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TRANSCRIPT - GR 07 29 22 *"Treating Opioid Use Disorder: Changing Care and Improving Systems to Reduce Overdose Mortality"* – Sarah Wakeman, MD from the Massachusetts General Hospital

UVA Internal Med

00:58:33Alright, everyone we're going to go ahead and get started, welcome to medical grand rounds, today we are honored to host Dr Sarah wakeman.

- 00:58:40Dr wakeman is a general internist whose board certified in addiction medicine and specializes in the care of patients with substance use disorder.
- 00:58:48She completed her undergraduate studies and Medical School at brown university.
- 00:58:53After completing her residency at Massachusetts general hospital she served as the ambulatory chief resident where she focused on improving the quality of the addiction curriculum for her residency program there.
- 00:59:04She then went on to join the Faculty at mgh and Harvard Medical School where she provides primary addiction care at charleston health Center.
- 00:59:11supervises trainees on addiction console team and serves as a medical director for the mgh substance use disorder initiative.
- 00:59:19She has since developed and is the current program director for a new acg me accredited addiction medicine fellowship as well.
- 00:59:26She has served on dozens of local, regional, national and even international committees dedicated to studying the impact of substance use disorder and alleviating patients suffering.
- 00:59:37she's a prolific author with numerous publications and the country's leading journals and last year, she won the substance abuse journal best manuscript board for her work, entitled.
- 00:59:46understanding why patients with substance use disorders leaves the hospital against medical advice, a qualitative study, please join me in giving a warm welcome to Dr Sarah wakeman.

Sarah Wakeman (she/her/hers)

00:59:59Thank you so much for having me it's a real pleasure to be joining you today.

- 01:00:04remotely sadly.
- 01:00:05But but happy to be here I'm excited to talk to you today about treating opioid use disorder and how we can think about changing both the clinical care we offer and also our systems of care to address the ongoing overdose crisis.
- 01:00:23Okay, there we go I'm disclosures I have written it bad to textbooks now I'm so get royalties for those and I'm an author and up to date and I formerly served on a clinical advisory board but no longer do.
- 01:00:36They going to start with the take home message in case you get pulled away or for clinical duties and miss the the genesis or thesis of what I'm going to talk about.
- 01:00:45You know, to start with really some staggering and terrifying statistics about the overdose crisis about ongoing death treatment disparities.

- 01:00:54Racism and how that's impacted the current overdose crisis and all of that can be incredibly discouraging and upsetting.
- 01:01:01And you know, fundamentally, I hope, what you take away from this talk is actually a message of hope you know opioid use disorder is an incredibly treatable condition.
- 01:01:09It is a privilege and a joy to take care of people with opioid use disorder and with all types of substance use disorder.
- 01:01:14And there's so much that we can be doing individually in our clinical practice and as leaders within healthcare systems we think about how to deliver effective and evidence base camp, so that message of hope and inspiration I hope is what you walk away with.
- 01:01:30But, to start with the staggering and not so helpful statistics we're in the midst of the worst overdose crisis in the history of this country.
- 01:01:39Last year, more than 100,000 people died from drug related overdose death, which is more than we've ever seen.
- 01:01:44And far surpasses the peak number of guests from HIV, at the height of HIV crisis, the peak number of deaths from firearms every year and then peak number of deaths from motor vehicle accidents.
- 01:01:53So when you hear words like crisis or epidemic, the reason for that language is really the toll of what's going on.
- 01:01:59And as you can see here that's continue to just track upwards and code has not been kind to overdose crisis.
- 01:02:06I think that's particularly tragic, in my opinion it's not really no one to die from an opioid related over to us, we know how to reverse an overdose when it occurs in the lock zone.
- 01:02:15We know about public health interventions and harm reduction strategies to reduce the risk of overdose and essentially to eliminate fatal overdose.
- 01:02:22And importantly for people who have the underlying condition of opioid use disorder, we know how to treat that condition and how to dramatically improve mortality rates for people suffering from opioid use disorder.
- 01:02:33and send me the ongoing raging overdose crisis is really a crisis due to inadequate care a total failure of our policies across this country and how we think about drug use and people who use drugs and a failure to offer effective treatment.
- 01:02:48We think about what's driving the death toll right now really increasingly is around the unpredictability of the supply.
- 01:02:54you'll hear people talk about a poisoning of the unregulated drug supply and that's really what we're seeing where.
- 01:02:59alyssa manufacture ephemeral analogs have penetrated the drug supply.
- 01:03:03And are driving the death toll predominantly months people who use opioids but also, most people who use other drugs like cocaine or other stimulants because of cross contamination in the drunk supply.
- 01:03:14Although early on in this current drug overdose crisis people talk a lot about it as an opioid epidemic, it really is on multiple substance use crisis and so you'll hear a lot of us now just use the terminology overdose crisis.
- 01:03:26And this just shows the range of types of substances that are found people dying from drug related death so.
- 01:03:33prescription opioids essentially have been on the decline since 2012 the dad dotted line that's Fries it's astronomically listen illicitly manufactured fentanyl.
- 01:03:42And then you can see that psychostimulants and cocaine, have also been increasing it's a really multiple sentences, but with that unregulated and unpredictable supply driving that the rapid increase in data.

- 01:03:56The other important point about that is that when we think about interventions to address this crisis in the healthcare setting we often have thought about sort of the supply side of the equation so i'm sure.
- 01:04:08You all thought about opiate prescribing it's something that's talked about a lot it's in the headlines obviously there's a lot of lawsuits going on and lots of narrative around.
- 01:04:16Rising rates of prescription opioids driving that rose crisis, and that was true in 1999 and in the early 2000s where as rising.
- 01:04:25Access in the Community to prescription opioids increased we saw a parallel rise and opiate related deaths and i'm treatment admissions for opioid use disorder.
- 01:04:34But that is not the currency of epidemic so prescription opioid.
- 01:04:38Rates actually peaked around 2012 and we've seen those decrease year over year and we've also seen deaths and use the prescription opioids decrease, and yet, rather than declaring victory and saying.
- 01:04:48we've solved the overdose crisis we actually have seen more people die every year than ever before, and that really gets at the demand side of the equation, which I think is where we as clinicians.
- 01:04:58And I would argue policymakers should be focusing, which is how do you treat people have an opioid use disorder, how do you reduce.
- 01:05:04people's drive to use opioids and how do you help people stay safe we're using opioids.
- 01:05:10Because, as people have shifted from prescription opioids into the unregulated illicit drugs supply given this poison and crisis their actual risk of death increases dramatically, so instead of saving lives actually increase the risk of mortality for people who are using opioids.
- 01:05:26cope, and, as I mentioned, has not been kind obviously too many health conditions or to our country at large, but certainly for the overdose crisis we've seen this dramatic uptick and overdose deaths.
- 01:05:38Nationally after there's been a bit of a flattening and there was a hope that we're actually going to begin to see a decline of overdose crisis.
- 01:05:44But starting soon after the onset of the coven 19 pandemic, we saw spike and total overdose deaths occurred related overdose deaths.
- 01:05:52and synthetic which is really literally manufactured fentanyl related deaths you saw the number for December 2021 was around 107,000 we cross that 100,000 threshold and April 2021, which is the first time ever in this country.
- 01:06:09And we continue to see worsening racial disparities overdose crisis, much like Kobe has reminded us at the health harms of racism and living a racist society, we see that more and more.
- 01:06:19overdose crisis as well, this is a recent dad actually released last week by the CDC and publish it and you are.
- 01:06:27And that showed, not only are their regional disparities and drug overdose deaths with rising rates in American Indian Alaska native populations.
- 01:06:35Black individuals and panic individuals but that at areas of the country that have the highest income inequality and have the worst.
- 01:06:44disparity and overdose death rates for black individuals, in particular, so the intersection of income inequality of racism of lack of access to treatment.
- 01:06:53And simmering behind that as our long legacy of the war on drugs, which is really criminalized communities of color for substance use over many decades.
- 01:07:03And that really echoes the devastation of the legacy of the war on drugs, the ongoing.
- 01:07:09Harm of the war on drugs, now the sorry overdose death rates and black communities in particular.
- 01:07:15And this quote from a piece that was covering the rising rate of overdose death rates amongst black Americans admits the pandemic.

- 01:07:22emphasizes that this is a civil rights issue is pressing it profound as any other and that the communities that are now being hit hardest by overdose deaths are the same ones that were devastated by the war on drugs which demonize black drank users.
- 01:07:34And people of color and tour families apart holiday neighborhoods by sending glass into prison instead of treatment and so it's just have that.
- 01:07:41In our mind as we think first as clinicians the incredibly important intersection between policy and clinical practice and then also just the huge impact of racism is playing in on quite laborious process.
- 01:07:56there's a sort of catchy phrase, sometimes in addiction medicine that addiction does not discriminate I think that's questionable but overdose definitely does discriminate so the people who are at highest risk of dying from an overdose.
- 01:08:06Our populations that are already marginalized or minorities and often left behind by our systems of supposed to care.
- 01:08:14This is data coming out of Massachusetts where I practice where they looked at people who died from an opiate related death.
- 01:08:20and found that the populations that greatest risks were amongst our most vulnerable, so people who experience homelessness for up to 30 times more likely to die from an opiate related overdose and someone who'd never experienced homelessness.
- 01:08:32And people who've been in present or incarcerated were 120 times more likely to die from an overdose other groups that are at high risk, in addition to black communities and.
- 01:08:41American Indian lot next communities, as we heard about are pregnant parenting people actually some six to 12 months postpartum is a really high risk of overdose.
- 01:08:50And so, when we think about our systems of care, our treatment models are really not designed with any of those populations in mind, so our addiction treatment system as what I would call a.
- 01:09:00High barrier low tolerance system where it's incredibly hard access care if you've ever tried to access care for a patient or a loved one or friend.
- 01:09:08it's often a very complicated system, you have to sort of know how to navigate it, how to advocate for yourself there's often financial.
- 01:09:16drivers to access care, and so, in some ways the system is most accessible to people who are at least sick or have the least number of competing priorities are barriers access and care.
- 01:09:27And yet folks who are at the highest risk of death are going to be the least able to navigate this system, so if you're on a house if you're dealing with trying to find a safe place to stay of getting.
- 01:09:35traumatized or recommend victimized on the street every day if you're bringing the trauma and burden of racism if you're trying to parent.
- 01:09:43And you're trying to access treatment, it becomes nearly impossible and so there's this mismatch between what is available for treatment and then actually the communities who need it, the most.
- 01:09:54Getting back to policy I think it's important to understand that many of the policies that we just take.
- 01:09:59sort of facts, like the whole scheduling of substances in this country, the fact that cannabis as a schedule one substance.
- 01:10:05And the ways we make things that we farm prison people how the criminal legal system works.
- 01:10:12When it comes to drug use or really deeply rooted racism and, if you look back at the history of one our drug laws were first being passed.
- 01:10:20All the way back to the early 1900s when the Harrison our conduct Act was passed in 1914.

- 01:10:26Which is the law that laid the groundwork to make it illegal for doctors to prescribe medication to treat addiction so that's why.
- 01:10:33That occasions like methadone and people are so tightly regulated and so difficult for us to be able to offer to our patients.
- 01:10:39There are articles, like this one, and the New York Times that were published that really played off of anti black racism to try to fuel voter.
- 01:10:46Support for this law to to sort of try and read policy.
- 01:10:52We know that this place on every day in our legal system that despite using drugs it's similar racist white people black button next, in addition, as people are more likely to be stopped searched arrested and convicted and harshly sentence for drug law violations.
- 01:11:05And the majority of people who are federal or state prison for drug offenses are black or Latin that's.
- 01:11:12An additional racism stereotypes of people who use certain types of drugs have also deeply impacted our clinical practice and our policies.
- 01:11:19This notion of sort of US versus them then being people who use socially stigmatized substances so you think about some of the more socially acceptable substances like alcohol.
- 01:11:29Our perception around alcohol use is very different than our perception around heroin use let's say or cocaine use or.
- 01:11:35enemy news, and this was an interview with Dr goal, who is one of the three physician scientists who discovered methadone as a treatment for opioid use disorder so he's on the top left here.
- 01:11:46and his colleagues actually his colleague and wife, Dr wonder.
- 01:11:50who's psychiatrist Dr Joel is an endocrinologist and then Mary Jean creek who is originally their research assistant and then Dr took over their laboratory.
- 01:11:58And they did the early experiments are published in JAMA 1965 around methadone being an incredibly effective and I really like saving treatment for opioid use disorder.
- 01:12:08and Dr dole reflected on his career in this interview in the late 1990s, where he really stumbled into addiction medicine.
- 01:12:16And he brought to it with this hand with him the same sort of stereotypes that many of us have been exposed to is just simply being members of the society that people who use drugs must be week then SP.
- 01:12:27untrustworthy they must lie, they must be dangerous and that that's completely false and you have those myths continue to drive how we take care of people who use drugs.
- 01:12:37Are policies within healthcare systems like hospital policies and then our policies writ large, as a society and our clinical approaches and care models.
- 01:12:47But, thankfully, despite a lot of ideological barriers and continued stigma and misinformation that's incredibly.
- 01:12:53Challenging to fight, but very important and the great thing is that we have a ton of science and the good thing about science is that it's true whether you believe in it or not, I think.
- 01:13:02has become more important than ever in recent years.
- 01:13:05And, and unlike other crises, we think about the HIV epidemic or the current cogan pandemic, where we really had to wait for science to catch up, we needed to wait for.
- 01:13:14breakthroughs and research to understand what we're effective treatments are, how do we save people's lives from those conditions.
- 01:13:20The interesting thing and the different challenge with addiction is that we actually have decades of research showing us what are effective treatments.

- 01:13:26And how to save people's lives and it's really an implementation gap it's, how do we take that research and apply it to the actual clinical care models to our hospital systems, who are primary care practices.
- 01:13:37To make addiction, treatment and easy to access and importantly to route it and the best evidence we have.
- 01:13:45The strongest evidence, when we think about opioid use disorder on life eating medications like methadone or buprenorphine and there are dozens hundreds of studies showing these medications to be.
- 01:13:55Effective and to be the most effective treatments, we have for opiate abuse disorder.
- 01:13:59And if you truly life saving, so the World Health Organization, at both medication suits list of essential medications alongside things like insulin in a retro therapy.
- 01:14:08And that's really because of the robust evidence showing the mortality benefit both in terms of all cause mortality and overdose specific mortality.
- 01:14:16This is a large Meta analysis now several years old, but looked at dozens of studies.
- 01:14:23Looking at all cause mortality and over to specific mortality when people are either engaged in methadone or buprenorphine treatment or out of treatment.
- 01:14:30And you can see that being on treatment reduces all cause mortality by at least three full and overdose specific mortality by about six fold so as a clinician.
- 01:14:39Any day that my patient takes their medication or methadone or buprenorphine I know is the day that they're probably not going to die, and that is an incredible thing and incredibly powerful, to be able to provide a treatment that is so widely effective.
- 01:14:54The other thing is, although there are lots of different treatment pathways and many of them I think we're not really taught much about men school what are effective treatments, we don't necessarily learn the research and our training and so.
- 01:15:05We may have as cursory understanding of evidence as sort of an average person would apologize, because it isn't a part of our training generally.
- 01:15:13And so many of the treatments that people assume are effective actually a very little evidence behind them, so I often get calls from colleagues or family or friends who are trying to.
- 01:15:22help find treatment for a loved one and across the board, almost unanimously that thing that people asked me for us put a detox or quote unquote rehab because I think that's what we see in.
- 01:15:32TV and representations as being sort of what addiction treatment looks like.
- 01:15:36But when you think about opioid use disorder particular there's never been a single study to show that short term medically managed withdrawal, which is what we quickly refer to as detox.
- 01:15:45or residential Inpatient treatment which number coakley call rehab is associated with improved outcomes and there you mentioned dozens and dozens of studies showing that actually outpatient two nodes medication.
- 01:15:57Is the thing that improves outcomes, this is a study that I do have a colleague or a reason national claims database to look at people.
- 01:16:04With opioid use disorder compare five treatment pathways to know treatment, so you can see here that the black line at the bottom is no treatment.
- 01:16:13The Orange line is Inpatient treatment so either detox or residential treatment, which was no better than no treatment in terms of impact on overdose.
- 01:16:22The blue lines are behavioral health treatment and then, though, the one effective treatment up here that's showing a reduction in overdose.
- 01:16:30raises methadone or buprenorphine and so, although you'll sometimes hear people say that there are multiple pathways to recovery, and that is certainly true, and in regards to.
- 01:16:40Much like any other care we should be engaging mature decision making with our patients and they should ultimately be the decision makers around what's the right treatment for them.

- 01:16:47And people at certainly found their way to recovery along different types of interventions, as they have with other chronic conditions.
- 01:16:54When we look at the evidence it's quite clear that there's the single most effective treatment for opioid use disorder and that would be medication treatment with methadone or buprenorphine.
- 01:17:02We haven't done that, on a societal level if you expand access to treatment and they've now that many observational studies that show you reduce overdose death rates.
- 01:17:09And so, Francis and shane country case study of that where they were in the midst of a heroin overdose crisis in the 1990s.
- 01:17:16And they made very different choices about how they regulated buprenorphine and so you're probably familiar with the fact that in the US, you have to get a special X number to be able to prescribe buprenorphine and prior to.
- 01:17:27About a year ago, you had to take at least an eight hour training tab or prescribe buprenorphine.
- 01:17:31France, in contrast, expanded access to buprenorphine by allowing all general practitioners to prescribe it there was no required training, there were no patient limits are requirements around toxicology testing or counseling.
- 01:17:42And you can see in the Gray boxes they're able to get 90,000 patients treated and less than a decade.
- 01:17:47And it's not 500 action in heroin overdose deaths to six full production after injection drug use and a decrease in HIV prevalence amongst people who inject drugs so we've seen the impact of changing policies and expanding access.
- 01:18:02So medication is a cornerstone, as I briefly showed you and, but when we think about the components of effective treatment, much like other chronic health conditions we think about a menu of options of supporting the individual in front of us, so the best.
- 01:18:14Evidence based treatments, we have, and also supporting their other health needs, and so the kind of components of effective treatment really for opioid use disorder, I think the medication is the cornerstone.
- 01:18:24psychosocial intervention should be available and offered and voluntary but there's no evidence to support requiring psychosocial interventions as a component of medication treatment.
- 01:18:34and recovery supports or not formal treatment, but our peer support generally so either mutual help organizations in the Community or.
- 01:18:41Recovery coaching, which is a lot a lot touch on at the end and so these are really important gems that can be incredibly helpful, but are not in and of themselves answer formal treatment.
- 01:18:51And then harm reduction to me as a part of the treatment continues to harm reduction is really.
- 01:18:55A focus on how do we reduce the negative consequences of use, irrespective of whether that individual patient is making changes in their drug use, and there are a range of effective interventions that will touch on in more detail.
- 01:19:09So it's a dental insurance you wanted to touch on us and I really think this is very similar to many other chronic health conditions we manage like diabetes or HIV.
- 01:19:17Where the reason we care what someone's a Wednesday or their viral load is because we want to prevent the acute and chronic complications associated with.
- 01:19:24hypoglycemia or with uncontrolled by rabia and it's not that there's any particular value about the person in those numbers it's really what we know about preventing other adverse health conditions.
- 01:19:35with diabetes, even though we have obviously loads of evidence about effective treatments and interventions and medications We then individualized that to the human being in front of us.

- 01:19:45So I may see someone in clients that I clinically would like to start insulin but if they are you know terrified of needles or don't have a refrigerator or God.
- 01:19:55able or willing in that moment to do that I wouldn't say you know you're clearly unmotivated you're in denial come back to me when you're ready to get care.
- 01:20:03I would try to work with that human being and figure out what the barriers are trying to partner with them around their health and see if they'd be open to starting an oil agent or.
- 01:20:10You know meeting with a diaper diabetes nurse educator and nutritionist and so that same approach is really how we need to be thinking about opioid use disorder, but has not historically been the approach.
- 01:20:20And then, importantly, the list of treatments is really a menu of options it's quite similar to diabetes care.
- 01:20:25Again, so medication is generally don't have diabetes there, but not always obviously some people can manage type two diabetes lifestyle interventions alone.
- 01:20:33behavioral support is crucial it's hard to manage a chronic condition it's hard to make changes it's hard to take medication everyday.
- 01:20:40Lifestyle changes changing your environment and then importantly regular monitoring, so we will never diagnosis of chronic conditions started medication treatment and never seen someone again, we would follow that person closely over time and the thing is true for opioid use disorder.
- 01:20:54We think about medications, in particular, since you talked about those it's really been the cornerstone of treatment for opioid use disorder.
- 01:21:00I think of sort of four main goals with medication treatment, so the first is really withdrawal symptoms so.
- 01:21:05Both methadone or buprenorphine relieve withdrawal symptoms and the pain and suffering of acute withdrawal and the fear of going into withdrawal is one thing that keeps people out there, using because.
- 01:21:15Even though generally people don't die from food all they can and, more importantly, or as importantly, the moment for many of the patients, we see they feel so tremendously awful that they're not going to be able to tolerate staying to get other.
- 01:21:28medical care, for example in the hospital already and think about what their goals might be around treatment or engagement and other resources so.
- 01:21:36Early aggressive and immediate withdrawal management is crucial.
- 01:21:40The next way that these medications help us by blocking the effects of other opioids if someone is on a therapeutic dose of buprenorphine, for example, even if they were to use.
- 01:21:49fentanyl or what they thought was heroin, they would feel a minimal effect and so that's sort of our relapse prevention tool and that you can sort of know Okay, I took my buprenorphine today it'd be a waste if I.
- 01:22:01spent the money on using and I know that my system, I feel safe, I feel I know that I would be able to sort of break through it.
- 01:22:08Importantly, these medications work properly by reducing creating and creating a strong psychological version one is opioids so.
- 01:22:15Even after the acute pain and withdrawal is manage people can continue to have cravings and that's what drives.
- 01:22:21Often people going back to using and so medication that can help with that craving that can allow someone.
- 01:22:27to feel normal that focus on other things to not be constantly obsessed by the urge and the need and the want to use opioids is hugely important.

- 01:22:35And then the last thing is preventing overdose and you saw the mortality benefit of methadone or buprenorphine and that's a hugely important goal and of itself, especially right now and it's the overdose crisis.
- 01:22:47And you choose which medication well, the most important medication is the one that patients going to take that's probably true for any health condition.
- 01:22:54And so patient preference and their prior experience is crucial, many people have tried methadone or buprenorphine they may try to not prescribed.
- 01:23:02They may have family or friends on it and so understanding what their preferences what they'd be open to trying and what their past experiences have been it's really crucial.
- 01:23:11And then understanding the different nuances of the treatment and that the structure of care.
- 01:23:16can be important, so if you think about methadone treatment currently can only be offered dispense out of opioid treatment programs which.
- 01:23:23Are quickly refer to a methadone clinic system has to go every day to get dosed and that could be a huge barrier for some people, the idea of having to go every single day.
- 01:23:32is just a non starter if someone's trying to work or they have.
- 01:23:36Other roles and responsibilities in their life but for others that can actually be a positive thing that it can facilitate engagement being able to check in with someone every day.
- 01:23:44can actually be an important piece of structure and so understanding those unique characteristics of the of the patient in front of us, you talk with them and make sure decisions about medication treatment is important.
- 01:23:56But importantly, much like policy and much like what we're seeing an overdose death rates racism, as it has played a huge role in what medications are access, accessible and who they're marketed to.
- 01:24:06This is a research Center in JAMA psychiatry in 2019 looked at national claims data for.
- 01:24:12Visits for opioid use disorder and found that patients who are seen for opioid use disorder were much more likely to be treated with buprenorphine if they are white and if they're a plaque or another race.
- 01:24:21And that's been shown in multiple different studies and when you think about sort of the arca be perfect, I really was historically commercially are marketed to commercial insurance and white individuals and.
- 01:24:32There has been this sort of two tiered system, a segregated system of addiction treatment, where and buprenorphine has been most successful the white people, whereas method unscrupulous more accessible to people of color.
- 01:24:45We think about how we actually deliver care so one thing is what is the evidence shows is effective, what do we know about the different treatment options.
- 01:24:52But then, a really important piece is how to involve people in the care, especially recognizing that many patients who use drugs and patients of opioid use disorder.
- 01:24:59have experienced intense stigma and discrimination and healthcare settings there's often a lot of fear about coming into care.
- 01:25:06And they may be dealing with a lot of competing priorities and chaos again if someone's on housed or under correctional control or.
- 01:25:15You know, dealing with poverty or any number of other barriers it's really tough to access care and a.
- 01:25:21Traditional rigid system where you have to you know call for an appointment supposed to be on a waiting list you've just show up at time you have to.
- 01:25:29be played, you have to wait to be seeing if to make it through an intake all of these sort of hurdles just to get your foot in the door.

- 01:25:35And when people are struggling so much and when it's when drugs on the street are so easily accessible.
- 01:25:41This is a really interesting study that was a qualitative analysis of a randomized control trials of methadone or buprenorphine treatment.
- 01:25:47And they interviewed patients who either were able to stay engaged in treatment or those who fell out of care to understand some of the themes that allowed people either to to be retained or not.
- 01:25:57And they found that patients fell out of care when they weren't welcome back so one person talks about not making it for.
- 01:26:03A medication visit for 15 days, because other stuff was going on in his life and it came back a day 15 and they told them that they had.
- 01:26:10Their clinic policy was after 14 days you weren't allowed back anymore, so he missed it by one day.
- 01:26:15And, in contrast, people who are able to cengage really talked about the importance of the staff and that staff who are caring who worked with them we're welcoming and non judgmental and respectful.
- 01:26:26And we're one of the most important facilitators I think that's really crucial for all of you in the work you do, because sometimes.
- 01:26:32You may not realize that those micro and carriers at the bedside and in the hospital and your primary care office.
- 01:26:37are actually an opportunity to offer a tremendous intervention, which is really on compassion and non judgment and enhancing someone self.
- 01:26:47efficacy, giving them hope and that was one quote from the study of a patient said, you know they showed me that there was a light at the end of the tunnel, they gave me hope.
- 01:26:55and to be able to offer that to people to be able to hold that for someone when they are going through a dark time in their life it's such a privilege and it's one of the many things that makes addiction medicine such rewarding area practice.
- 01:27:08So all of this evidence, and I could talk for many, many hours about the evidence supporting medication treatment in particular for opioid use disorder and general.
- 01:27:16treatment for opiate abuse disorder and thankfully, the National Academy of science, engineering and medicine summarize, a lot of it in this excellent report that came out a couple of years ago.
- 01:27:25And that was a you know close to 300 page report summarizing the evidence for medication treatments, you can see from the title that.
- 01:27:31Where they came down was quite clear there's not a lot of nuance there medication save lives.
- 01:27:37And they came up with six conclusions and the final conclusion.
- 01:27:40Was the medication treatment is effective across all treatments that I said it's ever been studied and and that was holding her feeling that available all types of approved medications for opioid use disorder.
- 01:27:50In any clinical setting or any criminal legal setting is denying appropriate medical treatment.
- 01:27:54So that's sort of a full stop statement if we're not making medication treatment available to our patients we're denying them appropriate care and so.
- 01:28:02This is a really important report that hopefully will continue to change clinical practice.
- 01:28:07And yet we know that there continues to be a gap, so this is that implementation gap, or we have all of the research, all of these.
- 01:28:14position papers and society guidelines and recommendations and the World Health Organization, saying that these medications should be accessible and offered and easy.

- 01:28:23And yet we know that most people don't use disorder and never treated with the medication treatment.
- 01:28:28And then, when we look across the country their treatment deserts, despite the fact that we're in the midst of this vast overdose crisis, and so this is a map of the country Sean counties that have.
- 01:28:38Either physician or physician and nurse practitioners were able to prescribe buprenorphine and you can see that fast parts of the country or particularly rural areas really have no access to treatment again, despite this ongoing crisis.
- 01:28:53And so I think that gets to some of the barriers and I talked a little bit about stigma ideology as being a barrier, I think there are a lot of myths that still persist around drug use, the people who use drugs.
- 01:29:03That persistent or medical systems to, and so I wanted to take a minute to this challenge, some of the myths that I hear a lot.
- 01:29:10or sort of subtly see play out the first is not talking about the full spectrum of substance use for all types of substances.
- 01:29:17And so I think we recognize this as clinicians and actually most of society does for alcohol use, where some people don't use any outcome, some people use alcohol and get positive effects from it and have no negative consequences in their life.
- 01:29:29Some people use alcohol at a level that is unhealthy or not good for their health, but they don't have compulsive use they don't meet criteria for an alcohol use disorder.
- 01:29:37And then of course we all see the devastating tool of alcohol use disorder in our patients in the hospital and in the clinic where people have sort of chronic chaotic use display consequence.
- 01:29:48But that spectrum applies to every type of drug, including heroin fentanyl methamphetamine cocaine.
- 01:29:53And I think we often don't have that in our head, because we don't hear from people who are using these substances in a way that doesn't meet criteria for use disorder.
- 01:30:00But that's important when we think about engaging with people around their use and around.
- 01:30:05Both what they see to see to be the positive effects that their use and also what the the negative consequences are and what their goals are.
- 01:30:11And it's also important as we are sort of stewards of information encountering some of the drug war myths and other risks out there tonight over pathologies all drug use, but really to see this through the lens of science and what we know about substance use for all types of substances.
- 01:30:27The next myth is that tough love helps people get better and this i'm sure everyone's heard about notion of tough love this is often.
- 01:30:34told the families that if they love their family member or care about some of the substance use disorder, they need to really make it hard on them to help them get better than need to kick them out or.
- 01:30:44Not help not sort of help them, and if they are their quote unquote enabling someone and that that people need to quote unquote hit bottom.
- 01:30:51All of these mantras which we would never say for another health conditions that we don't wait for someone with diabetes, to end up with an amputation before we sort of.
- 01:31:00work with them on treatment, we don't want people to hit bottom for any other condition.
- 01:31:04And we certainly recognize that love and support from family members is one of the most important ingredients when people are managing a potentially terminal illness.
- 01:31:13And this is a great article written by a journalist who herself is in recovery Maya solomon's sort of challenging the notion of tough love and she really highlights the fact that.
- 01:31:21And you know she used drugs compulsively because she hated herself and what she needed was love and support and acceptance, not to be sort of cut down to size.

- 01:31:30And that fear of mistreatment of being punished or treated badly because of her substance use.
- 01:31:35kept her actively using for much longer than if she thought she would have been sort of treated with compassion welcomed into care.
- 01:31:42And so really challenging that tough love watching, especially when we see it come up in healthcare and it does come up and some of our policies and approaches.
- 01:31:50And the reality is that kindness helps people get better, just like with any other condition, and this is an email, we received from a patient that we saw in our addiction console team.
- 01:31:59And the patient had been in with an.
- 01:32:01Infection related to injection drug use and.
- 01:32:04read this email to the provider who saw him and said I'm not sure if you remember me, but you are light my darkest times when I was in the hospital, I just wanted to thank you for all the times that came in, to talk and listen, while I was there.
- 01:32:13And then, more than you could ever know and he wrote this now that he's people in remission he's parenting and working.
- 01:32:19And I think we don't always get these types of feedback, but again, to emphasize those moments that you are in the room, with someone talking to someone that kindness and compassion and and partnership with someone is one of the most powerful tools we have.
- 01:32:34The other myth is that addiction is a poor prognosis illness, so when I tell people I am an addiction medicine doctor.
- 01:32:40Not infrequently I get some combination of like wow bless your heart or oh my gosh that must be so depressing and the reality is that it's incredibly inspiring I was in clinic yesterday.
- 01:32:50And, and you know saw three and my patients who've been in the throes previously of active severe substance use disorder and out of the hospital and I see us in the emergency room and they're all now in remission and working and.
- 01:33:04You know, living life and talking about their new partner their children one brought me tomatoes from his garden and.
- 01:33:10I think that side is not the side that people always get to see if they're only reference point for substance use disorder seeing someone acutely ill in the emergency room in the hospital coming back again.
- 01:33:21But, just like any other health condition with good treatment, most people will get better from substance use disorder.
- 01:33:27And readmission rates are on par with actually better than a lot of other health conditions we care for and so that makes it incredibly inspiring to work in the space, but also.
- 01:33:36Really lens urgency to the need to offer people treatment this tables from a long term study of opioid use disorder.
- 01:33:43called the post any where, in this sense can follow up at all people for about three and a half years and they found this is looking at buprenorphine treatment for opioid use disorder and they found that the end of three and a half years.
- 01:33:55or fewer than 8% of people still that criteria for severe abuse disorder so that's 92% of people no longer my criteria for the conditioner were in remission and we just simply don't see those sort of readmission rates with our health condition so again, this is a good prognosis illness.
- 01:34:12And yeah that's not often how we feel that's not sort of what we see reflected and there continues to be a huge need for change and part of that, I think, is the fact that.
- 01:34:21addiction medicine has been carved out as something separate from the rest of the medical system for a century.

- 01:34:26And physicians and nurses and other health care providers were members of society and if we're not taught about the evidence that we don't see this as a health problem we don't learn about it in our training.
- 01:34:35We get indoctrinated by the same societal views that anyone else does that people have addiction have somehow brought upon themselves with suffering that they deserve.
- 01:34:43And even though we hear more and more this notion that addiction is an illness or, this is a public health crisis.
- 01:34:49Our policies continue to reflect the notion that people are bad they're criminals they're doing something illegal.
- 01:34:54They may be sick but they're also bad people and they're behaving badly and therefore we don't want to help them too much and so until we can challenge that ideology and really correct that underlying mindset.
- 01:35:04The mere existence of all of this evidence, the fact that we have these life saving medications has not been enough to make a difference.
- 01:35:12So what is patient centered care for opioid use disorder will seem as patient centered care for any other health condition, where the person is at the Center of the equation.
- 01:35:20they're surrounded by their community by their healthcare providers their family, their culture and we get to partner with them around what their goals are what their past experiences are.
- 01:35:32We have to recognize the bio psychosocial influences on health, their subjective health needs and experiences.
- 01:35:37As much as we can to try to engage into your decision making and share power and that communication and relationships are based on mutual trust and that's how.
- 01:35:45we aspire to be for other health conditions, obviously we have room to grow in many ways for for other illnesses as well, but this is really the model for how to think about caring for someone of abuse disorder as well.
- 01:35:57And the essential components of care, just like those other medical conditions So what do you want to do you want identify that someone has the position.
- 01:36:03You want to make a diagnosis and talk to them about it and tell them what the illnesses.
- 01:36:07You want to immediately offer treatment and then you want to refer to a specialist if you need to and much like you would think about.
- 01:36:14You know CHF and identifying making a diagnosis starting treatment and then and getting a cardiologist if you need that extra support.
- 01:36:21More for some of the more severe illness that would be the same models, we think about abuse disorder.
- 01:36:26So if it's the same as other conditions, why are we all doing i'm wondering all providers offering this Martin health systems doing it and there's been tons of studies, looking at this and asking people, what are the barriers.
- 01:36:39i'm sure you all can think of barriers in your mind as well, but often the barriers that are cited I don't have enough time this is really complicated.
- 01:36:46These patients have lots of different conditions it's not just their opioid use disorder, so you know time resource multiple morbidity those exist for other conditions to and.
- 01:36:55What are generalists good at, but multi morbidity that's our sweet spot that's what we do.
- 01:36:59And so, really, I think, beginning to frame this the same way we think of any other condition with the same components of care is crucial.
- 01:37:06And then the last part is, I think we just simply don't talk enough about the joint satisfaction of this work, getting back to that notion that this is a good practices illness that this.
- 01:37:14Actually, is really rewarding work I think if people don't do it, they have this feeling in their stomach like it's going to be this like really difficult to counter and they dread.

- 01:37:22having to deal with it and it feels like some added burden when in fact again these visits are much easier than much of what we do and the reward is far greater.
- 01:37:34And so, want to think about how we can improve our systems of care, how do we get to a place where we really do approach this like any other health condition it's important to understand what patients experiences are of our current systems of care.
- 01:37:45And this is a qualitative study of patients with substance use disorder who left the hospital prematurely, so what we call against medical advice.
- 01:37:54And they really reflect on some common themes The first was that people's withdrawal was not treated that it wasn't taken seriously, they weren't.
- 01:38:00Given the medication, they need, so you know one person said, if I wasn't so sick if they would have just listened to my knees, I would have stayed if I felt like they were just taking it seriously.
- 01:38:09Another common theme was again getting back to what we can do.
- 01:38:12To simply treating people like human being, showing compassion at gentleness and there are lots of really disturbing stories out there about how people who use drugs have been treated and healthcare settings.
- 01:38:23And then the others to really be upfront about asking people what their needs are to say, do you need anything.
- 01:38:28You know, are you using anything with patients, if my doctor has given you medication for my withdrawal and when i've had to use heroin was in the hospital, how do they expect you to stay.
- 01:38:38I think when we sort of bundle those up in a common barriers that we experienced in hospital settings and then also Community based selling settings.
- 01:38:45They are sort of a list of different pieces so and healthcare settings you know what talent that hospitals for patients can feel really Carswell so people who've been incarcerated or prison before.
- 01:38:55being more mindful of that they're confined to a room often there's restrictions around their movement.
- 01:39:00segments are treated with suspicion, they may you know some hospital settings they may have security involved, they may have their belonging search they.
- 01:39:07You know, are brought in a trade meal three times a day there's a lot of things that remind people of that, if I can be a real struggle for someone who's been traumatized by systems in the past.
- 01:39:17oftentimes in healthcare settings I think well intended, but misguided there's this focus on abstinence rather than harm reduction, so there's this.
- 01:39:26Often, a lot of fear and worry about people using drugs in the hospital and focus on making that a zero event, instead of thinking about how do we try to reduce it they're treating people managing them.
- 01:39:36managing their pain and making sure that people don't overdose all there and healthcare settings.
- 01:39:42And really embracing the philosophy of harm reduction, which is rooted and respecting the autonomy and dignity of people.
- 01:39:47who use drugs are approaches for substance use disorders are often very different than for other conditions, and this can play out in.
- 01:39:54Everything from again who's logged have visitors or leave the unit to go down to the cafeteria to really life.
- 01:40:00impacting decisions like who's offered a liver transplant, for example.
- 01:40:04And there's this ongoing need for education and training and anti stigma work and it never ends, because, of course, one of the blessings of working in academic medicine as we get new people all the time.
- 01:40:13And that's the joy, but it means that there's a constant need for education.

- 01:40:16And Community settings, even if we sort of clean up our side of the street there's huge barriers to connecting people that care so.
- 01:40:22there's tremendous discrimination and this runs rampant and post acute settings like nursing facilities are often.
- 01:40:27They may not accept someone with history of injection drug users on a medication for opioid use disorder.
- 01:40:32there's simply a lack of availability of the types of care patients need especially patients who are medically complex.
- 01:40:38And more there may be additional programs but they're not comfortable managing someone with medical complexity and sort of medical post acute care setting or not comfortable managing someone with addiction complexity.
- 01:40:47There continue to be a lot of regulatory barriers and policies that limit our ability to offer the treatment that we know is effective, like immediate access to medications I've met from other people aren't feeling.
- 01:40:57And then even systems that supposed to care in the community, like the child welfare system which are you know supposed to be offering care actually quite punitive and catch feel Carswell.
- 01:41:09So how can we combat some of that stigma well within our own system there's a lot we can do, and that sort of the part we can most closely control all of there's a lot of advocacy and education effort, we can do another sentence as well.
- 01:41:20The government healthcare side, we can value and approach and fun put our money where our mouth is care for substance use disorder, the same way, we would care for any other condition.
- 01:41:28We can try to drop all the areas sure effective treatment, especially medication treatment.
- 01:41:33We can humanize this work and the people who do this work, but, most importantly, our patients who were lucky to learn from and really.
- 01:41:40humanize them in every way from the language we use to the can we provide we can talk about celebrate the joy and successes and try to inspire an advocate for change more broadly.
- 01:41:49i've always loved this imagery this is from the harm reduction coalition that.
- 01:41:52On the right is the sort of Baron tree of stigma, with no leaves and these dying sticks and then on the left of the tree of liberation, as what does it look like to combat statement to really support the this sort of dignity and lives and narrative of the people we serve.
- 01:42:08So I want to talk in the last few minutes and then leave some time for questions about how we tried to do this within a healthcare system here and then mass general where I work.
- 01:42:15And so we launched this effort and really started the work in 2012 but envisioning what this might look like and launched our first.
- 01:42:23Clinical services in 2014 and have expanded over the years since then.
- 01:42:27And our goal is pretty simple it was how do we begin to approach this like we would any other health condition, where we wouldn't send people to some.
- 01:42:33Non medicalized outside system to get care for their HIV or their cancer.
- 01:42:38We would want to integrate that and bring that into the healthcare system because it's a medical condition, and so, how do we do the same, how do we make treatment available, and people are in the hospital.
- 01:42:46When they're showing up to their primary care doctors when they are you know going in for.
- 01:42:51ID follow up when they're in the emergency room, and so we began to start a series of clinical programs that really integrated effective addiction treatment into those settings and we started with our Inpatient addiction console team.
- 01:43:02Which is a team of addiction specialists that see people in the hospital, so the same way, you would call an IP consult or cardiology consult.
- 01:43:08You can call an addiction counselor for any person who's hospitalized.

- 01:43:12We started what we call our bridge clinic which initially was literally meant to just bridge people from the hospital to the Community setting.
- 01:43:17But quickly we realized that there are gaps and barriers and all sorts of settings not just the transition from the hospital outpatient setting, and so our average client has become.
- 01:43:26A low barrier low threshold kind of treatment on demand model where patients can walk in they don't need an appointment, they can show up.
- 01:43:33And we try to engage with people and stabilize them and then ultimately connect them onto a longer term Community based services.
- 01:43:40Our hope clinic, which is a perinatal substance use disorder clinics offers integrated care for pregnancy and birthing people for.
- 01:43:47Parents and for their kids so there's an perinatal psychiatry gyroscope be midwifery.
- 01:43:54social work recovery coaching addiction medicine family medicine pediatrics all in one clinic that team is caring for the whole family unit.
- 01:44:02And we've integrated care to our primary care setting so that we have primary care addiction champion teams embedded within the practice that can offer treatment right in the primary care setting.
- 01:44:11And we started a robust recovery coaching program So these are people themselves in recovery from substance use disorder.
- 01:44:18That are not clinicians but really service amazing sort of human glue to help people as they're navigating this journey and we have 14 of these coaches now.
- 01:44:27And then, lastly, pregnant with our emergency room, we have 24 seven access to medication initiation of the ED and to try to really utilize the ideas of touch point to initiate treatment.
- 01:44:37just give me a sense of our timelines we first launched in 2014 we started with our Inpatient setting and our recovery coaches and then gradually expanded across primary care.
- 01:44:45opened our bridge clinic our consulting was initially available just on the hospital, the general medical units in the hospital and so it took us a few years to become.
- 01:44:54available across the entire hospital and then in 2013 we launched our perinatal clinic or a TV work and we started our addiction medicine fellowship.
- 01:45:03we've continued to realize, you can see I'm including sort of ongoing expansion and the primary care space.
- 01:45:10We look since the first five years of our clinical work in these different initiatives and saw that we touched almost 1000 patients on the addiction consulting almost 2000 and bridge clinic.
- 01:45:20And 225 and our hope clinic and then more than 3000 by our recovery coaches and we've really worked to build this into an academic service, we now have 110 clinicians and staff in our.
- 01:45:32In our unit, we have 13 we've had 30 fellows which had 41 start so.
- 01:45:3817 fellows over now our fifth year and we have a number of grants of clinical trials and are trying to study and write about this model to understand what works and hopefully share what we've learned with other settings.
- 01:45:50One of our earliest days is to try to understand the addiction console team we compared in a quasi experimental study people.
- 01:45:57Who were seen by the console team to people on services, where we weren't yet available.
- 01:46:02And match for severity of addiction that baseline and found that patients were seen rather consult team had a reduction.
- 01:46:08In addition, severity at 30 and 90 days and an increase in the number of days they were able to stay sober after discharge so suggested that there was a COMP plan packed up being seen by a consulting during hospitalization.
- 01:46:20we've also looked at the impact on readmission because part of our goal is to really improve the value and our health care model and it found that patients with opioid use disorder opioid.

- 01:46:29overdose, particularly in the medical service when their car addiction consulting they have a significant reduction in their readmission rate.
- 01:46:36So hopefully suggesting people get well and are able to stay engaged and community services, rather than coming back to the hospital and then obviously an important sort of cost argument there's we think about how to sustain mark like this.
- 01:46:47we've also seeing that that these sort of brief touch points in the hospital can actually launch a longer term.
- 01:46:54trajectory of treatment so it's not just this five days that you have someone in the hospital but you're beginning, something that continues after discharge.
- 01:47:01And so we found that during admissions and with opioid use disorder when a patient was seen by an addiction counselor provider, more than half of them are started on medication.
- 01:47:10And this is much more likely that consulting was involved versus if they were not seen by the consult team, and that this and they're much more likely to still get the medication 90 days later, and we looked at sort of the.
- 01:47:20mean duration of treatment after an initiation occurred in the hospital setting it was actually six months so again, people are engaging and post discharge care that continues on long after they're discharged from the hospital.
- 01:47:32And then, beyond the sort of brief numbers and you saw this quote earlier, but I think it really is a good reminder that.
- 01:47:37And that kind of experience, one that reward that providers get it being a part of this care, but importantly, that value that you can't really quantify in a study or and cost data.
- 01:47:47Is the sort of kind of the Culture change that we tried to provide in the hospital for patients.
- 01:47:53And the primary care setting, we found that being a practice that has integrated substance use disorder resources and patients were less likely to the emergency room and had a shorter.
- 01:48:02smaller number of Inpatient hospital bed days and compared to practices that didn't have those resources so bringing addiction treatment into the primary care setting.
- 01:48:10seems to allow people to engage in outpatient care at night and appropriately utilize acute care settings again sort of emphasize that value and cost document.
- 01:48:19And then I talked about this with the addiction console team that's sort of the initiation of treatment being.
- 01:48:24A touch point an opportunity that launches in the longer term care, but it's true in our other settings to so looking at people who started medication treatment after that first encounter with us and.
- 01:48:33The addiction consulting and that bridge clinic after connect with a recovery coach or a bad is one of our office space addiction treatment nurses.
- 01:48:40You can see that people really stay in care for a long time on medication so, most notably or their own banner since where people and remain to on treatment for more than 500 days.
- 01:48:53We looked at our bridge clinic impact and found that it was also associated reduction number can see department visits so.
- 01:48:59Getting back to that idea of how do we move people out of the hospital, which is probably not the best sending to deliberate action care and connect them into outpatient places where they can connect and launch.
- 01:49:09And or qualitative study of our bridge clinic and found that one of the most important pieces was really the philosophy and the approach of staff so echoing what we heard from some of those other studies, where.
- 01:49:18Patients emphasize that the staff treating them like they were a human being with dignity, really focused on trying to make their life better.

- 01:49:24was incredibly important that they felt never judged they felt like they are being treated in an understanding compassionate way that allowed them to feel like they could be honest.
- 01:49:34And that the ability to just walk in and show up and not need an appointment was really important, especially for vulnerable people who are leaving.
- 01:49:40settings like incarceration where they needed to just come on that that was a really valuable aspect of model.
- 01:49:47And then, lastly, that the physical space is actually important that people felt sort of welcome they felt like it was a warm space they felt safe there and sort of creating that nurturing environment for people really, really mattered.
- 01:49:59and similar to our email that we got from detection consulting we often get messages from people who come through bridge clinic and.
- 01:50:05This is just to highlight one that I think emphasizes the things that we can do is medical providers this person came into bridge clinic back in 2018 and get saved his life.
- 01:50:15And the thing he remembered most as first the kindness of the staff, noting on the past you've been treated, not necessarily maliciously by medical staff but generally made to feel like he was less than or or.
- 01:50:27You know, look down upon.
- 01:50:28And that he was treated with compassion and I'm honored so much, but the second because he knows that he was treated like a person with a medical problem, like a person with an illness and then no one else had ever done that, and that combination of.
- 01:50:39sort of respected genuine empathy and then being treated like a patient by a doctor was what he thought really seek to his life.
- 01:50:46think another important piece, for us, has been partnering with other departments and we work closely with cardiac surgery around.
- 01:50:52file for placing ever care for people with drug use associate endocarditis or for their cancer Center ID colleagues.
- 01:50:58Ob hepatology we have an alcohol related liver disease clinic obviously primary care or forensic trauma surgeon palliative care and those have been really fruitful collaborations across that the healthcare system.
- 01:51:10And our facilitators have been I think first and foremost strong support and commitment from leadership, I think it's important for leaders in healthcare to say.
- 01:51:17This matters we value this we support this, we want to be doing this and to have that message consistently for staff and then to make sure that people on the front lines feel supported that they have.
- 01:51:27They have champions to go to they have resources and care models to turn to and our amazing clinicians and administrators who do this work.
- 01:51:33As well as these inner departmental partnerships and champions have allowed us to do that.
- 01:51:38And then, lastly, and actually really matters to have nice space that was something that you know ends up being one of the biggest premiums.
- 01:51:44Even more so that funding is really finding space within our busy hospital settings and having welcoming and beautiful space, I think that's a message that this care is important that these patients matter.
- 01:51:55And that we value them and want them to be coming into our spaces so with that, thank you for listening, I think we have a couple minutes for questions.
- 01:52:03I will have not been looking at the chat but I'm happy to take a look, but also please feel free to unmute yourself and ask a question if you'd like.
- 01:52:12And I'll just read from the chat until someone jumps in so.

- 01:52:18Someone is mentioning that this is great work to increase access to care, thank you and how important it is to treat people humanely and that.
- 01:52:26transplant evaluation with.
- 01:52:28active substance use disorder is tough and so what resources can be offered to these very sick patients and what recommendations.
- 01:52:34Do I have around opioids during surgery for patients who are in readmission so who are in remission so two really important questions, the first round transplant.
- 01:52:42And I think there is a whole frame shift around change that's needed and that's probably a bigger conversation but partnership with.
- 01:52:49addiction medicine experts can be really helpful, I think, part of the challenges that.
- 01:52:54addiction care is not a one size fits all and it's much like any other health condition, you need to the patient needs to be assessed and their severity their treatment history.
- 01:53:02And then, what the right treatment for that person is needs to be determined that partnership with the patient and that can be really tough obviously someone's in icu with.
- 01:53:11You know, with with cute outcome we like to have a titus or end stage liver disease, and I think, also because sometimes there's this expectation that everyone should do this one thing so.
- 01:53:22that everyone should go to quote rehabber Everyone obviously there's often sort of abstinence requirements if I transmit teens.
- 01:53:28I think more and more we can shift of thinking about how do we find the right treatment for this person.
- 01:53:33And, and if someone is not going well it's not their fault it's not because they're bad it's because we haven't found the right treatment plan for that meant that shifted sort of.
- 01:53:41People don't feel treatment, the treatment can fail people is really needed a transplant space.
- 01:53:47And you know I'll put a plug out for our transplant team, which has been willing to try transplanting acute now CAP cases and that's been.
- 01:53:56A big learning curve, I think, but also really wonderful partnership to be able to work with our surgeons and our hematologist and social work teams to think about how do we support and.
- 01:54:05Often, people who are getting transplanted and in a setting of acute outcome, without any period of permission before surgery in terms of opioids.
- 01:54:14The most important thing is talking to the person who's in our mission undertreated pain, can be a huge trigger for recurrence I think we often worry about.
- 01:54:21triggering recurrence of opioid use disorder by prescribing opioids but not treating someone's pain can trigger that as well, so and think frank and honest and partner conversations with the patient about.
- 01:54:32What they're thinking, I think we want to treat pain, but we want to do so in a very thoughtful way.
- 01:54:37And you can try things like you know deciding how to time with a person with the plan will be engaging family members or friends that came about.
- 01:54:44If you're going to send them a home with a prescription a shorter duration with someone else who's a part of that partnership, like a family member of might be.
- 01:54:51Helping the person take their medication and really close buckle up and a plan for how you how you'll know if you're getting into trouble.
- 01:54:59And then the next question, are there any efforts to change regulation so that PCP is can prescribed method appropriate use disorder.
- 01:55:05Great question I think are highly regulated and stigmatizing system of methadone is rather unique to the US many other countries.

- 01:55:14General is prescribed methadone and it's a sense out of pharmacies and they're good pilots in this country that have shown that to be an effective model there's a great perspective piece, and then I looked around all.
- 01:55:23A year or so ago, arguing for that there is a bill.
- 01:55:27That tender MARQuIS from us to sexually is put forward that would allow stable patients to transition to.
- 01:55:33physician prescribed methadone so that he is stuck at least in the right direction, it would still require sort of initiation of care, through an opioid treatment Program.
- 01:55:41But there thankfully it's a lot of talk about the need to update method and regulations, and I hope we'll see some innovations coming, I see a couple people are selling out of microphones so please feel free to talk.

UVA Internal Med

01:55:53Thank you for phenomenal talk we've been on such an important issue for both our nation, and I think the world as well.

- 01:56:00Your slide with the graph showing improvement in mortality was buprenorphine over the other interventions study was particularly striking, for me, I wasn't aware that.
- 01:56:11I think, culturally, as you sort of hinted hours or often hearing more about detox and Inpatient rehabilitation, as opposed to be pornography, could you talk about how you talk about medical management or with your patients who might be already familiar with detox is an option.

Sarah Wakeman (she/her/hers)

01:56:29yeah yeah great question I think talking to family members and sorry the patient and family members be really important, because one thing.

- 01:56:38is even when you sort of talk to a patient they may be inadvertently getting pressure from family or from Community.
- 01:56:44or friends to not be on medication because there's so much stigma.
- 01:56:47And so the stigma about medication treatment is intense and it's one of the biggest services, I think that happens to people with this condition, where we have.
- 01:56:54Life saving medication that people often are shamed about being on or deterred from trying and if they're on it they're offered pressure to come off the medication, in a way that we don't really see what other medical conditions.
- 01:57:06So I think my approach of the patient is first to try to understand what their experiences and what they've heard some people.
- 01:57:11it's rare but occasionally people truly have heard nothing and are very open to hearing about it and just talking through sort of the evidence, much like I would with any other medication treatment much more often people have.
- 01:57:23Past experiences or preconceived notions and I think the most common and problematic is this idea that we're just.
- 01:57:29addicting someone to another sentence that's often when someone is heard that we're just going to addict me that suboxone or you're an addict me the methadone.
- 01:57:36And I think what I find helpful is talking about what is addiction so addiction is compulsively using a substance, despite bad things happening to you in your life.

- 01:57:43addiction is not taking a daily medication or needing to take a daily medication to feel healthy to you know work and parent and live your life and not die from overdose and not going to have to tend to see.
- 01:57:53And there's lots of health conditions where people take a daily medication and if they were to stop that suddenly they would get ill so someone.
- 01:57:59You know who's on, and I have pretenses or insulin or leave with a rock scenery you name it, I think there are many different models that.
- 01:58:07That we do this one, those people are not adjusted their medication anymore than someone who's appropriately being treated with dignity eunice addicted to the medication.
- 01:58:15Then one subtle thing we can do is as physicians is watch our language there's.
- 01:58:19buried in that as big confusion about the difference between physiologic dependence and addiction and those are two different things, and so to really be precise in the language that we're using.
- 01:58:29And you see this play out, also in the term addictive babies for babies that are experiencing withdrawal a baby could never be addicted they're not willfully.
- 01:58:36Using a substance and experiencing negative consequences, but that language implies that physiologic dependence is the same thing as addiction.
- 01:58:45there's also a great lake person article that I often share with families that if you Google it it's what to do if your loved one has opioid addiction and it goes through, and like a very.
- 01:58:55user friendly way the evidence and sort of countering the method of detox and residential treatment.
- 01:59:01And then, lastly, asking people what their past experiences have been because many people may have tried quote unquote detox before.
- 01:59:07and almost across the board, they had short term with any success with it and so I'm sort of exploring that letting them prove to themselves, actually, that that model has not been helpful for them.
- 01:59:17And can be one more way to sort of talk about it, and then I think you know you look back at those early 1965 papers by dolan responder and.
- 01:59:25This one was actually interviewed by the new yorker and some of her quotes in that article, are still relevant of you know, again, the difference between the addiction independence and, importantly, that.
- 01:59:34You know, some people can't stop their medication treatment or can achieve remission without medication that's great more power to them and other people need lifelong are yours on medication and that's great too.
- 01:59:45That you know molecule with people on our feet it's no different than a molecule of insulin and we really shouldn't be confusing certain medications with morality.
- 01:59:52And that the goal is permission, how can we help them again intermission and it doesn't really matter if someone's tilting medication or not, what matters is that there that there well and that they're eating they're both.

UVA Internal Med

02:00:06Great Thank you again for great job reflecting back to your treatment desert slide show the geography across the US.

- 02:00:16providers.
- 02:00:18And the new address it, partly just provider availability to provide addiction here any comments around.

- 02:00:28kind of the.
- 02:00:30Obvious guess around insurance and painted again kind of following certain so on here.
- 02:00:38Any any comments around some initial factors it causes.

Sarah Wakeman (she/her/hers)

02:00:45yeah so great question around sort of insurance barriers that contribute to these treatment deserts and certainly there are Simon and.

- 02:00:52You know they're very good teacher and medicaid expansion states, for example, have that are accessing and entrance plans and.
- 02:00:58States that have tried to drop any sort of utilization reviews are barriers to medication treatment have better outcomes so.
- 02:01:05Not required prior authorizations not having arbitrate those limitations or counseling requirements or treatment duration requirements.
- 02:01:12All of those were much more common years ago and thankfully, you know I think insurance actually see that.
- 02:01:17This is a better treatment that they're going to help their members stay well stay out of the emergency room stay out of the hospital and so.
- 02:01:23Many of the big ones like blue cross and others have really pushed to try to change their plans to to make it easier for people to get care.
- 02:01:31Obviously that's not true everywhere, and obviously there's many States that chose not to expand medicaid, and so there continue to be barriers.
- 02:01:37I do think one of the bigger barrier, probably, or at least a big one is you know the regulatory barriers around buprenorphine and so there's really no other treatment, where we have to opt into offering it.
- 02:01:50And I think that implies that has allowed people to feel like this is not within my purview whereas.
- 02:01:56It you'd be hard pressed to find a generalist who says, you know I I don't offer insulin or I don't offer live with moxie and you know just assumed to be a part of what we do is as providers, although some people may have.
- 02:02:07Extra passions or extra expertise in different areas, and so getting rid of that sliver requirement, I think it would be a huge step towards empowering.
- 02:02:15Particularly in rural settings primary care providers have teams to feel like they could offer this without having to do one more thing.
- 02:02:22it's important just to note as a final note, if people aren't aware of the binders administration did.
- 02:02:27make it easier, so you no longer have to do a training, if you want to treat up to 30 patients at any given time, which for most.
- 02:02:34Non specialists, is a reasonable amount, all you have to do is go online and submit a notice of a 10 it's sort of a few clicks takes about four minutes you put in your NPI number.
- 02:02:44And you can then get next number, without having to do the training and so that's really helpful to know just to have this tool in your toolbox for.
- 02:02:52That person who's being discharged that you want to send them with a discharge prescription or unit that patient that you find in your primary care practice that you want to be able to offer treatment to.

- 02:03:01To not have to think oh my gosh I have to go to this eight hour training course field offer this and hopefully we'll get to a place where there are no barriers to access on offering medication treatment in our clinical practice.
- 02:03:15I know we were well over the hour, I really appreciate everyone's questions and attention I'm very happy to answer for the questions over email or if people are on Twitter feel free to communicate that way but email is always open and thank you so much for having me today.
- 02:03:36Have a great day.