to a harm reduction model since our governing body is OASIS in New York and changing how we're treating SUD. Not sure how harm reduction is going to work, given the changes of opiods-- the dangers of opioids, etc. Any comments on harm reduction?"

SARAH WAKEMAN: Yeah. I mean, harm reduction-- well, I think first, the most important thing is it's not a question of harm reduction or treatment and recovery, but rather both and. Harm reduction-- the philosophy of harm reduction is completely congruent with the principles of treatment and of general medical care. And, you know, the most important step to getting into treatment is staying alive.

And so the first piece for us always is how can we keep this person alive, particularly in the context of the current overdose crisis, where rising prevalence of fentanyl and other synthetic

analogs makes every episode abuse so dangerous. So I think you can't not incorporate harm reduction if you're doing addiction treatment work right now, and that it really needs to be a part of our approach throughout the health care system and throughout the addiction treatment system.

MARTHA KANE: It might be useful to think about it as sort of a continuum from someone being deeply involved and very active in their use pattern to someone who's in sobriety and all the steps along the way that they might take to meet that. And the initial steps will likely be some version of harm reduction. And we, as a treatment system, need the support that, need to find ways to encourage that. Because that, of course, is the beginning of what may have been really become a stable sobriety.

As Sarah said, if someone shows up in the ER and they've had an overdose and they're willing to start medicine, even if that's all they're willing to do, they've begun to take some important steps. And any treatment system can begin to think about that, incorporate it, and gradually figure out how to help people move from simply reducing harm in their lives to actually beginning to embrace recovery and wellness in their lives.

MAUREEN FITZGERALD: Thank you both. Our next question might have been covered in your presentation, but let's go with it. "If not covered in the next portion, I'd like to hear more about getting buy in from clinical parties on pure recovery support as an addition to a continuum of care. Thoughts and suggestions on how to create a successful program that encompasses a whole health approach?"

MARTHA KANE: I would say that what we ended up doing was going to each of our constituent health groups, our primary care practices and health center based practices. And the first thing we said to them was we did a needs assessment with them. What is it you have? What do you need? And then, talked about how we might get there.

So that began to get the buy in to the whole model, the whole idea that we would begin to sort of work on multiple aspects. We also did a ton of education at the beginning about the harms, helping people understand the critical nature of early engagement, not waiting until someone's ready for recovery to actually start to get them involved in treatment-- harm reduction, if you will. And so in that process, it wasn't terribly hard.

Certainly, peer-based work has a long and storied history in the substance use treatment world-- or substance use world-- and it wasn't hard to sort of bridge from that general idea,

which most people accepted, that AA is a good thing-- or generally a good thing-- to the idea that we could utilize peers more directly in the health care work and the health and wellness work that we were going to do in the health centers.

So it's kind of a package. We didn't ask them to take on any individual idea, but we sort of drew from them what they thought they needed, and then, fit it to what we could provide. It didn't look exactly the same in every one of our settings, either. It was somewhat different, depending on the setting, the leadership, the particular people, whether there were behavioral health services available.

Some teams needed their security people there. Some didn't. So it really kind of varied team to team, I think, in terms of what they really wanted. And we allowed that. As much as we do patient-centered care, we sort of did team-centered development of our concept.

MAUREEN FITZGERALD: Great. Thank you. Our next question-- "We have been approached by several clients that are interested in recovery. However, they cannot afford any of the MAT treatment programs. What can we as a community do to help in these situations?"

SARAH WAKEMAN: Yeah. So that's so unfortunate. It reminds me again of how lucky we are to be in Massachusetts, where, again, most everyone has health insurance, and all of our health insurances all over the state are required to cover medication for addiction treatment. So we thankfully don't run up against the financial issue often.

I think in terms of what you can do if you're in a state that's not so fortunate, there's a lot of advocacy work to do. So if you're dealing with a patient who does have some insurance, but it's just that their insurance won't cover it, that's a wonderful area for advocacy and thinking about actually reaching out to insurance companies directly and figuring out at your state level, what sort of organizations you can partner with.

Many state chapters of the American Society of Addiction Medicine are quite focused on this, so that might be a great place to turn, as well from the legal advocacy groups like Legal Action Center. And then, there are a range of programs in terms of the cost. And so looking around to see if there are a lower cost options.

And then, lastly, if you work in a setting that has primary care doctors, getting your primary care doctor to prescribe so that patients don't have to seek care elsewhere, where they may be getting charged an additional cost, but rather, have treatment just be a part of their medical

care can be a really effective strategy.

MAUREEN FITZGERALD: Thanks, Dr. Wakeman. Susan Mickelson, our colleague from the Mountain Plains ATTC, asked, "I live in North Dakota, where we have one addiction psychiatrist in the entire state. Our problem is access to workforce. Do you do telehealth?"

MARTHA KANE: Yeah. I'm not sure what we would do for South Dakota, but I think what we do here is a model called ECHO, which actually comes out of New Mexico. I don't know-- Sarah may have more information about how you might be able to access that. But essentially, it is remote support for teams managing substance-using patients, which includes both a didactic piece, and then, specific case discussions related to how to care for the patient population. So in that sense, that service exists. I don't know how to access that, though.

SARAH WAKEMAN: Well, I would just say, also, trying to expand workforce is something that we're really focused on, and that might be another area to focus on. So we're just starting our addiction medicine fellowship program. But even without specialty training, building up the capacity in the general medical system is a great way to go. So, you know, our nurses are getting trained to be able to provide addiction services, our primary care doctors, and our internists.

So while we need access to specialty support for sure, at the same time, there's a fair amount that can be done by just empowering kind of the primary care workforce. And so that might be one place to start, while at the same time, thinking about other ways to access additional specialty consultations.

MARTHA KANE: Do you think your one psychiatrist would be open to doing some consults?

SARAH WAKEMAN: They can't talk back.

MARTHA KANE: Oh well.

MAUREEN FITZGERALD: Thank you. Our next question is about billing. "Do you bill insurance for the recovery coaches? "

MARTHA KANE: We do not. Our recovery coaches are not generally reimbursable by our health care providers, our insurance programs here. The state of Massachusetts through the Bureau of Substance Abuse Services does reimburse for recovery coaching. We have found that it financially makes more sense for us to simply incorporate it into our strategic plan efforts, and so that's what we

have done, although many of our behavioral health and community-based substance use treatment programs are utilizing the state dollars to be able to hire and employ more recovery coaches.

MAUREEN FITZGERALD: Thank you. Our next participant asks, "Our clients who are homeless often have high no show rates. Does the program have some flexibility on no shows for this population?"

MARTHA KANE: Yeah, that's exactly what we're talking about with the idea of low threshold care, so that kind of being available when the patient can get in and being able to kind of work that into your clinic day. Our Bridge Clinic essentially doesn't do scheduled appointments, for the most part. They will, but it's all walk in and drop in.

The Hope Clinic actually allows-- which is our clinic for pregnant women-- actually will see you whenever you come. They do schedule you, and they hope you come and they try to encourage that. But whenever you do show up, you will be able to access services and access care.

I think it's very, very important for people to have somewhere in some way that they can access care without having to have all the scheduled appointments. And that's not important just for them, it's important for us, as well, because it becomes too difficult to manage and too difficult to sort of continue to have energy for dealing with the population if all the time, we're dealing with them not showing up on time. Maybe it just makes more sense for a patient-centered point of view to get rid of the whole appointment situation and allow people to come in as they can.

People will generally-- they may have to wait, and they can understand that. If they want to make a scheduled appointment, they probably wouldn't have to wait. But, you know, it may just be as convenient for them to come in and wait. And typically, all we really do is offer them tea or coffee or some water while they wait. And they typically will wait. So maybe it's a model to think about.

Another idea would be not to go into it in a full way, but simply to pilot it at a site or two and see if that works. Maybe for a few hours or a half a day or a couple days a week, you have drop in hours, and they can just come and drop in during those hours. Maybe that's a great way to just get started with it. We've tried that in a couple of settings, and have found that works out very well, as well.

MAUREEN FITZGERALD: Thanks, Dr. Kane. Next question. "Does your buprenorphine protocol account for non-substance abuse addiction chronic pain?"

SARAH WAKEMAN: Yeah. On the inpatient setting in particular, but also in primary care, we frequently care for patients who have both chronic pain or acute pain and also opioid use disorder. So we factor that in in terms of our buprenorphine treatment. So for mild to moderate pain, we can often get decent analgesia just by increasing and dividing the buprenorphine dose.

And then, we've also worked with our anesthesia colleagues to come up with a perioperative protocol for managing acute and surgical pain in the context of patients on morphine. But for each patient, you know, it's an individualized assessment of figuring out what the right treatment is for that person.

We also have a relationship with a network of opioid treatment programs for patients for whom methadone is a better treatment option, and so we can directly refer patients who can be seen the next day or same day in the methadone treatment program to start methadone. So that's another wonderful option, both for hospitalized patients or for outpatient.

MAUREEN FITZGERALD: Thank you. We're approaching the top of the hour, but our presenters have graciously agreed to stay on for a few more minutes to answer a few more of your questions. Next one. "I am part of a team of recovery coaches. One problem that I notice is that many of our hardest cases are alcohol-related, single males in their 50s who live with an enabling roommate or enabling elderly parent. They're on disability of some kind.

May have a depressive disorder, or have had a significant amount of clean time, up to five to 10 years in AA or NA but have fallen off. Our problem is trying to get to motivate them at this stage in their lives, since they feel useless to society and unable to change. They often try to detox themselves and then represent at ED during the DTs. Do you have any success in motivating such individuals to accept change at this later stage of their lives? I have a hard time getting through to them."

MARTHA KANE: So yeah. I think what you're describing is pretty common to the work. I think anybody who struggles in this way is somebody that we have to find new ways to reach out to. So I don't know that we'd talk about getting through to them as much as we'd talk about trying to figure out what they might be motivated to work on, so stepping back and really taking a more motivational approach around what would make their lives better, what would make their lives worth living, even if they're not ready to stop drinking right now.

Sounds like there's a lot of life dissatisfaction for these folks. And one wonders if they could get engaged in or get connected to any idea of improving any part of their lives. And then, eventually, we can get back around to working on whether the role alcohol has is sort of preventing that or maybe making that more difficult.

But we typically would not-- if someone, you know, is not really interested in stopping their drinking, we would continue to work with them around making the quality of their lives better, figuring out how to sort of begin to approach it from that direction. And like I said, it doesn't usually take too long to get back to the fact that the substance use is generally blocking the process of improving their lives.

MAUREEN FITZGERALD: Thank you so much. Next question. "How do you make sure to involve families in your work?"

SARAH WAKEMAN: We have actually trained several clinicians in evidence-based protocols for working with families, and then, have those services available in most of our settings, I think to some extent for all of our settings, both inpatient and outpatient. So the offer is made. The therapy often does not actually include the substance using patient right at the beginning. The family can come in for services themselves. Families are deeply stressed by this, and often need support themselves before we're ever really able to work on the family interactions.

In addition to that, families often do participate in creating conditions where it makes it more likely that the patient will continue to have difficulties. This is all inadvertent. They don't mean to. They're doing the best they can. But the result is that they're often contributing as much as they are helping.

And so services can easily be done to try to help them figure out how else to interact with their loved one, potentially help their loved one accept the need for treatment, that kind of thing. So basically, the answer is we have created trained clinicians-- generally, social workers and psychologists-- in every setting where we have access to someone with those degree credentials to be able to utilize these evidence-based protocols.

MAUREEN FITZGERALD: Thank you. Next question. "Can you give an example of how the SUC initiative works with community coalitions on primary prevention?"

SARAH Sure. So our hospital actually funds community coalitions in three communities and the

WAKEMAN: communities that have our largest health centers. And these coalitions are focused on broad health needs. It's not just substance use disorder, but substance use disorder ends up being the primary focus of all three coalitions.

And they do a range of primary, secondary, tertiary prevention interventions. On the primary prevention side, they do a lot of work with building resiliency in youth and in family. So through supporting school-based curriculum like the life skills curriculum, doing sort of healthy activities, and building youth coalitions to, again, develop resiliency and activities for young people, as well as creating sort of education and awareness campaigns, both for youth and for their parents.

MAUREEN FITZGERALD: Thank you. "Please address the needs of dualy diagnosed those with mental health diagnoses."

MARTHA KANE: That's a broad question. We have-- as you have heard, this initiative is multidisciplinary, so there's been a strong behavioral health push within the initiative, as well as a strong internal medicine push. And in many ways, we have tried to create more integrated settings. So we have embedded psychiatry services into primary care. We have embedded social work services into primary care. The idea being that we could potentially begin treatment in that setting, and then, if short term care doesn't work, bring them into more behavioral health settings.

We work collaboratively very, very closely with our psychiatry colleagues during the inpatient stay to create integrated dual diagnosis disposition plans and work carefully to try to prevent this sort of drop out from care through those critical transitions, which is probably more likely to happen for people with dual diagnosis issues, as well. We've integrated our on campus dual diagnosis programs-- we have two, one for adults, one for youth-- into our initiative. And, like I said, we've now put recovery coaches into both of those settings.

So in every way, everywhere we can, we have created those bonds, created integrated multidisciplinary care teams to address those issues in an integrated way. When those services don't exist in the health center, it is certainly more difficult. And we have worked, then, to create linkages to community-based mental health services, and our recovery coaches have tried to work very diligently to link patients to care in the community when that's necessary.

So it's a critical part of it. It's a critical piece of the whole package, and needs to be integrated

very carefully and very thoughtfully. We've actually found that mental health and internal medicine folk work very, very well side by side in very integrated ways. The only thing I would say is that there needs to be some opportunity for clinical rounds or clinical case discussion in a shared care kind of venue so that there can be an integrated plan developed.

MAUREEN FITZGERALD: Thank you. Here's a question about an FQHC. "A struggle that we have in our FQHC substance use program is how to hold patients accountable, but still treating SUD as a chronic relapsing disease. Any recommendations for this?"

SARAH WAKEMAN: Well, I would say, you know, as an internist and also an addiction medicine doc, I think of addiction as very similar to how we manage other chronic conditions that have some component of biology and some component of behavior and environment, like diabetes or any other illness that's complex that requires shared decision making and engagement with patients, and also team-based care.

And so I think as we think about models of care for substance use disorder, I often challenge myself to think, now, would we treat a patient with diabetes this way? And so we often face barriers in terms of engaging patients around managing their other health conditions, but we usually approach those in terms of thinking about sort of how can we improve our systems or how can we try to remove or address some of the barriers in that person's life, rather than kind of thinking it's the fault of the individual or the individual needs to be different, so and as much as we can, try to structure our program similarly.

And I think similar to Marty's response to the question about the older patient with alcohol use disorder, the important thing is figuring out what motivates the person. You know, what goals does that individual have? Because most people have the goal of wanting their health or their life to improve in some way, and that means different things to different people. And so as much as we can, to try to figure out those individual goals, and then align those with whatever it is that we're trying to do in our treatment approach can be helpful.

MARTHA KANE: I think the notion of holding someone accountable implies that there's some sort of external standard that they need to meet. And I think Sarah and I have learned over the years that we kind of want to turn that whole idea upside down on its head and say that it really isn't about them meeting an external standard, but about them generating internal motivation to make change in their lives.

The only person they need to be accountable to is themselves, around their behavior change,

around them engaging in goal setting and pursuing their own interests. The substance use and the other issues will come along with that, as long as there's some internal motivation toward some kind of goal.

MAUREEN FITZGERALD: Thank you. "As an SUD provider in a large health care organization, one of the issues with coordinating care with our primary care providers is CFR 42. How does your model get around CFR 42, or are you requiring a release from each patient upfront?"

MARTHA KANE: Our legal department assures us that there's no getting around 42 CFR law and rules. So we, yes, in fact, do ask at time of care initiation whether or not a patient will allow us to communicate with primary care doctors or others via our electronic medical record. Our electronic medical record is system-wide. So in that sense, we have some additional challenges because if we write a note in the system, we have to sort of create some 42 CFR barriers for patients who prefer not to have their records be available to everyone.

So it creates a lot of complicated complexity and a lot of difficulty. However, it is the patient's right to protect that information, and we then have to sort of figure out how we're going to interact with the patient around that. And issues of safety and medication prescription, that kind of thing all matter.

In our record, medications are the only thing that cannot be put behind the 42 CFR firewall. So medication prescriptions are available on all patients regardless. And if a patient is not willing to have their medications viewed by their primary care providers in our system, then they are encouraged to find and helped to find care outside of our system.

But that's the only thing. All other notes and records can be kept behind the 42 CFR firewall, if necessary. And we do encourage patients to open up to the possibility of having their primary care doctors be able to sort of see those notes and records.

What we also find is most of our primary care doctors-- and we can assure our patients. Most of our doctors are really not interested in their detailed psychotherapy notes or any of that sort of thing. They really are mostly concerned about medical matters and whether or not a patient's coming to treatment. Those sort of seem to be the main things that they are really looking at.

SARAH WAKEMAN: I should just add that what Marty's referring to are specialty addiction clinics, so our Bridge Clinic, which is the only [proponent of this model, and our Hope Clinic that we've talked about

that would be 42 CFR Part 2 practices. All of the care that happens integrated within primary care because we're not holding it out as sort of specialty addiction care, but rather it's just a part of integrated primary care. It's not 42 CFR Part 2 protected, so that's an important caveat.

MARTHA KANE: Yes, that's absolutely right.

MAUREEN FITZGERALD: Thank you. The next question is related to smoking. "Are there specifically smoking cessation services, as well?"

SARAH WAKEMAN: Yeah. We actually have an entire tobacco treatment service on inpatient setting, as well as outpatient smoking cessation counselors and a tobacco treatment and research center that we work closely with. So while our team frequently does address tobacco use disorder, there is a separate specialty service that is focused specifically on that.

MAUREEN FITZGERALD: Thank you. Do you have any info on the treatment interaction with ARB for HIV positive patients?

SARAH WAKEMAN: Well, there's lots of information in terms of research information looking at treatment outcomes of patients. For example, with HIV who are treated with buprenorphine have much better ARB adherence and higher counts and lower viral loads. We haven't specifically looked at our data with respect to the impact on HIV positive patients in our system, but definitely, there is a wide body of literature out there.

MAUREEN FITZGERALD: Great. "What educational certification requirements do you have for recovery coaches? Is this the same as peer engagement specialists?"

MARTHA KANE: So let me answer the first part of that question. All of our recovery coaches are required to attend the Recovery Coach Academy offered by our state funded Bureau of Substance Abuse Services, which is modeled off of a similar program in Connecticut.

So they're all required to graduate from that. They're all required to get certified. They're all required to take ongoing trainings offered through that program. And they are supervised by a certified recovery coach manager. So he also provides education and training as a part of their ongoing supervision process.

In the state of Massachusetts, we also have a similar program designed for mental health survivors and peers, but it's not identically the same, and so it's sort of a parallel process. Some of our recovery coaches do participate or have participated in the mental health care

program. Some have not. We don't require it. But it is certainly an option for our recovery coaches.

MAUREEN FITZGERALD: Thank you. "Would you describe the HIPAA compliant process permitting texting between patients and recovery coaches?"

MARTHA KANE: Yes. We require that patients sign a consent form that's been developed and embedded with our legal department to protect their HIPAA rights. If they're willing to sign the form and allow texting with the recovery coach, then the recovery coach can text with them. If not, then the recovery coach is only allowed to use the phone with them to call.

I think, in addition to that, we really encourage our recovery coaches not to put any personal health information in a text. Mostly simple conversations about how are you, can we talk today, I'm getting a little worried about you, haven't heard from you, could you give me a buzz. You know, that kind of thing, rather than specifically identified PHI, just as a general protection. And that way, we try to protect our patients' confidentiality.

MAUREEN FITZGERALD: Thank you. Next question. "For coaching abstinence outcomes, are those results published somewhere?"

SARAH WAKEMAN: We are writing those up now. So they're not yet published, but we hope they soon will be.

MAUREEN FITZGERALD: All right. And next question. "Can you give an example of how the SUD initiative works with community coalitions on primary prevention?"

SARAH WAKEMAN: I think we had that one already.

MAUREEN FITZGERALD: Oh, I'm sorry.

SARAH WAKEMAN: No problem.

MAUREEN FITZGERALD: I'm double dipping on their questions. All right, then. I think we just have one more that I didn't catch, which was the big question. "Can you describe your detox protocol?"

SARAH Yeah. So in the hospital-- you know, so first and foremost, detox is not effective as a strategy

WAKEMAN: in terms of long-term outcomes for substance use disorders. So our goal is never to just detox people, with the exception of alcohol detox, obviously, but if we're talking about opioids.

So the occasions that we might use a detox protocol in the hospital would be if someone wants to start extended release naltrexone or if a patient is really adamant that they don't want to try medication for opioid use disorder. So in those cases, we would either use methadone or buprenorphine.

Regardless, any patient coming in with opioid withdrawal, we will treat with methadone or buprenorphine, and then ideally try to link them into ongoing care, unless they either wanted to start naltrexone or were not interested in pharmacotherapy, in which case we would taper their dose over the course of their hospital stay.

MAUREEN FITZGERALD: Thank you. Well, we're at 2:15. And we've made it through all of our questions. So I wanted to thank everyone for joining us today. And thank you, Dr. Wakeman and Dr. Kane. Just a reminder to everyone that the webinar's been recorded and will be posted on the Great Lakes ATTC website, I believe as well as other websites. And you will be giving information on how to get a CEU certificate. Cindy, anything to add?

CINDY: Yes. Thank you, Maureen. One more big thank you for our awesome presenters. We're getting lots of great comments in the chat pod. I will leave this room open for another few minutes. Those of you who have not had a chance to download the slides or the news release of the Wakeman article, you can go ahead and do that.

And yes, you will get an email from me, I'm hoping by next Tuesday, and it will be clearly marked in the subject line that is regarding CEs for this webinar. So stay tuned for an email from cindychristy@attcnetwork.org.

And yes, I think we're going to find a place for this webinar to live, the recorded version. It will be on one or more of our ATTC network sites. But in the meantime, if you'd like just to see the link to the recorded version, we can send that out. And everyone have a great afternoon. Take care.

SARAH WAKEMAN: Great. Thank you.

CINDY: Bye.