

- Kathryn Santoro: [00:00:00](#) Good afternoon. I'm Kathryn Santoro director of programming at The National Institute for Healthcare Management Foundation and on behalf NICHM welcome to our webinar today. Today's webinar is the last segment in a four part series exploring innovative strategies and evidenced based solutions to defy depths of despair and lift our society from crisis. We're seeing this crisis manifest in rising rates of depression, suicide and substance abuse and declining life expectancy in the United States. In 2017 a person died of an opioid overdose every 11.4 minutes. Overdose death from synthetic opioids like Fentanyl have skyrocketed since 2013. Despite significant efforts and funding support from the public and private sectors to expand access to Naloxone and medication assisted treatment, barriers to treatment remain.
- Kathryn Santoro: [00:00:57](#) Is there a path to progress in overcoming the opioid epidemic? Yesterday the assistant secretary for health Admiral Brett Gerrard reported that according to recent CDC data, overdose deaths have now fallen 4.4% over the past year. He also pointed to the importance of collaboration between federal, state and local government to achieve these decreases and today we'll hear from leaders in the public and private sector who are working to expand access to treatment in their communities.
- Kathryn Santoro: [00:01:29](#) Before we hear from our speakers, I'd like to thank NICHM's president and CEO Nancy Chockley and NICHM team who helped to convene this event today including Carolyn Myers, Kate Ellis, Katelyn Smith, Kierstan Wade and Alexis Wing. We hope you'll take a moment to explore NICHM's other resources on the opioid epidemic on our website and on the resources tab in the webinar console including our opioid infographic and our previous webinars highlighting efforts to prevent opioid misuse and expand access to evidenced based treatments.
- Kathryn Santoro: [00:02:05](#) You can find biographical information for all of our speakers along with today's agenda and copies of slides on our website. We also invite you to live tweet during the webinar event today using the hashtag #defyingdespair. I'm now pleased to introduced our first speaker, Carla Haddad the senior advisor on opioid policy in the office of the assistant secretary for health within the US department of health and human services. Under the leadership of HHS secretary, Alex [Azar 00:02:37] the assistant secretary for health is coordinating efforts across the department to address the crisis of opioid use disorder and overdose in America. This is one of the secretary's top four priorities for HHS and a priority of the entire federal government.

- Kathryn Santoro: [00:02:54](#) Carla has over nine years of experience working in the federal government to improve access to healthcare services, most recently as policy advisor to the HRSA administrator. We're so grateful she's with us today to provide an overview of the federal response to the crisis including their efforts to improve access to treatment and recovery services. Carla?
- Carla Haddad: [00:03:18](#) Thanks so much Kathryn. Good afternoon everyone and thanks again for the invitation for me to speak today. I'd like to spend the next 20 minutes providing a brief overview of where we are today in terms of the latest data and trends that we're seeing. I'll also spend some time talking about various strategies that the department has taken to combat the opioid crisis. I'll also touch on some of our priorities moving forward.
- Carla Haddad: [00:03:50](#) As you all know already, the opioid crisis is one of the most pressing public health challenges in the US. While there are multiple data sources out there, the national survey on drug use and health really gives us our deepest data on the state of opioid misuse in the country. This comes from SAMSA, the Substance Abuse and Mental Health Services Administration. The latest data from 2017 indicate that about 11.4 million Americans misused opioids in the past year and 2.1 million Americans had an productivity use disorder. In addition to that, we found that approximately 53% of individuals still receive their pain reliever from a friend or a relative. Really we're seeing that the extra pain relievers that are in the medicine cabinet are still a significant concern in this country. The most common reason for opioid misuse is pain.
- Carla Haddad: [00:04:51](#) Where are we in terms of the latest drug overdoses death count? There are again a number of data, various data sources out there. Last November, CDC released final 2017 drug overdose death numbers and in 2017 they found that 70,237 people in the US died due to drug overdoses. Among those, a little over 47,500 died of productivity overdoses. Again, this is predominantly caused by elicited, synthetic opioids like Fentanyl. However, in addition to that data source, CDC also does track on a monthly basis provisional 12 month overdose mortality data. You can see the trend on this slide so you can see that the peak was reached at about November of 2017 and then shortly after there you see a flattening of the curve and a very slight but substantial decline.
- Carla Haddad: [00:05:55](#) I want to make a note that this data you're seeing now is through October of 2018. Again, each month CDC releases new provisional overdose data and it's great timing that just

yesterday as Kathryn indicated, CDC released the next batch of data which runs through November of 2018, seeing a continuing positive trend. While unfortunately a few of the slides I'll be showing you today focus on the October 2018 data, CDC did just release new data yesterday.

Carla Haddad: [00:06:34](#)

This map shows, again the percent change in drug overdose death from October 2017 to October 2018. Again, from that specific 12 month period we saw a 4% decline over the 12 month period and with the newest numbers that came out yesterday as Kathryn noted, we're seeing a continuous decline and an increasing decline at 4.4% again, steps in the positive direction. We also see that some states have made really good strides in reducing the number of drug overdoses deaths over the 12 month period. We see that Ohio has done a great job in reducing. They're down about 22%. We're seeing West Virginia down 8.1%, Iowa down 14.7%. Again, a lot of great work among the states. Unfortunately we're seeing opposite trends in some other states, particularly in the western region as you can see. This is primarily due to the increase in psycho stimulants like methamphetamine. This is especially concerning and something that the department is taking very seriously in terms of really thinking about our strategies to combat the opioid crisis while keeping in mind some of the other emerging substances that are creating additional problems in many states.

Carla Haddad: [00:07:57](#)

Taking a look at this slide, this slide and table looks at the percent change in overdose mortality by class of drug. Again, from October 2017 to 2018. You'll see that again some progress is being made on some of the drugs you see however, we are seeing a rise in methamphetamine and cocaine as well. Again, another table here looking at the percent change in overdose mortality by class of drug through that same 12 month period showing similar trends that we saw in the last slide. Seeing good progress in terms of reductions in heroin, prescription opioids, and methadone. However, the synthetic opioids are still increasing and up about 11.4% from the previous year.

Carla Haddad: [00:09:11](#)

The provisional data from CDC indicates that are several states that actually have more overdose deaths involving psycho stimulants than synthetic opioids. In among those that we have data from, six of the 18 states that report this information you can see have increasing overdose deaths involving psycho stimulants. I just want to point this out again because this sort of data really indicates that some states are having more of an issue with psycho stimulants than with synthetics even and that

our policies and approaches both from the state, federal and local level need to really adapt to these emerging trends.

Carla Haddad: [00:09:52](#) Shifting gears a little bit, the public health crisis has really led to devastating consequences not only including increases in opioid misuse and related overdoses but also the rising incidents of neonatal abstinence syndrome or NAS that is due to opioid use and misuse during pregnancy. NAS is a drug withdrawal syndrome that most commonly occurs among infants exposed to opioids in utero. In addition to NAS, prenatal opioid exposure has also been associated with a number of different outcomes such as poor fetal growth, pre term birth, still birth and possible birth defects.

Carla Haddad: [00:10:41](#) Of course I also want to remind you all about the increase in injection drug use that has really contributed to the spread of infectious diseases more broadly including HIV and hepatitis C. In fact, we see that about 10% of new HIV cases are transmitted through injection drug use.

Carla Haddad: [00:11:07](#) Taking a step back a bit and thinking a bit more holistically about the issue, the assistant secretary for health Admiral Giroir often uses this publication as a really good example. This was taken from the American Journal of Public Health and it just summarized very well the type of approach that we really need to be taking to address opioid addiction in America. The article really emphasizes that no single program or policy will have a large enough impact alone to substantially reduce overdose deaths and it will require a combination of approaches and interventions through collaborations across various entities to truly make a difference in addressing all aspects of this issue when thinking about prevention, treatment and recovery services.

Carla Haddad: [00:12:04](#) Now that I've given you another overview of what we're seeing in terms of the data and the issue at large and recognizing the scale and scope of this crisis, I want to now spend a few minutes talking about HHS's strategy to combat it. Again recognizing the scale and scope of the crisis in 2017 the Department of Health and Human Services developed a five point opioid response strategy. These five points are illustrated here on this slide. The five points include improving access to treatment, prevention and recovery services, emphasizing the critical importance of medication assisted treatment as a component of evidenced based therapy. The second point is strengthening public health data reporting and collection to inform real time response. Advancing the practice of pain management to decrease the

inappropriate use of opioids. The fourth is enhancing the availability of overdose reversing medications and finally supporting cutting edge research that helps us improve our understanding of pain and addiction. Helps lead to new treatments and identifies effective public health interventions. I'll walk through just for the next few minutes each of these five points and provide a couple of examples of how we're implementing these items.

Carla Haddad: [00:13:38](#) Focusing on the first point which is better addiction prevention treatment and recovery services. In 2018 alone in just this past September, HHS put out historic levels of grant funding. More than \$2 billion to connect people struggling with addiction to high quality evidenced based treatment options while really placing a special focus on medication assisted treatment again. This includes a significant grant that were put out by SAMSA. I mentioned before that the state opioid response grants in particular which provides funding to each of the states and really provides them with the flexibility to use those funds based off the specific needs of their community and their population focusing again on opioid prevention treatment and recovery services.

Carla Haddad: [00:14:32](#) HERSA also put out a significant amount of money towards several different programs grants focusing on expanding treatment capacity and services in community health centers across the country HERSA also put out a lot of funding toward a new rural community opioid response initiative which is a multi year initiative again focused on providing a suite of interventions targeting opioid addiction among high risk rural communities and they had a number of workforce grants that went out, really building the behavioral health workforce. Again, a number of programs and investments have been placed into overall enhancing our prevention treatment and recovery services.

Carla Haddad: [00:15:24](#) Focusing on the second point, better data. CDC does a lot of work on this front and CDC currently provides funding and scientific support to help equip states with various tools to both track and report opioid overdoses and deaths as I mentioned earlier and to build and strengthen comprehensive prevention programs that include the prescription drug monitoring program. Third, when looking at better pain management we know that improving the practice of pain management is really critical because we see that about three out of four people who use heroin this past year actually misused prescription drugs first because of pain. With this in mind, we have strongly

supported the CDC guidelines on opioid prescribing and have implemented new checks with CMS to really do what we can to really minimize improper prescribing of opioids.

Carla Haddad: [00:16:24](#) You may have all seen that just a couple of weeks ago the pain management best practices inter agency task force which is a federal advisory committee released a final report on acute and chronic pain management best practices, really emphasizing a balanced, patient centered approach so that's another example of some of the work we're doing in the pain management front.

Carla Haddad: [00:16:50](#) Fourth, better targeting of overdose reversing drugs. Regarding this piece, we have continued to emphasize in the department the importance of widespread distribution of Naloxone either by direct distribution or by co prescription to patients who are at higher risk of opioid overdose. Just to give a couple of quick examples, we provided support to first responders and communities, states and tribes to purchase and distribute Naloxone and develop strategies on its use and to prevent overdose in those communities. Just last year, the US surgeon general released an advisory on Naloxone and opioid overdose that included some essential information on again Naloxone distribution and utilization for patients, for providers, prescribers and the public.

Carla Haddad: [00:17:44](#) Finally, we're supporting cutting edge research. NIH has done a lot of work on this front. In fact, they recently launched the helping to end addiction long term initiative, also known as the Heal Initiative with over \$850 million in funding in 2018 alone that focuses on the full spectrum of research around prevention and treatment of addiction and it's getting to the root of pain itself and the cause of pain itself. With this in mind, one of the signature NIH projects that is actually funded through the larger Heal Initiative is titled the Healing Community Study and we're very excited about this particular initiative. Through this study, HHS recently awarded over \$350 million in grants to really support a whole of government efforts in four key states. In Kentucky, Ohio, Massachusetts, and New York and the goal of this initiative is to reduce overdose deaths by 40% in select communities in each of these states within three years. Again, it's an aggressive approach but it's one that we are really excited to see and we are very confident that each of these states have a suite of interventions that they plan to implement and will make progress in meeting their goals.

Carla Haddad: [00:19:16](#) We also understand that to effectively address the crisis, communities really need to be engaged. This includes not only

doctors and nurses and the health professionals but also cops and teachers, mayors, parents, coaches. It really takes a whole of community approach and we think this is really what the Healing Community study is trying to get to.

Carla Haddad: [00:19:50](#) While this crisis was decades in the making and of course will require a strong commitment, continued commitment for many more years, I do want to share just a few positive indicators that our efforts are having a substantial effect and that we've made real progress from a public health perspective. In terms of decreasing opioid prescriptions, we saw that from January 2017 through April 2019 our initial market data suggests that when looking at the total amount of opioids, which is measured by the morphine milligram equivalents or MME's. When we look at that being prescribed monthly we see that it's dropped by 31% which is significant.

Carla Haddad: [00:20:37](#) This success has also been achieved while the administration has continued to emphasize the importance of appropriate prescribing of opioids for patients who experience pain and supporting the use and development of non opioid treatments. Taking a look at Naloxone prescriptions we've seen that again from January 2017 to April 2019 we've seen a 484% increase in prescriptions dispensed by pharmacies also a great outcome so far. And when thinking about treatment, we see that the number of unique patients who are receiving buprenorphine monthly from retail pharmacies has increased by 29% so again buprenorphine is one form of MAT, medication assisted treatment and we're seeing similarly that the number of naltrexone prescriptions per month have increased by more than 62%. Again, these are all again positive indicators that some progress is being made and of course there's much more to do but this gives us some hope that what we're doing is truly making a difference.

Carla Haddad: [00:21:52](#) As we look forward to the next year, we have several priorities that we will be focusing on at the department level and I just want to highlight a few of them. First, I've mentioned this a few times especially in the data overview slides but it will be really critical to broaden our focus, not only to continue to address the opioid crisis itself but also to address a resurgence of methamphetamine and cocaine before we feel that they are going to become the fourth wave of the overdoses epidemic. This is really important to the department and we're committed to taking this on.

- Carla Haddad: [00:22:31](#) We'll also continue to focus on again that whole of society approach to addressing opioid addiction at the community level. Working closely with our state, local and tribal partners and the Healing Communities initiative is one great example of that. Of course the recent passage of the massive opioid legislation that was passed this past October which is called the Support for Patients and Communities Act will help enable HHS to continue to build and expand our programs that align with the department's five point strategy. More broadly, I think this one is really important one, we have to transition away from a crisis framework into a more integrated sustainable resilient public health system for preventing and treating substance use and other behavioral health disorders.
- Carla Haddad: [00:23:25](#) This is more of our long term focus as we think about what we've been doing today and how we transition into that to a more sustainable approach looking ahead. When I say that, one item we talk about quite a bit is reimbursement and thinking about how we can better align reimbursement so that people can get paid for the right therapy. CMS has done a lot of work in this area and we look forward to focusing in that space more in the coming months and years ahead.
- Carla Haddad: [00:23:59](#) Just quickly a few other priorities for the year include encouraging that expansion of comprehensive syringe service programs. We know they're very effective and we want to continue encouraging that moving forward. Enhancing emergency room medication assisted treatment and insuring warm handoffs following an overdose and improving MAT during transitions into and out of the criminal justice system.
- Carla Haddad: [00:24:31](#) What I've discussed this afternoon are just a handful of initiatives at the federal level or supported by the federal government that will help tackle the opioid crisis across our country. Again, I do want to be clear that this victory is not going to be won by the federal government alone. The common theme here has been the importance of collaboration and a whole of society approach and I do really feel only by working together will we be able to fight this public health crisis and also just be able to lay a foundation for a healthier nation ahead. With that, I want to again thank you for having me and that concludes my presentation.
- Kathryn Santoro: [00:25:15](#) Thanks Carla and thank you for your leadership and HHS's leadership and commitment to this whole community approach to combat the opioid crisis. You highlighted many of the agency's efforts to expand access to treatment and just for our

audience, if you haven't checked out the HHS opioid website, Carla had a link to it on one of her slides. It's also a great resource for more information and also for finding treatment options as well.

Kathryn Santoro: [00:25:44](#) Next, we will hear from Dr. Ken Duckworth, the Blue Cross Blue Shield of Massachusetts medical director for behavioral health. In this role, Ken leads Blue Cross' strategic efforts in the areas of mental health and substance use disorders. He previously served as both the chief medical officer and acting commissioner for the Massachusetts Department of Mental Health, and as part of his role at Blue Cross he volunteers to see patients in the Department of Health early psychosis program at the Massachusetts Mental Health Center. He's trained an adult and child and adolescent psychiatry and is an assistant professor of psychiatry at Harvard Medical School.

Kathryn Santoro: [00:26:26](#) Blue Cross Blue Shield of Massachusetts created groundbreaking programs that expand access to care for people with opioid use disorder and provide education and other resources to reduce the stigma associated with opioid use. Their innovative efforts have inspired actions by other stakeholders across the country and they were recently recognized for their community wide approach to combat the opioid epidemic with a prestigious award from the Blue Cross Blue Shield Association. Ken has been leading many of these efforts and we're so grateful that he's here with us today to share this work. Ken?

Ken Duckworth: [00:27:06](#) Good afternoon and thank you for having me as part of this important conversation. Just a little more background on myself, I'm a child psychiatrist, adult psychiatrist and I have done work in addictions and in the population of serious and persistent mental illness and community mental health and I prescribe suboxone for years as part of a dual diagnosis treatment team. I've been gravitated to policy discussions and jobs because I think there's a lot that can be done on the system level so I joined Blue Cross Blue Shield of Massachusetts which as a provider I felt was a very progressive health plan and I was delighted to join the team.

Ken Duckworth: [00:27:54](#) Since I've been at Blue Cross, I've been trying to work the problem of making access to treatment of opioid use disorder and access to treatment for mental health disorders which are commonly occurring a big part of my role. I want to take a minute to tell you a little bit about Blue Cross Blue Shield of Massachusetts so we're a health plan that's a non-profit, we're based in Massachusetts. We have about 3 million members

through a variety of accounts across the state and of the 3 million people about a million of our people that we insure live in other states. If you took a job with a company that was based in Boston for example and they had a satellite office on Boise, Idaho we would be providing the benefits for the individuals who happen to have the plan in Idaho.

Ken Duckworth: [00:28:49](#) It's mostly Massachusetts and I've traveled my whole career in Massachusetts but I do want to emphasize that some of our policies do have impacts on people in other states. I'd like to take your attention to the first slide which is the Blue Cross Blue Shield of Massachusetts public health approach to the crisis and I think this will echo what you've already heard. We frame it slightly differently but I think in essence we're trying to work to row the boat in the exact same direction.

Ken Duckworth: [00:29:23](#) On the prevention side, Blue Cross Blue Shield of Massachusetts was very early to the conversation of making it difficult to overprescribe opiates. This was in about 2011, 2012 and I want to emphasize that this was not greeted with cheers. We were very early on to take a look at how the health plan as part of the ecosystem could reduce overprescribing and we went through a process with physician groups and physician leaders and they got on board. We had made some decisions to make it difficult to prescribe more than 14 days of an opiate to make it very difficult to prescribe a long acting opiate.

Ken Duckworth: [00:30:12](#) We exempted categories of prescribers such as oncologists and a few other sub specialties just to make it clear that we do appreciate some people do actually need opiates but the idea but there was many extra pills floating around which were ending up in medicine cabinets and causing vulnerabilities was well known to us. Briefly, the governor of Massachusetts signed into law a few years after we started this initiative even more restrictive idea, limiting prescribing to seven days and for our own data only at Blue Cross Blue Shield of Massachusetts we reduced over 20 million doses of opiates compared to the same amount in prior years. That's simply from working with the professional societies and placing some corridors on how much you could prescribe without talking to us.

Ken Duckworth: [00:31:18](#) This is the traditional use of the utilization management tool that I think was one of the initiatives to curb overprescribing. We are of course still evaluating every other option on the pain management scale because it's difficult to take a tool away from a physician who wants to do good for people. You have to really think comprehensively about the other alternatives. It's a pretty

long list from lidocaine patches to tens units to neurontin. It's a fairly long list and we did review of all of our treatments making sure that it was easy to access these other treatments, that the copays were sensible and that our policies were engaged in a way that we weren't simply making it difficult to access the pain treatment we were trying to provide sensible alternative.

Ken Duckworth: [00:32:19](#) We're actively reviewing acupuncture to be a possible benefit right now. The literature on acupuncture is not as overwhelmingly clear as it could be, however there are some studies that are indicative that it may be of import for some people to provide an alternative to pain. I do want to mention outside of the traditional roles of the health plan, we've invested in a program in the community called Drug Story Theater. This is all on the prevention idea. These are people who aren't Blue Cross Blue Shield of Massachusetts members, these are middle schoolers and a brilliant child psychiatrist named Joe Schrand who was on the show Zoom on PBS that some of you may recall. He developed a psychodrama theater program where kids in recovery get on a stage and do a presentation to middle schoolers throughout many communities here in Massachusetts and then they take questions from the audience.

Ken Duckworth: [00:33:24](#) The program is poignant and has some data that kids appreciate that certain things are addictive, that certain things require early intervention and certain things require conversations with parents. That's in the prevention space. This is what I know our health plan has done and as I stated earlier I want to emphasize the health plan is one piece of the ecosystem but I think if we're all rowing the boat from the same direction we're going to have a better chance together as a society to end this crisis.

Ken Duckworth: [00:34:02](#) Intervention is how we think of the use of Narcan. I was visiting family in Philadelphia perhaps a year or two ago and I read an article in the Philadelphia Inquirer that librarians in Philadelphia were reducing overdoses because Philadelphia has has a particularly compelling strain of heroin and many people were traveling to Philadelphia as reported in the story and ending up in the bathrooms of the public library. I reflected on this and realized that I work for a very progressive health plan that would work with many ideas that I would put forth and I said, "let's really take a look at how we're addressing Narcan as a benefit and what we could do to get more Narcan out there."

Ken Duckworth: [00:34:55](#) the first thing we did is we reviewed the copays for Narcan I will just say for Blue Cross Blue Shield employees, I have insurance

through my job like most Americans. My copay was \$50. We reduced that to zero and most people don't know that you can go to any pharmacy in America without an order from your doctor. You don't have to ask, there's no administrative burden, you can simply get Narcan. In Massachusetts the pharmacist is supposed to give you a five minute training. I was not given any training but I happen to be a physician who has administered Narcan in my day so it occurred to me that if you got it to zero copay and you structurally trained people to administer Narcan that we could increase the amount of Narcan in the commercial space. Then it occurred to me that we could work with creative employer groups.

Ken Duckworth: [00:35:52](#)

Many of you know the construction industry has very high rates of opiate use disorder and overdose deaths. Construction industry in Massachusetts has been very hard hit by that and we approached several of our accounts in this space and they were incredibly interested in teaching the foreman on their construction sites and their employees how to use Narcan. We created a Narcan toolkit which I'll show you in a future slide. We also did it to some of the towns of, cities of Massachusetts. These have been hard hit rural communities and communities that are really trying to figure out, if you had Narcan in your libraries where you had public bathrooms, if you had it in municipal buildings, you had more people trained there could be an improved access to treatment and also an awareness and consciousness.

Ken Duckworth: [00:36:50](#)

One of the things we also did is we showed the toolkit to our Blue Cross Blue Shield of Massachusetts employees. Let's say we have about 3,000 employees. We thought we would have four small sessions of 25 or so people. We don't have public restrooms, we don't have construction industries so two of the best use cases for Narcan would not seem to be apparent for Blue Cross Blue Shield of Massachusetts employees but we wanted them to know what we were doing with the construction industry and the cities of and towns of Massachusetts. We were impressed that 300 people came, we had to keep re-running the sessions because people wanted to know what we were doing. They had heard that our organization had been a progressive leader in this field and we had not won that award that you mentioned from Blue Cross. People did have a sense that we had some nice momentum going but many people wanted to get trained for people that they loved and I was very moved by this, the idea that office workers were living with people or loving people who had an

opiate use vulnerability and they wanted to be prepared to use Narcan.

Ken Duckworth: [00:38:07](#) That program has been well received and with the copay of zero for Narcan, we are seeing a substantial increase in utilization. When I talked to the company that makes Narcan, Adapt Pharmaceuticals, they described a phenomena which I had never heard of which was called, medication abandonment which is when people go to the pharmacy and ask for a medicine they learn that the copay is too high and they leave the medicine there. We of course have eliminated that problem by having zero copay. For our fully insured and for our self insured accounts, you can get Narcan at no charge.

Ken Duckworth: [00:38:51](#) I'm going to come back to that toolkit a little bit at the end but I just want to go through what we've done on the treatment side. We do think medication assisted treatment is one but not the only essential element of treatment and we've done a lot to advance the cause around medication assisted treatment. We removed the copay and the deductible, we're allowed by law for Methadone and the use of Methadone has gone up five times since we've made that change. I've spoken to several other health plans who are instituting Methadone benefits. Methadone is not a benefit for every health plan across America. It's just a good example that if you're giving a person a treatment every single day and you have a daily copay of \$25 the cost becomes prohibitive quite quickly.

Ken Duckworth: [00:39:50](#) We also eliminated the copay for Narcan as I discussed we've seen a substantial increase in utilization of that and for Suboxone we removed the prior authorization for 16 milligrams and under. I happened to be at a substance abuse disorder clinician meeting when the email come through and it's very rare in a health plan to have people hug you and cheer what you've done and that was my experience that day because filling out paperwork and having a prior auth is a burden on providers and we need the providers to take care of people and we made a decision to remove that prior authorization.

Ken Duckworth: [00:40:32](#) We also have an in source behavioral health team at Blue Cross. That means we have our own doctors, psychiatrist, psychologists, social workers, licensed mental health counselors. One of the things we do in treatment is we have relationships with all of the major detoxes here in Massachusetts and our case managers know the people who run these detoxes and we call and we say, "Is Ken there? We happen to have seen a claim that Ken has been admitted," and

they'll say, "Well, let me see if I can get Ken on the phone." The idea is that our relationship with the detox providers enables our members to speak to our case managers to see what we can do to promote their recovery. What is the next step of care that they might need? What kind of supports might they want? Do they have a therapist?

Ken Duckworth: [00:41:24](#) We removed all the paperwork burden for outpatient psychotherapy at Blue Cross Blue Shield of Massachusetts and we've seen a substantial increase in the utilization of outpatient psychotherapy. Again, I see mental health and substance use disorder as frequently intertwined so how we're thinking about our benefits of the mental health side impact people on a substance use disorder side.

Ken Duckworth: [00:41:49](#) On the recovery side of the equation of course recovery is a process, it's individualized. For some people it will involve work, family, faith. For other people it may simply involve medication assisted treatment. It's really different I think for each person. I've been really impressed by this but one of the things we did is we gave a million dollars of grants to 10 organizations across the state who have recovery coaches. We're trying to gather data. What have you learned from the recovery coaches that you have? How can you let us know how many people you can take care of? Are you following outcomes? How long do your recovery coaches stay in their job? What kind of continuity can people have with their experience?

Ken Duckworth: [00:42:45](#) We're doing this as part of a larger effort in Massachusetts to evaluate whether peer recovery coaches could be third party reimbursable. I happened to sit on the governors commission for peer recovery coaches and we're actively trying to sort the questions of who could be a recovery coach and how could that be third party reimbursed? Remember when you're a commercial health plan you're spending other people's money and when an account says I'm writing this check to you to administer this benefit, they want to make sure that they'll be quality and safety that will be administered as part of that. This is how we're thinking about this Massachusetts Peer Recovery Coach Commission, our grants from Blue Cross to the 10 organizations were an effort to gather data but I think the larger question that we're facing with the workforce shortage that we have in Massachusetts, despite the fact that we have a large number of training programs in medicine, psychiatry, psychology. We produce a lot of clinicians. Boston is essentially an academic center in medicine but we still feel that we have a workforce shortage in terms of some specialized areas of care.

One of the ideas is could peer recovery coaches supplement, not replace the current system of care. We're actively looking at that piece of the equation.

Ken Duckworth: [00:44:24](#)

Take a look at the next slide. I just want to show you this little toolkit that we put together. Again, this idea was borrowed from librarians in Philadelphia and when an account came to us and said, we want to train our foreman or our librarians in our city of or town of, or for Blue Cross employees themselves this toolkit opens up. It's the size of a makeup kit I think is a reasonable comparison. It has two doses of Narcan, information on how to identify someone who is overdosed, obviously it call 911. We are not trying to replace the highly functional emergency medical system, we're trying to supplement it. Some basic information on how to administer Narcan.

Ken Duckworth: [00:45:14](#)

We've hired people from the department of public health overdose response team to train our accounts in this pilot and to look at the next slide, we've also created a website for people who want to gather more information about their benefits at Blue Cross, what residential and inpatient programs are in network, it's virtually everything in the state but people want to know where do I go? Where do I turn to and we have the video from the Adapt Pharma on how to administer Narcan. Again, I was impressed when I went to my local pharmacy that I did not get trained to use Narcan and we thought it was important to put this out there. This website is publicly available, there's no need to be a Blue Cross member and I encourage you to take a look at it, take from it what you think it valuable. Emend it for your own purposes. There's no intellectual copyright here. We're all trying to advance the ball on this important public health problem.

Ken Duckworth: [00:46:27](#)

I'm going to stop there. Again, I just want to say the health plan is one part of the ecosystem. I'm interested in the audience's thought about other things we could do. I think we're pretty actively reviewing what we have how we're trying to advance the ball as a community but I'm always open to learning and I want to thank you for your attention and I want to thank this organization for putting together this important talk and for inviting me. Thank you.

Kathryn Santoro: [00:47:00](#)

Thank you so much Ken. Your efforts are really moving the needle to address the epidemic and we look forward to seeing the results of the recovery coaches pilot program and to really continue to help guide people on a path to recovery.

- Kathryn Santoro: [00:47:16](#) Our last speaker Hemi Tewarson will share how governors and states are working together to approach this epidemic. Governors are at the forefront of efforts to curb the opioid epidemic and it's related challenges and the National Governors Association Center for Best Practices team has been leading efforts for several years to share best practices and strategies to address this public health challenge. Hemi's overseeing many of these efforts and her role as the director for the National Governors Association Center for Best Practices Health Division. She has decades of experience in healthcare policy in the public and private sectors serving as senior attorney for the office of the general council at the US government accountability office and in private practice as a health policy attorney. Hemi, thanks for being with us today to offer a state perspective and share NGA's efforts and I'll turn it over to you.
- Hemi Tewarson: [00:48:15](#) Great. Thanks so much for having me and it's really a pleasure to participate in this webinar. I will talk quickly because I know we're running short on time and I want to be sure there's some time for questions from the audience since I see there's quite a few. Just very quickly for you all who are not familiar with us, the National Governor's Association is completely bipartisan. Our current chair is Governor Bullock from Montana and our vice chair is Governor Hogan from Maryland. We've been around a long time. This picture is the first time the governors convened in 1908. I'm going to keep going because I'm going to talk about opioids today. You can go to the next slide.
- Hemi Tewarson: [00:48:47](#) One thing I do want to point out about our work is that we work, I lead the health division but we work in complete partnership with our public safety, homeland security and public safety division because really the public safety folks have been on the front lines and seeing what's happening with the opioid epidemic so we really make sure that all of our strategies when we work with state leaders and with local communities really encompasses both the health side as well as the public safety side. We just want to be sure to share that with you all.
- Hemi Tewarson: [00:49:16](#) I'm not going to talk too much about this slide because I think Carla did a wonderful job with the data that's really identifying where we are going in this epidemic. I did want to just reaffirm that we are seeing this directly from the states. Certainly states are seeing synthetic opioids really taking off in terms of the deaths as well as the psycho stimulants that are mixed with the synthetic opioids and so that's really going to continue to be the challenge especially for our stats out west. I think their question is how do we think about the opioid money that we're getting

from Congress and thinking about redirecting it to these new challenges. I think that's going to continue to be a conversation from a policy perspective.

Hemi Tewarson: [00:49:57](#) Okay, just to give you a little bit of a sense of where we've been in the National Governor's Association working with governors on this we've really been working on it since 2012. Governors have been unfortunately having to lead the charge on this since that time. It continues to be a priority in their state even with the new substances that are coming into play. One of the things that we did in response to that was the governors signed a compact to fight the opioid epidemic in July 2016 and they asked us to come up with a road map. If your interested this is on our website, it really is about how states should think about strategies across the three spectrums of prevention treatment and recovery and I think Ken just provided some really good insights on what he's seen from the plan perspective in Massachusetts and Carla of course looking at the federal side.

Hemi Tewarson: [00:50:49](#) We all are working together on this but we are certainly focused on how states can partner with all these different entities to figure out a way forward on these challenges. I wanted to show you where we are with states, where we have been, where we are going in terms of state work and I'm not going to be able to have time to talk through all of these but I thought we could highlight a few of them for you. In our work with states, I don't think any one state has solved this but what we have tried to do in our work is highlight where are places where states really need additional support and are there models within those areas.

Hemi Tewarson: [00:51:25](#) What I thought I'd do is just talk about a couple of these. One is how we've been thinking about improving access to addiction treatment in rural areas. Another big area that we are working on is how we really get medication assisted treatment for justice involved populations we'll tackle a bit of work on that. We are doing a heck of a lot of work on addressing infectious disease related substance abuse so I'll talk about the progress we've had going on there and then how do we really think about no opioid pain management. I think Carla touched on and Ken as well about script limits and thinking about how to on the prevention side really get a better handle on how these are being prescribed in the forefront but then the question is there are people with chronic pain and what are those alternative treatment and we've certainly heard from different folks with pain and pain advocacy organizations that have really been clamoring and saying we are not getting the help that we need

so what are the alternatives. I did want to talk a little bit about the work in that front.

Hemi Tewarson: [00:52:32](#) What have we been doing for addiction in rural areas? In our project that we highlighted for other state leaders, we really looked at New Mexico and I wanted to spend a minute talking about New Mexico and their work through their tele echo project. We hosted a learning lab with three states so they could learn about what New Mexico is doing and they have been working on this since 2005 and what's really I think helpful to understand about what New Mexico is doing is they realized they don't have enough behavioral health providers to actually get those folks across their state so what they needed to start relying on is [inaudible 00:53:10] video conferencing technology and clinical management tools that can be beamed out from a hub essentially where they have all the expertise so those rural areas where they don't have that expertise.

Hemi Tewarson: [00:53:23](#) That's really what they've been doing. Since their initiation there have been 950 patient cases that have been presented in the virtual clinics and 9,000 hours of CME logged. Certainly been significant uptake of this strategy and they've also really required the Medicaid managed care organizations to get involved. Paying specialists with per member per month funds and also recognizing the role of the primary care physician to present.

Hemi Tewarson: [00:53:51](#) Medication assistant treatments are [inaudible 00:53:54] populations. Massachusetts, Ken your state, was the state that we modeled for this and really there is a reentry initiative that is a partnership between the department of corrections and the department of public health in Massachusetts. It was implemented in 2014 and it has really increased access to community based NAT especially those coming out of the prison systems to communities. We brought eight states to learn about what Massachusetts has been doing and really I think there is now a new movement to where it's inducting treatment upon transition at the facilities [inaudible 00:54:30] so really making sure to get the treatment to folks when they're coming out of the facility so they don't go back in because it really is a revolving door.

Hemi Tewarson: [00:54:39](#) One of the things I did want to highlight because of the interest in this topic we are doing more work now, actually this week. We're hosting trainings with nine states to help implement action plans around MET and corrections settings especially focusing on continuity of treatment and care linkages to social

support services in communities. If your interested in that they'll be more work coming out from NGA and the states on that front.

Hemi Tewarson: [00:55:07](#)

Infectious disease. That has been a big topic for us. Injection drug use drove a 350% increased in Hepatitis C between 2010 and 2016 so we really saw a need to really do some work on this. Kentucky was our model state and they were the first in their state to authorize comprehensive harm reduction which included syringe exchange and now syringe exchange programs have been approved in 60 of Kentucky's 120 counties. Pretty impressive. They really did that with partnering with their local leaders fire chief, police, religious leaders to really make sure that the communities embraced this concept. Although there's only preliminary data they have so far provided over 180 referrals to substance abuse disorder treatments and completed over 1,700 tests for Hepatitis C and over 2,300 tests for HIV. We have two briefs on this topic if you're interested talking about Kentucky specifically and the seven states that learned from them on our website so feel free to follow up if that's an area of interest. [inaudible 00:56:10] will be launching a new program on this focusing on New Mexico because there really is a lot of interests from states on this topic.

Hemi Tewarson: [00:56:21](#)

Wanted to talk a little bit about pain management. I do think this is an important part of the conversation. This is just a snapshot quickly of the limits, there's 33 states that had some sort of statutory limits on the prescriptions of opioids, 15 states had seven day limits, this is certainly most common. It follows the CDC guidelines, four states had three to four day prescription limits, this is more rare and then there's seven states where they directed other entities to set prescription limits. Some of those states, just a few of them, four of them set dosage limits where they actually looked at the milligram equivalent or MME's. This is a snapshot of what the states have done on that. I think what comes next, and this is really just a continuum of how states are thinking about it, okay you're listening the first time opioid prescriptions there are exceptions of course for certain type of chronic pain and cancer and that sort of thing.

Hemi Tewarson: [00:57:15](#)

There's also how do you promote the clinical guidelines for safe prescribing, how do you think about transforming pain management in and of itself and then how we expand access so I think these are the three areas where we're going to work on as we move forward. Just very quickly I think we talked a little bit, the presenters before talked about and Ken in particular

about acupuncture and there isn't a lot of evidence necessarily on these structures but states are starting to experiment so I just want to highlight quickly that in Ohio, with their Medicaid program covering acupuncture and chiropractic services and then in Rhode Island they have Medicaid communities of care where they're providing access to chiropractic care acupuncture, massage therapy along with access to nurse case management.

Hemi Tewarson: [00:58:00](#) I think the take away from this and we will have a paper coming out on this as well if this interests you is that states are stepping in gingerly and carefully in terms of the coverage of these services, sometimes only for certain indications like low back pain because it's not completely clear on the evidence but I think there's a real interest in figuring out how do we have alternatives to opioids to actually help people with their pain. With that I think I'll turn it over because we are running short on time so thank you Kathryn.

Kathryn Santoro: [00:58:33](#) Thanks Hemi. It's so important to learn about some of the best practice of using technology to connect people to treatment such as the tele echo program you described to really continue to inform new efforts to link people to virtual care for opioid use disorder. We had a few questions come in already on that and we'll start our Q and A session now so encourage our audience to continue to submit questions but wanted to open it up about the full panel about what can be done to make treatment more available to people, tele health options for substance use disorder treatment in rural areas but also in urban areas as well. Make sure you all come off of mute too if our speakers have their phones on mute.

Carla Haddad: [00:59:36](#) Sure, I can start. This is Carla Haddad. I think you've hit a few of the key points right there in terms of really insuring we continue to increase access to treatment for those with opioid use disorder. Tele health has been a big focus for the department, specifically at the Health Resources and Services Administration or HRSA. They have a whole office dedicated to the advancement of tele health and we've been making great strides in expanding tele health services in remote and rural communities that otherwise don't have access to providers or clinics nearby. That's been one area of focus that we've been prioritizing.

Carla Haddad: [01:00:19](#) Another one is utilizing and leveraging our HRSA funded community health centers across the country. I believe there are about 1,400 community health centers across the nation

with over 11,000 sites specifically for folks who do need access to treatment to be able to get affordable treatment there and really insuring that behavioral health services are integrated into primary care services in those health centers have been another focus of ours. We put a lot of money toward that effort. I think more broadly making sure we're attracting a strong workforce in this area and putting them in the right places. Directing them to communities that have shortage designations for behavioral health providers and also getting a better handle on what our current supply and demand will be in the future and thinking through how we one, attract perspective providers to the workforce and also thinking about what education and training we need to be providing them with so that they know how to treat and feel comfortable treating people with this disorder. Thoughts from me.

Hemi Tewarson: [01:01:37](#) Yeah, this in Hemi Tewarson and I completely agree Carla. I think those are great observations. One of the things that the states have really been focusing on is at least the ones we've been working with is the partnership with the communities. Really understanding from a data perspective what is happening at the local level so then you can understand what's needed to address those areas that are hard to reach. There are differences between those things and some cases you don't have enough buprenorphine waiver doctors for MAT so that's going to have to be the strategy and other places like a rural area there may be access to just even the critical treatment at more intensive level like a hospital that's farther away. In other areas, it's making sure your local law enforcement understands the strategies and with our work in Kentucky where we really learned a lot about their syringe exchange programs and how they set those up with their communities, it was when they did that and then they had to figure out what was the referral to care.

Hemi Tewarson: [01:02:39](#) It really catalyzed some of the work at the local level and understanding where the funds should go and how to partner with people effectively because I really do think this epidemic, it starts with communities and states there to support them and so is the federal government but it really has to be a community based approach if we're really going to get our arms around these hard to reach areas.

Kathryn Santoro: [01:03:04](#) Great. Ken, do you have anything?

Ken Duckworth: [01:03:08](#) Yeah, I'll just say we added a tele health benefit to the million or so people that are fully insured and we've been encouraging all

of our self insured accounts to add tele health as a benefit. I'd say we're over 50% of our three million members have access to tele health and that's something we continue to want to advance.

Kathryn Santoro: [01:03:32](#)

Great, thank you. A follow up question on NIS. We talked a little bit about it but this person was curious if the other speakers could elaborate on anything that they're doing either at NGA or through Blue Cross to address the neonatal abstinence syndrome.

Hemi Tewarson: [01:03:54](#)

Yeah, this is Hemi, I'm glad to speak first. Actually i was going to talk about it and I just, so now I can talk about it now I have the opportunity. NAS has definitely been something that risen to the top for us in terms of priority. It was already on my list of the nine areas or eight areas that we're working on and I failed to elaborate on what we are doing. We did a project this last year on this because of the interest from state leaders and we highlighted Ohio and I know the federal government has also been looking at the Ohio Moms program. Prenatal care is coupled with opioid maintenance through MAT in a maternity care home model and I really think the focus on returning care home model is really important and so during the prenatal phase the program supported the pregnant mom understanding what she needed in terms of medication, understanding the support, social supports as well not just the medical clinical side.

Hemi Tewarson: [01:04:52](#)

Then it moved also into the postpartum phase where they offer behavioral healthcare services, health education, classes on baby care and parenting and ongoing medical care for mom and baby to keep them together because as we all know opioid abuse disorder is a longer chronic, more of a chronic need for a pregnant woman and what happens after she has the baby. One thing I would say learning from that program we brought a number of states to learn from Ohio, there's some states that still have legal requirements on their books where the pregnant moms are really fearful of going in to programs because they won't and there's a stigma associated with you're a pregnant mom and you're using. Why would you do that? I think there is room in understanding at some levels but I think more education is needed to really makes sure that the pregnant woman feel comfortable coming in for treatment.

Hemi Tewarson: [01:05:48](#)

I also think, I would just comment that there's also the longer term and for [inaudible 01:05:53] it's more of a challenge of how to provide coverage to some of these populations after they have the baby as well so really important component of

really looking at the disorder more comprehensively. I'll stop there.

Ken Duckworth: [01:06:08](#) Yeah, from a Massachusetts commercial plan perspective, we support MCPAP for moms which is the Massachusetts Child Psychiatry Access Project which is child psychiatrists consulting to pediatricians and this is a variation on that child psychiatrist consulting to obstetricians. Any person in Massachusetts who is a provider can ask for a consultation with experts in the child psychiatry space and that is in effort to try to make sure that all varieties of vulnerabilities that happen in infants and children have specialized consultation. We support that endeavor and we think it's a positive.

Kathryn Santoro: [01:07:03](#) Great, thank you. Ken, you had mentioned that really interesting theater program and working with medical students and a follow up question for all of the speakers are what suggestions do you have for preventing opioid use misuse and abuse among children and adolescents and are there other programs out there that anyone would like to share?

Carla Haddad: [01:07:32](#) That's a really good question. This is Carla. I can touch on a couple of initiatives that we've been focusing on at the department level. We're very focused on and we very much recognize the issue of stigma. Stigma in communities, stigma among youth, among providers and just more broadly. One initiative that the CDC has been focused on over the last couple of years in particular has really been getting the word out about addiction and what opioids can do to you when you misuse them has been through their awareness campaign so they have an Rx awareness campaign that was piloted in a number of communities and states across the country and there were some pretty positive outcomes that we saw from those campaigns so I believe they're now expanding them to be more nationwide. I think again getting the word out through these types of awareness campaigns, television ads, et cetera has been one effort we've been taking and I think even beyond the HHS level at the administration level the White House has put out the truth campaign as well again gets the message across and is focused on peer type stories, so stories of folks who were addicted but got out but just sharing the powerful stories from people who experienced it themselves.

Carla Haddad: [01:09:06](#) We found that that's a way to really get to the use across communities. That's one area. We have also the, HHS has been collaborating pretty closely with many different departments across the administration but we do meet regularly with the

department of education and I know they have some specific activities underway in the opioid space.

Hemi Tewarson: [01:09:32](#) Yeah, that's great. This is Hemi. From a state perspective, it's interesting. I think the states have been so focused on the treatment piece because of the overdose stats, they have been thinking about prevention but it's been a lot in the prescribing that I talked about, really setting the limits because I think some of their data was showing that a lot of the addiction began with a prescription. Someone hurt their back and went out especially among the younger population and so really from our perspective that has been most of our work has really been focused on okay, trying to change the initial prescribing practices to insure that all populations including those that are younger don't fall into any sort of addictive pattern. That's just our perspective at NGA.

Ken Duckworth: [01:10:24](#) One thing I'll say. I was at one of the presentations, I've been to many of these presentations. This was in a rural town in Massachusetts and the principal of the middle school asked how many kids knew someone who had an opiate use disorder, so we're talking about fifth graders, half the kids raised their hands. It's not like they don't know and then the question was asked, how many of them know someone who had died from an opioid overdose and it was about a quarter of the kids raised their hands. What you realize is this is really impacting this middle school population and they are aware of what's happening around them. The question is how do you give them the tools to understand better the choices they make and the impacts that they have on the choices. The program's, I highly recommend it. It's called Drug Story Theater. You can just google it and it just gives you an insight into one creative program. I'm sure there are others but this happens to be a local work of creativity here in Massachusetts and I was able to convince Blue Cross whose community team, to help support and expand the program.

Ken Duckworth: [01:11:46](#) They happily did so once they saw it. I think all of us can participate in prevention activities. It's all to the good even if it's very difficult to do research to prove things. I think information and alternatives are really important to get out.

Kathryn Santoro: [01:12:09](#) Sure, just to follow up on the point you made Ken, what types of counseling and support services are recommended and available for family members of individuals struggling with opioid dependence?

- Ken Duckworth: [01:12:25](#) Well on the family side in Massachusetts we have a program called Learn to Cope which may be a Massachusetts specific idea but this represents a support network for family members. Of course by removing all the prior authorizations and paperwork around psychotherapy, we encourage family members to get psychotherapy supports as they work to support people who they care about who are dealing with addiction.
- Carla Haddad: [01:13:06](#) Just to add to that, this is Carla. One program that I can think of that relates to that question is the behavioral health workforce education training program. This program I believe was implemented one or two years ago and the whole concept of it is to equip, again focusing on communities and the health centers in communities make sure that we're equipping health centers with not only the providers who were prescribing buprenorphine or providing the treatment that is needed for people with addiction but also supplementing their care coordination team with social workers and psychologists to work alongside the other health professionals as its comprehensive team to provide the other psychosocial support services and recovery support services for individuals with addiction.
- Hemi Tewarson: [01:14:03](#) One thing I just would add I think as they're so on point, one thing that's maybe slightly different from what the original question was is we've also seen the success of peer recovery coaches and really using that tool to support the person with addiction as part of the family and there's states like Rhode Island that have really been modeled on how to use those different types of workers effectively and so I think the earlier question about workforce ties into all of that.
- Kathryn Santoro: [01:14:39](#) Great, thank you. I think the question is directed toward Carla because she mentioned some of the data. Do we have a sense of whether the cocaine overdose death increase is cocaine alone or poly drug toxicity because of the way it's coded by CDC and if this fourth wave is really massed in cocaine alone how do we insure the efforts address prevention and treatment especially in light of the fact that there's no MAT for these drugs?
- Carla Haddad: [01:15:11](#) Right, those are really good questions. The first one got to poly substance use I believe right? So cocaine deaths and if we know what proportion are mixed with other drugs. I don't think we have the exact specifics on that for the provisional drug overdose death data that I was referring to that gets published

by CDC on a monthly basis but we do know based off other data we've seen that a very high proportion of deaths due to cocaine and methamphetamine are also mixed with other drugs so poly substance abuse is a big issue. I can't say off the top of my head though the past data that we have exactly what percentage there is but it continues to be an issue and I think it might be actually included in a report that CDC released on the 2017 overall findings in terms of what they saw related to drug overdose stats. That information might be there. In terms of the second question, can you please repeat that?

Kathryn Santoro: [01:16:15](#) If this fourth wave is really massed in cocaine alone how do we insure the efforts addressed prevention and treatment especially in light of the fact that there's no medication assisted treatment for these drugs?

Carla Haddad: [01:16:28](#) Right, so yes. That's a really important comment and again we in the last couple of months the department has been very focused and committed to addressing the rise, the resurgence of meth and cocaine related mortalities before again it becomes the new wave of the crisis. We've had some internal discussions with various agencies across the department talking to the National Institute of Health, the CDC of course, FDA, our centers for Medicaid and Medicare services just to come together and think through collaboratively what the issues are. The issues are, yeah you're right. There's no medication assisted treatment for meth and that's scary so thinking about NIH and the research their conducting just exploring what else can be done in the research space to get a better handle on whether they can put research toward identifying new treatments in this area and again discussions are underway internally but we'll have more to share in the coming months on this.

Hemi Tewarson: [01:17:43](#) This is Hemi. I would just chime in that that was a great question because it's exactly what the states that we're working with are thinning about and are really challenged by. How do we really address methamphetamine and fentanyl and the mixture with cocaine and all of that. I would say the couple things that we talked about with states are fall in a couple of categories. One is there's certain pillars of the treatment and recovery spectrum that they've been building for opioids that could be transferrable to these substances and one is a peer support network. Another is a psychosocial support. Really thinking about is there cognitive behavioral therapy, what is the support that the individual have when they're actually going to go into detox and come off. I think states are still thinking about without having MAT what is the evidence based practice that

they really should be circling around and I would just since we have Carla on the phone here thinking about how federal dollars can be used more creatively to address these other substances.

Hemi Tewarson: [01:18:48](#) Obviously abuse is a part of it but as you're building infrastructure can you build infrastructure that's flexible enough to actually address these other substances as well.

Carla Haddad: [01:18:58](#) That's a great point and we've definitely been having those conversations at this level as well recognizing of course we're going to be continuing to focus on opioid addiction and the opioid crisis in general but in addition to that focus we have to get a handle on other emerging trends before they take over and before it's too late to really get a full handle on it up front. We do understand that it's difficult for states especially with the state opioid response funding that's significant amount of funding going to states. Unfortunately that can only be used for opioid related prevention treatment and recovery services so we're just trying to think internally about how we can create some more flexibilities in terms of the funding that we're providing states and communities with so that they can use specific funds to better address the specific needs of their communities.

Hemi Tewarson: [01:19:57](#) Yeah, and I'm sure you've all been talking to congressional leaders on it to think about what does [inaudible 01:20:05] 2.0 look like and what can we think about in terms of looking at these other substances so appreciate your partnership on that.

Carla Haddad: [01:20:13](#) Absolutely.

Kathryn Santoro: [01:20:16](#) Great. We had a couple questions come in about initiative specific to the Medicare population and what work is being done and not population but for mental health treatment and opioid use disorder and what's being done to monitor some of that population that is withdrawing from opioids and also what's happening with the death rate specific to that population.

Ken Duckworth: [01:21:00](#) This is Ken. I'll take a try at this one. The benefit changes we made across the board unless Medicare had specific rules so the effort we made was to go across the board, Massachusetts does have a Medicare population. If you look at the population of people with opioid use disorder, it really does run the gamut from the teens to the Medicare population but our numbers

with Medicare with opiate use disorder is relatively low just per square population but it is an issue for that population.

Hemi Tewarson: [01:21:42](#)

Yeah, and I would chime in, this is Hemi. I think there have been at least from our state perspective, some states that have really done an admirable job with the data that they have and really getting down to a much more analytical level of okay, where are the deaths occurring, who are they, who is going withdrawal, what are the clinical indications if they were in an EED or outside of an EED what can someone glean from the record? Some of those states and I'll just call it one, there's more than one. In Arizona that has a very public facing dashboard that has not all of this information but more of the information out there and I think it helps the public to understand a little bit more about what's happening with the epidemic in that state and so there's other states that are doing it as well but not all states are doing it but I do think it's a best practice and really thinking about how to use that data.

Hemi Tewarson: [01:22:34](#)

Data flows not just from the medical side but also from the public safety side is important to marry the two so the public safety people have some sense as well as the medical people and I think that's hard, right? It's two different, I'll just use the word, silos and systems and really merging those together I think has been a challenge but some states are really tackling it.

Kathryn Santoro: [01:23:00](#)

Great. Question of Hemi. Are there any efforts to create training for drug court judges on the best practices with MAT so that they aren't interfering with a doctor's orders for someone who has opioid use disorder?

Hemi Tewarson: [01:23:17](#)

Yeah that's a great question and in our Massachusetts project they have done I think a really good job with the drug courts and so we've generally highlighted the practices that they used in that setting and I will tell you just anecdotally just at the MAT workshop that we had this week we had a judge come in and talk about how he learned about this. We don't train the judges directly because we don't work with them in the judiciary branch necessarily but I think really we've been trying to partner with our executive branch folks in sharing with them that this is an important aspect of the whole piece, the whole puzzle of how to get folks out of the jails and onto recovery so great question and we're doing some work but if this person has any suggestions for me you have my contact information so feel free to send me more ideas.

Kathryn Santoro: [01:24:12](#) Great. Question for Ken but for any of the speakers. Can you talk a little bit more about the role as employers and how you're educating them on the ways to address this issue with workers especially in industries like you mentioned the construction industry.

Ken Duckworth: [01:24:30](#) Yeah, our perspective was a lot of the communities are engaged but just given my vantage point from the health plan, it did occur to me that employers represent a whole other way to engage their employees in this conversation. One of the things we did at Blue Cross is we had an event where people in recovery talked about their experience of being in recovery and this was an event that I think had some people approaching the issue with some trepidation. I'm just speaking about our own employee culture. This event could not have gone better. We had four individuals who talked about what their life was like in recovery. I received emails from people who worked at Blue Cross who said I've worked here for 25 years and today was the first day I felt that I truly belonged here.

Ken Duckworth: [01:25:26](#) The number of people that were moved by the idea of having conversations about recovery so that's just one employer group, it happens to be my own but that was an effort to really impact the culture around the acceptability of seeking help. The employer groups, we've done multiple events now with the Association of General Contractors, with the bankers association, there's a lot of banks in Massachusetts, a lot of public restrooms, a lot of vulnerable people come into contact with these public agencies. We're looking at some of the larger franchises that have public bathrooms so to me this is an area that we have to continue to investigate where we could do more but I will say the construction industry has been overwhelmingly positive with the idea that the health plan is trying to help them make a difference for this.

Kathryn Santoro: [01:26:32](#) Great. Another question for the full group and a lot of your organizations are also doing a lot around social determinance of health and how does that intersect with your work on opioid misuse disorder? Are we sending people home from treatment without housing, without food and what can we do to better address these issues?

Hemi Tewarson: [01:27:01](#) That's a great question. I'm glad to start. This is Hemi. In some of the work that we're doing just for example around corrections and reentry and MAT one of the things that come up for example was insuring Medicaid coverage for people. It's an expansion state Medicaid coverage coming out of the jail or

the prison so they get excessive services but then not just the medical services, also insuring that their linked to social support. That I think has been a very clear push in interest from the state level. I would also say outside of the corrections setting, we've gotten a lot of questions about recovery housing and how do we think about recovery housing because that seems to be one of the big challenges when you're actually getting people on a successful path to recovery is having them have stable housing so we've done of course in healthcare is housing projects which I think intersects with this area of opioids. It's one of the populations that I think states want to focus on and figuring out what does Medicaid play in terms of allowing coverage for the supportive pieces of housing and having them also partner with your housing agency and private developers and all that to think about where do we have affordable housing.

Hemi Tewarson: [01:28:18](#) I do think there's lots of links and there needs to be lots of links in order to really think about recovery more holistically.

Carla Haddad: [01:28:26](#) Right, and to add on to that, this is Carla. At the HHS level we have been having an number of conversations with our sister department the housing and urban development and labor to get a better sense of what the needs are still for expanding the wraparound services that are available to insure that folks who have treatment also have access to housing and job placement as well. That something that we are continuing to work on with our other departments but that has been another focus of ours in terms of making sure that people who are entering health centers and other facilities for treatment are also provided with psychosocial services and other recovery, broader recovery support services to make sure that they receive the comprehensive care and treatment that they need.

Kathryn Santoro: [01:29:25](#) Great. Well, thank you all. We are out of time. I know we didn't get to all of the questions and there was a few data specific questions so we'll try to follow up for people that had clarification questions but I do want to thank our excellent panel of speakers for being with us today and thanks to our audience for also joining us. We hope that you found some interesting information to take back to your communities. We'd appreciate it if our audience could take a moment to share feedback from this event by completing a brief survey which can be found on the bottom of your screen and we also would just encourage you again to view previous webinars in our Defying Despair series along with our opioid infographic and hope that's

all useful for all of the important work that's going on to address this important issue. Thank you all again for joining us today.