

MAY 21 NAM ACTION COLLABORATIVE ON COUNTERING THE U.S. OPIOID EPIDEMIC **VIRTUAL SYMPOSIUM**

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ELIZABETH FINKELMAN

Okay. Good morning, and welcome to this virtual symposium of the National Academy of Medicine's Action Collaborative on Countering the U.S. Opioid Epidemic. My name is Elizabeth Finkelman and I direct and oversee the work of the Action Collaborative on behalf of the NAM. You will learn a little bit more about the Action Collaborative in a minute. But first I'm going to describe our agenda for the day. Next slide please.

Of course, under normal circumstances, we would be convening today's symposium in the auditorium of the National Academy of Sciences Building in Washington, DC, but we're delighted that we're able to bring you this program virtually today. During today's virtual symposium Action Collaborative members and invited expert speakers will address among the highest priority elements of the nation's response to the opioid epidemic and how the convergence with the COVID-19 pandemic is impacting patients, families, the health system and the ways in which we may grow adapt and innovate in the wake of it.

Our program will kick off in just a moment with opening remarks from the Action Collaborative co-chairs, including Dr. Victor Dzau, who is the president of the National Academy of Medicine; Ruth Katz, who is Vice President and Executive Director of the Health, Medicine and Society program at the Aspen Institute; and Dr. Jonathan Perlin, who is President of Clinical Services and Chief Medical Officer at HCA Healthcare. Unfortunately, today we will miss hearing from our fourth co-chair, Admiral Brett Giroir, who is the Assistant Secretary for Health at HHS, as he is on the front lines of the government's response to the COVID-19 pandemic.

Following the co-chairs remarks, we will move into our keynote presentations, which will feature the stories and perspectives of two Shatterproof ambassadors who will speak to the ways in which the stigma towards addiction has impacted them and their families.

Following our keynote presentations, the remainder of the day will be structured around five 70 minute sessions that cross all of the Action Collaborative's priority focus areas and which include strategies and opportunities to overcome the stigma of addiction, strengthening health professional education and training, accelerating person centered and evidence based pain management, elevating promising prevention strategies, and building the essential elements of the health system that is equipped to prevent, treat and manage opioid use disorder and other substance use disorders.

Each session will begin with brief remarks from the panel moderator, followed by short presentations from the panelists and the moderated discussion and Q&A with the webinar audience. The entire symposium is being recorded and a whole recording of the event, along with speaker presentations, will be posted to the Action Collaborative's website in the coming days. We hope you will join the conversation on social media over the course of the day and tweet over the course of the webinar by using #OpioidCollaborative.

And then finally, before I wrap up, I do want to conclude by acknowledging and thanking the sponsors of the Action Collaborative, who make our work possible. They are all listed here on this slide for you to

review. And now I'm really pleased to introduce Dr. Victor Dzau. Victor is the president of the National Academy of Medicine and will lead off the opening remarks from our co-chairs and share some background about the Action Collaborative. Victor, over to you.

VICTOR DZAU

Well, good morning. It's great to see all of you at this virtual symposium. We are dealing with a crisis in the midst of a pandemic called COVID-19, but I we just want to make sure we bring back onto your radar screen, the issue of the opioid epidemic, and so this symposium. We're just one small aspect of this, but I'm going to tell you about the Action Collaborative, which is in many ways, bringing together the many pieces that we are trying to tackle with the opioid epidemic. So let me begin with first slide. Next, please.

So this is a crisis and, you know, it's already at over 130 Americans die every day from overdose, and that's 70,000 deaths from overdose. And in fact, there's 21 million people with an opioid use disorder and this is costing us about \$2.5 trillion. But it's not the, the cost of money only, it's the cost of lives, it costs productivity, housing, and security, it strains the justice system and so many other issues. That's what we're here to talk about today. So as the crisis is gaining its full speed, so to speak, it became very clear that the nation needs to respond and lead. The federal government has given more money, local and state agencies are working on this, but we're working first on coordination and the issue of moving collective actions together. What I'm saying is why many people are acting. We're not acting together.

And so in that context. There was a need for a public private partnership to bring together the major players to coordinate and develop collective action. The Surgeon General said, in tackling this problem, it's like eating an elephant, one person can't do it alone. You need a whole group and in this case, we call it a portfolio approach - that is no single policy will be enough. We need to work together.

In that context, we brought together 60 participants, including representatives from federal agencies. As you heard, my co-chair is Admiral Brett Giroir, who's the Assistant Secretary of Health. And many other federal agencies, CDC, SAMHSA, many state and local governments, companies, provider groups, health systems. We've recently added a group of people with lived experience. All these people coming together. A powerful collection of voices and being able to coordinate activities and actually develop collective actions. So I'm very privileged to be one of the co-chairs. As you see on the slide and I already mentioned, Ruth Katz from the Aspen Institute and Jonathan Perlin from HCA Healthcare are my other co-chairs.

So the way we approach this is by a public private partnership. We want to be inclusive, people working both in front line and policy area to work together. That's why this collaborative is so powerful, and why it came together. Once we came together, we developed four different priority areas, and we have a working group focused on each of them. Now, why did we choose these areas? Because these are areas that we feel have existing gaps. Each of these areas can benefit from a public private partnership: health professional education and training; pain management guidelines and standards; prevention, treatment, and recovery services; and research and metrics needs. I'm going to show you a slide on each one of these activities.

Education and training. We know that doctors, nurses, dentists, they're all on the front line there. And so what we found is that a critical role in countering the opioid crisis is by giving clinicians the appropriate education and training. It turns out that education and training is highly fragmented across the continuum, across the medical profession. Medical school, resident training, continuing medical education, but also into the professional world, involving nursing, pharmacists, you name it. So the whole

point of this working group is to look at the gaps, to identify these gaps, and create an action plan across the continuum, both professionally and interprofessionally. So a strategy for implementation in this collaborative is working toward standardization across the care team, so that people know what everyone else is learning and those standards are pretty much uniform across the country. There's commitment from the accrediting, certifying, licensure, and regulatory bodies to identify the requirements needed when you are in a specific profession. We expect you to be trained properly and certified properly – so this group includes ACGME, ANCC, ACCME, and other professional associations, the certifying and licensing organizations. And this is important, that education is coordinated at the top. The evidence-based criteria and programming that will come from this working group is a critical issue.

So next, it's important to identify what the guidelines are for chronic pain, when you're managing someone's pain. What is the evidence? It's a very important issue, because as you know, when you go to have surgery, you may need a prescription to help manage your pain, and it may include opioids. So as the FDA was analyzing their guidelines, they came to ask us if we could create guidelines for the evidence. And so this is what you see – this 2019 report created a framework to validate existing clinical practice guidelines, and then we are using that framework to identify the guideline for treating this condition or that condition and then we can apply that framework for the acute pain situation.

That leads me to say that this guideline is critically important and must be adopted, and that's the second output of the second work stream, on pain management guidelines and evidence standards.

The third work stream is prevent, treatment, and recovery, and we published a report in 2019 that validated that medication works. Medication based treatment for opioid use disorder is effective and saves lives. But the problem is it's not available to many people who need them. Only 20% of people do receive any type of treatment in a given year, and fewer received medication based treatment. We feel strongly that denying access to these medications is delaying appropriate medication treatment for the people who need them.

So you talk about prevention and recovery services. We think there's significant under treatment of opioid use disorder. We need to make sure that everyone who needs medications gets them – and why don't they? Well, there's stigma and the misunderstanding of the whole issue of substance use disorder. There's no incentive, reimbursement-wise, for practitioners. In fact, this problem of a coherent continuum of care for people suffering from opioid use disorder. So we need to make sure that all of these processes, not only happen in parallel, but in fact happen in a continuum. We see opportunities to combat stigma, realign the essential elements of care, and develop a framework to implement, scale, and sustain effective prevention, treatment, and recovery approaches.

So we have a paper from the collaborative that identifies these barriers – there are many, as you can see here, but importantly there are also strategies to address these barriers. The paper actually presents 25 different strategies, so we hope these will be implemented so we can treat the people who need it.

The final work stream is research, data, and metrics needs. There's still a lot that needs to be known, as well as what does and doesn't work. They will look at cross-cutting issues across the Collaborative and develop a research agenda that addresses all of the work streams.

So when I sat back and asked my team to plot this together, you can see all our activities. This slide shows the Collaborative in the middle, the entities and organizations working together. You can see the four work streams and the products that I just talked to you about. It's a very impressive amount of activity

done in a very short time we've only been working together for a year and a half. More importantly, we are not doing this in siloes. This slide shows you that this is part of a cohesive systems response. In other words, we are mapping everything to see how we are connected to everything else so this is all done as one part of a much larger system to solve this problem. If you look at the middle which are all the different entities across the country and working with us, finding how to connect with each other and coordinate and create a system so we can conquer this problem of an opioid crisis. Next slide.

So as you all know, we are in the midst of the pandemic in the midst of COVID-19. And lots of people are consumed with responding to COVID-19. But we want to point out that COVID-19 impacts severely this population that we talked about today, people with opioid use disorder and substance use disorder and pain. And therefore COVID-19 is aggravating the situation and making this crisis even worse, because people with substance use disorder and opioid use disorder are at high risk for contracting COVID-19, because of who they are, where they live, if they are homeless, but also because there's a lot of barriers to receiving care, emergency care, life-saving medications, medical therapy, counseling, social and peer support, many others. People are having trouble accessing care and receiving the appropriate medications and also people with chronic pain may be considered high risk. So there's a need to preserve the well-being of these individuals, and it's so important, because these are vulnerable individuals and during COVID-19 they are suffering even more.

So we put out a call to action. And across the collaborative, we've said that we need to put effort in addressing the needs of this population during COVID-19. So we've created a resource page, we had town halls, we will have a statement from the Collaborative, we're putting together a rapid response research agenda, and we are working on publications.

We are also working with ASAM to create a webinar series that will cover how to help individuals with addiction stay connected during COVID-19, ensuring that addiction care is managed across the continuum with challenges and promising practices, and the last is coordinating across the social safety net to avert a crisis among patients with addiction.

So this is it. I'm very proud of the Collaborative and its members and we are all working together on this crisis, this complex crisis that is aggravated by COVID-19, but together we can get it done. Thank you for being with us today.

ELIZABETH FINKELMAN

Thanks very much, Dr. Dzau, and now we'll hear from Ruth Katz.

RUTH KATZ

Good morning everybody - I'll be brief. I know we've got a big agenda and lots to cover today. But I just want to welcome everybody, and thank you all for joining us, for Zooming in, if you will. We know how busy everybody is. And so we appreciate your taking time to join us. Victor has done a terrific job as always and teeing up the challenge that the Collaborative is taking on as well as describing the work that we have been doing over the past year and a half with our four different working groups. I just want to underscore how important the work is that we're doing right now, as you all know, we're dealing with an epidemic, the opioid epidemic within a larger epidemic of COVID-19, but we want to make sure that the work that we're doing somehow doesn't get lost in fact that we're working harder than we've been working up until now, because this work is so critically important.

We're very excited about today's program, especially our keynote remarks from our colleagues and friends at Shatterproof, focusing on the issue of stigma. As Victor just discussed, the issue of stigma cuts across all four of our working groups and it's absolutely clear that we've got to take it on in order to make real progress across the board. I also want to just take a moment to thank Liz Finkelman and her team for putting together today's program. Having now worked myself on a number of these webinars, they're not so easy, particularly with large groups. So Liz thanks to you and your team for a great job. And thank you all again for being here today. And let me now turn the program over to our friend and fellow co chair, Jonathan Perlin.

JONATHAN PERLIN

Thank you, Ruth, and thank you, Victor. I think, in hearing both of their comments. There's been a tremendous amount of work accomplished and it's really so significant that I think all of us feel that we have additional work to do, particularly in an environment which has both Victor and Ruth shared is one where much of the oxygen in the room is sucked out by COVID-19.

So let me just make first three points. One that this is a tremendous basis on which to start in which to really provide guidance to a more effective health context for the care of those with opioid use disorder. I think today's symposium will really be an important mechanisms for organizing the next tranche of work, summarizing work to date and outlining next steps. And that's very much appreciated. And I'd add my thanks to Liz and the NAMM staff for their hard work.

My second point is echoing this point that Victor made about really the overwhelming effect of COVID-19 and how difficult for individuals with opioids and other use disorders to find care is, so critically important. I think there's one thing. Additionally, that so very special and that leads me to my third point, and it's really the sort of culmination of the trajectory of discussion today. And that is that the elements of a health system that's equipped better equipped to prevent to treat manage opioid use disorder. It's probably also better equipped to address issues such as COVID-19 to bring together, public health community resources and the formal health care delivery system in more coherent work. And so I think this work is tremendously important in its own right, because of the exacerbation for those individuals, but also think it's important as a model for better care that really is so sorely needed as, as demonstrated at this moment.

So it's really in that vein that I have gratitude to not only the organizing entities, the NAM and the Aspen Institute, but to each and every one of you for your contributions and very much look forward to learning with you and moving this agenda forward. Thanks.

ELIZABETH FINKELMAN

Terrific, thank you so much. I'm going to introduce our keynote presentations. So our keynote session today will focus on the effects of stigma with perspectives from persons with lived experience. The stigma of addiction keeps many people from talking about their disease and seeking treatment. For this reason, it is so important to lift up the stories of those who are willing to share them so that we can break the silence and help save lives. I am so pleased to introduce our keynote speakers. Marci Massa and Megan Kenney will be sharing their stories with us today.

Marcy and Megan are both Shatterproof ambassadors. Marci hailing from Chicago and Megan from Boston. As Shatterproof ambassadors Marcy and Megan are part of a national network of volunteer peer

leaders educating and empowering others to learn about and support shatterproof mission of reversing the addiction crisis in the United States. They will each share a personal experiences with the stigma of addiction and how it has impacted them and their families. Marcy and Maggie. Thank you so much for being with us today. Marcy we will start with you, and then turn to Megan.

MARCIE MASSA

Great. Sorry about that. Hello, everyone. Thank you so much for the opportunity to join you this morning. It's always an honor to be speaking on behalf of Shatterproof and their mission and to be my brother's voice.

On May 4 of last year, I became a sister to an angel, my younger brother, Tony at 42, due to relapse. For the first time in three years, and it would be his last. I knew early on after losing my brother I needed to park my pain in a place of purpose. It pains me when I think of what my brother's years of struggling not only did to him personally, but the impact it had on our family. See prior to my brother going into recovery program where he lived for 13 months graduated and entered recovery we lived in silence. We have the addiction with him for fear of judgment. I looked up the definition to stigma. It's defined as a mark of disgrace associated with a particular circumstance quality or a person. Disgrace the word in that definition really strikes a chord with me that very word is how those struggling with addiction have been made to feel shame and guilt or a huge factor. They keep those struggling stuck in their disease.

Unfortunately, like many families. We didn't realize how great that stigma affected our family until my brother had passed. Society's views of addiction made us feel we couldn't share the elephant in the room. Stigma gives you a visual of some scary person walking around with a needle in his or her arm. Someone who lives on the streets or under a bridge. It doesn't tell you how handsome. My brother was how we had a heart. The size of Texas. Yes, behind closed doors are sweet loving family had been affected by addiction. It's true. You can come from the best home on the planet and addiction will still live within your walls.

I often beat myself up. Now as I look back I was ashamed to share his struggles when he was alive. Why on earth that I care about others opinions, our family. Let the stigma guide our thoughts. It told us we should stay silent it told us not to take the time to educate ourselves and the fact that addiction is a condition that alters your brain. All these truths came crashing down as I joined grief support groups from addiction loss thousands upon thousands sharing all the same stories of their loved ones negative perceptions associated with addiction affected my brother self esteem daily Like so many others. The stigma told him he was a disgrace and as a result he suffered in silence which prevented him from reaching out and asking for help. That is why you're seeing me speak today, there needs to be a change in the way we view those who struggle. The stigma tells you that those who struggle in addiction.

I'm here to tell you that stigma lies. Many people discount the lives of those lost as a result of addiction focused is placed upon the death path versus the goodness in their lives. I'm here to tell you, and every life there is goodness in my brothers, like there was great goodness addiction was such a small part of who he was. I wish people could know how much time my brother spent alone thinking praying and crying out about his addiction expressing the loneliness and isolation. He felt due to his struggles. The hardest thing I've ever had to read was journal. I found in his room. A few days after his passing This journal I hold is full of page after page of heartfelt cries I'm loneliness and disappointment and himself. If you've ever had doubts of how those struggling feel, please use this journal I hold in my hands is a visual for your hearts. They want help, but the stigma silences them time and time again. He was the

sweetest, most kind, loving individual you'd ever meet. He's gone on in until his final relapse helping others in their struggles addiction wasn't the entirety of him. Each of us today struggles of some sort. Maybe it's an addiction, depression, anxiety, food. Imagine if all those around you only focused on your struggle. What would that feel like daily for you. My brother and our family. Unfortunately witness that very stigma in the hospital Tony had a medical issue related to a relapse and the nurse couldn't have been any more unkind. If she tried Her actions to my brother whisper heard you don't matter if stigma filters through hospitals, doctors offices nursing care and treatment facilities, it will continually discourage people from seeking out treatment. In speaking with numerous amounts of grieving families this reality is all too familiar reverse the shoes. If you want to get help on retreated portly would you want to seek treatment again. Chances are you to would walk away and shame you would let the stigma tell you yes you are worthless. There is no hope.

Please see them for more than their disease. Their lives are depending on it. They are somebody someone they are my brother. Why must we live in a world without compassion until it becomes someone they know 80% of the public views addiction as a personal failing a weakness or a character flaw until these views begin to change countless lives will be lost. We must learn to start treating addiction, like any other disease. So lives can be changed. It's alarming that with all the education facts and statistics that are out there that this epidemic isn't getting better. It's getting worse in More than 70,000 people were lost to the opioid epidemic, the Chicago Bears NFL football stadium seats over 61,000 people Think of that for a moment, the entire stadium filled with an additional 10,000 extra on the field. That's how many beautiful lives were lost to this crisis. It's more than a need for willpower or the just say no mentality addiction requires managed treatment addiction requires the stigma to end. This starts with you and me, each of you joining this conference today has the power to take a step towards that change.

It is my hope that today can be a day of change in your hearts and the very day, my brother died. One of the last things he said to my mom. Was mom I'm struggling to find my purpose, even though our hearts are broken. He's no longer with us it's become clear to me that the purpose he so desperately search for on earth will go on in his death. I will continue to be his voice, please educate yourself to know that that addiction does not discriminate don't think this will never happen to my child. Thousands last each year. Our young children and adults that made them fatal mistake to try something just once. With that said, I'd like to leave you with a short video What touches me more than anything is to see the beautiful faces of just some of those loss to addiction. It helps tremendously to break down the barriers Tony could have been your child your sibling neighbor friend. It's not those other kids. These are all our children.

Thank you so much for the opportunity today to share my brother's story made the change begin with you and me.

ELIZABETH FINKELMAN

Thanks so much, Marcy your remarks were beautiful and, you know, I think we're I can speak on behalf of everyone listening in that we're so grateful that you're able to be your brother's voice. And please continue to do the good work that you're doing and spreading these important messages.

MARCIE MASSA

Thank you so much.

ELIZABETH FINKELMAN

Of course. Thank you. I'm pleased to introduce Megan Kenny, who will also share her remarks with us.

MAEGAN KENNEY

Thank you, everybody. Marcy that was a beautiful tribute to your brother. And I think when we sort of see these stories and you know we speak from experience, whether that be firsthand, or as a loved one, I think we really sort of appreciate the battle that we have ahead of us. And then also, you know, the opportunities to speak to these types of experiences which, you know, are not always easy. So I appreciate you and I thank you for sharing.

Right now as a fourth year clinical side the graduate student in clinical psychology. I'm coming up on eight years and recovery this July, amazingly, which is wild to just think about I sort of look at my journey to this point and I recognize how much stigma has played a role in a variety of different ways. Starting when I was actively using and trying to seek help. And also just now as a professional in the field. Who has this history, and it's definitely been stigmatized in a variety of ways for that so I guess I'll just start with saying that when I was actively using there were some experiences that definitely compounded the problem that amplified the immense shame and pain that I was in at the time.

I just want to sort of bring to light that I think oftentimes people who are actively using get stigmatized in a variety of different ways as we're talking about today. But I think what we fail to recognize is the massive amount of emotional pain that the person is likely in that either drove them to use that substance in the first place. Or that's keeping them in a pattern that they just can't seem to get themselves out of despite the fact that they desperately want relief. And so I can put myself back into that place. And remember the times that I would do my best to try to figure out a way out of the hole that I was in, and I had tried lots of different medications. And I remember at one point I had learned about vitriol And I was, as I described it sort of like one foot in one foot out of my recovery process at that time because I was still sort of trying to negotiate the terms of my own Recovery Plan and I was using a betrayal, but I wasn't using it the way I really should have been, and I was still trying to sort of, you know, use in between and I remember at one point that you know I had detox myself at home that was sort of like the way that I treated myself because of the stigma. I didn't want to go to the hospital that was in my town and have to admit the problem that I have I knew people in my town. I don't want to go to a meeting and raise my hand and say I had this problem, because everybody in the town knew my family and I didn't want to Shame, my family and my family. Most of my family didn't even know that I was struggling. Some of my extended family members. So that was a lot of pressure. And so I remember trying to manage this all on my own.

And I remember detoxing myself in my house and had made it a few days and I still had some buprenorphine left in my system. But I knew that I was vulnerable and I knew that the second that I sort of got back out into the real world that I was probably going to use. And so I had had a prescription of Naltrexone And I thought I was at a safe place with the amount of opioids that I sell left in my system to take it and not put myself into precipitated withdrawal. And that did not happen. I got incredibly sick and I had to go to the emergency room, and now I was faced with multiple dilemmas. I was incredibly physically ill. I was psychologically tortured, and it was all manifesting in that moment, and it was sort of all crashing in on me. And then I had to go to the hospital and my town and then do the one thing that I absolutely had avoided for years, which was admit that I had a problem to people that I was afraid. We're going to judge me and people who are pretty close to me geographically

Until I walked into that emergency room sick and desperate and at a point where I was sort of broken and just willing to take whatever help. I could get And I will never forget the experience that I had with that emergency room physician who, when I walked into the emergency room with my mother and said, I'm an only child, and I'm very close with my mother, and we have a great relationship, it's okay that she's here. He told me, Well, you know what I'm going to have your mom leave the room. So you and I can talk. And when he did that. He then turned to me after my mom left the room and said okay so now that your mom's not here. Why don't you tell me the truth. And I said, well, Doc, I am telling you the truth. I'm struggling I've been trying to help myself. I took the Naltrexone now I'm sick and I need some fluids. I know I'm dehydrated, you know, can you please help me. And he insisted that I was lying, that there was no possible way I could have been this sick from the amount that I was telling him that I took, and the interaction. He then asked me the severity of my drug use as a way to sort of make me prove how bad I really was. And I remember in that moment, pulling my sleeve up and showing him the cyst that I had in my arm and explained to him that I had been crushing up pills and injecting them. And then I was out of place right now where I was so broken that I was just desperate for help.

And he looked at me and said, Well, you might as well be shooting hamburger meat into your veins, because that's what you're doing to yourself. And I remember these experiences with this doctor being so devastating to me and I still even just get worked up now and I tell the story because The, the shame and the pain had kept me away from seeking help. And here I was at a place so desperate for somebody who is supposed to be a professional Who was supposed to sort of have the skills to be able to talk to me and maybe hold me in that moment, you know, psychologically, to be able to say, like, you may not have any hope in yourself right now but I do. And here are some options. And here are some ways you can help yourself.

Luckily, that was a turning point for me. I was sort of not capable of withstanding any more pain from all of these different angles that I ended up recommitting to a vivid trial program with a new doctor and started to take it really seriously. And I will say, I think, large and part my commitment to that program. The fact that I was able to stay on trial for three and a half years, start a master's program with a year of recovery under my belt and then proceed right into a doctoral program. So now, seven years straight of Masters and Doctoral level education will be done in about a year and a half. That all came from the betrayal doctor that I want to go and see actually believing in me in that moment when I told him. That this was the way that I wanted to run my recovery. And then I had tried different medications and then I had diverted them each and every time. And then I was not successful with them and I did not take them seriously. And therefore they weren't going to be an option for me at this point because I needed to take a turn and the vivid trial was an option. I just felt like I needed to sort of shift my perspective on it a little bit.

And I felt like I was at that point. And he listened to me. With compassion. He honored what I had to say he respected my education as a User that I knew what I was talking about when it came to these medications and the ways that I was using them and how they were going to help me and how they weren't going to help me. And he really let me drive the boat on my healthcare decision making process at that point and that is exactly what I needed.

I was not somebody that should have been doubted I was not somebody that should have been challenged when it came to what I believed was going to help me. And I should not have been somebody just like anybody Marcy's brother, anybody that we know that's ever struggled people that have passed from this because they didn't get the help that they needed Should have never been discarded. The way that I wasn't that emergency room that day and if I had not found that vitriol doctor, I may not be here

speaking to all of you because I may have succumb to the pressure Of the institutional and personal stigma that were perpetuated against me that day, and that emergency room.

It's kind of funny because years later, I ended up working for that hospital with that doctor Who did not know who I was and praised me for being an absolute rock star in the behavioral health department for the job that I did. And I still never had the guts to tell him who I was. So that's sort of like a funny point to the story. I mean, I think overall, I'll just sort of end with my experience of being a master student Having a history of addiction being very public about my experience, because I do not want to see any more people suffer. And I think we can talk a lot about stigma and we can have conferences like this. And we can even put out calls to action.

But I think you really see the underlying feelings, the unconscious biases. The micro aggressions that we experienced on a daily basis from even people in the field who may be conscious of it and aware of it, and may be doing it intentionally, but maybe not. And I've had experiences. Now with this history of mine being brought back to the surface as a way for people to discredit what I have to say. Or judge me in some way stigmatize or essentially discriminate against me. And so I'd like to say that eight years in recovery that stigma and that shame goes away. I would say the shame goes away, because I make it go away because I speak about it. And because I call it to the table, and I'm not afraid to call out the fact that within our communities. The recovery community, the mental health community. We are perpetuating stigma left and right. And that is the problem, because if we don't recognize that within the community. We are perpetuating the problem we cannot expect society at The larger hole to respond the way that we actually deserve to be responded to. So it's sort of my perspective is, sort of, we have to work in and then work out. And so it's the reason why I'm so passionate as a professional in the field with this coupled living lived experience also note that my dad's in recovery.

He and I actually host a podcast together called the dictionary podcasts, in which we share all of our experiences and opinions and points of view about all of this. He's not a professional in the field. And so we balance our perspectives on this and it often comes back to the same place. There's a lot of stigma and there's a lot of stigma. That's not talked about And as long as we're addressing it. And we're actually willing to be brave enough to say this is happening, and it's happening from the people that we least expected from Then we might be able to see some changes made. And so I appreciate everyone taking the time to listen to what we have to say as people with experiences. Um, I think when we can speak from these experiences and we can show the nuance challenges of what it's like to be an active addiction to be in recovery to be a loved one family member. To be a professional in the field, we really start to recognize the gravity of this problem and we only Make changes when we're willing to speak about it. And so that's what we're doing today, so I really appreciate everyone taking the time. To join us as an incredibly important topic and I encourage everybody to try to think about ways in which you can start to change your interactions. With people with this experience of the way you talk about this in the most subtle of ways. Think about the really small. Exchanges the conversations that you have with people and the ways in which you talk about this subject that might be contributing to the overall problem. It's these little changes that we can make that actually end up making the big waves. And so that's why I encourage you all to do. And so I I thank you all.

ELIZABETH FINKELMAN

Thank you again, Maegan, and Marci thank you so, so much for sharing your stories and powerful messages with all of us today.

Again, on behalf of the nm and everyone watching this webinar. I really hope that you both will continue to do the good work that you're doing and continuing to break down the barriers around addiction. And particularly with respect to stigma. I think you've certainly reaffirmed for all of us that we still have very far to go and dismantling stigma and Certainly, we hope that through our work, we can help you and your colleagues, make a difference and change this culture that continues to persist, unfortunately.

In addition you have also provided a very powerful backdrop for our first expert panel session, which is going to focus specifically on addressing the stigma surrounding opioid use disorder.

So as we transition into session one and we can move to the next slide.

SESSION ONE – ADDRESSING THE STIGMA SURROUNDING OPIOID USE DISORDER

ELIZABETH FINKELMAN

As we learned from our keynotes stigma remains a pervasive barrier to accessing and receiving quality treatment and care. And I am pleased to introduce an expert panel who will discuss evidence based strategies initiatives and other Critical opportunities to reduce stigma towards opioid use disorder across the health system and beyond.

The session will be moderated by Dr. Kelly Clark, who is the immediate past president of the American Society of Addiction Medicine. And joining Dr. Clark are Dr. Colleen Barry, who is chair of the Department of Health Policy and Management at Johns Hopkins Bloomberg School of Public Health. Dr. Margaret Jarvis, who is chief of addiction services for Geisinger addiction medicine and the Geisinger Neuroscience Institute. Elizabeth Finkelman: Mr. Matthew Stefanko who is director of the National stigma initiative at Shatterproof and Joy Rucker who is executive director of the Texas harm reduction alliance.

Their full biographies are available on the event website for you to access and please note that we will be taking questions from the webinar audience during the last 10 minutes of the session. Please use the comment box on your screen to answer to enter a question. We'll get to it later. And now I will turn things over to Dr. Clark to get us started. Thank you.

KELLY CLARK

Well, thank you, Liz. I appreciate the introductions and you've done a wonderful job of talking through the terrific panel that we have for you. I'd also like to thank the Shatterproof ambassadors that just spoke for making this really personal and bringing this into our panel so we are going to listen to everyone give a presentation and then we're going to have plenty of time for Q & A.

But Dr. Barry, we'll start with you. Thank you.

COLLEEN BARRY

Great, and it's a pleasure to be here today and I want to echo Dr. Clark's Thanks to Marcy and Megan for their willingness to tell their stories and underscore why this topic is so very important for us to be talking about today. Next slide please. So the way I conceptualize stigma in this came out in our last presentations is based on this conceptual framework by felon and link which includes labeling and

stereotyping, but it also includes separation status lost power differential and of course discrimination. Next slide.

In stigma matters on multiple levels on the individual level, because as we heard it can lead to risk your use. And it can lead to profound social isolation. But it also matters on that health provider and health systems level because, again, as we heard it can lead to much poor quality of care. And then under investment in the training and treatment structure infrastructure that we need as a society. Finally, on a societal level social stigma translates we see from the evidence base into discrimination and jobs and housing and insurance coverage. Neighborhood resistance to offering services lower support for policies that are public health oriented and greater support for punitive policies that are grounded in shame and punishment. Next slide. And we measure stigma as a research community in a variety of ways, including social distance measures. That tell us that Americans are unwilling to have people with substance use disorders, for example, marry into their families and incredibly high levels or work closely with them on a job on jobs. Next slide.

In terms of individual blame views related to toward people who are addicted to opioids, for example, being to blame themselves for the problem. And this this notion of lack of self disciplined which contradicts what we know scientifically related to the role of addiction as a chronic medical condition. Next slide please. And lead to these real information gaps. For example, in this study. We see that basically half of the American public believes that there is no treatment for example for opiate addiction that is effective over the long term. In the face of what we in the scientific know community know is a strong evidence based supporting medications that are gold standard and life saving. Next slide.

And we see that the kind of attitudes that Megan described are not uncommon primary care physicians and these same kinds of studies have been done with other health professionals are quite similar in certain cases even more stigmatizing than those of the general public. Next slide. And these attitudes include what are known as NIMBY measures attitudes again among MD is, as well as other health professionals, next, next slide. And the news media unfortunately reinforces these stigmatized views. This is just one example of a study that was done over a 10 year period on stories related to the opiate crisis, showing that about half of all news stories used at least one stigmatizing term. Next slide.

So what can we do. Next slide please. So I think the main takeaway from my presentation is the evidence base for how to combat stigma is profoundly lacking. We know very little about how scientifically how to reduce stigma toward people with addiction. How to reduce stigma toward medications to treat addiction and how well evidence from other stigmas stigmatized conditions. Apply to fighting addiction stigma and I think in other areas of science we dig in there and we use Randomized control trials and other strong research methods, whereas in the area of thinking about how through communication and other strategies we can grapple with. Stigma we tend to go with intuition and that's dead wrong. If we want to really be able to turn the tide with regard to stigma. Next slide.

So that was the motivation for this recent piece that I wrote with a colleague of mine in the New England Journal of Medicine and it was a call to Build a evidence base in stigma reduction to combat the addiction crisis in in that piece that came out in the beginning of April. We highlighted a few principles that we do know based on the limited existing research that is available, but really underscores the need the critical and urgent need to build this evidence base immediately. Based on what we know. To date there for real principles that come out number one use of person centered language. Language is essential for stigma reduction. In all settings. Number two, emphasizing solutions appear to appears to reduce stigma.

Number three. Use of sympathetic narratives that is stories that humanize people with addiction may reduce stigma, but there's some cautionary tales in the literature and the devil is in the details in terms of how this is done. And whether it's done in a way that doesn't reinforce the role of the individual and individual blame. And number four for that stigma reduction messages should emphasize connected to the point I just made societal rather than individual causes of addiction. Next slide. So we have a number of different resources to use for person centered language, including a really helpful a memo that came out in 2017 from the Office of National Drug Control Policy. And for the Associated Press a style guide in 2017 related to use of person centered language in the news media. Next slide.

In terms of emphasizing solutions. This has been shown in a variety of different studies and we're increasingly seeing a orientation towards solution messaging. Including in the title of this recent consensus study that was done by the National Academies emphasizing the role of medications in saving lives. Next slide. I'm not going to talk in depth about sympathetic narratives, except to reinforce the point I just made a minute ago, which is narrative and stories like the ones we have just heard. Can be powerful in particular and combined with factual information. And you can see here in this study, a three fold increase on the part of the American public and willingness to be supportive of policies related to know Luxor and distribution to friends and family members, but there is the potential force for narratives to reinforce individual claims. So, so these kinds of efforts need to be done with evaluations tied to them to make sure there aren't unintended consequences. Final slide please.

And emphasizing societal versus individual causes is crucial. Just one quick example of this fourth takeaway from our New England Journal of Medicine perspective. We found in one study at 10% reduction in public support for punitive policies requiring providers to report, pregnant women who've been misusing opioids to state authorities. In an experiment where we really emphasized in drew out the barriers that these women face to accessing treatment. So, making it clear that there is a broader societal role. And this is not just an individual problem that's my last slide. Thank you very much.

KELLY CLARK

Thank you, Colleen. We appreciate your perspective and the information that you've gathered and put out there through the New England Journal. One of the things that I'm personally very happy to be moderating the session given sort of an MD MBA approach is that what we have in this session really is a Colleen is talking through the scientific evidence in a in a large evaluation of the evidence base. Then Dr. Jarvis, Margaret, will be talking through scientific data from the health system in which she works and studies that she has done. Then we'll hear from Matthew well while we may have less from a scientific evidence base we have good models for dealing with this from a business case. And I think Matthew will be talking through how this has occurred using parallels to other kind of stigmatizing disease states in the past. And then Joy will be talking through really from the, the, the person with lived experience. You know, people on the ground, how they're dealing with stigma and what they face in harm reduction areas. So really pleased to have such a diverse view that really gives us a three dimensional sense of what we're dealing with, with stigma. And with that, I will hand this over to Dr. Margaret Jarvis.

MARGARET JARVIS

Thank you, Dr. Clark and thank you Dr. Barry, there's a lot of what you presented that we saw in the study done at Geisinger. Actually several years ago now. Um, so, next slide please. I'm going to move through these fairly quickly because they're very meaty slides. And was a fairly dense project if there is anybody who might be interested in a complete set of the slides, I'll be happy to get that to you.

But I think I can get through some of the highlights of this on. And as I said, much of what I'm going to tell you that we saw in our experience at Geisinger is exactly what Dr. Barry has seen in the literature. So we undertook a Project to understand our own staff and their bias towards people with substance use disorders. This took place in the waning hours of 2017 there were almost 1200 people who were queried, they are all healthcare professionals and I'm a little over 1000 of them responded. Next slide please.

So the, the questions had to do with what qualities of these people might contribute to their likelihood to Blaine help or stigmatize patients with substance use disorders. Next slide please. And as you would expect. And very much along the intuitive realm that Dr. Barry said we probably shouldn't rely on. But what we got. Sometimes, um, what you would expect is that we saw that as we see increasing knowledge about substance use disorder increasing familiarity of About the personal statements and personal stories and improved adherence to best practices you started to see less stigmatization And there were some very curious findings that people within our system within the guys in our system in Pennsylvania would typically either have very high familiarity with Persons with substance use disorders or very low and the familiarity was measured in ways that might have had to do.

On the low end of intensity with people who had seen movies or read stories about folks with addictive disorders versus perhaps having had People in their family or friends who had been affected by the disease or had had actual personal experience in treating folks with the disease. Next slide please. So there's this by modal distribution of Folks in our healthcare system, who either acknowledged that they never seen anything that had to do with an a story about somebody with a substance use disorder Versus folks who had seen a great deal of it. And that's, it's just a curious finding that among our staff. We've seen the this distribution and it I don't have an answer to what that means, but it's curious. Next slide please.

The other thing that we saw. And again, you might intuitively expect this is that many of our staff and Many of our staff would not be familiar with, or commonly make use of what or are and we're best practices for the treatment of opioid use disorder. Or to have any idea how to help somebody get to treatment. Next slide please.

This is the staff who responded so a large number of nurses and clinical support staff. Some physicians and a number of advanced practice providers evenly distributed amongst age groups and primarily female as opposed to male. Next slide please. Knowledge was of the disease was Tested with like scales against statements of treatment around or physiology around opioid use disorder. Next slide.

Familiarity, as I said before, had to do with any sort of familiarity, whether that was knowing somebody personally having a personal history with a substance use disorder versus even having seen a TV show. Next slide. stigmatization again had to do with was measured with lacquered scales around statements about stigma and blame. Next slide please.

And then best practices had was measured using a Likert scale. And looking at things that were very clearly best practices at the time and 19 excuse me 2017 Just revealing my age, um, and which still are best practices. Next slide please.

We saw that as knowledge and familiarity and best practice scores increase the likelihood to blame decreased. Next slide please. As familiarity increased it the likelihood to help increased. Next slide. I'm interesting finding was that folks who have our advanced practitioners. So, nurse practitioners, physician assistants were less likely to stigmatize patients with substance use disorders than anybody else.

Women were less likely to blame or stigmatized patients with substance use disorders than men. Even after accounting for everything else. Next slide please. Another significant finding was that the overwhelming majority of people who were quarried with this survey did not know much about substance use disorder at all. And those who were in a position to be able to affect treatment for patients with substance use disorders did not adhere to best practices.

These two last slides suggest that there are some very simple educational work to be done that, though, it certainly wouldn't go all the way to addressing stigma would go some way to helping and probably would be pretty easy to achieve. Next slide please. That's the end of my presentation. And I'm looking forward to hearing from everyone else.

KELLY CLARK

Thank you, Margaret, very interesting information, particularly that last slide or two. I'm sure we'll have some discussion about the implications of that a bit later. Next we'll hear from math Matthew Stefanko from Shatterproof talking about sort of a parallel and a business approach to handling stigma. So, Matthew.

MATTHEW STEFANKO

Great, thank you. We're really excited to be talking about this. This topic today and wanted to thank the National Academy of Medicine for creating the forum and also for our ambassadors for, you know, sharing their stories, which I think will parallel really well with a lot of what we've found And I like the way that Dr. Clark really frame this up. I mean, this is certainly More of a business oriented approach but deeply rooted in a lot of the academic academia that's already out there and a deep recognition that moving forward. There's a lot more academia and knowledge that needs to be added to the space to truly create a change. Next slide.

So just touch on this briefly because I know others will be speaking on it today, but we're already hearing from many of our partners that COVID-19 is exacerbating many of the impacts that they're seeing from the epidemic with folks with the UD being especially vulnerable and knowing what we know about how substance use and depths of despair. Increase do economic trauma and stress and these sorts of drivers that we think it's especially important now more than ever that we're thinking about and dealing with and addressing the stigma around OUD. Next slide.

So when we started looking very broadly at the epidemic. And then the key drivers of it. We tried to boil it down to roughly nine and when we looked at those and in sort of a very broad sense We realized that a majority in fact seven of the nine or were heavily or partially or entirely driven by stigma, whether that be individuals not seeking help. Insufficient treatment capacity with providers either being unwilling or unable to help and things like the over criminalization of those with SUD or OUD. Next slide.

Despite this, though, we're not seeing the same level of national well funded evidence based coordination that we're seeing across many of the other responses to the opioid epidemic when it comes to stigma. There are certainly Amazing partners and you'll hear about some of those today who are doing work in localized environments, but the same sort of evidence base, the national level of attention that we're seeing in other places, whether it be the locks them distribution or treatment access, you're not seeing that same level of attention when it comes to stigma. Next slide.

So because of that, we approached McKinsey and Company and the public good projects so leading health communications nonprofit to Really try to understand what other movements had done successfully and really try to incorporate those both, I think from a evidence based on how you actually reduce stigma, which Dr. Barry Reference, but also what movements did in practice to actually create momentum and we reviewed hundreds of publications interviewed dozens of experts and I'll you know very quickly. Go through some of our key findings and how that generated into our plan but clearly you know there's a lot more here. And so if you're interested in having a conversation, please reach out. Next slide.

So other folks have touched on this today and I know will be a topic, but we really identify and public stigma structural stigma and self stigma as things that we had to be aware of. When thinking about and having a nuanced response to addressing stigma, but really importantly, and this has been brought up in the previous presentations. The opioid crisis is uniquely facing this sort of fourth form of stigma against Medications for opioid use disorder. And these are certainly that stigma. Certainly we throughout public structural and self but it's clear that many in the community Believe that this is something that where you're treating you know quote one addiction for another and that type of Stigma certainly has a significantly detrimental effect, given what we know about the effectiveness of those medications. Next slide.

I want to touch on this really briefly just because this was something that was really evident from a lot of what we've learned from other social change movements which is that if you are looking at a stigma Against SUD within a within a vacuum and you're not understanding how those things layer on top of other forms of racism discrimination bias many more that are that are on this PowerPoint page.

You're not really doing justice to a lot of folks that that need the support and the help and you're just not creating sound policy in response. If you're not kind of considering and thinking about how to weave these in. Next slide. Let's spend a little bit more time here because I think this is really the culmination of a lot of our. A lot of our work and the research and We boiled down dozens of success factors that we had heard from our from our many expert interviews and publications and really tried to combine them into a digestible set of factors that we saw in most if not all movements and like I said previously, this is a combination of You know mechanisms that actually are proven to reduce stigma, but also how you in practice, create a movement so I'm certainly having a well funded central actor or set of coordinated actors and benefit the creation of rapid change with those working together.

Any points two and three really dovetails nicely with what Dr. Barry outlined and certainly a lot of her and her team's research as well incorporated into this It's not just about education. It's not just about language it, you have to get really into the details of how you're doing that education, the messages that you're sending and if you're not taking that kind of very surgical approach to education, you're not going to achieve the types of results that you want more practical basis and you know points four through six, talk to you know really learning about how movements created change so Activating influence institutions first employing positive and negative incentives to create a stakeholder behavior and get people to get engaged. And actually do the stigma intervention and then also that action was mobilized both at the grass tops. Right, so it was senior people very invested in this issue, but also local communities and grassroots efforts. Next slide.

So at a high level We identified multiple stakeholder systems that needed to be addressed. I think one thing we learned is that it taking a one size fits all approach certainly Not going to be effective and that the type of stigma that individuals are feeling from their providers is very different than what they're

feeling from their employers and I think our ambassadors actually really touched on this Nicely explaining sort of the nuances that you know what they're hearing from their providers and what they're feeling from their family members. Next slide.

So within all these stakeholder groups. We think there's a simple standardized set of actions that can be taken many of these deeply rooted in success factors that we had outlined earlier. On whether it be sharing stories language changing policy and shatterproof has been working diligently for the past Six to 12 months and will continue to do so over the coming year to build off the shelf content wraparound tools, things that are easily Able to be implemented and items that we hope to give organizations to implement and to Dr. Barry's point things that we hope to study. Right. I mean, there's a lot more that needs to be evaluated. On top of this, but we believe there's a standardized set of tools that at least be implemented a day that will likely very likely reduce stigma and certainly as first sort of evaluating around. Next slide.

We know very clearly from the evidence that if shatter prefer to do this alone. It wouldn't be nearly as effective as if we got many other institutions involved. So we were getting to work with partners who we know we need dozens of to scale and fund this effort. The 10s of thousands of allies who actually need to implement the action items and do the actions that are sticking reducing and the dozens if not Hundreds of coalition members that we need to partner alongside with actually bring in more partners and lines to achieve a significant level change. Next slide.

But a high level we're hoping to launch in Q1 of 2021 But between now and then we'll be doing a lot of work to really Create that coalition that broad coalition of partners and allies and continue talking about the importance of stigma and how it relates to The opioid epidemic, especially in the time of code with the shame and social isolation that's around day the ultimate goal being that we can achieve some tipping point For mass adoption, similar to what we've seen in other social movements that have made, you know, significant strides like marriage equality or HIV AIDS and. Next slide. Just want to thank everyone again for taking the time in the space, please reach out. We have a multitude of resources and you're certainly able to provide a lot more depth. On the plan and the resources available. So the emails here and happy to send you more detailed sides as well. Thank you.

KELLY CLARK

Thank you again. Matthew for that overview. I know that you can get very granular into the plan that shatterproof has, I would encourage folks to go to the website and take a look at what's really involved. In their plan, and I'm sure we'll have some opportunity to to dive in a little bit more during this particular town hall and before I go to join Rucker, I would just like to encourage people If you're having questions. If you're having comments. If you have things that you'd like to, to hear addressed, please just enter them in in the Q & A section on the webinar and That will come up to us. So at this point, I'd like to hand it over to Joy Rucker from the Texas harm reduction coalition to give us that sort of boots on the ground approach and what Stigma there is. And there's huge stigma in the harm reduction feel put upon the harm reduction field. Thanks.

JOY RUCKER

Thank you. Thank you to both Megan and Marcy for sharing your stories, really appreciate that. Yeah, it's very touching. Um, so it's the Texas harm reduction alliance not coalition. It's okay. We get confused a lot. Next slide please.

So I really wanted to talk to give a definition of stigma, because I think we talked about it and we don't really look at what it actually means and take it in. And it's under undesired differences to be sticking stigmatized is to be is to hold contempt. Shunned and rendered socially invisible because of a society socially disapproved status. And many people have talked about this already, but I think that, you know, we're sometime we talked about stigma and we don't really take it down to the next level on how that really impacts, folks. Next slide.

So other people have talked about this, as you know, one of the challenges of being last is that other people are covering the same information, but I think that from a harm reduction perspective, we talked about from the ended the individual, the family. In the community. So I wanted to talk about the individual and people have already talked about. Some of that on their own personal experience. But what people experiences, sort of like when you go to your family's house and they lock up all their valuables. And they hide their medications and right so within that within your own family you experienced stigma. You know, another example is non drug related stigma is when people talk loud to blind people, you know, are not wanting to touch people who are disabled or ill. Next slide.

And stigma in terms of institutions, you know, it really does come out to how it's translated into public policy, practice and funding decisions. So while I'm grateful that there is quite a bit of money coming out. To address the opioid Crisis, people have been overdosing for years and then hasn't. It's only become a crisis in the last few years when I'm young, white teenagers. Have been identified as overdosing and that all of a sudden, there's a ton of money that is flowing through Our country and I don't say that to say that It's a bad thing. It's just part of What happens with stigma. If you don't look at all the all the factors in that. Next slide.

So stigma also is internalized Where people and people have talked about that already on how you feel about yourself in the shame that you feel when you're struggling with a problem. And, you know, if you go and get help. What the what the attitude is going to be on the other side of the table, and it's very discouraging and you're already struggling with something. You have no idea how to manage. Next slide. Stigma by association. So I want to, you know, what we experienced in the harm reduction field is um People will assume because you work in harm reduction that you are currently using drugs and I was at a meeting one time at a high level meeting and this one director said, I know that there's people in this room that are high and, you know, and I was like, Well, I, you know, like, I'm wondering who that person is because All of the harm reduction representatives, we were all drug free. We were all living in recovery. So the assumption that By Association creates stigma as well. Next slide.

Of course, we've talked about language and how you can change that. I think it's very important words are very powerful and we And we really have to take the time to understand how they can impact people as a person with lived experience. I remember every single encounter that was negative with the medical profession based on their words next, next slide. Racism plays a huge part of stigma. All of these factors come to bear in how people have a perception of people that use drugs. So you cannot just look at that drug user without looking at all the other institutionalize factors that creates stigma and races wanted them. Next slide.

So we can see this in the mandatory minimum sentence, how In the crack epidemic that there will harsher sentences for crack and they were in crack was mostly used by people of color Compared to a Coke snorting users who had much more amounts of cocaine and got less sentences instead of a small gram a

few five grams of crack were sentenced to five years in federal Prison, so that, again, is a stigma. When people look at that and that's what gets perpetuated to us in the news. Next slide.

Economics. People talk about this, it impacts persons available resources for insurance access to services in housing. All of that, if you could, if I go into my doctor and because I have insurance because I have a job because I'm house. I'm going to be treated differently than someone who shows up that doesn't have housing that doesn't have insurance, or who is unemployed. Next slide. Poverty again to the impact if you look at it in terms of like the HIV continuum of care and how African Americans were impacted by that and the end we have less worse outcomes on the continuum of care and lower rates of linkages to care. And that's the same thing within this epidemic around opioid use. There are more people that are marginalized because they don't have the access or resources to the kinds of treatments that are available. Next slide. And then for my final slide, you know, I really think it's what are your personal beliefs about people who use drugs. Do you have biases on the types of drugs method of use up. Sorry. Um, do you believe drug use as a disease or moral failing. So I always you know in my work, I think that we can talk about stigma and we can come up with. recommendations about language and look at systems, but the bottom line comes It comes down to what is your personal belief and how do you, how do you see the people that come in that you're supposed to be treating you And I know from my own lived experience that when i when i was actively using I was treated very differently than when I had a job and insurance and I showed up with I showed up in a much more presentable manner then then when I was actively using. And so for me, it's really, we have to ask people that are treating other people With addiction issues. It's really what how do you see these people that come into your office and what is your belief around them.

So that is my last slide because I feel like that that really is the personal part of what drives us we can make recommendations, but people really have to internalize look at themselves and ask themselves, you know, how do I really feel about the people that I'm serving. Thank you.

KELLY CLARK

Thank you. That was very well put. I appreciate your comments very much and I'd like to stay on them, actually, as we as we start out this discussion, just a piece of information first that this town hall is being recorded and will be available later for people to watch again. And all of the slide decks will also be available. And actually, I want to take a minute and commend the speakers. For getting through very robust slide decks in a very short period of time and just making all that information. However, available to people to go back and digest later when the decks are available. So just that information, the decks and this recording will be available. I'd like to go back to something that Joy just said, just very recently, which is around language and that language is very, very powerful. And you put up a list of some of the common problems we have with language dirty drug screens and others Just during the course of today. I've heard two. There are two terms that just are really important to me that are That I wanted to throw out. And what I would like to do is to ask each of you for your one or two. Terms or constructs that you think are really stigmatizing and really just bother you, and you would like to have addressed. Because until we get our language discussions to understand underlying constructs. We're not going to particularly get anywhere from here. So, so the first thing, Joy, you said that you were living in recovery. And I often hear people say that people have recovered. And as you mentioned, this is a Chronic brain disease and you don't recover from chronic diseases you get into recovery, which means you're living your best life you're managing your, your, you know, your condition. You don't recover from Parkinson's, but you are in recovery and for doctors we infer remission where people have no signs or symptoms. Of disease, but being recovered gives this acute care construct. That's really at our odds and i think is

stigmatizing because of that because it blames people is that they had recovered and now somehow they've managed to get this disease, not to get a disease, but to mess up again. So that language that you use this really important I think about Working or being in the process of recovery. And the second thing term I heard, and I heard it in the right contract text with quotes around. It was the term of graduating from a treatment program. You don't graduate from an inpatient stay because your diabetes was out of control. You don't graduate from a cardiac you don't care. You don't graduate from treating your Parkinson's in a more intensive You know that's it's an episode of care direct doing a location, but that graduation concept against is stigmatizing i think that that It gives some impression that people are all fixed now And you know, when they use again they messed up because they had been fixed. So those two pieces of language. I think are really stigmatizing And aren't often included in lists of stigmatizing language. But I'm wondering for each of you. What pieces of language and constructs. Do you find really stigmatizing in ways people might not have typically thought of, or might typically think of, but they're just really impressive to you.

MARGARET JARVIS

So you've already mentioned one that Just bothers me. I'm not quite sure why it does, but it does and the terminology around drug screens were there. It's clean or dirty. Somehow It's something I keep addressing over and over again. I try really hard to make sure I'm doing it differently. And it's frustrating. Um, That's just a pet peeve.

JOY RUCKER

Sure. Um, I guess mine is how we define recovery, um, You know, people often think recovery is strictly abstinence base. And I think people define their own recovery, um, whether I'm on medication assisted treatment or I'm completely abstinent, I think that we make the assumption that recovering is only about abstinence based and I'd like I'd like to be able to add to that recovery is based on a person's definition of what they are changing in the in. What's the quality of their life. It might not have anything to do with stop using drugs.

COLLEEN BARRY

So I'm going to weigh in here. Maybe if that's okay. Kelly. I want to, I guess, first to make the point, and I alluded to this before, but I want to say it clearly that we have rigorously done research evidence that clearly shows that use of words like addict and substance abuse. Increase stigma relative to a control arm, where more person centered language is used. So these terms have been shown to drive up stigma. So we need to eliminate them from our vocabulary. If we want to change people's attitudes. I think for me, one area that I've been thinking a lot about and talking a lot about is the language around opiate agonists and medications. More generally, and I think words like substitution and replacement therapy are just not helpful in conveying the role of the life saving role of Medications for opiate use disorder. And I think one sort of rule of thumb for me is if we use different language or different approaches related to insurance design, for example. In an addiction context, relative to what we do in other areas of medicine. If there's not a clear reason to do so. Then my intuition is, it's driven by stigma. And so I think that we really need to think about integrating Care for addiction in a in a much more central way and then language and stigma of flow from that. I think the last thing I'll say about how we think about medication is, I know this. The term. medication assisted treatment Matt is very commonly used in the field. My only sort of small quibble with that language is these are life saving medications that are gold standard with a

Large evidence spaces and they're, they're not really assisting anything and to my point a minute. A minute ago. In other areas of medicine. We don't use this medication assisted term to refer to medication. For us to move to the point where we refer to these medications as medications for opiate use disorder as opposed to medication assisted treatment. I know that that's something that might take some time, but that would be an aspiration that I would have

KELLY CLARK

Right. I would add to that, just that ASAM does not use the term, the American Society of Addiction Medicine, the addiction physicians of America does not use the term medication assisted treatment. At this point, for the reasons that you said some people I know when they say MAT they clarify it to mean medication for addiction treatment. The National Academy of Medicine document was asked to put out a document about medication assisted treatment, and as you know that documents. Basically refused to utilize that language and uses medication based treatment and instead, and also the medication for opiate use disorder are all pieces of language that are being used now rather than the stigmatizing construct that somehow you know insulin assists the treatment of diabetes. Medications assist the treatment of addictive disease so well put. Matthew, do you have anything you'd like to add in there.

MATTHEW STEFANKO

Yeah, I mean I think all sort of copy and echo Dr. Barry. I mean, I think we actually had to ask ourselves the same question of what are the one or two that that might be a priority because as we think about transitioning, you know, dozens of words into practical, you know, types of tools that organizations can use we're creating, you know, short videos and really having to center in on a few that we think are especially important. I think the evidence that Dr Barry was referring to around addict and abuse were especially important for us to raise in terms of how much evidence there is around those specific term.

So those are the ones that were really dedicated to getting widespread sort of removal of with the one caveat being, I think, and I'm sure others on this call can speak to this better than I can. That You know, they're still wanting to know about sort of the reclaiming of language and whether or not those who are in recovery. Or active addiction and how they use words different than sort of the general public, or providers and so on so forth. So I mean, then certainly our approach with these words is You know a lot more research to understand which are statement sizing centered in on a few that we know are stigmatizing and really focusing those efforts on The public providers, people who would sort of use stigmatizing words against others but not necessarily within the communities themselves.

KELLY CLARK

Right. Thank you. Yeah. With people with substance use disorder or with substance use disorder in general, having not been taught about this disease state and that lack of familiarity is so strongly associated with You know, A wide variety of doing things that we don't want them to do and not doing things that we do want them to do. And then the issues about even when they know what to do. They don't adhere to some of these best practices and some of the questions that have come up.

Our people with lived experience also from Shatterproof, who spoke earlier spoke about that construct and I'll just call it the construct of that coming out of the closet of being sort of the face of people with addictive disease so that people who've got a who are healthcare providers, put a normal face, you know, this is your, this is your preacher. This is your high school, you know, football coach. This is your etc. You

know, we, that's a lot to ask for, for, for people who have a stigmatizing disease. But, but what can we do to help address these, these two issues that you brought up, and I'd like everybody's kind of concept on this, which is how do we drive some of this change around making addictive disease taught and known by healthcare providers and then people with addictive disease to be known to their providers as well as the. How do we hold people responsible for delivering this evidence based and best practice care?

MARGARET JARVIS

Boy. There's a lot we can cover. There were at least a lot that I've seen over the last years But I think one of the things that I would like to have people respond to is a phenomenon that we have seen, and this is while I'm talking about the Geisinger system. I can't imagine it's just Geisinger at all. Um. In fact, I know it isn't. But As the folks who work in our division in the Addiction Medicine division at Geisinger take care of patients who have substance use disorders. It's not an uncommon thing at all to find situations where these patients are being prescribed medications that simply are not good for them that carry a great deal of Addiction potential themselves.

So for instance, the folks we see, like you're prescribing people an opioid who are also receiving Benzodiazepines or stimulants from other physicians. We see that commonly and as we try to address that our clinic practice has been that we make phone calls, we write letters we try to get in touch with the physicians who are prescribing these other medications to say let's collaborate on the treatment of this person and try to make sure that we both know what the other person's doing so that the patient never receives a toxic combination of medications and while that has been a somewhat successful technique within the Geisinger system where we have great control over the communications and we have some ability to influence those who are in authority as we do this with physicians who are outside of our system, we never get phone calls back. We don't get responses to letters and the patients often are in a position where they are continuing to get medications that could be dangerous for them.

And so, to your point, Kelly. There's a piece of meeting to develop some, um, Some standards and some body of authoritative body that's willing to take a stance and say this is not good practice and something needs to change here. And like I said within our system, the system does that. But beyond that, there's not a boatload of oversight and perhaps there's, there might be a way someday of being able to do that. And I think that could make a big difference.

MATTHEW STEFANKO

Yeah, I mean, I think there's, there's a few things that that we're doing at Shatterproof are seeing. And I'm actually excited to hear from Richard Bottner, who I know is going to be speaking on the next panel who to speaking a little bit to the Education piece, but actually getting in front of providers in or in a big way. From a continuing education standpoint around the stigma and the language to use and all these sorts of things. But I think it's important to also work, you know, more upstream and I know that you know sort of outside of the stigma initiative Shatterproof and many others are pushing and advocating for more education on these topics earlier on in the context of medical schools and elsewhere. To really get that training those stories, all those sorts of things happening earlier so that people are coming into Practice with that sort of knowledge and then I think you know the final piece here, which I think you touched on is this Concept of stories.

And I know that and narrative and Dr. Barry has done a lot of research on this all week. Most of it to her, but Certainly from an implementation standpoint on it, collecting stories, a diverse range that represent a

lot of different people. Who, like you said, it's your preacher to your brother. It's your, you know, teacher and being able to bring all of that to light in that sort of In those stories and making sure that those stories are really customized and speak to the people that they're being delivered to is really important. So That's a big component of what we're working on building a large library of stories of those in recovery and using all the great kind of evidence base. Around what kind of prompts and messages. Those people need to communicate in their stories to actually have a stigma reduction effect with providers and others.

COLLEEN BARRY

So just to chime in. Thank you so much. Matthew for those points I agree with them. I think education is critical, but we can't just focus on folks that are in their training because there are so many providers out there that we know don't have the information, information they need.

We just did a recent published study with the Annals of Internal Medicine and it showed very low knowledge among primary care providers that effective treatments exist. Very low interest in treating people with opiate use disorder and very low interest in becoming waived to prescribe buprenorphine. And so I think that it's essential that we change their attitudes in one area.

To Matthews point that I think really shows promise from the literature is conveying that treatment works in a meaningful way. I think part of the resistance we see on the part of medical providers, you know, you think of your typical emergency department position. Who sees people coming in, again and again, who are experiencing an overdose that can lead to hopelessness and providers want to have hope. And I think that we have effective treatments and we just need to in a way that is meaningful convey those stories that are all Out there on how people have gotten into effective treatment have done well and are living productive lives. I think those kinds of stories and experiences can be transformative in getting our medical community more excited about being part of The treatment system and being part of the solution to the opiate crisis that this country is facing.

KELLY CLARK

The key word you said there Colleen is effective treatment. And the truth is, when we say that we mean evidence based treatment works. And the truth is that most of the treatment in this country. Does not utilize evidence based techniques.

I see Joy making a big nod with her head, and so it's not that quote any old thing that I call treatment works. It's that specific things that are evidence based work and the burnout that we see among providers is they keep sending people into the same things that we know are either not helpful or harmful. OUD going into a you know in into some place to be for a few weeks and come out without medications increases the risk that those people will be dead within a month, then, had they not do. You know, gone into that kind of facility.

COLLEEN BARRY

And I couldn't agree with you more. I think this is an essential point systems need to change. And that can be part of the pathway to reducing stigma one. One thing that has come out of our research that's quite interesting Is when you when you look at attitudes related to mental health, we see that among friends and family members of people with a mental health disorder that there is much lower stigma relative to the general population. But interestingly, we don't see that. Among Friends and family members of

individuals with substance use disorder. And I think part of that. That what was very surprising finding to me is that loved ones of people struggling with addiction see them moving in and out of really ineffective treatment and they lose hope to. And so I think that All of these pieces come together and give us a roadmap for how to really tackle both systems of care and stigma at the same time.

JOY RUCKER

I think that we have this definition of what recovery is and what treatment should look like and so When medical providers don't see that immediate outcome where it's like, Okay, you're now not using drugs, it, it looks like a failure to them. I think that even defining you know recovery, um, in how the words that we use, like being a productive member of society, like, what, what does that look like to the individual, not to the provider.

It's like, what does that look like for me, and I, I just think that we, we are so locked into a traditional way of thinking. That it just makes it hard for people to break out of that that paradigm, you know, to think differently. It's like, what is What does treatment look like for me and you know in harm reduction we use the phrase any change any positive change any small change is positive. So if today I'm eating out of a dumpster and tomorrow I'm in the food line getting food from a shelter. That's a positive change. And we don't we people have different values and how they judge what that change looks like.

COLLEEN BARRY

But I do think it is important for providers to reframe what success looks like to them, too, because if we only focus on changing our notions on the part of individuals, then I think stigmatizing views in the health profession, like we've heard about at the beginning of the session will continue. We need to redesign redefine success. In all of the communities and settings in which individuals are living and moving through a process of recovery.

KELLY CLARK

Sorry, we got two minutes left here, it just having looked through the questions, just a few more things to let folks participating in this know.

There were some questions about COVID-19 and access to addiction treatment. As Victor said earlier National Academy of Medicine and the American Society of Addiction Medicine are doing some webinars on addiction during COVID-19 and they're, they're actually is one on this topic. Tomorrow I believe Dr. Jarvis will be part of that discussion as well. So I'd encourage people with the COVID-19 questions to check that out as well as the recordings of prior ones.

You know there's been a number of discussions questions coming in about making that paradigm change among the traditional 12 step peer support groups in that construct. I just wanted to call out where a lot of the questions have been around here.

Some questions around payment structures so that we can more fully integrate addiction medicine as a specialty and caring for this this disease state into the medical system. And so those things have been through two.

If I can get let you each have 10 seconds for the one thing you would like people to take away from this love to let you have those 10 seconds now.

MARGARET JARVIS

Alright, so the issue with the insurance payments, we've been talking about value based payments for forever. And it's taking an extraordinarily long time to see that be realized it would make life so much easier for everybody concerned. If we actually saw that adopted, but it is slow and there's a lot of talk and limited amount of action.

COLLEEN BARRY

Yeah, I think in the context of COVID-19 all of these issues become so much more difficult. Because folks are more vulnerable. They're not getting access to the services they need both treatment services, but also harm reduction services. So we need to keep the drug crisis foremost in our mind as we think about how it interacts with the pandemic.

JOY RUCKER

What we are experiencing here in in Austin is there is a lot of focus on people that are un-housed in this epidemic and without the understanding that there's a subculture of homeless people that use drugs and there's not been any kind of system to address that. You cannot just isolate people and a shelter and then expect them not to go out and use. So I think that, you know, there's always this subculture that we don't think about, and nor do we create options for all right.

MATTHEW STEFANKO

I think it's that this is this is doable, that there is a growing evidence base and that every organization has a big role to play and addressing stigma and that there are actions that everyone can take and hopefully that, you know, depending on the organization. You can figure out what those are. But recognize that it's even more important now to do that than before.

SESSION TWO: HEALTH PROFESSIONAL EDUCATION AND TRAINING: PERSISTING GAPS AND PROMISING PRACTICES

ELIZABETH FINKELMAN

Good morning and welcome back to the Action Collaborative's Virtual Symposium. Our next session will focus on health professional education and training, persisting gaps and promising practices. To overcome the current addiction crisis and mitigate future such crises, it is essential that the healthcare workforce have the knowledge, skills and training required to care for individuals with substance use disorders or pain as well as to prevent and recognize the symptoms of these conditions.

I'm delighted to introduce a panel of experts and educators who will discuss strategies to close gaps and health professional education and training to improve care for people with substance use disorders and pain. The session will be moderated by Dr. Steve Singer who is vice president of education and outreach at the Accreditation Council for Continuing Medical Education. And joining Steve are Mr. Richard Bottner, who is a physician assistant and an affiliate faculty member and the Department of Internal Medicine at the Dell Medical School at the University of Texas at Austin. Dr. Daniel Alford who is the director of the

clinical addiction research and education unit at Boston University School of Medicine. Dr. Charlene Dewey, who is a professor of medicine and a professor of medical education and administration at Vanderbilt University Medical Center. And Dr. Deborah Finnell, who is professor emeritus at the Johns Hopkins University School of Nursing. Their full biographies are available on the event website for you to access and please note that we will be taking questions from the webinar audience during the last 10 minutes of the session. Please use the Q & A box on your screen to enter a question. And now I will turn things over to Dr. Singer.

STEVE SINGER

Terrific. Well, it's a pleasure to welcome all of you. I really want to express my appreciation and gratitude for being part of this effort. This is going to be a conversation of colleagues and peers who are educators focused on addressing these critical issues. Many of which have been so really beautifully elaborated this morning.

I'm just going to give a brief introduction, which is really kind of a summary of how the Action Collaborative's Education and Training work group has been approaching these issues over, over the past year and a half in the way that doctors our describe this morning.

So our workgroup is one of several the co-chairs described this morning and the mission of our workgroup is here. And it is that we're together working toward a coordinated interprofessional patient and family centered approach for the continuum of health professional education that addresses these issues.

What I want to highlight is I've pulled out some of these key terms from that mission and part of where we are currently in the work of the work group. Is we are moving towards sharing an action plan that really has been a collaborative effort to determine from the number of stakeholders that are part of the action collaborative and Several of our speakers in this panel are part of that are part of this workgroup to address these challenges in an educational manner. That is comprised of connecting with practitioners to get their investment and sort of ownership from them about the educational challenges that we need to address.

To collaborate across the educational community both interprofessionally and across the continuum of health professional education to really raise up the educational impact of all of our efforts collectively also to understand that the effectiveness of education, whether it's at the undergraduate training level residency or very importantly for practitioners or clinicians in practice or for Inner professional teams. Is something that we have tools and we have methods to conduct education that meaningfully changes practice.

However, there's a methodology and evidence space for that that might not be equally distributed across our efforts. So I'm excited about the conversation that we're going to have about how we can make sure that education equals learning and that it's that it's productive effort and not duplicative or unproductive effort.

The last thing is that we understand. And I think the discussion this morning about stigma. I really highlighted that There are a number of different educational gaps and practice gaps and that the strategies that we take to address those gaps have to be complex, and as differentiated As the challenges

themselves. So something that I hope that our panelists will address is how do we ensure that it's not sort of one solution to fit all. But that we can have a very articulated and complex approach to really address educational challenges where they occur.

The sum total of all this. And I think what I will try to help as a facilitator this morning is to say, how can we best support educators. I think that the collaborative recognizes that that there is a lot of educational expertise and a lot of educational activity that's already occurring. And that's going to be abundantly clear. From what each of our educational experts are going to share. The question is how can we work together collaboratively to support each other and what can the Action collaborative do really to raise all boats in the educational approach.

So with that, I'd like to first introduce Richard Bottner who is Physician Assistant, and it's going to lead us off with a brief presentation about the educational work that he's been doing at University of Texas.

RICH BOTTNER

Thank you so much. Good morning everybody and thanks for having me here today, and I'll be speaking specifically about the role of opioid use disorder treatment and reducing stigma of patients with substance and opioid use disorders. Next slide please.

Early on at Dell Med we were doing a number of somewhat disconnected things around addiction, not only within our medical school, but really throughout the whole University of Texas at Austin. One of our main introductions to treatment outside of the classroom setting and education about that treatment. Actually started as a quality improvement project at our academic medical center. It was a partnership between our departments of internal medicine, psychiatry and Population Health and with the support of our GME programs, our residents, we launched what we call the buprenorphine team. This is a picture of the team on the screen. And it's a volunteer inner professional multi disciplinary group that works to identify patients who have an OUD at the time of hospitalization starts buprenorphine as a routine part of hospitalization for patients who are interested and then provides a referral and sort of a hot hand or not even a warm handoff but a boiling hot hand off.

To a community based treatment program at discharge, the only program of its kind in Texas. It's one of the very few in the country. And there's actually a handout today that you can access toward more about that program. Next slide please. The reason I share that is because as we've worked on that program for the last couple of years in what was supposed to be sort of this narrow Quality Improvement Project. It really turned into something so much greater so much better and more meaningful, not just for us as practitioners and for our patients. But actually, for our trainees.

So, in hindsight. What we've actually done is create this ripple effect where we can have these discussions and teach about treatment and stigma and recovery. Not only within our GME program, but across the whole school, including our USP program. And of course this has tremendous ripples as our trainees graduate and go elsewhere throughout our county or state and in our country. Next slide please.

So what we really started to do is shift the culture to create interest in a topic in a diagnosis in a patient population. Within an environment where that interest may not historically, be strong or maybe present at all. And of course I'm referring to, you know, training environments across all of the different health professions. Early on in our CME curriculum. Our MS one students, first year med students participate In a

inner professional experience that crosses numerous different disciplines throughout the entire university. It's a year long program it meets monthly covers various topics.

One of those topics is addiction and substance use disorder and that program by its very nature is inner professional the content for it is curated by a pharmacist from our College of Pharmacy. And it's taught by a multi disciplinary group of stakeholders from the college's of medicine and nursing and social work pharmacy. And so the inner professional and multi disciplinary approach to systems of care for patients with addiction is critical. And therefore we must teach this topic in a similar environment in an inner professional and multi disciplinary environment.

Now this course has been happening for the last four years long before we started our hospital based treatment program. But again, I share this because the inner professional aspect to all of this is woven throughout our entire university and certainly throughout our medical schools curriculum.

In addition to inner professionalism. What I really want to focus on. And these two minutes is stigma. We've heard a lot today about the importance of stigma. I am trained in hospital medicine. I do not have formal Addiction Medicine training. And when I think about the work that we've done over the last several years and reflect on My experiences and my training beforehand, as well as our kind of initial barriers to doing your treatment work in the hospital. I can't help but think about how so many of the issues around care delivery for addiction and therefore teaching about it is, is really rooted in this sort of deep and pervasive stigma. We haven't taught a lot about addiction within the health professions training programs in large part because of that stigma. We haven't Advanced policy in a, you know, at the national or state level in a truly meaningful way really because of that stigma and of course patients with substance use disorders. Are held back from employment and housing and of course health care because of that stigma and so while we've started this treatment program.

I might argue that what we've done more of is start to normalize opioid use disorder as the chronic medical disease that it is by creating and pushing conversations about this that maybe weren't happening before so the remaining initiatives that I'll briefly discuss are really focused on that piece on that stigma reduction with really the goal of eliminating stigma of just completely destroying it.

We've had a number of initiatives over the last few years that seek to do this. So, with the support of our CME program. We engaged with medical students to put together focus groups where handfuls of medical students facilitated discussions with people in long term recovery about stigma and how that stigma affected them. With the support of our GMB program. We created a flip simulation where we use standardized patients to play the role of the physician and the residents to assume the role of the patient experiencing a unique after the experience. The, the majority of participants said that that it would really change their practice and how they would practice in the future.

We've offered X waiver trainings as a medical school to our community here in Austin. We've had dozens of residents participate in those waiver trainings, including the majority of our family medicine residence.

But the item that I'm probably most excited about to share with you today is our participation in the AAMC opioid education challenge. So we received a grant to put together online modules that are specific to reducing stigma of patients with opioid use disorder. These are not sort of traditional voiceover PowerPoint. They are interactive. They include original video content of people in recovery. They incorporate interactive learning activities. And of course they are designed for all health professions trainees and practicing professional so they include CTE for, you know, physicians and nurses and social

workers and pharmacists. And of course, we built in robust assessment to make sure that we're meeting our goal of reducing stigma and when this launches next month. It will be available free of charge, of course, because it's supported by the grant and. Next slide please.

This is just a brief outline of the modules. And this is a brief outline of some of the topics that are covered in these modules and I won't read them out loud in the, in the interest of time. And this is just a brief screenshot of what the modules will look like. It's kind of just a teaser. It's sort of hard to envision what it would be like to do an interactive module with the 2D picture but just to just to tease you about it and. Next slide please.

So again we anticipate these modules being available to all in the medical community sometime next month will be partnering with several organizations to make sure these are widely available, and that includes shatterproof who you heard from Earlier today, the address on the screen is where the modules will live right now look forward to our medical school homepage, but later it will go directly to the module.

So please don't hesitate to reach out to me after today. About this or anything else that we discuss and I'll close by saying that it's truly important and impactful to not only train, but to empower future health care professionals from all of our different disciplines to appreciate addiction as a medical diagnosis and to understand that there are many things that we can do effectively to help patients with that illness and that we do the best work to achieve that goal when we do that work together. Thanks.

STEVE SINGER

Thank you, Rich, thanks for sharing your presentation. And just as a reminder for folks listening or watching on line. You can chat in your questions using the Q & A box. I saw that there was just a question that came in and it will bring those questions back around when we open up for Q & A with panel. Now I'd like to ask Dr. Dan Alford to talk about his experience in Boston with safe opioid prescribing education.

DANIEL ALFORD

Good morning, and thanks for having me. Let's have the next slide please. So the agenda. I'm going to talk about an area that we've started in which was creating an objective structured clinical exam or asked you for residents and then faculty and talk a little bit about the challenges of doing that and talk about how we took it to a larger scale through a national CNA training program. Talk a little bit about how do you measure success with such a large program and some of the challenges to measuring success. And then talk about lessons learned in next steps.

Okay, next. So the ASCII came about because I realized pretty quick quickly that when I would present a case that was challenging to me and clinic and primary care clinic through PowerPoint. People would be pretty quick to respond, saying, Okay, this is what you should do they realized that it wasn't that easy for me and that so much of what we do the challenges around say for opioid prescribing for chronic pain. Has to do with communication, how we talk to patients.

So luckily we got a grant through that centers of excellence united to develop this honesty and so He asked me included, you know, how do you assess and manage hope you would miss huge risk realizing that not everybody has the same risk. How do you measure outcomes right benefits and harms and talk to patients about it. And then how do you assess and manage worries and behaviors, people who run it

early, or take an extra dose next So the, so we targeted residents. That was the initial plan. And we found significant improvements and knowledge confidence and self reported practice after going through this that obviously included stabilize patients.

In fact, the observers next But it also became apparent that training residents alone will have less impact of their faculty who are their mentors who precept them in clinic don't support those learn safer opioid prescribing practices through reinforcement and modeling and You know, as opposed to managing diabetes, where there is a real strong evidence basis and there's not a lot of variability in practice among faculty and presenters. As you know, with safer will be prescribing in the treatment of chronic pain. There's not a lot of evidence supporting it. And there's tremendous amount of variability.

So We were hearing from the residents that they were not being supported and what we taught them to do next. So we developed an ASCII for faculty So that we could teach them how to teach their residence. So we did find significant improvements and knowledge confidence and say from opioid prescribing practices hand in Resident teaching. So that was our ultimate goal next So asked keys are wonderful. Right. I mean, they, they are all about skills based Acquisition people get immediate feedback they go from station to station. They get to practice. It's tremendous but it's resource intensive right It's logistically complex it's expensive. You need trained observers faculty observers. He trained standardized patients. If you've got, you know, four stations and a standardized patient doesn't show up, you're in big trouble. So you need to have extra standardized patients. So it's very resource intensive next And really, you can only train a small number of people at a time. I mean, we would train eight residents and a half day which is not very efficient, but it's you know the results speak for themselves but it's labor intensive. Okay, next.

So we wanted to, you know, we got the opportunity to move this education safer overprescribing education to a national scale through the FDA opioid risk evaluation and mitigation strategy. And what we developed based on an FDA particular blueprint that you need to adhere to was something called safer competent opioid prescribing education or scope of paying which we started in and essentially, it's a two hour case based online, but we also do in person trainings at various states, we've done I think 30 states. Where we have state resource panels included.

So there's so people get to know what's available to them within their state. We've done webinars live. And then we've made them in during we even created a monograph for people who don't want to do it online. And most recently, I'm really excited. We created podcasts actually 620 minute podcasts that go through the entire curriculum in a conversational way. That I think is very engaging know around that or resources that are around this to our curriculum is we did up the trainer's toolkit, because we wanted others to be able to get their learners to use the material that they learned. So we asked you know them to have their learners to scope the pain. And then use this tool kit which had case studies role plays videos communication videos that talk about demonstrate someone having a conversation with a patient that they're inheriting who's on hiatus opioids, or a patient who has an unexpected urine drug test results. So some of the more complicated conversations

We have these communication videos. We also creating some micro cases, these are too many cases, again, of very common complicated scenarios that people have like someone took extra pills and ran out early. How do you have that conversation. We also developed with some other funding mechanisms supplemental programs like You know, how do you taper opioids and a patient centered way. How do you set up your practice to do this program presented as a program for surgeons a program for emergency medicine, folks. And then we did a train the trainers program. So we taught a cohort of people around the country to be able to do the in person training of the online program. And what we found was

that That folks actually did equally well to the experts in train a much more rural population of providers next Okay, so since 2013 we've trained actually over 181,000 individuals from every state.

And we did do a two month post evaluation early on and we saw that there was an increase in knowledge and two months, increasing confidence and self reported practice change and improvements and attitudes towards patients with chronic pain, who are on opioids next So how do you measure success for a national program.

I'll tell you the things that are easy to measure like how many get trained and that was the main milestone for the program. There was 320,000 prescribers that prescribe long acting opioids and so they have a certain percent that they want to train, so number trained or things we did to improve knowledge proved attitudes confidence improves self reported practice change - these things are easy to measure and they are measured.

But what we really want to measure for a national safer opioid prescribing program is improvements in clinical performance. Improvements in public health outcomes like decreases in prescription opioid related harm. Decreases in prescription opioid related use disorder overdoses deaths mercy department visits diversion. So these are all public health outcomes that we would like to see this training impact. And then finally, I think probably most importantly, we'd like to see improvements in patient outcomes are we seeing patients who are treated by these learners have decreased pain improved function and quality of life.

But the challenges are next. One. A CME perspective, it's really hard to get data from participants, right, people don't do continuing medical education expecting to do pre and post surveys And so the response rates are generally very low. We want to limit the burden to participants. So we saw that when we do they pretty aggressive pre survey before there was a big drop off people just dropped off and didn't take the program. So once we got rid of that that was no longer the problem. limited access to participants at follow up and the data is self reported right people are saying, yeah, I made this practice change or what does that mean next It's also really difficult to attribute the changes that we're seeing to education. Because other things are going on simultaneously. There's naloxone co prescribing and distribution is expanded use disorder treatment.

You know the prescription drug monitoring programs, law enforcement closing pill mills, national state guidelines, ensures putting in prior authorization so Are the changes and overdoses are the changes and people becoming addicted related to prescription opioids, the education or is it one of these other things that are happening simultaneously. So we're not working in a vacuum.

So, to me, the lessons learned from these two major educational endeavors. Is that we definitely need to include foundational knowledge because there's been a lack of that historically in medical school and nursing school social work, school of pharmacy school, you name it. But we really need to focus also on communication skills acquisition, how do you talk to patients in a way that you're not treating them as a suspect or criminal You're treating them as a patient who has a chronic problem and you're trying to manage them with a medication that carries a lot of risk. And so how do you have those conversations next It also can't be about prescriber education and there's been so much focus on let's train prescribers how many prescribers have you train, but with anything complicated and time consuming and primary care that we do. We don't do it alone right we involved in entire healthcare team.

When I have a patient with diabetes who I'm starting on insulin. I know that my nurses and pharmacists can help me. Well with safer opioid prescribing for chronic pain. The nurses, pharmacists and everyone else has been inadequately trained has the physician, so we can't expect that they are knowledgeable to help us manage these patients. So everyone needs to be trained and everyone needs to be trained. Now, it can't be this stepwise process because as I mentioned with residents. The residents. In fact, we need to be trained simultaneously and the entire healthcare team needs to be trained because if you're a training prescribers first And they get no help. It's going to be really hard to implement some of the strategies that we talked about, including Universal Precautions using agreements using urine drug testing pill counts right bounty program and so forth.

We need to determine it. So, you know, it'd be easy to just say, Okay, what's, what's the harm in doing education, but really It's a time commitment for people. Right. And because opioid education is becoming more and more of a mandate at the state level has a quote unquote solution to the opioid crisis. It's an easy thing to mandate right say Listen education has been inadequate. So let's require everybody all you know practicing clinicians to do open education. But the question is, does it work when you mandate it and we've Gotten some prelim we took a preliminary look of people who went through the training in a state that didn't have a mandate versus those that had a mandate and I'll tell you that the people who went with a mandate were less satisfied with the exact same training and we're less saying they would, they were less endorsing I'm going to make a change.

So we're seeing differences and people who feel that they had to take it versus people who are voluntarily taking it next. And so, maybe, maybe, actually, it isn't about educating everyone right. Maybe it's actually ensuring that everyone is competent right so we Some people probably are quite good and they shouldn't be forced to do the education. But I think if you're going to have a DEA license and you're going to prescribe opioids for chronic pain. Then you should be able to show or demonstrate some level of competency. And the question is, hey, you know, how do you do that on a national level and certainly there are, we can talk more about it, but there are adaptive learning Platforms where people, you know, kind of take a test and don't have to do the education if they Answer questions successfully and certainly I work with the New England Journal of Medicine knowledge. Plus Program on developing an adaptive learning platform that's out there. So there are ways to do this next. And that's it for me. Thank you.

STEVE SINGER

Thanks, Dan. Terrific. Now I want to introduce Charlene Dewey, who's going to talk about her experience.

CHARLENE DEWEY

Well, thank you, Steve, thank you to my panel speakers. Thank you to the National Academy of Medicine for allowing us to have this platform. And I always say thank you to the team that supports everything. So Liz, Aisha, and Jarrett. Thank you guys for all of your help.

I'm going to start with a simple reflection. This is a patient. Her name is Miss Sally and she's 53 years old and a female. She has used opioids and various formulations over the past nine years. After motor vehicle accident and she now has chronic low back pain and fibromyalgia. She drinks on average one to two glasses of wine over most days of the week in order to help with her sleep and reduce anxiety for which she's also on one milligram of Xanax. So she presents as a new patient in your clinic, the health care provider be at the advanced nurse practitioner, the physician, the PA Will take a quick history complete a physical exam and may quickly refill muscle is medications as requested, we would consider this a miss

prescribing event and there would be at least 10 different reasons that we would understand about how physicians prescribed so on..

From that typical case what we have found is that we have this unique situation in which In my role as an assistant dean and director for the Center for Professional Health where for the last 30 years we've trained physicians PhDs advanced nurse practitioners, dentists, etc. In the professionalism topic of proper prescribing What we found is that there were many lessons to be learned. And again, it's from this unique look in that we're looking backwards.

So we're looking from what the outcome was whether Miss Sally ultimately died of an overdose, or whether she got sick or went to the emergency room. Or maybe she didn't have a significant complication. But she wasn't really addressed as far as whether she has a potential opioid use disorder or multiple drug use disorder. And so we see things from the back end. And so we're trying to fill the gap of looking at what physicians do that, get them in trouble and that what could get their patients in trouble.

So those lessons that we learned help us have a better understanding of what is actually lacking in some of our educational efforts, we've identified gaps, such as federal rules. And regulations that are not always clearly found not always taught to providers. We have found that they have very little understanding about what mis-prescribing is and how easily even a good intended provider can fall into a miss prescribe We've also found that their understanding of substance use disorders and opioid use disorders are not Very strong they have significant stigma and bias, as was pointed out by previous speakers.

They aren't very well trained in SBIRT or how to use appropriate screening tools to make it a more efficient process in their clinic. And they have personal challenges which Dan kind of just talked to a little bit around Not having been trained on some of the effective communication strategies. The conflict management, the emotional intelligence to be able to handle a patient who might be stressed or distressed or disruptive during the clinic visit They might have their own personal biases and their own personal stigmas related to substance use disorders that might also be a challenge for them prescribing in a safe way. And then there's office space challenges in this day and age of the quick get people in get people out as the example of that typical case I gave with Miss Sally. Not enough was done to adequately assess that patient and to do what was best for her as an individual for her as a family member for her as part of community.

So all of these things were identified as gaps. And so what we've done is we've looked at different educational interventions that can be helpful. We've published on some of these. We've also use simulation training and ASCII type Instructional strategies to help train physicians to interact with patients in a better way. We've also put together programs and teaching activities that we do in an outside of Vanderbilt, we developed competencies and are developing EPA is now and it's all around the Again, this aspect of the backwards.

Look, what is the outcome we want. And what's the competency. We need to develop We've developed different tools, kind of like Dan said, like a teacher's tool kits, so to say we have this teaching proper prescribing control. Prescription drugs for clinical teachers based on 16 different tips that we've gathered Through what we see that physicians and other providers need to improve their prescribing practices. We've developed web based modules that go along with this and we have live training, of course. And then we have these other clinical and practical tools that help individuals in the clinic setting. Next slide.

So one thing that we know is that we have these assumptions and the assumption is that teaching equals learning. But we also know that that's not always true that learning might not be sustained learning doesn't necessarily always result in a skill or a change in attitude. So we have to look at the domains of which we teach connects click. So if we look at education and education in different venues different formats different levels. That increase learning so that we look at whether learning is actually occurring and what is being learned.

Because we've all heard of the hidden curriculum and those kind of things that will perpetuate things like stigma. We want to make sure that the learning is the proper learning and that that learning translates into behaviors and those behaviors translate into clinical performance and that clinical performance results in outcomes that are positively impacting our patients and our healthcare society. So as a curriculum designer, we look from the outcomes first looking backwards.

And so we have to think about for all of opioid education not only what we teach, but how we teach it, what tools and strategies are we using that increase that learning that can translate into behaviors. When do we teach it what's most important at different cycles. What's most important for us medical student or a nursing student compared to a resident compared to a practicing physician. And when in that sequence does information need to be reapplied so that it builds upon what they've learned previously. And then, to what degree which helps us understand as Dan was getting to the point of competence and whether we train people to leave our training process with some minimum level of competence that can result in performance. And again, that is being measured by the outcomes that they have on patient care. Next slide.

So we can look across the continuum and see that in GME, CME, or community based education, which means students residents, practicing clinicians and in the community that there are different levels of what should be taught. There's also different methods that might be better at doing that. And there might also be different specialties that need slightly different educational focus compared to other so primary care and how they differ from the, the general surgeon or someone who's doing procedures that will prescribe an opioid that's different than, say, for example, an anesthesiologist.

And just emphasizing this example of GME and that proper prescribing practices really start at the GME level. And so we need to think about what's pertinent to that prescriber at that time and what general formats of teaching are going to enhance not just knowledge but also attitudes, behaviors that can then translate into performance and then we need to measure those things.

And on this one, looking at the big idea of curriculum designing there are elements that are consistent. One of them is, if you click, you'll see that faculty development comes up in every one of these areas because Faculty can for very good efforts, especially around stigma and treatment for substance use disorders. The terminology that was brought up earlier in in in the first session or two.

If faculty are using patient sensitive language, then how will our residents and our students learn to use patient sensitive language and then also thinking about in the public interest. And how we do that. I think academic health science centers play a role in educating our patients and educating our public around these issues and that's where these partnerships becomes so important. If you click once. We'll just highlight that in CME. For example, this is Dan was alluding to this. The importance of not only just their individual level. So these are people who are now out in practice. We can give them knowledge through webinars we can teach them content, but until we know what they're doing in their office practices. We don't know that they're actually improving anything that translates to a patient outcome. So we want to

see what they do in their office level and help teach to that. And again, giving them learning tools and job aids are really critical. As far as an instructional strategy I came on through the training at Harvard Macy for leaders in education and one of the quotes I came out with was Make the right thing to do, be the easiest thing to do. And so, almost every tool or thing I develop is about making sure that the provider can implement it easy and effortlessly in their clinics. Next slide.

So in summary, I think that there are still gaps and challenges that we have to face. And we have to realize that our experience is going to be a little bit different because again we're looking at it from the backward. End of people who've already gotten into trouble. But I think the benefit of that is that it helps us really hone in to what is the minimum skills that our learners need In order to prescribe safely. So if we click once Will see that I believe that education can be informed by our learned experiences. So from everyone across all the different levels using reflective practices using experiences that help influence attitudes is really an important piece. Next.

And that education should be designed to promote learning positively influence attitudes, but also to enhance skills that result in these improved performances. That are directed toward the desired outcome. And that's always going to be patient safety patient treatment outcomes, things like that. Next one. And then lastly curriculum designing for opioid education really is going to require many individuals, you have to think about That across the continuum having that team and I think rich talked about this, of having those individuals that are going to be the catalyst. The go getters that get it done across all the different training levels. And so I will also say that we have one of the AAMC grants and we're now taking our blended learning program of using the 16 to teaching tips to train faculty at 10 other institutions and then those 10 faculty become The opioid prescribing champs for their institution. Where their residents and their faculty can train in our learning based platform where they get the seven modules for proper prescribing, but they also get teaching tips, they get the teaching tip guide. So that again this can be disseminated across different institutions and different departments. Thank you.

STEVE SINGER

Thank you, Charlene. Now we're going to turn to Deborah Finnell who is going to share with us a nursing education perspective on these gaps.

DEBORAH FINNELL

I want to echo my thanks for being part of this panel and I'm my presentation, I'm going to start with talking about what we've done in terms of higher education. Some continuing education and then promising practices and persisting gaps.

So on the next slide, you can see that one of the initiatives has been funded through some SAMHSA and through her grant funding. We've received both of these at Johns Hopkins, but a number of schools across the United States have also received these grants to infuse Substance use content into their nursing curriculum, both the pre licensure and advanced practice curricula and so far. In total about 75 schools that have been have received this expert funding and those include nursing social work and others SAMHSA first initiated the these grants in 2013 for expanding beyond medical schools. In the next slide, you see the on some initiative specific to opioid related content and in the face of the epidemic.

The American Association of Colleges of nursing worked with the White House to initiate an opioid initiative pledge and we had 200 member schools that signed on to this pledge and recently there was a

survey last year of trying to determine what schools have done with that pledge, in terms of educating around CDC guidelines and also what they've done in terms of integrating content into their curriculum.

And in 2019 SAMHSA provided funding for schools of medicine physician assistants in Nursing with a focus there and nurse practitioners, for the purpose of enhancing or introducing content related to the safe prescribing of opioid and also to advance the number of Providers who are able to prescribe buprenorphine. What we did at Hopkins was focused on content related to safe prescribing management of chronic and acute pain addressing stigma and culminating with ensuring that students had 24 hours of education for the buprenorphine provider waiver.

And then the next slide, you can see that on another opportunity was provided by SAMHSA in 2020 or curriculum that's related to the identification and treatment of substance use disorders, and this was particularly focused on professional schools. Or schools that that were professional or I'm sorry, professional organizations to try to further disseminate Education into the workforce and into other schools across the nation to ensure that students receive this valuable information.

In here, one of these grants the charge is to pilot the curriculum make revisions with 10s of pilot schools and then in your shoes with an additional 10 schools to Continue to provide that curriculum and also one of the charges was to develop content education or questions that would be put on licensing exams or certification exams and I'll talk about that in a minute. In terms of some of the challenges. And the next slide. One of the things that Dan mentioned was this challenge between it as we're educating students and the students are going out into clinical practice or working with Faculty educators that on. They weren't receiving the same information as their students were so our students where we're getting pushback from their clinical preceptor hours with. We don't do that here or You're not using the right sprinting measures, etc.

So with funding from SAMHSA we were able to launch a online education program. That was focused on screening brief intervention and referral to treatment for healthcare providers and another grant that we receive was through the CDC on an American Association of Colleges of nursing That was also received by the University of Pittsburgh School of Nursing. And rather than kind of replicating two different projects in two different universities. We collaborated on a project that would bring the expertise of our to our schools together and we developed a self paced online course specifically focused on alcohol screening in and brief intervention.

And the next slide. Oh, one of the things that we realized is that we need. We had competencies for nursing related to substance use. But we didn't really have competencies that were multidisciplinary competencies. One of the things that we did was on with SAMHSA funding again from the state targeted response technical assistance consortium, our professional organization wrote competencies for physicians for nurses for social workers and for physician assistants and pharmacists. And we identified core competencies across all of those disciplines. So we really wanted to have, what are the outcomes that we were we were expecting. Graduate nursing graduates from our schools to attain and also nurses who are in practice, whether they be generalists or advanced practice nurses And then another opportunity that we realized was that if we were going to, in fact, move this content across the United States in nursing curriculum.

We needed to provide some guidance for nurse educators and so three of us who were funded by SAMHSA for integrating Substance related content into our curriculum collaborated on a document where we looked at the American Association of Colleges of nursing essential oils that are used to guide

and build curriculum. And map competencies, the content that we believed was essential to those essentials and our goal was to provide guidance for other nursing schools and other nurse educators across the United States, so that we could really infuse this into all nursing schools across the United States.

And the next slide, I talk a little bit about promising practices and I highlight here a systematic review and meta analysis that was done by Platt and colleagues in 2016 Where they looked cross 52 trials with different providers providing brief interventions in this in These trials focused on alcohol use, and what they reported was that the those that were delivered by nurses had the most effective in reducing quantity But not frequency of alcohol consumption and this was important validation for many of the US, who had been championing and writing policy papers about encouraging nurses to become engaged in this important evidence based activity.

One of the other things that we can see this comes from Barnett on it published in 2019 and 2017 nurse practitioners and P is a have been allowed to obtain federal waivers, allowing them to prescribe buprenorphine and this was Legendary legislation that was extended in to the other roles of advanced practice nurses In this map that shows the trip buprenorphine treatment capacity of that refers to the number of patients that are potentially treatable by nurse practitioners and p as a to prescribe buprenorphine per hundred thousand population. And so you can see what the point here is that were nurse practitioners and PhDs are really stepping up efforts in rural counties are very difficult to reach populations and where they're making a significant impact.

One point I would make is that and nurse practitioners and PhDs who start with a waiver have a minimum of 30 patients and that can be expanded to 100 patients after 12 months. And another point that I would make is that nurse practitioners in Tennessee, as well as our colleagues are specifically barred from prescribing buprenorphine. And the next slide, I talk here about some of the persistence persisting gaps so we do not have widespread dissemination of evidence based activity and practice that has yet to occur.

We have on essential substance use related content that's absent or limited that's up that's on nursing licensing and nursing certification examinations and the requirements for attaining and utilizing that x waiver for buprenorphine and limits, they access to and receive of treatment. There's a persistent gap up on restrictions on practice for advanced practice nurses in many states across the United States. So these are maps from the American Association of nurse practitioners website. On the left, the map shows states in green, that have full practice authority for nurse practitioners yellow for reduce practice and then red states for restricted practice the map on the right denotes states that have Made changes since the covert 19 pandemic and states with full practice authority or look are noted here in that light gray. There are 22 red and yellow straight states that have suspended or waived aspects. Aspects of the practice agreements and seven red or yellow states have not taken any action.

And the point that I want to make is that with the pandemic and lifting. Some of these restrictions among those States really illustrates that we have The need to bring this advanced practice nursing workforce to full scale and is past time to move all states to full practice for nurse practitioners and the last slide is just the references that I cited during this presentation. So Steve, I'll bring it back to you.

STEVE SINGER

Okay. Terrific. My brain is sort of overflowing.

I think that through the four of your presentations, we've really gotten a very interesting perspective on really the diversity of educational approaches being taken. Deborah ending with your presentation was a great demonstration of workforce and other regulatory related challenges and opportunities. So before I we've been watching questions come in through the Q&A a box before I circle back with some of the audience questions I'd like to pose.

One question to all four panelists and maybe you could just respond very briefly we we've heard about. And I think from our own Settings. We know of the tremendous impact that COVID-19 is having on the work that we're doing, and the communities that we serve. Through an educational lens, I would ask for each of the panelists to just take a minute to reflect about what you see as a significant impact and challenge with regard to the educational work that you're doing. Also describe for us some strategies either that you are taking currently or that you think that you will be taking in order to meet this challenge.

DEBORAH FINNELL

Right, thanks. Um, so I think this kind of ties in with the stigma and one of the things that is alive and well is the moral paradigm I and I have for 20 years been Pushing promoting the science base. The neurobiological base. I think we have to really understand that these are brain based diseases and disorders and to understand it from that perspective, just as we do with any other chronic health disorder.

And I think the other thing is the immersive competencies that I mentioned earlier, there are core competencies that that really cut across all of the disciplines. And all of the professions and if we can look at an inner professional education approach to address that education so that All of us are as pre discipline pre professionals are sitting in the same room and learning the same content. Then we can look at how do we move that into practice and then in practice settings. I think we have to look at How do we utilize the talents, the knowledge, the competencies of all of the healthcare professionals within the culture of the of the healthcare setting to provide that on a pipeline, if you will, from screening all the way through to treatment and referral to treatment if that's required. But I think, to really look at how do we do as Rich coined the hot hand off instead of a warm handoff.

CHARLENE DEWEY

Or in my interpretation of your question, looking at what significant challenges we have and what strategies are we taking during COVID-19. I see some of the big challenge as continuing education, with an emphasis on caring for patients with substance use disorder. Being a challenge because everybody's focusing attention toward the COVID-19 patients. And we don't want to leave the rest of our patients feeling like they have no place to go, or to have access to their providers. So certainly, keeping a message that is alive, saying that we always care about you, no matter what your condition is even during this pandemic, we want to take care of you. I think is really important as a big strategy to help us get over that challenge of making some of our patients feel isolated and maybe even experiencing more stigma than they usually what I would also say the challenges around education can be significant. If our faculty again in the Faculty Development range. Are trained are prepared to take education in a different venue.

So, for example, our courses, our last prescribing course was the first week of March. And so when COVID-19 happened. And we started shutting down everything and March, because all of our trainings are live trainings, we had to quickly shift. To an online platform and how to do that to continue and maintain the instructional integrity of making sure that our learning outcomes are going to be adequate. was certainly

a little bit challenging, but because we had very intensive skills based training. We, we had to come up with, you know, a little bit slightly different way of doing that, but we still had our standardized patients come into zoom.

We still use groups. They still practice. Asking patients questions and doing histories. So it's that flexibility and being nimble enough to translate some of our educational things to online learning quickly,

And then the last thing I will say is, you know, in education, we have this delay of When the studies get done to when they get published to when we read them to when we actually make a change to maybe when it gets accepted into somebody's curriculum. And so things that are educators can do.

For example, I listened to the NAM webinar two weeks ago on addressing substance use disorders during COVID-19, and from that presentation, I made a Short module. Put that in our learning management system and sent it out to all of our grant participants. Now I can't make them do it. And I can't make medical schools use those tools, but what we can do is try and get them prepared quickly and decrease the lag time from when we find valuable information to the time we get it to our learners.

DANIEL ALFORD

Yeah, sure. So in terms of COVID-19, all of our live meetings were cancelled and we are doing monthly webinars in different days of the week and different times. We also are we've added some content because clinical care of its change we're not seeing patients in person. So we can't do your drug tests or For, you know, we don't see them.

So we talked about the DEA guidance that we don't need to have inpatient contact, you know, with a new patient and we're prescribing for We just need to do a telemedicine visit. And they've also given guidance in terms of How we can communicate with pharmacies around even scheduled to prescription. So we've changed the content to include changes in practice, you know, kind of telemedicine. But also how to interact with pharmacies during this time as well.

Can I say. Lastly, The timing of our podcast release was perfect, because I think people who are juggling. A lot of things at home, including taking care of their kids and trying to like learn and everything else. podcast or what people seem to be turning to so be able to do you know 620 minute things while they're doing other stuff. I think was a good opportune time for us to release our podcast. So, so that's pretty much what we're doing.

RICH BOTTNER

So I think you know when we think about COVID-19 in sort of the public health response. My mind sort of immediately again goes to language and stigma. We've been promoting this idea of social isolation where what we really mean is physical isolation and I'm very concerned about The impact of social isolation on our patients and our people with addiction.

We have an abundance of evidence and knowledge that that social distancing that social isolation can trigger recurrence of disease and make existing disease work. So we're really concerned about it and want to be educating around that.

So we've done a number of things. One is trying to increase our education around telemedicine, not just from a clinical perspective, but also from a practical one. So, With regard to treatment. I'm sure we're all aware that the DEA has been more lenient, if you will, with some of the methadone and buprenorphine regulations during this time. And so, educating Our trainees about what that means, even if they're not in a position today to prescribe those medications understanding the regulatory response in times of public health emergencies. I think is important. Our Foundations of inner professional collaborative practice class that I mentioned earlier, we actually did take our last section of the class, which was supposed to be a End of life counseling palliative care. standardized patient lab and moved it over to zoom and I have to say from, from my perspective, I actually think there were many aspects of it that were better on zoom By having a telemedicine interaction.

And we were very intentional before and after on educating students about best practices for engaging in a tele medicine interaction. I strongly believe that even when this you know pandemic is over. There's going to be a lot of increase usage around telemedicine so educating our trainees around that and how it relates to all diagnoses is important.

And then I also think, you know, the pandemic, just like the opioid epidemic is really bringing to light. Our broken healthcare system and all of the many different health care disparities that exist. And there's been a lot of discussion around that and I think we have a unique moment in time where we can Leverage for lack of a better word, all of the health care disparities that are happening within coded and help Our trainees relate that to other health care disparities that we've seen. And certainly the opioid epidemic has a an abundance of health care disparities. So we're doing a lot of that education.

And then finally, I think this is a really good opportunity to help trainees find their way into advocacy. I don't think we promote that well enough across the health professions about the role that That trainees can play and not just advocating in their professions or for their professions, but advocating for patients and for systems change. There's a lot of sort of political discourse happening in the country now. And I think this is a really great time to help take some of those discussions that I think a lot of our trainees are having amongst themselves and help them kind of hone that and certainly looking at that, through a lens of substance in opioid use disorder is a really valuable one.

STEVE SINGER

So thank you for all your responses and i and i think Rich you you've sort of teed up a good note for us to end on. In just the last few minutes that we have at the very beginning of his comments that this is a crisis that we cannot we cannot solve by ourselves. And many, and each of you have talked about interprofessional approaches and multi layered approaches as a final comment and we'll sort of go back around again and rich, we'll start with you. As an educator looking to other educators do you have. My question is, what, what do you need, or What piece of advice would you give to other educators about how we as a community can best support improving the impact of our efforts overall.

RICH BOTTNER

Absolutely. Um, from, from my perspective, the interprofessional and multi disciplinary aspect of this education is absolutely critical and paramount. This is a Sort of new world of education, not just because of COVID-19, but because of all of the different types of topics that we're trying to teach.

You know, from a, from a stigma standpoint, this idea of the hidden curriculum is really is really serious and I know some others have discussed that there was a New England Journal article Last year talking about it at UCSF Medical School students who passed away. During medical training from an opioid poisoning and the authors of that paper. I think we're really reflecting and questioning about how stigma. And our assumptions about patients with addiction are somewhat universal and a detriment to our healthcare system and to patients. And I think one of the things that they were trying to figure out is how could they have done better.

One of the ways we can do better is offering that inner professional perspective. So the program that I spoke about Earlier, our buprenorphine teen program that program includes pharmacists nurse PA advanced practice nurse physicians from psychiatry internal medicine palliative care, social worker Chaplin. I don't think we could be more multi disciplinary in that in that group. And it's 100% because of that multi disciplinary perspective that we that we bring to the table that we've been able to accomplish our goals of not just treating Offering education about treatment and actually offering that treatment but reducing you know stigma. And so, again, I think we learn So much from each other and we take those lessons that we learn from each other back to our various disciplines and those of us in this program today. Where the where the champions right where the, where the role models and I think it's really important that we encourage those cross disciplinary and cross profession collaboration. It's absolutely critical.

STEVE SINGER

Thanks, Rich. Okay, we were in the final minute so just a lightning round from each of the panelists, maybe one or two words of what you think is the key thing that as educators we could contribute to each other to help us make our efforts more effective.

DANIEL ALFORD

Sure. So when it, when it comes to going to say for overprescribing mentioned chronic pain because there isn't a robust evidence supporting And because it's so subjective in terms of the patient interaction with benefit and harm. You can't just transmit knowledge. We really need to focus on communication and being empathic for patients and paying attention to the patient experience, right. You can't just create a bunch of check off boxes. You really need to think about how is the patient experience during all of these kind of procedures that we're doing to keep them safe and it really has to do a lot with Communication skills. So focus on you know the challenges that people are going to have in this area where everything is subjective and not very evidence based

STEVE SINGER

Great, great. Dan and I take that also as an imperative that that we should and can include Patients and families and others have lived experience as partners in the education that we're developing and providing so I know that many of you are doing that but I I'm taking that from your comments. All right, Charlene a quick comment.

CHARLENE DEWEY

I would probably be the collaboration and quick dissemination of materials. There are plenty of us that have great things that we're doing. But the more we can get it out there. The more people have the opportunity to choose which ones fit their, their model for teaching best I think would be beneficial for all of us. And as educators

DEBORAH FINNELL

So I think I would concur in terms of the cross disciplinary sharing And so many schools of nursing that I know of, are struggling with either trying to get this content into curricula, where they do not have subject matter experts and to use the collective of the subject matter experts across disciplines to really push this throughout the United States.

STEVE SINGER

All right, well thank you to the panel, thanks for all of you listening. I'm going to hand it back to the National Academy staff but we appreciate your time.

ELIZABETH FINKELMAN

Thank you, Steve. And thank you to all of our panelists for your terrific presentations and discussion. We're now going to take a relatively short lunch break, at least for those of us here on the east coast and will return with session free at 12:40pm Eastern. Thank you.

SESSION THREE: PERSON-CENTERED, EVIDENCE-BASED PAIN MANAGEMENT

ELIZABETH FINKELMAN

Okay. Good afternoon and welcome back to the Action Collaborative Virtual Symposium, our next session will focus on person centered evidence based pain management.

Effective pain management is critical to curbing the opioid epidemic and preventing future prescription drug crises, it is also essential to ensuring quality person centered care. I'm delighted to introduce this panel of experts who will discuss promising practices and critical opportunities to strengthen person centered pain management. The session will be moderated by Dr. Helen Burstin who is vice president and chief executive officer of the Council of medical specialty societies. And joining Dr. Burstin are Dr. Roger Chou who is a professor in the Department of Medicine and medical informatics and clinical epidemiology at Oregon Health and Science University. Dr. Chuck Rich is Medical Director at Community Care of the Lower Cape Fear in Wilmington, North Carolina. Dr. Christina Mikosz is a medical officer in the Division of overdose prevention at the National Center for injury prevention and control at the CDC, Dr. Daniel Knecht is vice president of strategy and innovation at CVS health and Ms. Penny Cohen is founder and CEO of the American chronic pain Association.

Their biographies are available on the website for you to access and please note that we will be taking questions from the webinar audience during the last 10 minutes of the session, please use the Q&A box on your screen to enter a question. And now I'll turn things over to Dr Burstin.

HELEN BURSTIN

Thank you so much and we're really excited to have this important session today on person centered evidence based pain management. For those of you who've been following the work of the collaborative, you may know that we actually had a work group focused only on opioid guidelines and evidence and we, fairly quickly, our wonderful work group decided we needed a more expanded lens to make sure we really got at person centered evidence based pain management as part of the overall countering the opioid epidemic crisis.

So as you'll hear during the session today, we'll have some presentations that really touch on issues about acute and chronic pain. The use of opioids, the use of non opioids, the importance of shared decision making the importance of really thinking about both short and long term, long term impacts, as well as really understanding the impact on a patient's and the importance of Partnership with patients as we go through many of these issues like tapering Prescribing and ongoing management. So with that, I'm going to turn to our first presenter Roger Chou who give us an overview of the acute pain management work and guidelines that are beginning to emerge out of NAM and elsewhere.

ROGER CHOU

Thank you, Helen. It's great to be here and thank you to everyone for joining this session, I know things are very Challenging right now. I am going to be talking about acute pain specifically about guidelines and evidence standards and how they tie into this to this theme of patient centered care.

Actually So just a little bit of background. You know, historically, a lot of the guideline efforts have really focused more on chronic pain. It's been assumed that acute pain is effective and we know that acute pain is often treated and relieved By opioids. However, there is emerging evidence that a number of acute pain conditions actually respond Similarly to non opioid and non pharmacological approaches. We do know that opioids can provide effective relief for severe acute pain or when patients don't respond to other treatments. So this is definitely not to say that opioids don't have a role. But we're also learning that using how we use opioids for acute pain can impact long term use and associated complications with that.

I think it's also important to recognize that practices in the US differ from many parts of the world. In 2017 17% of the US population received at least one opioid prescription and this is much higher than most countries. And the way we prescribe opioids for acute conditions is actually quite different as well us dentist prescribe opioids 37 times more frequently than dentists in the UK. For patients undergoing minor surgery in the United States. They receive opioids seven times more frequently than Swedish patients. So I think this at least calls into question. You know what, what accounts for these differences and are they really Helping to improve pain, as I mentioned being prescribed opioids for acute pain is associated with long term use.

We have multiple studies now showing that And opioids, as everyone knows, are associated with unique risks, not just to the patient. But in terms of diversion and misuse and societal issues. I'm a lot of the material I have will be is comes from a recent report that comes from the National Academies on framing opioid prescribing guidelines for acute pain. It's really trying to develop the evidence to develop patient centered guidelines. I was a member of this committee and.

So this was an ad hoc committee convened by the National Academies, the task of the committee which identifies existing guidelines on opioids for acute pain. Identify high priority conditions for guidelines

develop a framework for evaluating the evidence in guidelines. Evaluate existing guidelines using that framework and then develop a prioritized research agenda to enable us to have more evidence based guidelines in the future and Just a little background on guidelines for acute pain. The goals. The goals of a guideline are to promote effective management of pain. At the same time, we want to avoid harms, including those associated with opioids. So these are both important facets. We don't want to reduce opioids and then have people have uncontrolled pain at the same time, we don't want to, you know, over prescribed opioids and Have people have unnecessary complications. There are a number of guidelines out there. There are also what I call what we refer to as policies. So these are not Guidelines in the classic sense coming from a professional society, but from a state or local jurisdiction about how opioids should be prescribed for acute pain. Many of the guidelines address opioid prescription duration and dose, some of them require accessing PI data.

The one of the issues, however, is that the evidence base for guidelines is currently limited. Almost all of the guidelines focus on effects on opioid prescribing. So how much opioid is prescribed. What is lacking. Is evidence on effects on patient outcomes, both beneficial. So how well is pain control how quickly can people get back to work, etc, as well as harmful. To people have side effects. What's the do they end up on long term opioids and do they end up having problems for them.

And there's other outcomes like the need for refills trying to get results on the weekend, for example, which can be very difficult at times. I think that we have to acknowledge that it's difficult to evaluate long term outcomes when we're looking at a treatments for acute pain as well as misuse and diversion. So this has been a challenge in the field and.

There are a number of key principles that the committee. Worked off of one is that guidelines should be based on evidence that evaluate the efficacy and effectiveness of interventions on health outcomes. Guidelines for us, the highest quality evidence available. And the last is really important that even though guidelines are developed To apply the populations of patients that they need to allow for individualization of care, to the extent possible. Every patient is different and their needs and context can influence the way that we manage them the next slide.

This slide just shows the guideline development process. It is a pretty extensive process that we go through to develop clinical practice guidelines. We start by having Establishing the group determining the scope, what the guideline will focus on We apply an analytical framework which we're going to talk about in a second. We do our literature search and evaluate the evidence and then we develop our recommendations. This last piece that orange arrow is critical that it's that you're not done when you put out a guideline, it's important to see how the guideline works what the impacts of it are on patients as well. And so there's this feedback loop that should take place. And sometimes that that that that's done to more lesser degrees and.

The analytic framework is critical. I would say this is one of the centerpieces of the NASEM document. The, the idea is to be able to show the evidence links that we need to get from the left side of the framework, which is a patient presenting with acute pain to the right side of the framework, which is the health outcomes paying function quality of life. Other side effects. To get from the left side to the right side we have to look at various links. So we can look at how opioid prescribing strategies directly impact. Those types of outcomes.

But as I mentioned before, oftentimes, we don't have that direct evidence and we have what we call intermediate outcomes. So we can see how much opioids are prescribed. How much are used and

unused. How many refill requests. There are But those don't directly, tell us what patients are experiencing and we need to also look at these other links to, to, to understand What does it actually mean if somebody doesn't use their opioids. What does it mean if somebody you know has to have a refill request. How does that impact their quality of life, etc.

And so the analytic framework is really important for being able to show these different links and also to understand where we have gaps. And so as I mentioned before, we have Quite a bit of evidence. Now we're accumulating evidence on the effects of different opioid prescribing strategies on intermediate outcomes. But we're still lacking evidence on those Patient and population health outcomes on the right analytic framework enables us to be very explicit about the types of evidence. We're looking for and to show where the gaps exist as well as where the evidence is present.

As I mentioned before, one of the goals of the panel was to identify priority conditions for acute pain guidelines. These were based on How frequent or common that can see the conditions where are the procedures being done where whether there is a gap in terms of practice. Whether there's uncertainty or other issues in terms of prescribing so as you can see, there's a number of surgical procedures that were identified As well as a number of medical procedures, including dental pain a low back pain is very common, of course, things like sickle cell disease and musculoskeletal conditions.

And then it's then the panel also identified a number of research priorities. And as I mentioned before, it's critical that we understand the effects of prescribing strategies on health outcomes, not just how much opioids are prescribed, we can't assume that you know that tells us the whole picture about what's happening with patients. We also want to understand the effects of prescribing strategies on population level outcomes as well as individual level outcomes. In other words, things like how much, how many overdoses are occurring in a community. When these types of strategies are implemented.

So it's not just looking at the patient that's being prescribed opioids, but other people who are impacted We need to understand opioids and prescribing in the context of non opioid interventions. So it's important that research and guidelines. Think about the context of other things that are being used. There's key patient populations. That we also need to identify research for. Think about the clinical setting in which opioids are prescribed for example an ED versus primary care setting. And as mentioned before, really understanding the link between intermediate and health outcomes.

HELEN BURSTIN

Great, thanks. Roger. You raise so many important and interesting issues. Next we will hear from Chuck Rich who will give us an overview of the work he's been doing with our workgroup On opioid tapering. I'll mention that as we started to prioritize the work of our workgroup with my co chair, Deb Houry it was striking how unanimous the focus on this topic was as an area where we needed both better evidence as well as better guidance on how to work with patients and clinicians.

CHUCK RICH

Thank you, Helen. Appreciate that. Just as a background for everyone, today, please understand that I am a primary care physician representing the American Academy of family physicians on our work group and As a result, I'm still actively involved in the clinical practice in rural underserved area with a great deal of patients, which I've been impacted by social determinants of health. Which has led for many reasons to the issues of chronic non cancer pain and the use of long term of the treatments in that pain.

As the background. I mentioned that. But one of the areas that is not covered. Very well, or is in the process of being better developed and made the guidelines that were Used to say in time is the subject of the legacy patient. A term that we use and the treatment of those patients that are already on long term opioid therapy for chronic pain. These are individuals that may have been on opioids 5, 10, 20 even 30 years of continuous use. That is what you may be again face with as a physician and that this patient present to you.

Unfortunately, some of those pain patients in addition to possibly being on high dose opioid therapy, they often are our own it in combinations with benzodiazepines. And hypnotics so you've got quite a combination of medications that you may be faced with again, particularly in primary care setting in terms of what to do. Which when you're confronted with those patients you ask yourself the question, What do I do? Do I said that's not a patient that I can handle? which we're absorbing a lot in a lot of primary care settings to stay in time. Do I just continue with the status quo or do I investigate what really should be done how best manage these patients. Here's the subject of opioid tapering. Next slide.

As you as you may be aware, in essence, intuitive. Again, we are saying that there are some benefits to be obtained for look when tapering. Certainly again there's more need for more studies, but We are enough from several studies including one released this past year, that in a lot of patients who are successfully type, for there is an improvement in pain and function in those patients just upon functional scores, etc. There is a lessened risk of accidental overdose and death. As well as an improvement in side effect profile, such as constipation from long term opioid use. As well as effect on other organ systems and clearly again certain there are certain high risk populations with to certainly won't like to reduce the ongoing usage of opiates for whatever reasons such as for pregnant population.

Conversely, we wonder, again, are the risk of opioid tapers. There are some anecdotal stories of patients which have had to adverse effects of tapers, but This clearly is an area where we need better research and we'll touch on that the end of the discussion, but clearly We are concerned that tapering may be associated with worsened pain, certainly in the in the acute term, but hopefully not in the long term.

You may unmask through the process of tapering on diagnose of codependency and substance abuse. You may also diagnose behavioral health issues which has been quiet said in the patient's profile for some time. And they've never been addressed and certainly again ramp it up through what tapering or rapid discontinuation of opioids in the patient that's already on long term opioid Therapy certainly can lead to the precipitation and withdrawal syndrome. And the consequences of what would happen of that and I won't necessarily address that in today's discussion that certainly that can occur in someone who is rapidly tapering or suddenly discontinued from the long term therapy.

We think about it two scenarios in terms of the patient that may present to you that you would like to consider or may be a sub a candidate for tapering. Ideally, you're talking about an individual that would come to you, requesting that they be tapered off of their of view what therefore have a good therapy taper down I really acknowledge that this is them unusual to rare occurrence. I had been ratified through my career to that actual I've had several patients, including want. Oh, very high does Up your therapist that came to me with a request that they'd be type, type or down. This was a per patient coming from another provider.

Certainly, again, if you get those individuals, you'd like to Strike while the iron is hot, as I say, and try to find out what is motivating and that individual and then work with them to facilitate that tapering again of successful manner. More commonly, as you can imagine, is more like that the provider initiated taper that

you'll be faced with again in dealing with these patients. This is where you determine after an assessment of the risk versus benefits of their therapy, shouldn't they be considered for a taper.

You also want to think about, again, what may be a factor, which in your mind is leading to a need for type or such as Medication at adverse events on long term therapy accidental overdose and other factors. And in that situation, which represents With this patient population, the provider initiated type representing the most common form of open typing. Again, the reason that you would want to consider those typing those patients.

One of the strategies that successful in pain management and in certain for opioid tapering is patient buy in and shared decision making. Have already mentioned that in this situation with tapering you're trying to refresh from the standpoint of understanding what they want may be a motivating factor for patient tapering And what you can act upon from the patient presentation which may be a give you a step up to actually motivate the patient to participate in taper. Several in some of those discussions and the type of process you're going to, you're going to be discussing the risk versus benefits. Possible protocols that you may be looking at for in terms of how you're going to consider a table with a patient

And again against discussions concerns the patient may have including again what may happen through the pain and wants their risk of withdrawal. These are certainly discussions that I like to entertain and the very first discussion of the patient that the sometimes presenting as a new patient But we certainly recommend that that discussion be maintained throughout the entire take from process in terms of maintaining the patient's motivation and maintaining the patients by him.

What we're talking about briefly some adjectives to taper, one of which is the subject of interdisciplinary teams. This is primarily been looked at mostly in the inpatient setting. But in the outpatient setting. I think clearly. Again, there is certainly a need for further research in terms of how it can be done. In my own practice. I've certainly made use of care managers, working with the facials on an outpatient basis behavioral health staff.

All the way from psychiatrists, all the way down to the hybrid of social workers to pharmacists in terms of certainly helping to spread The information about the risk versus benefits of long term opioid therapy and how best to work with the medication that are that they're taking.

Another tool which I have use in my practice, which again has been talked about in one of the research articles listed here is tapering agreements, similar to the clinical Contracted which you may put in place when the patient is presenting to you for their pain management care. Similarly, a tapering agreement can be constructed in That access an instrument that you in the patient can refer back to during the process to help remind you, and the patient terms what you read upon in terms of how to taper the Long term therapy again and all the elements which can be included in that search things as the speed of type or watch your endpoints are what provisions, you may have to evoke in terms of deal with deviant sis from any type of process, including the need for consultation.

I've mentioned briefly speed of tapering and I will say, Again, this is an area where we need a lot more research in terms of the best recommended speed of tapering that should be undertaken with a patient. Suffice it to say one size does not fit all. And you will learn at it through the process of tapering that in many times the speed of a taper may be much slower than you ever anticipated. The various guidelines hasn't have given the various suggestions in terms of what the I recommended tapering speed. But I,

again, I encourage you to be patient and exercise again and understanding that this process may often be much slower than you would ever want.

One thing also to realize that sometimes the endpoint of tapering may not be the complete discontinuation of all long term opioid therapy for patients. But may result in just a reduction in their dose is to the lowest effective dose is particularly in combination with other medications. Again, we do have some tools which we have recommended to help guide that process. These are functional assessment tools and objective tools. Which when used in the process on an ongoing basis allows you to compare scores and this is the visit in terms of how patient may be doing during the tapering process and are they doing well or they're not doing well and this is possibly a reason to possibly pause process.

As I alluded to behavioral issues, Additional research really needs to be done in terms of truly, truly, truly establish the incidence of Conditions. But certainly, suffice it to say that in many of the patients but anecdotally, and from research. There is clearly a substantial proportion those patients with mental health issues. Some of those concerns, including start with depression personality disorders. And as you can imagine, substance abuse disorders. During the process of caring for patients. We do recommend the use of various health assessment tools to guide that process. There, I will go into the discussion of those tools, but they are out there, and it certainly again it's beneficial to use those tools, but the initiation of the tapering process and throughout that process.

One general comment that I would make in reference to this process of tapering if substance abuse disorder is detected and are suspected in many respects. Ultimately, the patient is from one of tapering to one really becomes more management and treatment of the substance abuse disorder. Some additional and jobs that have do suggest be considered and type in process non pharmacologic therapies do have a benefit. These patients in terms of helping to reduce Some of the factors which may be leading to the patient's chronic pain. And therefore again by reducing those factors, you're able to therefore again, hopefully, less than their dependence upon the use of your therapy for manager that pain. Certainly from a non pharmacologic standpoint, there's some good evidence looking cognitive behavioral therapy.

But, and also in practice such things as chiropractic therapy, physical therapy, and even patient exercise amongst all this may be some non pharmacologic therapies which will help the process. Many of us are aware of the various pharmacologic and jobs that again are available to help manage pain. Besides, of course, I won't go into discussion of that. But suffice to say one of the goals of use of these therapies is again to listen to depends upon lesson usage of the aqua therapy as a mainstay of managing the patient's chronic pain. In practice. Many of the patients that I've seen Sort of one of the first things that I've done through my practice is make use of getting us and jumped a therapist on board to help less. And again, the, the dependence upon opioids.

Number one, patients on pre existing long term opioid therapy from gone cancerous pain should be considered for tapering. Number two successful tapering as I've alluded to may not result in complete cessation of afterwards. But hopefully tapering to the lowest effective dose is based upon assessments of pain and function. Number three as of alluded to typing is often going to take months and often years. Number four, strongly recommend the use of adjunctive strategies and therapies to aid in the taping process. And hopefully, again, less than the patient depending upon your pain relievers. Number five, that's also patient by in patient education is critically important both of the initiation of any type of process and through out the tapering process and again is best to achieve your the a shared decision making process and filing I guess I've already alluded to, there's a lot of areas that are still We have a lot

of gaps that are still regarding the process of both you're typing deceptive vocal typing and you'll see hopefully further research of answer some of those questions to come
HELEN BURSTIN

Thanks so much, Chuck that that was a really rich discussion and as you, as I've been watching the chat box raise some important questions that will come back to during discussion. Next I'd like to turn to Christina and because from CDC to give us an overview of their work related to guidelines for chronic pain.

CHRISTINA MIKOSZ

Thank you, Helen. Thank you for the opportunity to speak today. This is Christina Mikosz of the National Center for injury prevention and control at the CDC. I'm going to spend my time talking a little bit about the 2016 CDC guidelines for prescribing opioids for chronic pain. I'll start by walking through some of those recommendations statements or then talk a little bit about this application and the CDC guidelines about close up my presentation by talking a little bit about the guideline update process.

The CDC guidelines for prescribing opioids was released in March of 2016 was published in that morbidity, mortality report by the CDC and also was published in him. And it was I it was providing recommendations for the prescribing medications for adult population. So this focus on patients aged and older. Specifically, and outpatient primary care settings and this focus again on treatment of chronic pain. I was not intended for use and active cancer treatment, you don't have care and the life care. And as mentioned before, the primary audience for the CDC guidelines primary care providers and specifically those working in family practice or internal medicine and was targeted towards physicians, but also nurse practitioners and physician assistants working in those practices.

I'd like to start by highlighting some of the recommendation statements in the guideline that was relevant to initiate therapy. So first and foremost, opioids were not considered first line treatment. for chronic pain maximizing nod or three treatments for chronic pain was a recommendation and we should establish a measure progress towards goals. Discuss benefits and risks of patients with a series of your leads us immediate release opioids when starting opioids, rather than extended release formulations and for management of keeping readings were less welcome.

This my focuses on recommendations and element to starting or continue opioids. As mentioned before, maximizing use of non opioid treatments that would include medications that are not appealing as all as well as non pharmacologic ways of treating us like exercise. Using caution when increasing the dosages, so we assessing the benefits and risks of increasing dosage to greater than or equal to 50 milligrams per day. And avoiding or justify increasing dosages to greater than or equal to 90 milligrams per day on depending on the individual is the benefit calculation for patients and their context and Also checking and opinion for other restrictions on including high total dosages avoiding concurrent prescribing a benzodiazepine to opioids. Prescribing naloxone.

So for those patients in that higher List of overdose and then offering or arranging for our medication assisted treatment or any patients. There were specific guidance and the 2016 guideline for patients who already were receiving long term. That there were some sections that we're putting into those patients who were already on long term. Okay. So these patients is recommended to regularly review the benefits and risks. I continued opioids and providing interested and motivated patients with support to slowly taper off visitors.

Establishing goals with patients who do continue on opioid therapy and then again maximizing in treatment modalities with non pharmacologic and non pharmacological Also empathetically reviewing risks associated with continuing to suit your needs, offering a slow taper if benefits aren't felt outweigh this Again, this is something that's the tone of individualized basis for individual patients and for those patients who do agree to taper agreements and lower dosages working very closely with the patient, it And also, lastly, closely monitoring and meeting over those first for those patients.

What was suggested in 2016 guideline as a starting point. Again, it depends on the individual patient. But perhaps 10% per month, or even a slowly. And again, individualized plans for tapering based on patient goals or concerns for context for Something I like and again in the same vein is individualized plan, allowing for pauses in the taper or depending on where the patient is taking us Accessing appropriate expertise if considering to bring what I can see I discussing with patients. The increased risk for overdose on the return to prescribe higher dose, just making sure that that risk is highlighted for patients.

Again remaining a group to silence means it depression opioid use disorder that might be masked final paper is Dr. Jay Butler, and then again optimizing psychosocial support for inside you that either they get to the In the time since the guidelines, released in 2016 CDC has walked in the areas to pick on this slide to disseminate and translate the guidance that isn't In the guideline. It's not enough to simply publish the guidelines of the public, you work the reactivity to make sure that the content and the recommendations with the guideline work well understood by us.

And so just to highlight a few efforts in that area first for translation and communication we developed a full suite of translational products that are available. at CDC website that helped to translate the content within the guidelines of things like fact sheets on. We have a mobile app to go on to your smartphone, just as a few examples. clinical training. We have a suite of interactive our condition training modules as close to the CDC website that walks through the guidance and the CDC guidelines. On offer some self check and questions and I could see me there also immediately following the guidelines was a series of webinars to clinical audiences and also walk through the guidance.

And number three, health system implementation, we've worked very closely with a member of health systems to Better integrate the guidance in the CDC guidelines into the workflow. So this would include efforts as such as clinical decision support. Working to better integrate this into each arms. And then lastly, working closely with ensures the pharmacy benefit managers to better implement the guidance and the guideline, especially with our non pharmacological. Next likely Wanted to touch a little bit on this is about. So efforts to improve over prescribing reducing this use of opioids and overdoses have been commendable, but there have been some policies and practices that have side of the guideline. I did I go beyond its recommendations are inconsistent with its guidance.

For example, the guideline doesn't support abrupt tapering it doesn't support sudden discontinuation of opioids. Unfortunately, it's the inappropriately cited to justify current limits are cutting off of opioids. And we have heard reports of this application beyond the guidelines very clearly stated scope. So for instance, some examples there would be Applying the recommendations to patients and cancer treatment, which was not the intended scope or those patients experiencing post surgical team. Remember that intended audience for the guideline was primary care. And then also miss applying the guidelines dosage recommendations medications for your use of awesome that We continue to work to address this application of the guideline beyond it's in scope.

So what's missing on this slide represents A letter that CDC had sent in February of 2019 to the American Society of Clinical Oncology The American Society of hematology in the National Comprehensive Cancer Network that we iterated As Stephen the guideline that the guideline is providing recommendations specifically for treating chronic pain outside of the realm of active cancer treatment period of care and end of life care. Also that guidelines for pain control, specifically in sickle cell disease should be used to guide decisions for that patient population, not the CDC guidelines that was intended so And then again, I can't emphasize this enough clinical decision making should be based on an understanding of that individual patient clinical situation.

That functioning their life context and our goals for pain management and really to carefully consider the benefits and risks of all treatment options. That's like with In a New England Journal of Medicine commentary and accompanying CDC media advisory that was also released Last year I the guideline authors outline some examples of this application of the guideline and they highlighted advice from the guideline that sometimes overlooked. But is critical for safe and effective implementation of the recommendations. So just to cite a quote that was in this commentary quote Affected implementation of the guideline requires recognition that there are no shortcuts deceive of describing Which includes assessments of benefits and risks patient education and risk mitigation or to appropriate and safe reduction or discontinuation book reviews. Starting fewer patients and opioid treatment and not escalating the high dosages in the first place for reducing them as a patients prescribed diagnosis in the long term.

In the meantime, consistent with the 2016 guideline conditions can maximize the use of non opioid treatments of view with patients the benefits and risks of continuing of your treatment. Provide interested in motivated patients with support to slowly taper off your dosages closely monitor and mitigate overdose first for patients who continue to take up your high dose opioids and offer a range medication assisted treatment. Just a word about the going up the process. So in the 2016 guideline. We had noted that CDC what a revisit the guideline to determine whether the evidence gaps had been sufficiently close to one of the recommendations.

And release of the 2016 guideline. There have been calls for CDC to provide a guideline and prescribing opioids for acute pain. So beyond its initial scope of chronic pain on these requests have come from professional specialty societies and senators. Looks like In order to identify whether evidence gaps and been sufficiently address to one updates to or an expansion in the scope of a guideline. CDC funded Agency for Healthcare Research and Quality to conduct five systematic reviews on the effectiveness of opioids non opioid pharmacologic medications and non pharmacologic treatments for both acute and chronic pain.

The three draft reviews on non pharmacologic non opioid fun of logic and okay treatments for chronic pain but posted for public comment last October, and the final versions were very recently released and based on that CDC has determined that a guideline updates. Is the two reviews on treatments for acute pain or anticipated to be released later this year. And that can help inform decisions on whether CDC will further expand the guideline to the treatment. Looks like So what the evidence of these new systematic reviews me allow for it could provide potentially for additional detail and I pharmacologic and not overdoing pharmacologic therapies for chronic pain.

It could update information on benefits and risks and I pharmacologic non opioid pharmacological opioid therapy for chronic pain. It could expand guidance on acute pain and could potentially expand guidance. So just to outline a few steps that will facilitate the to the CDC guidelines for prescribing opioids, as

mentioned, it's been reviewed with the five systematic evidence, who use CDC is also requested the establishment of a board of sight to the counselors expert work group to provide input to the CC Andreessen was born. Scientific Counselors And the guideline update development process will include a public comet theory to the Federal Register once and not do an expansion is traffic.

HELEN BURSTIN

Thank you so much. Christina really helpful. And as I was looking at the chat several questions came up about your plans to update that will return to in the in the Q&A as well.

DANIEL KNECHT

Thanks for the opportunity to speak with you all as a really important topic I'm coming to with a little bit of a different perspective. I still practice medicine as a hospitalist but My day job is working at CVS at now in health strategy. So thinking about your health needs of our members and communities we serve in developing and executing strategies to impact those so People get.

So you're very well aware, the unprecedented circumstances as our society finds itself. And as it relates to the opioid related deaths. Unfortunately, this graphic is overly simplistic right on what it does not take into account is the large number of individuals struggling with undertreated or mistreated pain that sort of them was the proceeding epidemic to this. Overview occurrences, we find ourselves in think the other sort of new ones here is that there is a substantial shift between opioid related deaths from prescription painkillers description opioids to elicit Opioids such as heroin and increasingly ethno or also poly substance. Use increasingly cocaine with this synthetic fentanyl. So this is an ever changing Crisis, we find ourselves in. And then, you know, only a few months to go eat toast glimmers of hope, as it relates to reduction in individuals died from drug related overdoses.

I'm very nervous, see what the implications of COVID-19 will be an individual struggling with chronic pain or substance use disorder, more broadly speaking. So when we came up with this very simple strategic framework here on this. It's an arrow. But if I had my druthers, that actually changed the slides and make it look like a flat balloon. And in so when you think about a balloon if you clamp down on only one part of the balloon. It has three forms of re emerges and you really haven't made much of an impact. So our thinking here is we need to be as holistic and comprehensive and impacting the opioid Crisis as possible.

So on the far left hand of the slide. It's prevention. So that's present preventing misuse and abuse of opioids before it occurs. So, has any health insurance. We have clinical policies in place around access saying a pain treatment modalities. So our policies. provide coverage for physical therapy, occupational therapy chiropractic care allure it of non opioid Medications, including as early sort of pharmacy benefit we put in place a seven day limit on opioids prescribed for acute purposes such as post surgical And acute pain.

We do have prior authorizations in place for the use of opioids for chronic indications and then really is an opportunity for our clinicians to have a peer to peer conversation with the prescriber just ensure proper Thought and consideration about prescribing opioids by at the end of the day we respect that therapeutic alliance between the patient and the physician. But at the same time, you know, they're really, really needs to be some guard rails around these products. So that is to prevent prevention pillar, I will call out A very innovative program that my colleagues as retailers that have launched.

So it's essentially called an OTC opioid switch program so when a customer comes to our pharmacist for a prescription for an opioid for a simple dental procedure or pharmacist will carry conversation with that individual. Around if they would be interested in trying an OTC Advil ibuprofen and acetaminophen in lieu of filling that first opioid prescription. So we've had a really encouraging data they're ultimately if the patient wants to fill the prescription of appeals. We don't get and we certainly will abide by that. But again, we feel like that additional author of education and counseling is valuable.

The next pillar is intervention. So as many of you are aware CVS is very large healthcare company sitting on a large repository of data. And insights. So this is where we use our data analytics in a way that we can produce a lot of value to the to our customers. So we have a number of programs in place that prevent doctor shopping by looking at multiple locations. We have another program that we ran for a few years, where we sent letters to prescribers opioids that fell in the, sort of, we call them super prescribers but really was the doctors that are in the far statistical significance. Direction in their own way. So the top 1% of prescribers top 5% or perspiring and let them know that they're prescribing habits were not in norms with their peer group. And you get the question, however, is would you refer these prescribers to the authorities and we can answer is we work closely with our Special Investigations unit to work with Lawrence law enforcement when there's clear potential illegal activity going on.

But the purpose of that program really is to say, you know, physicians one do while they're just sometimes are studying clinical inertia haven't kept up with the CDC guidelines for example, and would benefit from that nudge. Also in the intervention bucket. We feel in our hand is an underutilized resource. So we were the first payer to remove the copay on our can for some of our members. And the idea there was, we wouldn't want an individual who had a prescription for an opioid plus now locks on our can to go to the pharmacy and walk away. If there was a copay or financial barrier in place. So we've also donated in our can across the country, in conjunction with a little community partners.

And then finally the support pillar and as that epidemic continues to shift from opioid prescription opioids to the illicit opioids. This is increasingly important. So how do we identify and support our members that are struggling with opioid use disorder or substance use disorder and get evidence based treatment. And so we were one of the first payers to remove the prior authorization on buprenorphine and other medication assisted therapies. We have a program called the guardian angel program, which I'll talk about in upcoming minutes.

So this is sort of gives an outline of our overall strategy and as the epidemic continues to shift to me. A, we will continue to sort of move our resources around and make the biggest impact for our membership. Alright so guardian angel programs are really unique and impactful program on. So, essentially this this program was launched based on a really important clinical inside we had we notice every month our members. Were us, you know, suffering opioid overdoses in the hundreds each and every month. So we, we launched this program where we essentially have a skilled clinician solely focused on making telephonic calls to our members who have had an overdose. So we have claims data that trigger that triggers the program to say we had somebody who ended up in the emergency room had an overdose and we need to have an assertive outreach to help these people So we've launched this program over the course of a year and a half. And we've had some really good outcomes. But essentially what happens is our case manager calls this this member and engages in motivational interviewing trying to understand what happened. How we can help. And I think most importantly connecting these individuals with local resources, namely physicians who prescribe medication assisted therapy and provide evidence based care for opiate addiction.

And so if you look at the next slide. We've had really encouraging data we've had We've engaged over 50% of our members, we've done outbound calls to we've helped over 1000 individuals who are victims of an opioid overdose and on the left hand side of this line. Really the take home here is you look at this just a sheer diversity of individuals across our country are struggling with opioid use disorder. We help individuals as young as seven days I 17 and as old as And we have 60 here, but even older than that and you know there are routes to opioid addiction are quite varied some we all we hear firsthand. Heroin is being used as a party drunk and high school or an individual who have who received opioids after an athletic injury or After struggling with chronic pain for a while but ultimately they end up With an overdose. And so the whole purpose of this program is to break that cycle of addiction and connect them to local resources.

And then the last program on the upcoming slide is an academic detailing program so as you all know, the genesis of this of this opioid crisis really is due to inappropriate and overcome inappropriate marketing of opioid so we took a page out of that playbook and Partnered with a nonprofit organization based in Boston called a low self. And what we're doing is deploying a Field force of 30 specially trained academic detailers he's your clinicians whether they'd be pharmacist. doctors or nurses to visit and not participating providers literally knock on their door sit down and provide them face to face education around how to appropriately prescribe opioids for acute and chronic pain. But also had a screen and treatment support people with opioid use disorder. So we launched this more than a year ago we've Engaged over probably 10,000 providers are physicians today and we're getting really great feedback from the provider community. I think the resounding insight is that these doctors don't have sufficient training or the training.

The CDC guidelines and other guidelines. It really is embraced. So we continue to innovate on this program, we're now rolling out a value based contract with these providers to incentivize them to further engage with our providers, but also pay them for You know value based payments, if they're prescribing opioids prudently and avoiding common opioids. Prescribing which is a huge driver for opiate overdoses. So more to come on that. But it's a really exciting program and actually Dr makers on our advisory board that helps curate the guidelines were proliferating to these providers.

HELEN BURSTIN

Wonderful. Thank you so much, Daniel, there was already some great questions in the chat box about how do we make that a standard for other payers, which is a high praise, I think, and perhaps we'll come back to that. So last and certainly not least, I'm delighted to turn the podium over to the virtual podium. Over to Penny Cohen, who's the founder, founder and CEO, the American chronic pain Association has been really integral to our efforts, particularly to our patient listening sessions.

PENNEY COWAN

Quite often what we do is we look our health care professionals to take care of us. And the problem is they quite often they don't tell us that there may always be some level of pain. Our expectation may be for them to treat us to just get rid of it. Of what we don't what they don't realize is the amount of Fear that a person has when it comes to chronic pain and the fear of further injury if something happens. You know, they're assuming that that pain or if they have an event to go to quite often what will happen. So that they don't have more pain, whether on the bed, go take more medication. And that's how they run out of these medications and tend to get in trouble.

But they really do need reassurance of that their pain is we heard this morning from Megan Kennedy about the stigma that people with opioid use disorder have that, you know, everybody was paid and looked at the same lens, even when they're taking medications for chronic pain. And so they need that validation. They need to be relieved. They're very defensive. So if providers only believe they're paying it will take away a lot of the defenses that they're getting the feedback from for people.

So, we look to our health care providers to help us. To begin to help us manage the pain problem is that they really many of them have limited experience. They are not sure you know how to help us is as we begin that journey from passive patient back an active participant in your health care. So quite often what we hear is learn to live with it.

And so this is what it looks like when they tell us to learn to live with it and I have no clue what this is. I could not solve it. If you asked me to, you know, however, if I took a few classes and I started with algebra work my way through off to, you know, play geometry trig even differential equations. And I had a really good teacher and I worked really hard. I could solve the problem. The problem is we need to be taught. We don't know how to live with pain. Somebody has to teach me. Don't tell me please, teach me. Teach me how to live with it and that's really key is, don't tell me teach me. So we have to learn to live with it. And part of the problem is when you talk to a person with pain all they talk about is what pains taken away from them.

They never we never. No one ever asked you, what can you still do. And I think that is one of the keys is what are your abilities. What is that you can still do. And so as I said before, we really have to begin moving from the cancer patient to an active participant in our healthcare. Realizing the goal of pain management is to improve quality of life increased function and reduce your sense of suffering. And again, nowhere in the school does it say get rid of your pain completely. That's not something that's going to happen for most people living with pain.

So to do that. So one of the big problems is, again, you know, we go back to that path of patient the person must become an active participant in their home care they need to know, what's their role in managing their pain is they moved from patient best person. As we heard earlier today from Daniel Alford, excuse me if I if I pronounce your name wrong about the communication gap between providers and people with pain. So what we need now is a way to better communicate to bridge that gap we meet. And so there's three, you can click three times to show that it's we need things that are more easy to understand. more informative and more efficient, so that we can begin to communicate in that short amount of time that we have a dark provider. what our needs are and what's going on with us and how to explain what's happening.

So the first thing is, you know, on that scale of zero to 10 which most people's pain, you know, really don't like we decided that we needed to have a quality of life scale is just going to measure function we flipped the scale, meaning zero you even you can't even get out of bed dev zero malfunctioning, all the way up to 10 where you function is a normal person without pain and so every one of these numbers has a function which is really the key to moving from patient to person and regaining some control of your life.

But there's also a lot of other things to contribute to our payment or never asked or never thought about in that again that short amount of time that we have with our provider. So we've developed this intake form where you can ask them their pain score and we still use the secret of 10 because that's what they have to chart. But then we're going to ask them a number of other things, they're stressed or exercise or sleep. You know their fear of the pain taking their medications prescribed to side effects or constipation

their sexual activity their appetite their moves. How isolated they've become has alcohol. But this is a one time thing.

But when you go into your provider you they're going to ask you how you are going to tell them this is how I feel today. We don't remember we could go a month ago or what happened between our visits. So that tool that I just showed you is now interactive on our webpage and you can actually track this each one of those measures. And begin to print out. You can actually now begin to speak when you go or your provider can pull it up for you.

A graph of this is exactly what's happened. And you can begin to now connect the dots that maybe the pain score went up because you weren't sleeping. Maybe you have side effects either took too much medication or didn't take enough You were constipated. I mean, the number of different things you're isolated. So maybe that's more key towards the depression. Rather than even what's going on with the pain. So it gives you clues on what area, you might need to focus on for these folks. And the other thing we always have problems with is how do we describe our pain because we want to be believe we want that validation, as I said earlier, so in Britain chronic pain associations developed a number of Pain maps and these everything I showed you a free on our webpage. It's just available to access to anybody. And this one in particular is for low back pain and they'd asked for your pay radiates from And you just put your cursor right on the place where it is your hip your buttocks, or whatever. And it'll ask you know what are the symptoms. How does it feel numbness burning and they're animated little things and they go on the top score. And then the intensity of your pain and then how does the pain begin. And there's a number of questions and what makes the pain worse.

So you can actually then print out a map of your paint a picture's worth 1000 words. So instead of trying to explain all this You have maps. We have them for headache pain fibromyalgia diabetic peripheral neuropathy and also for nerve pain. And other thing is that people get confused about how to take their medication and they're the ones that are responsible for that. Keep in mind that, you know, There's only so much a provider can do and then it's up to that person to sort of follow through. And so we actually work when we declared September pain awareness month ahead a number of partners. We did a toolkit for pharmacists one year. And we work with the Pharmacists Association and develop this tool to help people better understand how to take their medication because they don't remember they would call our office and ask us So did they take it morning or night or what time is a day just take it with food without all you have to do a circle. These You know, what are the side effects and what are the things that you have to be aware of, you know, that the restrictions. When you're taking these kind of medicines. And then most importantly, especially with opioids is have a store them and dispose of them properly.

But so what are the other responsibilities of a person living this pain if they're really going to move from patient back to the next slide. So we have this this what we call our 10 steps from patient to person, and they're not like a 12 step program where you have to do each step. in any order, except for the I believe the first two and the first one is accepting the pain, knowing that At some point in time, you have to realize that pain may be a part of your life. That doesn't mean it has to control your take over you. But it may be a part of your life. And then you actually have to get involved. You can't just sit there and expect someone to make you better. It's not going to work. We also need to know what our priorities are. We need to have a reason to get out of bed in the morning. That's why learning what are, what our priorities are. What our abilities are so we begin to look at our priorities and set some priorities for ourselves and then to have realistic goals. The problem is pain is never consistent, we have good days and bad days, and then the good days we try to do so much we don't pay ourselves. We don't listen to our body. That's

where they get in trouble. So they often will take more medication than they should. And they get into trouble because they run out before they should. So we really have to set realistic goals or narrow down To small manageable steps and listen to our body movie feel that first out stop just rest for a little bit and then knowing their basic rights. It's actually really important Because pain takes so much of our self esteem away from us. Many of us because we've gone through so much in your code. That's all in our head and all these other things that We need to feel like we have the right To be treated with dignity and respect their right to say no, the right to make mistakes, the right to do this using the possible, the right to ask for help, all those things.

And emotions do play a part. So you really have to begin to recognize emotions and understand that there are no wrong feelings and inappropriate actions and recognize your emotions. And begin to deal with each one as it comes and then obviously you know stress is going to pay a huge part in your in your pain and increasing your pain. So how do you learn through that. How do you tell your body To begin. First you have to listen to it and then relax and this is this is something that takes a little bit of effort takes training. We actually have Some audios on our webpage and a beautiful video on how to relax or five minute video on relaxation and just read you through your whole body to relax. Again, that's free An exercise is so very important. And this is something that you really do have to do With on your own. A lot of people in our theme. I can't tell you how many websites and how many emails. I've gotten That you can actually mad, they show you how to do exercises at home just getting out and walking know keep moving. That's really important. And then again, looking at your abilities, not Focus on your disabilities. I really believe that 80 or 90% of how well someone does really depends on their attitude.

And then to really reach out to other people and let them know that they're not alone because pain is so very isolating And the more we isolate the more pain tends to take control of our thoughts, our deeds and it just completely consumes us.

So to sort of sum all this up. We always we always talk about a person with pain like a car with four flat tires. And everyone's expectation is all I need is one pill and I'm good to go. The problem is though inputs air and one of their tires in a bag of the 30 40% is designed to do, but they still have three five cars and they can't go anywhere. So the question is, what else do they need and for every person is going to be different. It could be physical therapy. It could be counseling. It could be nutritional guidance, maybe a pyramid support group when they get all four tires filled it's their job to maintain their car, you don't take your Car back to the dealer and say, wash my one to have a filler up secure job if something goes wrong with the top car and we take it in for a checkup. You see it's a combination of treatments and therapies with the person was paying at the center is going to get you up and get you going again.

So thank you very much for your attention and excuse me. That is our web page again all the tools I showed you are free on our website or you can call our office to get direction. Thank you very much.

HELEN BURSTIN

Thank you so much, Penny. Appreciate it. We are at time, it turns out, but I have been given special dispensation. If our speakers can stay with us we'll try to go till two o'clock eastern time to try to capture some of the questions they have been a remarkable amount of questions in the chat box. I think many of which you have addressed as we've gone through it. but why don't we try to highlight a few key areas to start with.

This issue of unintended consequences of guidelines came up repeatedly in the chat as well as our prior discussions, including specifically to Christina's point about misinterpretation and misapplication of the guideline. How do we prospectively, think about measuring the both positive and negative impact of guidelines and I really liked what Roger said we can't just look at how much Opioids are prescribed in terms of the outcome of a guideline what how do we better interpret. Some of these Outcomes that were mentioned like function and quality of life into the assessment going forward?

ROGER CHOU

It has been a challenge to evaluate policies and guidelines, because you know, by nature, you know, these are implemented in the real world. They're not randomized trials, etc. and a lot of the research has focused on looking at data from administrative databases, which are just not set up to look at those types of patient centered outcomes. I think that we need to develop you know perspective registries where Perhaps using some of the tools that Penney or similar to some of the tools that Penney describes where patients can be reporting their outcomes. And we can actually understand What's happening, not just with the guidelines and related policies, but with different types of treatments and approaches and things like that. I think that would be a pretty powerful. Tool to look at it. But I think the bottom line is that our tools right now are often administrative databases, which is mostly you know billing and coding data and they're just not set up to look at the types of patient outcomes that are really important.

CHUCK RICH

Yeah. I would also add a second what Roger just said, and I would extend that even further to say again, look at the practical what the practice based Application of the what happens again and measure the effect actually in the real world practice, not so much in in the academic center, but in the primary care practice discreet level practice again that you have these patients and day in and day out into practice.

CHRISTINA MIKOSZ

This is Christina. I just wanted to chime in and I echo everything that Roger highlighted about limitations of common data set. Several often use of this kind of evaluation. I can speak to what CDC is doing it a lot of our work looking at opioid prescribing trends, the claims data to examine what trends look like an opioid prescribing and No doubt, as far as Roger highlighted it really does lose that downstream impact on patient says it's not well captured there. However, it does have some utility and looking at least in the intended audience. For example, the CDC guidelines and taking a look at provider populations and who may have had some impacts that open prescribing practices that could have been potentially a downstream effects of the CDC guidelines, which of course was just talking to friends. Right. Yes, certainly. I do appreciate comments limitations.

HELEN BURSTIN

Daniel. Any thoughts from the perspective of a payer that often is pretty reliant on claims data, certainly not the initiative, you mentioned, but maybe your perspective on how we can get from where we are now, to where we need to be would be valuable.

DANIEL KNECHT

I'd say, um, you know, we as an industry to add the limitations of just data demographic data, I think. By in the era of increased engagement and topper ability, being able to tap into our EMR data is really important, I think, also, we just need to be more, you know, patient centric and really get their insights And much more than, than we are now. So I think that's something you know as an industry room. We really need to put more effort into.

HELEN BURSTIN

Yeah, I think that leads in nicely what Penney pointed out around, don't, don't tell me teach me and the importance of shared decision making is really a cornerstone for a lot of these discussions. Any comments around how we might really be able to build more shared decision making, including around tapering and other topics into what is often a very crowded clinical visit as one of the participants pointed out on the chat.

PENNEY COWAN

Yeah, I can begin by answering and, you know, using some of the tools that we had Letting the person page, excuse me, know that they have to prepare for their visit ahead of time. So that they're ready to really have a meaningful discussion and then that they have that right to ask questions and not to leave the office, unless they understand what they're being told. Or the teach back moments for the provider to actually ask the question. Do you understand what I just said because too often, people just sit there and shake their head. And they really don't even know they're just doing it. So I think there needs to be more understanding between the we're having a meaningful conversation that that person was paying has every right to ask questions and be part of that conversation.

CHUCK RICH

It can start from the minute the patient checks in the lobby of a practice, you can actually start administering tools layer. That a patient can be filling out while waiting to be seen in terms of documenting their experiences and water expectations are plus again. And one of the things I teach providers is to take a second slow down and try to listen to the patient for at least a few seconds and everything what, what a few seconds of just listening to the patient can make to that patient encounter.

ROGER CHOU

Yeah, I was. I was just going to say. I mean, I think it's important for I think actually clinicians actually aren't always clear what fair decision making means they think it's just leaving it to the patient or just going along with what the patient is saying, and it really does need to be a shared process. And there are some decisions that are more you know, the applicability of shared decision making really depends on the decision.

So if a patient is unsafe if they've had an overdose. For example, and it's unsafe to continue them on opioids, you know, that's a decision that clinician has to make But decisions can be made on a shared decision making basis about how the tapering would go, how frequently or how quickly it would go, what kinds of tools can be used to help the patient through that. And I think the clinician has to be clear about what kinds of decisions, you know, are really amenable to this shared decision making process.

And like I said, there are times when the risk just outweigh the benefits and it is the responsibility. I would say of the clinician to take action but there's always a role for shared decision making. I guess is my point, it's just has to be clear, like exactly what is being addressed in that process. Yeah.

DANIEL KNECHT

No, I think that's right. I think from a perspective, you know, we are when we make our clinical policies we rely on You know body of evidence available and in the space of chronic pain and so unfortunately there's not as much as we'd like to see. So it is threading a needle, but ultimately our viewpoint, as I said earlier, is, you know, trying to Hold that relationship between patient and then position as sanctimonious as possible as we can.

HELEN BURSTIN

That's a great point. Another person in the chat box, specifically talked about what strategies patients can use when they face barriers for non opioid related therapies that many of you emphasize the importance of including behavioral health services a complimentary pain therapy so Some of you know we as part of our the ministry. We're working on a patient journey map to really see where there is evidence, where we can help patients as they explore that journey. Maybe in our last two minutes. Just a quick lightning round for the speakers who could stay with us briefly just if you had an opportunity to do something right now to really address the issues of pain management for patients, particularly in light of what's been happening with But, bit of a resurgence in telemedicine. What might you recommend that we focus on next.

PENNEY COWAN

From both start first been in I think that, you know, encouraging people staying in touch with people. Again, I talked about that isolation. And I think that's only more intensified with COVID-19. So I know like for our support groups. They're doing a lot of them where they're doing they're actually doing zoom meetings or at least reaching out and calling each other. And I think for providers to have that telemedicine so that they don't miss her appointments with a lot of people. They're afraid to go out looking Thinking, I have all these codes, the same conditions that I'm going to be more rest.

So I think telemedicine is an excellent way. But again, you know, just to reach out and make sure that they don't miss those appointments. They depend on them. And I know I heard about the know they can't do the urine drug strings and all of that right now. So, you know, I'm not sure how providers are dealing with all that we've covered when people can't go in, but you know just staying in touch with people and keeping them active is really important so that they can maintain all this great

ROGER CHOU

No, I would agree with Penney and i think you know the In the past, I think. Telemedicine has been under utilized in the arena of chronic pain as well as treatment of Use disorders, and I think this is an opportunity, I guess, to really bump that up. I mean, this has actually been a long standing problem. People who live in rural areas and being forced to come, you know, drive two or three hours to see their primary care doctor every month or every three months. You know, it's really, really has that really been a reasonable strategy or, you know, you know, should we have been doing a lot of this all along. So I think

this does give us an opportunity to rethink some of our practices I you know the some of the zoom or the You know, face to face, online stuff is actually, you know, probably just about as good as doing things face to face. And so I think we need to shift our thinking. We need to, again, understand the patient perspective about the kinds of burdens and and you know that are being placed on them and to try to work around these things and to You know, again, just facilitate care and patient centered way.

DANIEL KNECHT

Yeah, I think the only thing I like great comments by the, by my peer panelists is just let's not forget about that the social determinants of health. At this time, you know, good nutrition. Addressing isolation. On those sort of. We don't do that, then those that domain has been guiding you know as had shorts for a long time, you know, it's even harder now with COVID-19. But that's when we really have to be innovative and address some of those topics.

HELEN BURSTIN

Yeah, and I'll add that Having seen the disparities that have become very apparent during COVID-19 as just shining a light what's already been there about thinking even more broadly about other factors that are going to limit patients access.

CHUCK RICH

Yeah. Yeah, just a willingness. And I said, well, but I think the power of bravado just the willingness to pivot and go and go with, but we have there's these are challenging times. And certainly, again, it's nice to be able to see the patient, every month and the clinic and do the drug free and every month in the business, but we can't do that. So we have to adapt and within reason, they get adapted make use of those Little things such as telemedicine.

CHRISTINA MIKOSZ

Sure. This is Christina. I think great points have been raised by others on the panel. I'm don't have much to add to that, you know, I do think it'll be interesting to See how telemedicine practices, maybe tweets since coated is really forced us to have a quick pivot. It really has exposed vulnerabilities. If we're patients for pain management and you know there have been some annotations of policies by federal agencies to help us to enhance our medicine. So I think we see stand alone a lot that is great.

HELEN BURSTIN

Thank you so much. And thank you to this wonderful panel for I really shining the light on some incredibly important issues as we move forward around pain management.

SESSION FOUR: MOVING AWAY FROM A TREATMENT ONLY APPROACH: ACCELERATING EVIDENCE-BASED OUD PREVENTION PRACTICES

ELIZABETH FINKELMAN

All right. Hi everyone this Elizabeth Finkelman, welcome back to the Action Collaborative virtual Symposium, our next session will focus on moving away from a treatment only approach.

Accelerating evidence based OUD prevention practices. So treatment has been a major focus and addressing the opioid crisis but experts are turning to prevention strategies and hopes of earlier and more effective interventions. And so I'm delighted to introduce this panel of experts who will discuss strategies and promising opportunities to prevent opioid and other substance use disorders. That span clinical care, social and community based services policy and practice.

The session will be moderated by Alonzo Plough, who is chief science officer at the Robert Wood Johnson Foundation and joining Dr Plough is Dr. Elizabeth Salisbury-Afshar who is director at the Center for addiction research and effective solutions at the American Institute for Research Dr. Marcus Plescia who is chief medical officer at the Association of State and Territorial Health Officials. Dr. Helena Hansen who is an associate professor in the Department of Psychiatry at NYU Grossman School of Medicine. And Mr. Devin Reeves, who is executive director of the Pennsylvania harm reduction coalition.

Their full biographies are available on the website for you to access and please note that we will be taking questions from the webinar audience during the last 10 minutes of the session Please use the Q&A box on your screen to answer or to entertain me a question. And now I will turn things over to Dr. Plough. Thank you.

Alonzo Plough

Great. Thank you, Liz and good afternoon and late morning on the west coast to all the people listening. I'm going to just frame, a little bit of what's going to be a very exciting set of presentations by the panelists and I'm going to think a little bit about this being as moving toward A prevention approach rather than just exclusively away from a treatment. Only I think part of what we want to come out today is an imperative for prevention. With a clear understanding that is connecting prevention to treatment, but trying to really think about how we can maximize the opportunities that are currently missed around prevention in opioid use disorder or substance use disorder in general,

I always turn to The writings and thinking of a particular social epidemiologist Nancy Krieger, Harvard, when I think about the challenges ahead of us. And some of you know, Nancy talks about getting to the causes of the causes. And those things that are prior to the manifestations of social determinants. What is it that makes housing poor, what is it that makes populations marginalized. What is it that creates those life conditions that provide for our set the stage for an equal life outcomes, those very important as we talk today and you will see it through all the presentations. Understanding the social determinants. What is the causal next was there. What are the possibilities for the earliest intervention along this pathway. And it's complex.

But it actually is a pathway that we need to understand And it also involves a different kind of both trans disciplinary and multi sectoral approach. And as we go through what the speakers are going to present and the discussion. I hope we aren't scared away from the fact that Most of us aren't trained and most of our institutions aren't aligned to do the kind of prevention, we're talking about today, but hopefully this will be a guide. To what that looks like. So we can think about these broad shifts his life conditions these social determinants of health as we see also in COVID-19 and I'm sure we'll come back to COVID-19 a lot today. Are responsible for the differences in mortality difference in outcome difference in prevalence that we see related to race and income. Also a variety of isms influence these social determinants and we need to consider that if we talk about this today.

Some of the things that I think a prevention frame lets us think about is, you know, what are the early precursors, and understanding of cultures of despair, whether they occur in urban or rural areas, how can we What are better indicators before that is manifested clinically in addiction or other problems. How do we think about well being and in an earlier way as part of the prevention pathway. What, what do we do to drive our intervention systems toward those earlier intervention points. Before you get to an early stage of clinical our diagnostic threshold that sort of the essence of moving to a prevention grain. And the social determinants thinking that you'll see is very much a part, and many of the panelists are talking about the way we think about levels of prevention stages of prevention. And the role of social determinants and the role of other factors of marginalized populations who get worse outcomes than our fear and just given those conditions.

I'll end this framing with a little heads up on and maybe a spoiler alert on a Special Issue coming out on from health services research that relates to a year long project that foundation has done the number of researchers around the country. On rethinking how we capture graphically, the social determinants of health and think about it.

But here's a spoiler alert, as you look at it, major question is, is it a pie chart. Maybe, maybe not. If it is, but things have changed since that wonderful baseline work on nearly 25 years ago role of genetics as we're thinking a little less. This is before people thought about epigenetics. Right, so probably less than genetics. Of probably smaller role of behavior FTC behavior as a correlate of social conditions and opportunities, probably a large role in understanding the social conditions. A larger role and understanding environment broadly defined, and actually a larger role than that pie chart shows for healthcare, particularly in terms of access unequal access lack of health insurance and how that becomes a Social determinants of health.

So with that, just to kind of kick it off. We have a great panel wonderful information that they're presenting So we will start out just in the sequence you see on your slide. So Elizabeth I am turning it over to you. And I'm going to hope everybody kind of stays within reasonable confidence intervals in their allotted time, Elizabeth.

ELIZABETH SALISBURY-AFSHAR

Thanks so much. So I did just want to give a disclaimer that I am an addiction specialist and family doc and public health doc and I just looking at the title of this and just thinking like, it feels although I've worked a lot of my career in public health. Also, just want to acknowledge that although the title says we're moving away from a treatment only approach that I don't think any of us are suggesting that we're moving away from treatment as part of our approach. I spend a lot of time sort of focusing on expansion have access to treatment and just want to be clear up front. And I think it's still an important part of the bigger picture, but definitely not the only part.

I was, I think I was largely invited to sit on this panel because I am an action collaborative member in the prevention, treatment and recovery group. And we've been working on a white paper that focuses on how to apply the prevention framework of the levels of prevention to opioid And opioid use disorder. And I just wanted to spend a minute or two sort of describing what it is, in case people aren't familiar, and then talking a little bit about where some of our conversations have been this far. We had hoped to have the paper ready by now, but probably not surprising to many on this group , COVID-19 kind of put us, you know, realigned some of our priorities, unfortunately, and we will we will get there but for the prevention.

The levels of prevention frameworks really uses the point at which someone Developed or chronic disease or condition as sort of a central point of the model. So any interventions that are focused on preventing the onset of that disease or health condition are considered primary prevention, so In the case of type two diabetes. This would include things like maintaining a healthy body mass index, you know, exercise, healthy diet, etc. secondary prevention or interventions that are aimed at identifying that disease or condition early So often, things like screening tests and then initiating treatment of that disease or condition as early as possible. Ideally, even before people are have developed symptoms or before their disease has progressed.

So in the case of type two diabetes. This would include things like annual screenings and early initiation of treatments. And then tertiary prevention includes interventions aimed at mitigating negative consequences of that condition. And so one of the things that I think was really striking for me as we started having this discussion about how we apply this framework in the opioid space. There are a few things.

So one when we talk about prevention. Around substance use. So often, our focus is solely on preventing initiation of OUD. And we actually had quite a few conversations about what fell into that category of primary prevention, was it only prevention of any opioid use or was it also prevention of the development of a use disorder. And so, you know, I think that when we think about the war on drugs and a lot of the framing that's happened in our country about people who use drugs. You know, it's often sort of this assumption that anyone who uses heroin. Anyone who uses illicit substances is going to develop an addiction. And that all people who use drugs are bad and all drug use is bad. And so one of the things we spend a lot of time talking about is that primary prevention should include not only Working to reduce the chances that someone initiate drug use, but also work to reduce the chance that someone who does initiate drug use goes on to develop a use disorder.

And so often when I give talks to medical providers or even late audiences. I spent a lot of times we're talking about and reminding people That many people use drugs and alcohol. And in fact, the majority of people who use drugs and alcohol. Do not go on to develop a substance use disorder. And we know that there are certain factors that are protective and certain factors that increased risk for the development of that use disorder. And this is definitely an oversimplified visual, but I think just to give us a sense. So we know that there is a genetic predisposition. That can increase the risk that someone develops these disorder. This has probably been best studied In the case of alcohol use disorder where we think about 40% of the chance of the likelihood that someone developed an alcohol use disorder is based on genetic predisposition. Obviously there are also behavioral factors that apply because in the case of substance use disorder. You can't develop a use disorder. If you've never tried that substance. And then there are many, many environmental factors. That can either be protective or increase the risk that someone develops use disorder and I just listed a few here, and I know many of our panelists are going to be talking about additional factors today. But these include things sort of at all levels.

So if the interpersonal level at the community level at the sort of institutional and structural level societal level and policy levels. So we know things like parental substance use can increase the risk that Young people try substances. We know that adverse childhood experiences. For example, the more adverse childhood experiences, one has the higher risk for developing addiction. We also know the institutional structural factors. So things like eco equitable educational opportunities living wage jobs as well as racism can play a role in the likelihood that someone develops addiction. So as we started as a group really looking at levels of prevention and interventions specifically it, you know, using this framework.

Again this isn't an exhaustive list, but I think one of the things that we found is when you look at the evidence base with regard to what actually has been shown to reduce the risk of developing addiction. I'm in the primary prevention space. You know the it was it was somewhat limited specifically for opioids. So a lot of the youth, education programs have really focused on alcohol, tobacco, and marijuana. We do have some youth based youth skill based Youth Education programs that have been shown to reduce prescription opioid misuse, but there's very little actually looking at The transition to opioid use disorder and also not a lot specifically looking at people who initiate youth with illicit opioids, which we are seeing increasingly. There is some evidence for prescription drug monitoring programs in the primary prevention space, but it's much been much more focused on, or at least the outcomes that have been found are much more focused on Reducing prescription related opioid overdose and we've all seen the data from CDC showing that we're sort of transitioning to increasingly illicit drug related overdoses.

And so, you know, the impact that please will play I think is, is Evolving as we see reduced access to prescription opioids and increasing use of elicits and increasingly method methamphetamine as well. When we look at secondary prevention, a strong evidence base. There's obviously been a lot of focus. On increasing access to medications for opioid use disorder. We know that this is an intervention that can show pretty Short term impact. So through increasing access to medications like methadone or buprenorphine. We have been at the population level reductions in mortality. Reductions in illicit youth increases retention and treatment, etc. So again, a lot of focus there.

And I know I probably don't need to say more to this group about that. And then in the area of tertiary prevention strong evidence base for syringe service programs, particularly around reducing morbidity and mortality, morbidity around HIV and Hep C transmission, as well as skin infections related to injection drug use and then in the case of naloxone distribution reductions and mortality at the community level.

The levels of prevention and really start thinking more broadly about a couple of things. So one is As Alonzo mentioned, what are the what are the actual changes in our society in our culture that have led to this increasing demand. As well as what are the structural factors that are going to be increasing the risk that someone develops addiction and then makes it harder for people to add.

It's really important that we start sort of broadening our lens. And so in the earlier years of the of the opioid crisis, I think there was so much focus on what are the interventions that we can implement right now that we will be able to measure an impact. Within the next few years, within this election cycle, if you will. And how do we implement those as quickly as possible. I think we're now finally at a stage where we can start thinking much more critically and recognizing, we need to continue to do the things that we've already started with increasing access to treatment and increasing access to SSP.

But simultaneously, we need to be also asking those questions about the structural factors, so I listed a bunch here. I am not going to go through them all in detail because I know many of my co panelists will be describing them. But in the areas of primary prevention, I think really thinking about what are the protective factors that can be enhanced. How do what and how do we reduce risk factors like reduction in adverse childhood experiences, reducing trauma, increasing educational opportunities, housing opportunities. How do we enhance family support and ensure access to living wage jobs in the area of secondary prevention.

We've heard a lot about stigma today and I just want to say in working with patients with addiction. You know, I hear so often that people were afraid to step forward or to disclose or to ask for help because of the stigma, you know, in the broader society because of fear of losing it losing a job. Because of stigma

that they experienced when they tell a medical provider that they have addiction or the stigma they experienced when they actually receive addiction treatment services. So a lot of work to be done in that space.

Additionally, we know many people with substance use disorders have co-occurring mental health condition so ensuring that we have actual parity. So we have it in LA, but not usually in practice with regard to access to mental health screening and treatment services or supportive housing. I had the opportunity last year to visit Portugal, where I was really impressed by the fact that they have a really comprehensive sort of support systems in place for people with addiction that includes housing for as long as someone needs it. It also includes job training and job placement programs, and I think it was just a model that as I thought about the struggles that many of the patients I work with have would be so immensely helpful in their lives. Finally, incarceration diversion programs, we are seeing increased uptake across the US but increasingly, I would say in rural white communities and it's really been only since this has been seen as more of a white disease that we've really started to have a conversation about the fact that we can't arrest our way out of the opioid crisis, and so I think it's really important again to acknowledge the racism that has played a role in all drug policy in the US. We know that addiction is a medical condition and therefore I would argue that incarceration is not the right treatment, if you will, is not the right response to a medical condition we need medical and other support services to really support people.

Finally, in the area of tertiary prevention, I know Devin will be covering many of these. So I'll move through quickly housing first models. We do have them in the US. We do not have enough. We often have taken the stance in the US that only people who are not using drugs, only people who are abstinent deserve access to housing, deserve access to treatment, deserve access to jobs. And I think that this has been the wrong approach. And so we know how thing first models work. We just need to fund them. Overdose prevention sites. Again, I think Devin's going to talk about this. I had the opportunity to visit several programs in Canada. I think one of the things that I brought home with me that I was most impressed by was actually the level at which the peers, the people who are actually using drugs and engaging using those services as clients, were also employed at these programs. And the importance of job opportunities for people who are actively using drugs and finally safer supply is not something we talked about a lot in the US, but also visited some programs while I was in Vancouver and saw how it could be a tremendous benefit for people for whom methadone or buprenorphine specifically just haven't been the right fit.

So I just want to end on this side, which is this model of recovery. And I think that is such a beautiful model. And I also think it's a great recipe for prevention. If we think about it in the broadest sense possible. So, it focuses on health, or what I might call wellness, home or access to safe housing,, a safe place to live, a sense of purpose, and recognizes the importance of community.

So often when I look and talk to my patients about the factors that led them to drug use in the first place. The factors that really led, you know, caused them to develop addiction and then have kept them in that cycle for so long. It always stems back to one of these for and for many patients. Unfortunately, all four of them. And so I would just encourage us all again to pull the length back and think broadly about how we're addressing this moving forward.

ALONZO PLOUGH

Great, thank you very much, Elizabeth. We'll move to our next speaker, Marcus.

MARCUS PLESCIA

Right, thanks Alonzo. I'm really pleased to be here and have a chance to present to the committee. I'm here representing the Association of State and Territorial Health Officials. This is just a quick slide that describes the work we do in our membership. We basically represent the state public health leaders in every state and in the US territories and then we also represent the staff of each and every state and territory health agency, which has a workforce of about 100,000 people.

This particular topic, moving beyond treatment, moving beyond treatment as the only approach to the opioid situation is one that we've been very, very interested in and asked for quite some time now because our membership and our workforce is so focused on prevention, the different levels of prevention. And so I put up a slide here just to give a little bit of background. This is a commentary that Mike Frazier, our CEO and I wrote about a year ago in *The American Journal of Public Health* really sort of urging along this very theme that we need to continue to be very attentive to treatment approaches to opioids, but we really need to find ways to move beyond that and look at ways we can prevent this in the first place. We actually used a framework in this commentary that was a framework that was developed by the Institute of Medicine, a few years earlier, looking at different approaches to prevention and we use the framework of looking at universal approaches, selective approaches, and individual approaches.

I just want to speak to that a few minutes in the commentary. We talked a little bit about universal approaches which are really societal interventions that try to deal with many of the social problems that are clearly an underlying cause for addiction and we actually cite in the commentary, the work the Trust for America's Health did, setting out a national resilient strategy which we think has some very good suggestions of how to approach those things in communities and is it has a very strong evidence base. On the other end of that spectrum of prevention, indicated interventions, we discuss among other things prescription drug monitoring programs. So the idea with an indicated intervention is you want to identify people who are maybe in an early stage of experimenting with or using drugs or alcohol and intervene at that point before they develop a significant addiction and we felt that prescription drug monitoring programs are a good example of that. And then sort of in the middle are selective interventions that are aimed at groups or groups that are greatest risk. And one of the examples that we used for selective interventions is ACES, or adverse childhood experiences.

And that's what I'm going to speak a little bit about since we've had the opportunity to ask them to do quite a bit more work trying to explore this. Particularly state public health departments can work on beginning to impact basis and I'm going to spend the rest of my presentation just giving you a specific example of something that we're doing. But I did want to start off with this context. I've also given a link to this article if you're interested. We did make it open access, so that people could have availability of it.

So I think people are familiar with the concept of adverse childhood experiences. These are basically harmful events that occurred during formative years and you see that they sort of fall in a continuum. There are certain things that can set up a greater likelihood for children to have adverse experiences, but then you see as you go up the pyramid there are so many outcomes that are of importance to us. If you can see the virtual boxes really puts this in the context of health and public health and you see the wide range of things where there's been clearly an evidence based link between adverse childhood experiences and various health or public health outcomes. One of those being alcohol and drug addiction.

So we've had the opportunity to begin to try to really explore work on Adverse Childhood Experiences and what kind of portfolio there is in states through some funding that we have from the Centers for

Disease Control. And I think this is important because there's a great deal of research and evidence based around how adverse childhood experiences are. But how do you actually approach that and put things into practice that can impact those experiences or help mitigate those experiences is what we wanted to explore and what we think is an important role per state and territory health Departments. And so our platform or work really runs across three areas that I'm going to talk about each one briefly. We started something called an ACEs learning community. We've done a legislative scan looking at some of the policies in state government that can be impactful around ACEs and then we've done a capacity assessment tool and survey of our membership to get a sense of what state public health departments are doing in this area, who's doing it. What kind of work is going on and what kind of capacity we see having in place. I don't have a slide about the ACEs learning community. So just a couple of things about that learning communities are very common intervention for us to enact. So we convened a group of states, often their early adopters on a particular area. And then we really create a very collaborative experience where states can share best practices amongst each other. And out of that we're also able to pull away some of those best practices that we can ultimately share with other states who are trying to get started on a specific area. So that's we have seven states in that collaborative now. And that's sort of an ongoing activity.

This slide just gives an example of some of the areas through the learning collaborative place. These are some of the community level interventions. The first of which is evidence informed the other two are considered to be more evidence based and these are things that we've seen in the seven states in our learning collaborative. I think most people are quite familiar with the Nurse Family Partnership Program. That's quite widespread as far as its use in state and local public health departments. These just a few examples of some of the other things that we've seen states experimenting as well.

We are very, very interested in policy because we represent state public health leadership. We have an opportunity to work very closely with state leaders who are capable of introducing policy or influencing other policymakers to introduce policy and have a great deal of influence around that. As I mentioned, we've begun to try to map out what some of the different states are doing around policy that pertains to ACEs and this is just some examples. We thought that the basic framing of the issue as it's done in Utah was very helpful in that it lays out and provides additional credibility and visibility to the issues around ACEs and then some very specific things that deal with some of the underlying things that set boundaries up to experience ACES, social conditions and some of the interventions around livable wage, increasing minimum wage, earning caps tax credits. All of these things are things that are emerging that we're seeing many states start to experiment with and then other areas that are particularly compelling right now in the middle of the COVID epidemic like paid leave.

So that's a little bit about our learning collaborative and some of the policy interventions that we're seeing start to emerge in states. And now I'd like to go a little more broadly and talk about this assessment that we did across all states and territories, looking at kind of what is the capacity of infrastructure to work on ACEs in state public health departments and you'll see we got a 75% response rate, which is quite good. And again, the objectives were really to begin to understand what the capacity was. So, some of this is pretty basic, but I would say that the work around ACEs and really a lot of the work around specific areas that are more oriented to disparity and social determinants is still going on. What we found is that most of our respondents in states who are working on ACEs type of areas are in a maternal and child health component of the State Public Health Department. That seems to be the area that's been the most engaged. And then about half of respondents are spending at least half of their daily work on ACEs, so half. I mean, I don't think we had very many instances where we had full time equivalent. So it's probably somewhere person working have to pull time on this particular area.

Infrastructure capabilities. So, you know, in addition to having the infrastructure within the State Public Health Department. Most of the work in state health departments is done through partnership with others. And you see that here with aces. About three quarters of jurisdictions are working in partnership with other parts of the public sector. Around issues related to aces and then interestingly, a little more than two thirds are actually beginning to enter into public private partnerships.

And I'll just close now by giving you a little bit of a sense of the kind of areas that we are seeing states to be to develop capacity and then the next show you some whether or not I broke this down in the same format that you just saw from Elizabeth looking at primary prevention, secondary and tertiary. So, you know, we see quite a bit of capacity being built around programs that are designed to give children a stronger starts A considerable men around teaching various skills that can be helpful with preventing or mitigating the effects of aces and then around more secondary prevention. A lot of states are now collecting information about aces in their Behavioral Risk Factor Surveillance survey and a number of states are beginning to try to use those data to better Target their interventions quite a bit around behavioral health and schools. And then in the area.. Those were tertiary at the orange or the tertiary interventions and then the, the blue intervention facilitating Child and Adolescent linkages to care. Many of secondary prevention. So those are some areas that we see beginning to emerge that States feel like they are beginning to have some capacity to do.

Lays out some areas where the capacity is less some areas we think we could begin to see more development and movement and these are states. These are were states recommend replied that they had either no capacity or very limited capacity. So working in with children who are parents of incarcerated settings. Working to pediatrics rent screening four aces screen phrases and substance abuse treatment. And among young parents and then working in juvenile justice. These are some specific areas that we're going to try to focus on seeing how we can develop more opportunities for sense.

One of the things that I am very proud of, of the work at ASCO is that, you know, in the midst of this COVID-19 epidemic that really has, you know, completely Occupied our leadership i mean it's been very difficult to do much of anything else in a state or local health department right now because of the covert outbreak. But early on we put some out for state health department technical assistance really trying to keep some focus on The whole issue of opioids and particularly on the issue of adverse childhood experiences because we're in a setting. Now that is just so such a Such a significant risk to see more and more of that. And so I'm not going to go into detail, I want to stay within my five to seven minutes, but I didn't want to show this slide. Both of the, I think the audience has these slides as well. Both sides have a link that you can follow if you want to look at some of those specific materials that we've Developed but some of this really is trying to anticipate the back that carbon 19 is going to certainly exacerbate aces and it's so we're already beginning to see data suggesting that it's exacerbated the issues we've seen around us. So thank you very much. That concludes my presentation.

ALONZO PLOUGH

Great, thank you. Thank you very much. Marcus. Our next presenter is Helena Hansen.

HELENA HANSEN

Thank you so much. So I first want to make sure you can hear me.

ALONZO PLOUGH

You're good and clear.

HELENA HANSEN

Great want to start by pointing out that the opioid crisis inspired the most biomedical treatment oriented policy response to substance use and recent US history. So that's just something to bear in mind. It's a leap forward from earlier prohibitionist and drug war responses. But our enthusiasm for pharmaceuticals has not been matched by intervention on Route social causes of overdose and we paid the price.

And accelerating overdose deaths. So this could be otherwise, France, for example. Next slide please. Often held up by us treatment advocates as an exemplar of dissemination and overdose prevention has other critical components to its opioid policy that are not mentioned in the US. Foremost is a well funded national network of coordinated community based harm reduction and treatment centers.

But offer comprehensive social services, housing assistance peer support as well as we've been orphaned methadone or Suboxone, syringe exchange and safe injection facilities. These centers reach low income people and immigrants who can't easily access primary care doctors, despite universal French health coverage. The centers have nimbly adapted to go visit employing outreach workers to provide mobile services and medication delivery in a coordinated national fashion.

So back to the US for a moment, early reports on the compounding effects of COVID-19 and opioid use suggest that opioid use disorder increases the risk of death. While COVID-19 restrictions on clinics and social contact contribute to the risk of opioid overdose. So social determinants of health connect these threads. And this is a window of opportunity for us to invest in social determinants and community based services. In the year after I first spoke with this collaborative I've worked with members of the Collaborative and additional co authors on two articles about addressing structural and social determinants of opioid use disorder and I'll share the highlights from those now.

In the first paper we establish parallels between opioid use disorder and COVID-19 in terms of their social determinants and unequal death toll by socioeconomic status, race, ethnicity, and geography. We show how traditional pie charts. Next slide of percentage contributions of social determinants outcomes. And I think a lot so was hinting at this Next slide are somewhat linear. Next slide. Well, few well newer infographics represent a less linear more interactive model of social determinants of health. Next slide please. That are important for showing how for example, local economies housing and work conditions and healthcare access all influence each other. This sets us up for us, for our argument that addressing social determinants of health in opioid use disorder and COVID-19 requires a multi level comprehensive approach because each level of intervention influences the success of other interventions.

So, for example, stabilizing housing an income makes clinical care more accessible and sustainable over time. We also highlight the literature on social determinants of opioid use disorder initiation and outcomes in particular. So out some of those have already been mentioned by other panelists including trauma discrimination and stigma punitive drug laws.

As well as post industrial economic and neighborhood displacement, leading to disrupted social networks. For a model of successful intervention on social determinants of health. Next slide please. We look to AIDS activism that led to integrated peer support social services, housing and community based harm

reduction as well as community input into federal and state funding allocation which dramatically lowered aids death rates. We then provide examples of successful opioid projects in the US that integrate social services with clinical care and draw on community based and cultural heritage organizations to meet at risk populations where they are, including.

The remote spoke and hub model which integrates multi specialty care with primary care in rural and urban areas as well as social services. The criminal justice continuum of care for opioid users and. Next slide. An initiative to integrate medications for opioid use disorder with Native American traditional healing practices as well as breakthrough a partnership of opioid Providers Peers in recovery and African American and Latin next churches to integrate community members with treatment. We end with a call for robust state and federal funding for integration of clinical and social services peer support and harm reduction. But also for defining upstream policies like economic revitalization and dis invested neighborhoods and affordable housing as well as interventions in themselves as interventions in themselves for sin dynamic opioid and COVID-19 deaths.

In the second paper we critique the simplified reading of Ann Case and Angus Deatons depths of despair argument as a linear relationship between the industrial white working class unemployment and overdose deaths. By pointing out that life expectancy and drug use very significantly among low income communities. We point to the ways that media representations. Next slide of opioid overdose as.

After that, Media representations of opioid overdose as a white problem. Next slide. Makes invisible its toll on black Latinx and Native Americans. We historic size, the role of institutional racism and US drug policies through the last century from early 20th century Prohibition. Prohibitionism to the war on drugs. Next slide please. And contrast government responses to heroin and crack problems in urban black and Latin next communities of the 1960s to add framed as a crisis of crime with government responses to opioids and white suburban and rural areas of the 2000s framed as a crisis of public health. We provide a theoretical analysis of structural racism as a fundamental cause. Next slide. Of the current opioid crisis, including the ways racism has negatively affected whites who were, for example. Next slide please. targeted by opioid marketers and inadequately protected by regulators who focused on drug focus drug control on communities of color. We then recommend opioid interventions that address structural racism from including communities of color in the narrative of who's affected by opioids and in the development of national and local policies on determinants of Overdose next slide to requiring racial impact assessments of opioid related policies. Thank you.

ALONZO PLOUGH

Thank you. Our last panelist is Devin Reaves.

DEVIN REAVES

Yeah, hi, everybody. Thank you very much, and everybody else has been awesome. All right. Hey, everyone. I'm so excited to be here. My name is Devin Reaves and I'm the executive director of the Pennsylvania harm reduction coalition And probably the first thing I want to just say really clearly as I'm a person that has used a lot of drugs. I did 10 years of research using drugs experimenting with drugs and that was Really shaped my experience, becoming a professional who really does drug policy if you are interested in sassy tweets and Instagram means please follow me on social media.

Here's a little bit information about my organization. And so I explicitly want to say I often have a hard time working with academics, working with doctors Because they're walking around with their like white jackets on and just white people nonsense and academic towers and not everyone is like that. But that is often my perspective. So I always feel weird when I'm asked to hang out with academics. Because I say things like the war on drugs is the problem. And if that's not the first thing we're saying if you're using code words like discrimination or social determinants of health. To me that's BS, it's white people oppressing people of color, it's people in power oppressing people of color and then what does that look like. Well that looks like a drastic increase in Black and brown people in jail looks like our prison system ballooning.

We talked about ACEs. This is what we're talking about right here. This is what drives everything. So that's where we need to start off And if we want to fix this. We need an actual advocacy movement research papers are excellent. I love research papers. But, you know, if we don't have academics that are stepping out of the tower going to their state capitals, learning how to communicate. Learning how to speak everyday person that research doesn't matter. And we also need everyday people that are passionate about substance use disorder and at my organization. We have something called the hero initiative. It's about identifying people that care educating them on how to be change agents and then activating them.

And so the war on drugs has done a lot more than just create a prison state in the state of Pennsylvania. It's also created this nation that is at risk of HIV and hepatitis C outbreak amongst people who use drugs. And if you look at this map. This is really scary almost the entire country is at risk of an outbreak of HIV and hepatitis C amongst people who use drugs because we don't do a medicine first response. We do a criminal justice response.

And so we think that harm reduction is the solution and let me just like push back a little bit on what Elizabeth said though I thought everything she said was excellent. Harm Reduction is its own thing. It's not prevention. It's not treatment harm reduction should be the big umbrella and everything that everybody else saying is actually underneath that right The broad goals of harm reduction or reduce the health, social, legal harms associated with drug use and let me be clear, doctors, the system hospitals other ones. Oftentimes doing harm. You know, when we have somebody who experienced that overdoses. In the last panel and the doctor says, Well, I'm going to take you off that medicine that is actually doing harm to the patient. It shouldn't be just about a shared decision making process. It should be about how can I provide you information on how to reduce your risk of overdose.

Harm Reduction is also a social justice movement advocating for policies and resource interventions that can meet the diverse needs of drug users and their community. And ultimately harm reduction says you are still a human being, even though you use drugs, you do not become an animal that deserves to be in a cage which we do on wholesale Right, and so the practical harm reduction definition is harm reduction is any intervention which mitigates the risk of a dangerous behavior, right. People do silly things like jump on a perfectly good airplanes. I would jump out of an airplane. If we were all going to die in the crash. If I didn't get into that. Parachute and jump out, however, to do that, under any other circumstances seems outlandish to me. Right. But people do that. They think it's fun and I'm ok for that. And I want them to have a parachute but we don't in whole judge people who jump out of airplanes as somehow morally defect.

And there's all these other examples of harm reduction helmets seatbelts airbags. life jackets and let's get a little more controversial condoms are form of harm reduction, right. We've got a lot of places in America. We don't give out condoms. We tell people I understand you're 16 years old and you figured out

that sex with someone else feels excellent and orgasms are awesome. However, don't do that. And then definitely don't do with anybody else. And here's no information about how to keep yourself while doing these things. And then we also have conversations about what consent is and then we're surprised when we have a rape culture.

And so, access to the lots of is something that feels very middle of the road I want everyone here to know that the very first program ever to give out in the last one, the people that use drugs. Was a harm reduction program in Chicago recovery lines over 20 years ago. And let me tell you how upset FDA was in the government. We're going to come in. We're gonna rescue you can't do that drug users can't be trusted to save each other. Boy, were they wrong and it took us 20 years to change the policy perspective right and we still do dumb things with naloxone Right, there's all these myths. We need to get first responders and lots of. I can't tell you how many places in America. The cops don't want to Have naloxone on to save people right we're seeing in dumb places like India, the cop said we're not going to save people with naloxone because of COVID-19. Great. I'm glad we gave you this life saving tool when you're not even going to use it.

We need to flip the script. Number one, we need to focus on giving the last two people who use drugs. We didn't make sure number two behind them is other bystanders. So that means if somebody in your house is your new drugs. You want to make sure your loved ones have lots of and the least important people have lost them. It's actually seven first responders. Because I can tell you as a black man in America. I'm not trying to call the cops or anything. No reason, don't call the cops unless I'm going to die. I'm not calling the cops. Right. And I can tell you, as a former drug user. We are mostly feel that way we don't want to call the cops. And with the proliferation of drug delivery, resulting in death charges were cops and DHS arrest charge people for murder for overdoses people are less and less likely to call 911 even though we have not wanted Samaritan policies. This is super important for our West Coast people were fentanyl test strips are we're. No, it's just making a new appearance as opposed to the east coast where it's been there for a long time. We need to have fentanyl test strips Seattle Portland, San Francisco, la we're seeing fentanyl showing up in press pills in rent our hair black tar heroin. We need fentanyl testers.

Syringe service programs are excellent intervention when it comes to harm reduction and they do all these things on the left hand side. They don't just pass out syringes, but sadly most places in the country that needs Certain service programs don't have them right we see here blue states are in service programs are legal green states they may be local legally And red states are actually explicitly illegal. Now this map is confusing. There are some insurance programs in Texas, even though it's read The blue state of Florida, even though that whole state is blue. There are only some insurance programs in West Palm Beach Broward in Miami Dade County. So the rest of that state might be red. Right. And in Pennsylvania, we're Green, but only fit Pittsburgh and Philly. Do we have legal syringe service programs. And just to show that it's not like a Democratic Republic thing Alexandra.

These are the US Secretary of Health and Human Services says sir insurance programs aren't necessarily the first thing that comes to mind when you think about a Republican House under day We're in a battle between sickness and health life and death. And let's be clear. The reason that syringe service programs are explicitly illegal is because legislators teamed up with cops to pass paraphernalia laws where they said we found these junkies. But they didn't have any drugs on them. So we couldn't arrest them. Let's make the shift. They use drugs with the legal so we can lock them up and get them off the street. And we really say the same thing and 2020 points. Let's lock them up, put them in jail to get the treatment and that's supposed to be better. I don't think so.

overdose prevention sites overdose prevention sites are amazing interventions, they work in you know countries all over the world, millions of times people have used drugs in overdose prevention sites. Zero times as somebody died. However, the Trump administration thought it was worthwhile to spend time, money and resources to try to ban the first supervised injection facility from opening up in America. We need more lead we anything that strips away the war on drugs lead is awesome. Here's some information about leaders about we aren't in government response. It's about improving public safety. Reducing the number of people entering the criminal justice system undoing racial disparities sustaining and really strengthening the intervention. And just to make it clear black people are getting screwed by the war on drugs. Right. So we see more black people in jail for drug crimes than we are represented in the general population that is just not fair. Right, this is racist race racism. So anytime you're going forward, talking about anything about. And again, I cannot thank you enough. We're centering of white people there. The problem that they had the problem, the solution. The solution is he'll come to black communities and that makes us mad when we are dying at a greater rate and being impacted by a greater rate than white people. We must, in the drug war. For these reasons, once you're part of it. Your life is screwed child custody voting rights employment business and student loans. occupational license public housing assistance and these are the basic parts that are like supposed to be guaranteed you as a human being in America. Thank you.

ALONZO PLOUGH

What a panel. We haven't gotten a lot live since we haven't gotten a lot of questions from the audience. I'm going to start. I'll start with some but I encourage you to take it any other way that you want to go on this one, but I'm going to start Since I'm the moderator. I have some privilege.

I'm going to start with how this is reconnected me to my public health practice life, which is a far longer life than this philanthropic life, you know, and it takes me back to You know, starting the syringe exchange program in Boston. When I ran Boston and then evolving it in in Seattle King County, as we As Devin says we realize harm reduction with a rubric for all of what we were doing, you know. But this leads me to the question.

Around how do you bring these systems of awareness together as a Seattle help director at a local level, I could bring the police chief and the fire chief and the MS director Together to say don't put do a response call beliefs and paramedic and we're going to be given out let no action. No one's going to call so As we the issues we've talked about aces housing. I'm going to throw it out to all of you. These are locally nuanced solutions. And these are also national champ policy challenges. I'm going to toss it out to you to think about how you would work on this. Continuum of hyper localized action versus national strategy?

DEVIN REAVES

Yeah, sure. I mean, I think I would like to see national standards around prevention. I can't tell you. Prevention is our biggest enemy as a drug policy advocate, we'd have prevention, putting out messages like don't use drugs. You don't want to be a loser. Lot. Don't say that people who use drugs are losers stop that stopping our enemy and we also need to see national leaders inside of the prevention space, taking a broader perspective, saying things like effective drug policy is good prevention. Right, I do resonate with what Elizabeth is saying, and that you know these things are part of prevention overdose.

But so often, prevention is like, to me, they feel like this elitist group where we're over here. We take care of the children. And that really fits into the political narrative of constant and cops and politicians really politicians they say I want to focus on prevention, because that is A that is an easy thing to do, politically, they don't have to catch any chance they don't seem weak on crime. And if we don't have prevention saying yes there with us, then we see infringing and radical nothing I've said is fringe radical there's 30 years of research around everything I say when Richard is often skewing things that sound good. Like there.

HELENA HANSEN

So if I can hop in. That's fantastic. And I want to second Devin on a couple of points. One is that we really do have to continue to have the eye on the prize of national standards. I'll just give us an example.

Something I've discussed with the opioid collaborative in the past year, which is in New York City and Staten Island, which is the Wealthiest in widest of our burrows. We have a program called Project hope it's a product of collaboration between the CIA's office and community activists there to Systematically divert people who've been arrested on low level drug charges from sentencing and to channel them towards Drug treatment partnering with a peer who's in recovery a host of other services and this organization has diverted over 50% in the past couple of years. Low level people who have low level drug charges from sentencing, but we don't have the same program in The South Bronx, which currently reports, the largest number of overdoses and their arrests and sentencing gone. So if we just leave it up to local action we're going to, we're going to see more empowered white communities. Doing things to protect themselves are not going to see the same kind of proactive measures applied in low income black and brown areas. That actually are actively being repressed by criminal justice agencies and things like that.

So that's an argument for national standards. But on the flip side of that, I think we also need to highlight and celebrate local innovations. So the key is, and I think a lot of times it's a failure of imagination in many areas. So we need to have cross fertilization of ideas and technology exchange. I before this panel. I just got off the phone from an evolving international network of people who are collecting data on A community based harm reduction organizations in many different countries and how they're creatively responding to COVID-19 and so much great So many great ideas have come up that kind of exchange already. Actually, I want to put in a plug for National Academies of medicine because it was really the two papers that I described That inspired this international collaboration.

But the idea is to get things like what's happening in France on The radar in harm reduction centers that are part of a nationally coordinated well funded effort in France onto the radar of US policymakers and then there are People who use drugs themselves for being incredibly innovative, for example, hosting virtual safe injection so Protecting each other by being on screen where they do have access to screens. A lot of them don't have, as you know, we've heard today. But protecting each other by watching each other digitally watching over each other digitally. So there's so many creative solutions that many different levels that need to be Highlighted and exchange. But then we also do need a national agenda to act on those and make sure that these the benefits are evenly distributed. Great.

ALONZO PLOUGH

Elizabeth wants to get in, get in here. And then Marcus, I encourage you to jump in. Yeah.

ELIZABETH SALISBURY-AFSHAR

Yes. Okay, great. So I completely agree absolutely need national standards, and I think we have to be really, really thoughtful about equitable distribution of resources, I guess. I want to pick up on something you said though about hyper localized. And I think, you know, most of all of my professional work has been involved more in Chicago and specifically when I moved back to Chicago and started working in public health. There was a lot of pressure that we needed to be focusing on prescription opioids, because of the national conversation about opioid related overdose deaths, but yet when we first. We didn't have good data locally.

But secondly, as we really started to Publicly report on our data, what we saw is that what we had in Chicago was an largely African American 45 to 64 year old population who was using Pretty much solely illicit opioids, as we dug deeper into the data to cross map it with prescription drug monitoring programs. We saw that very few of these folks ever Had access to prescription opioids right because historically, they did not have healthcare access and even if they had, we know that there's bias and who gets prescribing opioids in the first place. And so I just say that to say I completely agree we need to have national standards, but I think one of The challenges in this space has been that people want to pick a program from name your place across the country.

Where the drug use patterns can be really different, where the demographics can be different, where there are different sort of underlying factors risk and protective factors. And we just see that abuse trends are really different in different parts of the country. And this is also, I would argue, equally important. When we think about solutions. Need to be based on Community level strengths as well as community level risks and we need to understand what our local data shows when we're making Public health plans and yes you know it's important, but I think so often we see research done in these centers of excellence, often with white communities. And it's really important that we're thinking about all those factors when we develop local plans for response. Yeah, certainly COVID-19 points out the importance of region city site specific but you also need national guidance that is going in the right direction. Marcus hands with ASCO you are dealing a lot with local, state, federal nexus, maybe you might want to comment on this.

MARCUS PLESCIA

Yeah well I really have. I mean, I think, to begin with, as we've been thinking about opioids and particularly this idea of moving beyond just this treatment oriented approach. I've really shifted to a very strong policy approach social policy approach and, you know, I think we were there. And then what COVID-19 hit, you know, seeing these amazing discrepancies. Based on income, you know, if you're poor, you're way more likely to get code, you're more likely to die from it. If you're a person of color.

The exact same thing you look at, like, You look at who couldn't hold up in their house and who can't. And you know, it's just it But we saw all of this around the addiction and around the open. I mean, it was kind of there. You know, flashing at what could happen and you know very little got done to address some of these underlying factors that have caused. I mean, there's been this huge increase in the number of people who are addicted and I, you know, I don't, I don't understand that. I mean, it's not it's not the addiction, per se. It's the at the fact that so many people are so I don't know.

I mean, we need to deal with some of these social issues we need to deal with a lot more equity in amongst people who have access to resources that people who don't and you know I mentioned early on I think that Trust for America, South. There's a number of others who began to sort of lay out some of the

policy framework and it goes way beyond health and I don't know what the best word is but you know this social determines i mean These things, the things that make people sick. And that's where we need a reference

ALONZO PLOUGH

You know, you know if this helps us to double down at the foundation on our health equity framework. I mean, we were committed but COVID-19 said told us how important it is for us to read double down and two and then pound important that equity framing is because we're all the things you just said, Marcus, the inequity, that the cost of inequity. And marginality is just brought to the surface for those who hadn't seen that before. And then Devin, I think you had your hand up.

DEVIN REAVES

You know, one thing that I think that is happening kind of in parallel with this idea of focusing on treatment works and the power of the treatment industrial complex. Is this kind of narrow idea that stigma is the problem that I find really frustrating at times. It's like we need like I talked to policy people like what's your policy goal. We want to bust stigma. What does that even mean.

Let's be clear, the war on drugs was created to destroy black and brown people it ran out of dark meat and start eating white. And that's why we're getting pushback on war on drugs policies because they're showing up in white communities. Stigma is not a great word and I understand that an academic sense around stigma and there's all this scale of stigma really what we're talking about is that is Quantified policies that discriminate against people and we call it stigma, or something else that's nebulous not discrimination, it becomes hard for people to really assimilate that and see how we can break that down.

Right. I'm not discriminated against. If I'm a felon. There's a legal thing. I mean, I don't want to think, because I've found there's legal things that say, I can't vote, I can't do this. I can't do that if I use drugs. I'm not stigmatized. I'm at risk of murder and harm by the state. Right, and I think that we need to start just being more explicit and I understand sometimes I put on a suit and I talked really nice. To politicians, but I think we're in a setting like this, then we can get a little bit looser and start called things like they are Because all the code switching. I have to do on a regular basis to be an advocate, you know, I need to see other advocates also stepping outside of that thing.

Let's say racism. Racism is the thing. Right. And when I heard my co panelists say that that felt good, because when we're not at the national level, we're in Dubuque, Iowa or Nebraska or rural America. We don't hear people saying that, and that is a problem.

ALONZO PLOUGH

All of that is so, so important. I know we're coming to the end of our time. But these are critically important. I want to give everybody one short shot to give us your last sort of 15 second sound bite on this, but on this notion of that we need to look at the historically in trance policies of institutions and legal structures that perpetuate These crimes of the past, racism, all the isms and carry them forward and codified ways, one has to tackle that as a core driver of the kinds of things that we're seeing.

And I agree with you, Devin, one needs to see stigma, any, any perception of person's life conditions in that broader context. So quick hitting 30 seconds for everybody of things you want to make sure our listening audience.

MARCUS PLESCIA

Well, I'll be really quick. With this, you know, and not that everything's about COVID-19 but that's what we're living right now. And I mean, is it just it it's I mean you know I think everybody on this panel knew about the kinds of things that were. I don't think anybody on this panel probably that surprised at what happened around race and socio economic class would cope it but it if this didn't get the attention of the public, then I don't know what's going to, and I think it did. And so I think the time we have. Is a very bad situation room, but the one, one of the good things about we have the opportunity to use this, try to address some of these things, and I hope we will. And again, I think it we have to address some big societal policy issues and I think local work is very important, but it's time to fix some stuff that is affecting people in all kinds of communities. And if we don't do it now. I just don't know when we ever will.

HELENA HANSEN

I'm going to try to squeeze in two points. One is along the lines of racism and power inequalities. And this may be cynical, but I think that some people who really buy into a racist structure may not be either surprised or disappointed about the inequalities and COVID-19 deaths or the growing any qualities and opioid deaths.

This is very tall order, but it's opioid crisis opens up a window on how whites are hurt by structural racism and I think we have to continue to come back to How white people are hurt by racism and affluent people are hurt by social inequalities. There are studies showing that the life expectancy of affluent people is lower in highly socially unequal societies, there is a cost to it. Then the second thing is And this is back to a point, Elizabeth raised about how we can't have a one size fits all policy response I thoroughly agree.

I think When one thing I want to bring out about the example of the AIDS activists that I highlighted is the degree to which engagement direct engagement of the people affected by opioid deaths is critically important, because that way we get to creatively tailor. Responses in local areas. Feed the democratic process and in that way also contribute to social determinants of health positive health outcomes by strengthening community participation. And a ability to act on one's own well being. So community engagement and representation in the process of setting this health pop these health policies, particularly among people who use drugs is going to be critical.

DEVIN REAVES

Yes, if you are a person of privilege that at home sits on the local opioid task force. Be willing and able and eager to give up your seat to a person in recovery that uses drugs. That's an explicit way to do what Helena just said.

Number two. If you are on this webinar today, you actually know more about drug policy than 99% of politicians in your state legislature, it is on you to be civically engaged. My state legislator knows who I am. When I walk into his office. He's like, shit. Devin's here again. He wants to talk to me. It should be the same way. And at the same time he calls me when there is a legislative issue that's around drugs and

alcohol. You are an expert. It's honor to be the key, the key information for your elected officials, you're not doing it. You are part of the problem and complicit. Thank you very much.

ELIZABETH SALISBURY-AFSHAR

Oh, I want to thank everyone else for calling us to action, because I actually just want to Close in a with a question that I struggle with a lot. So if anyone has suggestions or solutions. I would love to hear them, but I think, you know, When I think about social determinants of health and racism and as Alonzo put it all the isms and how they applied to the opioid crisis or to COVID-19 I think one of the things that comes up is, if we really try to get the causes of the causes.

What I hear back in response, having, having worked for government is like, oh, we could never You know, say that living wage is a response to the opiate crisis or we could never say that like this thing is a responsive to big that we aren't going to see results in this election cycle. It's never going to happen. And so One of the things I spend a lot of time thinking about is, like, how do we frame. It. We all recognize that there would be tremendous positive outcomes with regard to the opiate crisis with regards like in so many avenues and areas of life. Including but not limited to health outcomes. So how do we get enough political momentum behind these issues that we all know matter so much.

And as Helena put would have a really positive cumulative impact on our broader society. But how do we get enough political will to be able to do these things that we know matter so much but may not be able to be measured on a positive impact with one particular outcome in the course one election. And that's often what we're up against. In the world of policy. So I would just encourage people to think about that in addition to the calls to action.

ALONZO PLOUGH

Well, thanks for everyone. We could go on for another hour, I can assure you, as the co Chair of the working group on these issues. We will jump off from this presentation and recommit and redefine the work of that subcommittee. To incorporate the questions that you've loved this within the information that you've shared so thank you to all my co presenters all the listeners that have stayed on.

SESSION FIVE: BUILDING A HEALTH SYSTEM THAT IS EQUIPPED TO PERVENT, TREAT, AND MANAGE OUD

ELIZABETH FINKELMAN

Okay, welcome back to the Action Collaborative's Virtual Symposium. Our next and final session of the day will focus on building a health system that is equipped to prevent, treat and manage opioid use disorder. Currently our healthcare system is not sufficient. We designed to address and promote the holistic needs of individuals with opioid and other substance use disorders.

So I'm delighted to introduce this panel of experts who will discuss how to build the needed capacity competencies quality of care payment structures and incentives. To ensure the quality and affordable health care for individuals with opioid and other substance use disorders. The session will be moderated by Dr. Andrey Ostrovsky, who is managing partner at Social Innovation Ventures and joining Dr. Ostrovsky are Dr. Corey Waller who is a principal with health management associates. Dr. Kelly Clark, who is immediate past president of the American Society of Addiction Medicine, Miss Kate Berry, who is senior

vice president of clinical affairs and strategic partnerships at America's health insurance plans. Dr. Sherry Dubester who is executive vice president and chief medical officer at beacon health options and Dr. Shari Ling who is acting chief medical officer Centers for Medicare and Medicaid Services.

Their full biographies are available on the event website for you to access and please note that we will be taking questions from the webinar audience during the last 10 minutes of the session So please use the comment box on your screen to ask a question.

ANDREY OSTROVSKY

I'm really excited to have you all participate and we're talking about a really important topic. Which is building a health system that is equipped to prevent, treat and manage opioid use disorder. Again, I'm Andrey Ostrovsky and I'm really honored to have an incredible group of true experts on the subject. And before I jump in and hand over the reins to our experts. I wanted to just set the stage a little bit if we could go to the next slide please. Thank you for disclosures all of my conflicts of interests are on this website. So take everything I say with a grain of salt.

In terms of how the flow will happen. I'll give this quick introduction. Each of our great panelists will give some remarks over a five to seven minute period will then have a moderated Q&A that I'll prompt our Panelists based on some of the themes of what they're discussing now. And I'll also leave some time to make sure that you, the audience can chime in with questions, I will be keeping an eye out on the Q&A section so If a question pops up in the middle of the session. And it's really topical and timely, I'll try to incorporate it, but we will leave some time at the end.

So for context. So when we can have a conversation really about any chronic condition, including opioid use disorder without talking about What is really top of mine from public health perspective, I gave a talk about one month ago. And share the slides, similar to this. At that time there were about 40,000 deaths in the US as of this morning 91,000 over 91,000 deaths which is absolutely terrifying and we see here some of the trajectories of where covert is still to go in terms of mortality. This doesn't take into account of the morbidity.

And speaking morbidity, that's not just a health care or medical morbidity. There's also the upstream health determinants, namely socio economic status and employment rates have pretty significantly plummeted. So when I gave this talk a while ago. It was at 22 million folks that are unemployed and. Next slide please. We're now at 39 million and that is 15.9% almost 16% of the working age population. We see here, relative to the Great Depression. Just how high that very steep peak is in terms of unemployment and this has pretty significant implications for behavioral health issues, particularly around opioid use disorder.

There's some pretty powerful research done by case and didn't that looked at some of the drivers around what has been popularized as depths of despair. So deaths from overdose. Alcohol cirrhosis and suicide and there was a pretty strong link between socio economic status and particular income and educational attainment. And what this data show is middle age non Hispanic whites in the United States mortality rates relative to other countries. Now a slide I don't have here, but something that is emerging as a pretty prominent issue around mortality rates is the disparities that are emerging around COVID-19 and they are just such a critical issue to look at here. And when we think about COVID-19 we think about unemployment rates and we think about associate morbidity and mortality. There's a unfortunately

perfect storm for Turning back all of the progress that has been started to make around decreasing overdose deaths.

Unless they're ready we go. And so how do we think about The future state of the opioid use disorder prevention, treatment and recovery system, and I have to give credit to Dr. Corey Waller who introduced me to this really great concept of the four C's and those include capacity. Competency consistency and compensation and throughout the remarks that will here today I'll be bringing us back to these four C's and thinking about some of the Health Plan perspective. Some of the government perspectives on these issues. Some of the provider perspectives on these issues, and most importantly, will really need to dig into some of the consumer people with lived experience. Perspective on these issues and so capacity, just to be precise here is the system correctly sized to fill the needs For the community. It is serving from a competency perspective does the system have the right education, training and evaluation of all aspects of the treatment system, including prescribers therapists administrators and peers. From a consistency perspective is the system delivering high quality care and from a compensation perspective is the system paying the right amount for the right things.

And so will now have a few remarks from each of our panelists and the each panels will have about five to seven minutes and palace. I think you all have generally worked with me before. Really keep us to time and not just along. We'll have plenty of time for Q &A.

COREY WALLER

Thanks, Andrey, I appreciate that. You know, as we try to work through this, you know, the four C's and there's probably a fifth one hanging out there called community, but we're going to focus on the other ones that you know that we can really as a system development piece approach it in a way that's helpful. Next slide.

If we, if we look at those four C's. Again, you know, this is not an opioid treatment system we have to build an addiction treatment system. And that includes co occurring capabilities and all the aspects and so I always tell the people that fund me to help them build systems just secretly even if it's called opioids, you're getting an addiction treatment system. That we build because to build one is just a fool's errand, in a sense, because the way you treat opioid use disorder has its specifics. And it's a pretty narrow approach and a number of different pathways. Alcohol is a little different methamphetamine is 180 degrees and then everything in between. So when we start to look at building the system.

When we talk about capacity. It's not just about the capacity to treat people with an opioid use disorder. It's about the capacity to treat people who would like treatment for addiction period and right sizing that system. So let's talk about that one at the beginning. So next slide. If we really dig into capacity, then what we look at here is all of the levels of care that it needs to be delivered in. So this is not a matter of We just have to get a whole bunch of people who can write for a medication or are we just need a lot more therapists or we just, you know, a lot more inpatient beds. The answer is yes and yes when it comes to opioids, but also for addiction as well. But also what I don't want to do is overbuild certain aspects of the system. And this is where kind of the local community and regional payment systems and capabilities of those around really come into play because if we're looking at level one. That's great. If we have outpatient treatment. But if you're sicker than what level one needs and you need to be in level two, with greater interaction, over time, you're more likely to fail at level one. And then if you need if you have an You know, an unsafe Recovery Environment and you need to go to level three, then we need to have that

available or you need higher level withdrawal management. We need to be able to apply that And then for level for the sickest patients. We don't have very many of those very few people can identify a location in which there's an available bed.

Not to mention what we've talked about earlier, which is a complete dearth of delivery capability within a hospital based systems, with the exception of Dell in Austin. which funny enough, was the first hospital ever worked in as a teenager working in the EKG or just looking at banks of EKG. So yeah. Bravo for Dell.

So competency is the next one. After this, and with competency, we have to really think about What we mean by that, and I love the slide earlier that talked about how teaching is not necessarily learning I think that's a really important thing. And it's not just about teaching somebody about the pharmacology and implementation of certain medications. We have to make sure that the therapists that are delivering the care for these patients really understand the approach to cognitive behavioral therapy for addiction. For co occurring illnesses. How do you comport those two. How do you work on all the early life trauma. What if you're a therapist in a jail or prison, the approach to that subset of the population has to be Framed differently in the knowledge bases there so competency is not a general overarching 30,000 foot view competency, but really narrow and specific to what do you do, and what is the scope of work you provide And this has to go all the way to administrator competency. If you try to drop an addiction treatment clinic into an outpatient Group and they put you in with the normal. I have a medical assistant who takes your blood pressure and I have a nurse who, you know, Does some education and that and they give you 15 minute appointments. It's just going to fail. It's not going to be effective.

So the administrators need to know everything down to the nuts and bolts of how do you do Group based visits. How do you make sure that an intake visit has the right amount of time. How do you make sure that you bill for our combined Care in the appropriate way. And so the administrator competency is important and then peer competency Is not about teaching them about addiction, because they teach us about addiction on a regular basis. It's about teaching them how to work within the healthcare system so that they can get the most done for those that are trying to be in recovery or stable in recovery. Next slide. And this has to be followed by, you know, how do we really approach consistency or quality. And this is the full scale implementation of structural measures and outcome measures. What is the service array or package of deliverables that we should expect if somebody shows up to a level one or level two or level three.

And then insurers can feel like if they pay \$1 they're getting a dollars worth of something back because this is the real issue is, you know, people say, oh I treat opioid use disorder really What, what do you mean, do you just write a message or use a couple of words of motivational interviewing or do you have a full array of services that when they walk in. They're doing a you have an official assessment tool you have a level of care placement capability you refer them when they don't meet your level of care so that it's not that You're a hammer. So everything is a nail and making sure that they can move through the system.

And then the fidelity to the same levels of care is important because people want to interpret it in the way that best suits them and their payment model and we need to switch that to Kind of really the best of the best being high quality delivery systems like we have stroke centers and trauma centers and things along these paths.

And then the last one, which I think is important for the sustainability of the system, which would be on the next slide is compensation. And when we talk about compensation, we need to realize how ill prepared the addiction treatment ecosphere is for doing anything close to value based payment. You

know, if we just look in if we look at even fee for service and we're going to try to go up to a PA and pay it parody. If we look at things like in Colorado there VHS have 650 million a year, which sounds like a lot until you look at what they need when you calculate it out if it was a parody, which is right around 4 billion. So at this point we don't have in most really any state, the ability to deliver high quality care on a consistent basis and make sure that people have access to education and consistent competency and training. And when we talked about what at and it was doing earlier when they started looking at academic detailing This needs to happen in wholesale fashion across this and you can't do that if you don't compensate with an appropriate margin for somebody to build this into their HR package in their, in their risk mitigation package in their system.

So when we look about how are we going to pay. It's not just about the amount that we pay. It's what is the type of pay that we do. Is it for a service or an outcome. Is a capitated or is it for population, you know, how do we look at this as it goes through so I would say that the one that I that I usually add will keep it tight on this one is the community because this is also a huge one. Which is talking about what is the community role. Well, we've talked about that we've talked about NIMBY we've talked about structural racism and how it actually alleviates access to direct care in certain locations. So if we're really going to build a system that treats people with addiction on a consistent and predictable basis. And then know we're getting our money's worth. When we pay somebody to do that service. We have to make sure that it lives within a community that can be as predictable and helpful as the remainder of the service line.

ANDREY OSTROVSKY

Some Cory. Excellent. Thank you. You mentioned ASAM criteria. There are a couple of times and answer very appropriate that we have Kelly Clark, Dr. Kelly Clark. Next, who is the past president of the American Society of Addiction Medicine provider policy expert.

KELLY CLARK

Well, thanks. Andrey. So before we can start answering this concept of how to build a health system that's equipped to prevent, treat and manage OUD or opioid use disorder. We have to start at the very beginning, which is let's treat addiction, like every other chronic disease. Next slide please. When we think about addiction as a chronic brain disease. The implications there are very clear, you know, a brain disease means there's stigma involved. We know how to approach chronic diseases. Right. We know what the outcomes are which the outcome is not perfect adherence to a treatment plan, do you always do what you're supposed to do.

But what we're trying to do is use a holistic approach to help people manage their disease state. Using a medical multidisciplinary kind of approach and the outcomes because it's not an acute thing from which you recover, but it's a chronic disease, the outcomes are around Decreasing the morbidity and mortality related to that disease state so that the medical complications and the early death risks related to that disease state. Decreasing the total cost of care and increasing functioning or basically stay alive become healthy stay out of hospital and get back to work. This is how we look at every managing outcomes. These are what we look at for managing every chronic disease state.

So let me just throw out a couple of pieces of language. To just to see things up when we're talking about treatment okay remission is what we physicians do we look for remission and patients, which means The person's without active signs and symptoms of their disease that's remission. It's a medical recovery is a process by which a person lives their best life and manages their chronic condition recovery as a whole

person goal, the medical goal is around remission. But we don't think a person is a bad patient if they can't achieve remission right and simply treatment adherence does not mean recovery. So keeping that in mind, water, our goal.

When we think about this addiction as a chronic brain disease. The implications are physicians are involved with care medical care is based on evidence based a core of best practices where there is a longitudinal Individualized bio psychosocial treatment plan with quality metrics and healthcare dollars are used to pay for treatment. At parity.

So just think of this as another disease day we use an individualized treatment plan based on structured best practices just individualized something is not sufficient. Or just using a cookbook of structured best practices is not appropriate. If we start out by thinking, how are we going to approach the chronic disease. The same way we do have other chronic diseases, it can inform every step in building what we need right provider right dose right place Right kind of treatment for as long as necessary at a specific point in time during the course of that patients chronic disease. Management.

Where are we now, well, you think about what does it take to treat a disease. People need to start out by getting a diagnosis. They need to be evaluated by an appropriate clinician. People don't just walk in and say, Hey, I have got x, y, z disease and treatment starts now has to be an appropriate clinician who knows how to do the examination and evaluation and establish the working diagnosis. Then the clinician works with the patient to make an evidence based treatment plan they work the plan they implement the plan. And deploy those, those, those resources and then you go back to the top again evaluate by the appropriate solution. How well is that plan working What do we need to change, etc. That's how we treat any, any kind of chronic disease.

What we're dealing with here is in the United States we lack an adequate infrastructure capacity to treat the population with addiction at all stages at all levels of care. We have never belt built an adequate evidence based treatment structure. Next slide. So we talked a little about Andre mentioned the ACM criteria. I'll talk about that in a minute continuum is a Basically, it's the same criteria, which is in an electronic evaluation. Mode. Next slide please. And I do want to mention to everyone that this is this is being recorded. And the slides will be available after this talk. So I know I'm going through these quickly, but these are resources that will be available to you later and Corey mentioned the continuum of care. There's not just an inpatient or outpatient, the same way. You know, impatient is when people sleep over A nursing home is impatient and an acute care hospital is impatient, but there are different levels of care, right, an outpatient visit where you see your doctor. Once a month is different than a cardiac rehab program where you go regularly several times a week and go through protocol. Both outpatient, but different levels of care and programs. And that's what we see with the ACM criteria and the ACM criteria they delineate these levels of care and define those elements.

So say person who has had an evaluation and it's determine what kind of dose appear, they need so they need to go to an inpatient say a medically Kind of supervised or monitored withdrawal kind of program, there's currently no way for the patient or the payer to know whether a treatment. Facility is even has the capacity or capability to deliver that level of care. The programs are licensed by states without consistent criteria. There's one state that made up their own a Sam criteria which I find really interesting. They may have their own ACM 3.2. What is this And when we look at what's really even out there in the in the programs. The majority of treatment programs in this country do not Offer a patient's medication for addiction treatment methadone or buprenorphine extended release naltrexone they don't offer what we consider to be the baseline essential element of care in their program.

So when we look at what is going to be needed. Looking at what are the elements. And each of these levels of care, which are about staffing and kinds of care and hours of treatment and etc. and utilizing this as a baseline to make a consistent floor is what we're going to need to do for consistency standpoint and. Next slide. Currently, people have heard of joint commission and for car which are accrediting organizations, but when they have credit the credit for at a very high level. And the kinds of things that they would have credit for or not, the kinds of things that are looking at the actual baseline quality of care delivery that we were talking about with something like this kind of criteria.

ASAM have partnered and have developed a level of care certification program for which payers and patients and their families and All kinds of folks could actually know that there's been a third party that's come in and looked at the protocols and policies of a program to even say they have the capacity to deliver appropriate care. So next slide. Thank you for your kind attention and I'll look forward to our question and answer time

ANDREY OSTROVSKY

Wonderful Kelly Thank you so much. That was wonderful. I have a ton of questions. I'm going to hold off on those questions, but I think this is a time very timely to think about how our peers, thinking about a lot of these issues.

KATE BERRY

Thank you so much for including me in this conversation. And for those who might not be familiar with America's health insurance plans we represent the health insurance industry. All different types of health plan Medicare Advantage Medicaid managed care commercial employer sponsored individual.

Very briefly, I mean, we're very much focused on the consumer experience the patient experience promoting affordability and value. Our plan. Think about this whole issue really holistically. So we think about prevention, early intervention and supporting treatment and recovery and so that includes You know, really thinking about how do we reduce the opioid prescribing, how do we better manage pain care, for example, those are ways to sort of reduce the Incidence of addiction to opioids.

So we have a number of initiatives underway there we've got a very active member of work proof, but I pleasure of leading for several years on ethical issues policy issues related to opioid addiction, and that includes really looking at The merging the CDC guidelines around opioid prescribing and pain treatment and developing some measures to consider how provider performance measures up with the CDC guidelines. So that's something that we tried to do to kind of promote sort of the front end of all of this.

On the treatment and recovery side. we've focused in a number of areas here that includes promoting really looking at, you know, how do we engage clinicians. How do we engage patients, how do we engage The families, the caregivers, etc. To ensure that we're treating this as others have said, as a chronic condition that we reduce stigma that we integrate care with the primary care practice as much as possible. We really try to look at our their alternative payment models to encourage you know alignment of incentives among everyone in the care process to drive better outcomes. It's that promote ongoing care over time.

Sure that we have the right team approach. CMS has even considered different alternative payment models for substance use disorder. That that we're seeing that, making a difference in Medicaid managed care programs being piloted by plans, including a major health care costs and others. I think it's also really important, especially right now with COVID-19 to about how do we leverage telemedicine to promote increased access. We all know that we have capacity issues, not enough providers are providing or have the DEA waivers to support medication assisted treatment, how do we use telemedicine to reach people in these times, and we have a number of different examples there we're seeing significant increases in the use of telemedicine to provide this type of care and I think another area where we see some challenges that others have also said relates to measurement of quality. How do we make sure that we have the right measures in place the right infrastructure in place to promote measuring and improving substance use disorder treatment in in this era.

ANDREY OSTROVSKY

Perfect. Thank you. Thank you so much, Kate. So I think these are great questions. And I'm excited to dig in and see what might be some answers to those questions. What is working or what isn't working, and why.

SHERRY DUBESTER

Thanks so much, Andrey and I'm glad to be here and today I am representing Beacon Health Options as the chief medical officer. And if you're not familiar with Beacon is on mental health and substance use disorder management company and serves as a bunch of specialty programs. But I'm representing them because Anthem has purchased Beacon. So we are now under the Anthem umbrella. Luckily, I was an employee for 18 years before going to begin and actively involved in the opioid use disorder strategies they are so I think I can fairly represent both organizations. So my PR perspective.

Our focus has been and really continues to be approaching opioid use disorder holistically and I'm using that to holistically broadly. Holistically means that we're focused on standing prevention to recovery. It means that we're focused on whole person care. And we've heard you know many speakers talk about this today, and certainly includes thinking about physical health and behavioral health as well and substance use, it means thinking about the broader will be which starts getting into social determinants of health and then starts to talk touching on disparities and all those areas are very important for one person here. And then finally, my PR perspective, you know, he can is not an island unto itself known as the Anthem, or any other care, the focus has to be on collaboration with providers with external organizations and I'll give a few examples of that as we go on.

And I'm going to only focus on and really trying to make this one come alive from prevention, treatment and management perspective. So starting with presentation, under which I would include screening and early identification intervention, I really more in the bucket of secondary prevention. One area that we focus on now for several years is working with primary care providers to increase the rate of substance use screening and assessment so that expert model of screening and brief intervention referrals into treatment. We pick up in the adoption of screening and reimbursing for and under CPT codes for since six to 2016 and we have seen a steady increase in those rates most recently 60% increase actually from 2018 to 2019. So the numbers are still not where we would like them to be.

But we've certainly seen an ongoing increase we've also been doing a lot of the Project ECHO and for those not familiar with Project ECHO, you can think about it as a learning collaborative that started with

hepatitis C, having New Mexico when there really weren't enough specialist to have the time to see it and The needed to be more upscaling in terms of the comfort and the skill set of primary care providers to treat hepatitis C. It's actually a great model for opioid use disorder as well and substance use more broadly, because we need to upscale and increase the comfort of our primary care physicians and extended providers in those practices. To feel comfortable addressing opioid use disorder.

So we have launched. These are called hubs in Connecticut, New York and Florida focused on opioid use disorder and have further expansion plans. anthem. So received some funding collaboration with a couple of university systems to basically make it more affordable to drive additional provider uptake of the model. We've also done a fair amount on analytics and analytics are important for a few reasons. One is that predictive modeling helps us restricted by our populations that we manage so that we can ensure were intervening in the right way at the right time. We also incorporate a fairly robust pharmacy and Linux, which helps support safe prescribing patterns and Around fraud, waste, and abuse to really focus on problem areas like toxicology lab services and sometimes providers, where we're concerned over utilization and other patterns of concern.

And only this area of prevention, we focus quite a bit on integrated approaches to behavioral health and physical health, so that we can identify members who are struggling early Looking to treatment. The focus is all about providers, we're looking for integration and we're looking for innovative treatment models, of course. Masculine food education for abuse disorder as an option doesn't mean that everybody can choose to be on a medication, but it has to be part of the conversation. And then we look for delivery models, whether it's in the home, whether it's facility days but leaving and 24 seven access and prices support. But all those models have to also really embrace quality metrics and focus on outcome metrics and an appetite in the bigger picture to from fee for service to more of a value based reimbursement model. I tell a digital expansion in terms of digital tools was already a focus area before with my team and I'll certainly spend a talk a little bit of time talking about what's happened since I tuned in terms of that.

But what's interesting is that it's not just the treatment program components. The technologies now are able to add applications such as geo monitoring social networking components, it really becomes a kind of a rich ecosystem. If you will have capabilities that we're very excited about. quality metrics and we have definitely a direction is going towards preferred provider networks and will be piloting that in New York later this year. And tying that value based programs on the anthem side there's a set of 37 substance use disorder facilities that are involved in a value based model that is currently running From an external collaboration perspective, which is extremely important.

Certainly, I've enjoyed working with keeping the past around some of the eight have work. Shatterproof is doing very important work in terms of bringing together a broad set of stakeholders, so that we can improve the adoption of evidence based care and strive for as much consistency as an access I don't think we want to solve for this a million different ways when it comes to metrics when it comes to value. And so we all need to respect the independence of these companies, there's a lot we can do in common. And I think it's extremely important, not just for you do, but certainly It's great to be working from that angle in this position. Blue Cross association is working on substance use disorder centers of distinction and we're part of that. And we're also piloting with Alliance for addiction payment reform of highlights to look at how we can build in a kind of a case of essentially that allows coverage, the components appears that sometimes aren't covered, especially on the commercial side.

Perspective is enhancing now we have gravitated more and more towards field based staff who still with us telephonic types of interventions, but we, in general, find that field based staff is very important. We

also are telling pilots that look at working very deeply with our facilities to introduce patients to the option of medication, from the time of detox and then ensuring community affair. And then finally, a much deeper focus on social determinants of health and really trying to get that data. What are the next slide. I'll just make a couple of comments on the world of coke. Yes, I will do this next slide, very quickly, because really what it sums up is that there's been a dramatic shift to virtual care delivery overall for us. There's been an increase of 5,000% In overall mental health adoption by behavioral health providers and we've been spending a tremendous amount of time supporting our providers so that they can successfully deliver care via tele health Including for opioid use disorder, including in terms of medication treatment and getting higher levels of care.

We've had many providers attended monthly webinars and we're also shifting many our services including Services, we have delivered in the field like peer support to deliver via tele health. So there's a lot here and we can certainly talk about it more during the Q&A but it has been a time of real challenge, but also opportunity. Thank you.

SHARI LING

And have a chance to actually learn from you greetings colleagues and thank you for the kind invitation to be part of this panel and Jarrett, shout out to you for the technical assistance. So if I could have my next slide please, which is my obligatory disclaimer slide that this is for really for purposes of public education and engagement, but imposes no obligations of no financial Conflicts to disclose.

So just as a reminder, CMS and the beneficiaries, whom we touch upon we cover approximately one in three Americans and the challenge for us is that it is a increasingly complex population of beneficiaries. And So, you know, when we think about the challenges and the characteristics that you've described in the four C's and how to approach this. We really want to Enable maximum and optimal use of The policy and program levers to meet the beneficiary healthcare needs but it becomes very challenging sometimes because those needs are quite diverse.

So this is a graphic depiction of our CMS strategic vision. There are 16 priorities laid out and the yellow arrow just illustrates that fighting the opioid crisis is one of the agency's priorities. We do focus on, you know, a person centered approach. And so as we think about Transitioning from volume to value we really are trying to think about how to keep the beneficiary, the patient at the center of everything.

So back in 2019 we finalized a CMS roadmap, which actually built on the HHS roadmap being that CMS is one of the agencies within the Department of Health and Human Services and I'm just going to take you through a couple of, of the, the Updates being that we actually are now in 2020 and 2020 is actually going by pretty quickly. But really keeping things at a very high level. So we, I think it's more important for me to convey how we work what the opportunities are the program and policy vehicles and try to circle back and tie them to as many of the seeds as I can. So, next slide please. So as, as you can see the pillars of the CMS roadmap to address the opioid Crisis really is on prevention, treatment and also use of data.

And you know, when we talk about prevention, I was able to hear some of the prior speakers and we're not talking about, we are really trying to focus on prevention, by way better pain management or optical pain management and as you know Some of our work included finalizing the acupuncture national coverage determination as a vehicle to improve pain management for chronic low back pain is just one example. Of prevention.

And then the second pillar being treatment, enabling access to treatment for oh UD and, finally, to be able to really unleash the power of data we have multiple data sources including claims that we've used for heat mapping But again, this is in the Medicare population. We also are bringing online and Medicaid data as well. Next, next slide please. So as we are moving forward. We are certainly using all of the program and policy live levers that we have at our disposal to prevent better manage or better treat and also be able to release to the public data and data for action.

Across all CMS programs and being that CMS his role is really that have a pair, the most robust data that we have really comes from the administrative claims. So, next slide please. So, As, as we are going forward. I wanted to call attention to the support act and there. There are numerous provisions in the support act that CMS. has a responsibility for implementing and this is just one of them. But it's a extremely important and broad provision section 6032 which There were several requirements, one of which was to consult with the pain, best practices task force that HHS, and the lash stood up and completed. But this results in a action plan to address the opioid crisis utilizing CMS programs and policy levers. But also will result in a report to Congress.

Now the action plan. We also held a public meeting to inform the shape and content of this action plan. And also then reviewed all of the recommendations that came in by went public comment and the public meeting, according to a pic chart, if you will, that Assess feasibility by impact. So what you will see when we're able to release the action plan and the report to Congress is those recommendations that we believe are both actionable and also have high impact across the cares care settings.

So this is just a graphic depiction of the different programs and policies that CMS has authority to implement And I would like to just take a moment to try to connect them with some of the seeds. I don't think I have all of the seeds covered here but As a payer compensation is kind of what our major roles as part of HHS and again we are focusing on that translation or transition from volume to value. Heard Corey's opening remarks and, you know, understand that each population of Patients and also providers is at different points in in evolution towards value to in order to get to value we actually need robust quality measures. That can really speak to improving health outcomes in the population that the measurement is intended to be applicable to when it comes to competency

CMS also has authority to set the health and safety standards and expectations for Medicare participating facilities on a national scale. And so, you know, we have. And I think the exception, there is in the health professional space where CMS does not have authority for oversight over healthcare professionals. But nonetheless, those standards can then be we can we can survey to assess compliance with the conditions of coverage and participation. So I think that is one way that we address both consistency. And in a way, competency. I think it capacity is another aspect, though, that in the public health emergency With. With. We actually look to enhancing flexibilities by and use of technology, by way of Telehealth provisions as broadly as we could.

Really attempting to meet the needs of healthcare delivery so that it could provide access to our beneficiaries and in a broad and unencumbered way. We also enabled workforce flexibility so that not only facilities could get patients where they needed to be in the event that you know they needed to meet the search capacity, but also for healthcare professionals to be able to really function at the top of their license. So There were enormous challenges on many levels and the kind of information that I heard shared today is exceedingly helpful to us.

As we are evaluating and looking at, you know, what are, what have we learned through this public health emergency where are There opportunities to actually improve healthcare delivery at that that results in better access and improve outcomes. So the kind of information that you've shared would be really, really helpful for feedback to us and we understand there remain gaps and hurdles. That we must be attentive to but we have the opportunity to, to, to think about solutions as they apply to the various program and policy levers that that i i have displayed here. Next slide, please. I think the following slides are all resources, which is probably the best part of the presentation. So we can make those resources available to the audience.

ANDREY OSTROVSKY

So thank you very much. Perfect. Thank you so much. And thank you to all of our panelists. I want to jump right in. One of the things that I think are applicable across all of our panelists comments is the issue of payment in particular around Tele health. Right now we are in a state of public health emergency and so 1135 waivers are in effect. But once the state of public health emergency goes away those waivers and the associated flexibilities go away. There have been some plans across the country. I think the most recent one. I saw was Blue Cross Blue Shield of Tennessee that put out a statement said moving forward. They are going to reimburse Telehealth in parity with in person. Services moving forward and maybe I'll start with you. Sherry doctrine investor. About what your thoughts are Moving forward beyond, beyond the end game of COVID-19 and towards a steady state of the kind of what will be, I guess the new normal. What are your thoughts about reimbursement of Telehealth. In parity with in person services beyond covered

SHERRY DUBESTER

Now I think not be well couple things. One is, you know, I think in the environment of COVID-19, I think, CMS has done the right things by just completely running Tele health coverage. I think as the situation stabilizes. We do need to go back in and look at, you know, what services do best with Telehealth. What about telephonic versus do because you lose obviously some significant effectiveness aspects with just telephonic for higher acuity. Is really doing it via tele health adequate. What about hybrid models that I bring together in person and tele health and, you know, digital tools to amplify and so I think we're going to be looking at how you bring together new and more innovative models of care but Tele health which many of us have been trying to nudge along for a few years. Took a giant step forward and a lot of that is great. And we certainly want to make sure that we're reimbursing in a way that continues to support its deployment in the best ways possible But I think we also have to critically look at, like, where it doesn't vest and where we need to combine it with in person and other components to make a very healthy ecosystem here.

ANDREY OSTROVSKY

Perfect. And I'll have everyone comment on this. But maybe I wonder if we could go to Kate Barry. I'm wondering, is there a role for a HIP to play in the convening function to aggregate some of those Approaches around evaluating Tele health and to what extent should it be incorporated into a standard of care. So, is to eliminate some of the Redundancy or siloed recreating the wheel health plan to help plan to health plan. Any thoughts on a hip or another convenient entity, perhaps National Academies of medicine role in something like that.

KATE BERRY

So yes, this is something we're really giving a lot of thought to and I will say back in late March, you know, our chief medical officers. Were saying, look, we need to open up telemedicine as much as possible. So we were, we agree. I agree with some you know what sherry said that To open up, what can be provided through Telehealth and to expand access in that way, it's really, really important. And we're starting to think about. So what changes what of those changes that have Occurred should be sustained and maybe not everything. I think it's important to really think about You know what needs to happen you know in person, what can happen virtually I do really believe that a lot of What we're seeing in terms of virtual care can be sustained and can augment capacity in these areas.

And yes, we're going to try to Really think about both from my you know you standpoint and You know where the impact is and where the growth is and what the patient experience is and what the provider experiences and what are the policies that we want to see carry forward. So absolutely we you know, we're working on that we're thinking about it. It's not an easy thing to look at. Because if you think about it, this has been only You know, two months so far and and you know there's brand new codes. That state to a lot of this care and what type of technology can be used and how that's the band is in particular under Medicare, as well as elsewhere, so Absolutely. I think we all need to work together to figure out how do we carry forward and make sure that we fully leverage telemedicine in a way that helps patients and promote support of affordability and value in the long term.

ANDREY OSTROVSKY

Thank you, Kate. And before I go over to Dr. Clark two things that really stuck out from what you said. One is you've pointed out that you all are pulling out the collective views of many of the chief medical officers at your member plans and what that makes me think of is To what extent are we as a collective group of thought leaders pulling out the consumer voice, the person with lived experience voice to inform our Tele health policies. The other thing that Struck me about what you mentioned Kate was the types of providers that Tele health policy will impact and I think what extent is Tele Health Reimbursement going to be at parity permanently for peers or other types of Providers Could you comment on some of those themes are specifically the question of what is the correct path forward for permanence of parody of Telehealth payment relative to in person care.

KELLY CLARK

Excellent. Okay, so what we're doing right now and kudos to CMS for jumping on is we are providing virtual visits. That are not consistent with the extreme regulation that we've had around Telehealth and telemedicine in the past. And that's incredibly important right now during the crisis, and thank you, CMS and thank you, Sam. So for relaxing and thank you to eat today for a relaxing. A lot of what you've done as well. When we're talking about doing virtual visits, you know, let's, let's talk about some of the areas where this is really important in a positive and somewhere where This is not addressing our issues. So when we're doing things that look like an ACM level one, a seven level two, when we're looking at Individual psychotherapy physician visits, etc. The way we would do with any other medical disease.

I want to talk about how we deal with every other medical disease. Okay. Here is where virtual visits are extremely helpful. Okay, and very, very easily integrated For those who have access to the technology as patients. Okay. We have a big problem with a homeless population of criminal justice population. rural populations that don't really have access to internet type capabilities and so forth. And this is where some

of that audio only has become so incredibly important during this epidemic. But when we get into levels, three and four, where people need 24 hour care they need. Clinical oversight 24 hours not sober homes not residences but clinical care. That's not something you can do by Tele health, that's something that you have to put together. And I've been very concerned here in many states where the payers are not providing payment, not only at parity, but at all. For treating addictive disease using virtual visits and I'm also concerned to be hearing from some sectors about diversion of Medication particularly buprenorphine products and as we addiction, has snow, you know, buprenorphine is diverted around as much as your anti histamines at Your antibiotics or diverted your insulin type medications.

You know, we've got diversion of lots of kinds of medication. So one thing to allow this to continue would be to look at that kind of rate of diversion versus other chronic care kinds of medication. So we have to set ourselves up to gather The information that's necessary to show what we believe we're seeing out there in the community, because before we can really say yes, this is useful. We need to continue to pay for this, which We absolutely do. Because we've got lots of barriers to care. We're going to have to make that make that case using some data that we need to collect

ANDREY OSTROVSKY

Wonderful, thank you, Kelly and just to echo what you pointed out about appropriateness of Telehealth One of our attendees. And actually, one of our persons with lived experience work group members, Edna Boone pointed out an excellent quote, which is In Telehealth can be a great tool with appropriate guardrails, and making sure that we don't create a Have and Have Not scenario around Telehealth. So to your, to your point, Kelly.

Corey. you work with a lot of states in a lot of different settings. What have you seen that informs the correct path forward around. Telehealth payment.

COREY WALLER

All I think, you know, just to be blunt and honest, which is my forte. I know, it's crazy. But the reality is we don't know what people do when they get on the phone. We don't, we don't know what they asked. We don't know how they interact. We don't know if it's the right person on the phone. I mean, how are we, identifying that it's the correct person that we're having an interaction with. I mean, even just checking an ID. I think that those are real issues that we have to think about on the other side of that.

They're now people in rural and remote areas that have access to treatment that didn't have it before that otherwise would have been at super high risk for overdose and death. So we need to and pretty rapid fashion in conjunction with the federal side in the state sides put out some guidance on what is a Solid addiction based telemedicine evaluation and interview. What are the components that need to occur. What are the ways in which you are should be checking ID. How do you documented appropriately so that when you do bill for it that people who pay for it, know that they paid for something Because, you know, when you look at fraud, waste, and abuse. This is right for that because it's new, you know, and it Seems to be the American Way to rapidly find out how you can jump into something without it.

I've had 50 calls from people who want to start a telemedicine company. And I will tell you we're going to be if we don't pick up speed will be pretty far behind on something that I think, quite honestly, is the future of healthcare. In this space, especially with the large amount of remote and rural areas that we have in United States without direct face to face access with a clinician. And I have to say I'm scared to death

about Us ramping up some of this prescribing and then the DEA pulling that rug immediately out with very little, you know, you know, landing path. And it without coming up with something some intermediary step or something because I think that the risk of mortality from that is huge.

ANDREY OSTROVSKY

Thank you, Corey. And Shari, you've heard some thoughts about what the future state of tele health payments should look like. What are your, what are your thoughts about how CMS could help facilitate a thoughtful systematic approach to what that should look like.

SHARI LING

I can say I will, I will say, I think, you know, the questions that you're asking of yourselves and of the system. I think those are really important answers. Even just knowing what is the service that is delivered and Corey, to your point, to whom. And you know what, again it is, it's still about what does quality look like what might be some minimum standards and how would we know I think, you know, we always have to be willing to accept that the alternative hypothesis is true. That's where the data takes us. So I think this is a tremendous opportunity for us to learn as.

And as I was hearing in listening to the conversation. I think this is the challenge we have is that we have such need. We have to go fast, but we have to be thoughtful and the vertical and measured at the same time. So, you know, I even knowing what Good outcomes are there are a few core outcomes that we can all agree upon which we would anchor in the questions around that is a step forward and having a community like this and learn in action. I mean not learn in action, but learn in action would be I think that can help you know propel the field and the care in in a thoughtful and Evidence supported way. And when I say evidence. I'm not necessarily implying the need for randomized placebo controlled trials with.

There are many ways to learn and there may be also gaps in data that I'd be curious to know what is it that you would you would like to know that you that you don't and have difficulty because the data don't are not available. So, you know, I think I look forward from learning to learning. I look forward to learning from you all, and I'm just so pleased with how thoughtful. You all are in, in looking at different aspects of the problem and still at the forefront, you know, laser focused on providing the best care to the people who we serve. So thank you.

ANDREY OSTROVSKY

We've heard from our panelists speak to the code potentially being an opportunity to accelerate many innovations that have just taken so long, including telehealth, but not innovations as well like Getting just parody in general for behavioral health services. Somatic and behavioral health integration has been talked about for a long time, and it seems like it's starting to happen. Corey, maybe I can ask you, have you seen an acceleration of the reintegration of somatic and behavioral health and since we only have about four minutes if we could have like a 45 seconds answer so we can hit another question.

COREY WALLER

I saw momentum, but I think it's going to COVID-19, it's going to crush that momentum because Overall, but there were a lot of partnerships that were being formed between Typically non partnering people standard hospital systems with provider basis and an outpatient behavioral health looking to come into

that, but because the net massive financial hit That these systems are going to take their now not looking at capitalizing The systems to be fully developed in on the back end of that the vast majority of integration that was occurring at least at the county level was paid for by county government programs which are now going to be fully next I mean like if you look at the Behavioral Health and Addiction Treatment integration at the California Department of Corrections, the largest prison system in the country.

I'm in charge of a project, putting addiction treatment in there right now. And their new budget, just because of what's currently happening with COVID-19 just got cut by, you know, they took 50 billion off the top. I mean it's not Small numbers. So now that integration and smooth access for somebody to walk out into an integrated program just is gone. And without support these this is going to happen in every community because we were just starting to get hospitals to lean into this but they're being crushed. And as a practicing emergency medicine doctor, I will tell you when I work my shift on Sunday. I'm twiddling my thumbs and all I'm seeing is covert and super sick people don't have to have it and that's just a reality of every other hospital, even if COVID-19 doesn't exist in their space. They're getting crushed.

ANDREY OSTROVSKY

That's very helpful. So we have a minute and a half left, and I'm going to put all of us on the spot, and I'll volunteer myself. First, let's think of Five parting words that we want to leave the audience with That pertain to the future state of the prevention, treatment and recovery system. So I'm going to think, when the spot here. I'll go first, and then I'll just go kind of an Brady Bunch of order whoever's top left my five words are How Do you accelerate value based payment sorry seven. So those are my five I'm Corey, what would be your five or up to 10 words that you want to leave as a parting remark.

COREY WALLER

We cannot be risk averse.

ANDREY OSTROVSKY

I love it. Okay. Kelly.

Kelly Clark

Go to ASAM's website – that's American Society of Addiction Medicine.

I also have to say that the we're having a COVID-19 and addiction webinar with the National Academy of Medicine and ASAM tomorrow to get at some of your questions and we're doing another one in two weeks. I think the one in two weeks.

ANDREY OSTROVSKY

Beautiful will count that as an extended five words, Kate.

KATE BERRY

I'm gonna say COVID-19 is going to create a mental health need that is unconscious

SHERRY DUBESTER

COVID-19 is an opportunity to reinvent

ANDREY OSTROVSKY

Oh wait, a way to end it on a perfect note we are finished right on time, Liz. I think we can hand it back over to you. And if you don't take it over. We're gonna just keep talking. Okay, thank you, everyone.

ELIZABETH FINKELMAN

We'll see you tomorrow. But no, you get the volunteer of the month award, that's for sure. All right, thank you. All that this is a tremendous session. We appreciate you know all of the panelists for hanging in there, towards the end as well as our webinar. And so again, thank you all for your presentations and discussion.

So to conclude this symposium by extending our special thanks to all of our speakers and to all of the webinar attendees for participating and taking the time to join us today. Today spirits of touched upon a wealth of topics and opportunities to stem the addiction crisis will simultaneously strengthening the health system. And improving outcomes for patients and families also heard our speakers touch on the convergence of the opioid crisis and the COVID-19 pandemic covert certainly put an enormous strain on individuals, families. Our health system, the economy and society more broadly. But, however, as we've heard today, despite the weaknesses, the pandemic has revealed. It is also demonstrated our capacity to rapidly innovate in times of urgency. So as we emerged from the pandemic.

It will be important to reflect on not just the gaps that revealed, but also the important lessons learned. What worked. What did not and providing continuity of care and care delivery and maintaining social connection and reaching those who are most disadvantaged or disconnected and across changes that were made to regulations policy and practice. Before, and in the aftermath of the pandemic.

And I want to underscore that the finance action collaborative on countering the opioid epidemic remains committed to highlighting the most promising and evidence Based and actionable opportunities to support the health and well being of individuals with substance use disorders and chronic pain and we hope that you'll continue to follow our important work as we go forward. So again, thank you for your participation today.

And as a reminder, this webinar has been recorded and in the coming days you'll be able to view the webinar recording as well as the speaker slides@namm.edu slash opioid collaborative and if we go to the next slide, the next slide. Like Holly. I do want to do another plug for an upcoming webinar if you're if you want more. There's more to be had. We have a webinar tomorrow at 2:30pm Eastern in collaboration with a Sam focus on treating addiction across the care continuum during Challenges and promising pack practices we have a terrific set of panelists lined up.

So we hope that you'll join us again for that session tomorrow and in the interim, please stay safe and while and enjoy the rest of your day. Thank you all for being with us.