2024 Integration Forum – Recording Transcript

November 13, 2024

1 "Maria Yerstein" (1578761472)
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Good afternoon. I am Dr. Maria Yerstein, a psychiatrist and Medical Director at the Massachusetts Behavioral Health Partnership. It is my great pleasure to welcome you all to this important conference where we will be focusing on substance use disorders and their treatments in Massachusetts.

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My passion for supporting our Members who suffer from substance use disorders began during my time as a medical student, which coincided with the peak of the opioid epidemic. Working in the emergency department and in acute recovery centers.

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I witnessed firsthand the profound impact that these disorders have on individuals and their families. However, through my work as a psychiatrist, I have also witnessed the resilience of people who have successfully recovered and have gone on to lead healthy and fulfilling lives.

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These patients and their determination have been a constant source of inspiration for me. At MBHP and in Massachusetts, we have built robust support systems that have contributed to these recovery stories.

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This forum aims to explore substance use disorders comprehensively from diagnosis to treatment and next steps. It is essential for primary care providers and behavioral health clinicians to work collaboratively in this area, and we hope that this program will foster stronger relationships in this regard.

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We are encouraged by recent data showing a reduction in opioid overdose deaths in Massachusetts in 2023 as compared to 2022. However, we must not become complacent. Our goal is to continue improving access to quality substance use treatment and empower everyone attending this conference to utilize the full spectrum of resources available to them in Massachusetts. We now have more options and support for our members and patients than ever before.

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Before we proceed to the agenda, I would like to highlight the importance of people's first language. Throughout this conference, you will hear myself and our speakers refer to individuals as ones who

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suffer from substance use disorders rather than ones who are defined by their condition. Although this may seem like a small thing, it is a crucial part of reducing stigma and allowing people to seek care when they need it without shame. Lastly, I would like to thank our state partners or their support in allowing this forum to happen. Now let's take a look at our agenda for today. Dr. Steven Descoteaux, a specialist in addiction medicine and a Medical Director at Carelon, will start by discussing best practices for screening for substance use disorders and providing Medication Assisted Treatment. Tracy Nicolosi, Director of Addictions Services at the Office of Accountable Care and Behavioral Health at MassHealth, will then provide insights into the different levels of care available in Massachusetts for substance use disorders. Heather Towers, Director of Clinical Operations at MBHP, will talk about the resources available for patients and provider. Dr. Descoteaux will return to prevent case to present case studies that will integrate everything we've covered today. And lastly, I will moderate a brief question and answer section which will include all of the speakers. So I welcome you and encourage you to put questions as they come to mind in the question and answer feature in this forum.

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A few housekeeping items. Participants for this forum are in a listen only mode, so please put all questions including technical issues in the question-and-answer feature. Program information can be accessed at the link that's provided in the chat.

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For closed captioning, click the CC icon and then select the language of your choice. The webinar is being recorded and the link will be provided and emailed to everybody after the event. The form is eligible for CEUs and CMEs.

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And lastly, there are NO disclosures for any of the program faculty or planning committee members. So thank you again for joining us today and I'm now going to hand it over to Dr. Descoteaux to begin our 1st session.

16-21 "Steven Descoteaux" (1252077824)
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Good afternoon. I just want to say welcome and thank you to all of you who are joining. We're really pleased with the interest in the turnout, and we're happy to share a lot of really good information for how we can all work together to better serve our communities. I am Steve Descoteaux. I'm initially trained in internal medicine, but later became board certified in addiction medicine. I worked in an FQHC doing primary care early on in my career, so in the early 2000s, so I know how important and how demanding that job can be to be a primary care provider. So today I wanted to

share some data about how things are going with respect to SUD in Massachusetts. There's some nationwide data as well that we'll share and then move into some way, discussing some ways that we can help do more for our patients with SUD, particularly with alcohol use disorder and open use disorder. There's a lot that we can do in the primary care setting. There's a lot that Carelon can do to support your teams in getting, you know, more people in engaged in, in treatment. Alright, so with this slide, I just wanted to remind people, 2021 this is outdated, it has gone down a little bit since then. 80,000 people died from opioid related deaths in that year and, but that same year 2021 140,000 people died of alcohol related deaths. 58,000 of which were acute injury from drinking too much. So one of the things that we often lose sight of when we're talking about substance use disorder treatment and a lot of attention gets put on opioid use disorder. I think we need to make sure that we're keeping our eye on the ball for our people with alcohol use disorder.

22 "Steven Descoteaux" (1252077824)
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Okay, next slide.
So these next few slides I have some graphs and data that I pulled both from the CDC website and also from the Mass.gov dashboards that have a really a great collection of interesting information on them.

23-30 "Steven Descoteaux" (1252077824)
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Next slide, please. So this is from the Mass.gov website showing us that we were actually able to reduce opioid deaths between January 2023 and four. You can see it's trending downward steadily year over year, and this is the first time in a very long time that this has happened. Next slide. So, this is consistent with what the national trends are, that things have actually taken a turn for the better in terms of drug-related overdose deaths. The next couple of slides I'm going to show you what's going on in Massachusetts because not all parts of the state are enjoying the same success as others. And also certain populations are more still more likely to be affected by the by overdose deaths. The green line in here represents Black, non-Hispanic people in the Commonwealth and as you can see there's been a steady increase with some periods of leveling off, but the trend is still that more and more Black people are dying from overdose deaths. The dark blue line is white non-Hispanic people, and that's shown a nice leveling off and even reduction in overdose debts in the past couple of years. And the blue line, the light blue line represents Hispanic patients who are experiencing even a better reduction in overdose deaths. Next slide. This is a look at Massachusetts data by county. I wanted to point out that not every place in Massachusetts is enjoying the same success although I want to call out Barnstable, Essex, Middlesex, Plymouth, and Worcester counties because they've shown from 22 to 23, anywhere between 15 toa 21 % reduction in their overdose deaths, which is really fantastic. A few have experienced increases in overdose deaths, particularly Suffolk County, so those of us who work in Boston are with patients in Boston, the number went from a pretty big number to an even bigger number. So that's a pretty significant trend, that's, that's happening in Suffolk County. Just reminds us that we need to do better at connecting with our patients in the inner cities and people that are of African American descent. Next slide.

31-42 "Steven Descoteaux" (1252077824)
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So I wanted to include some data on emergency room visits. This is national data. During one year there were a million 700,000 people that went to the emergency room for alcohol related complaints or problems, whether it was detox or just that they were looking for help and in that same year about 400,000 presented to the emergency room for a reason that was the primary reason being for their opiate related behaviors. And then the other thing I wanted to call out is that

emergency departments have become champions of identifying and treating their patients who come in, whether it's connecting them to care in a detox facility or an outpatient drug treatment program and (even) they've also been able to expand the number of people that get a first dose of MAT medication in the emergency department before they leave, particularly and methadone. So with this, I just wanted to make sure that we understand how important it is that we all work together, that if we're in a primary care setting that we connect with the local emergency departments and vice versa, so that when emergency departments are initiating treatment for patients that there's a really a better handoff back to the outpatient community providers. You know primary care practice might be more interested; some might be more interested than others than continuing somebody else about some or following up after someone has alcohol related issues or detox. So it's important that we all work together.

Next slide. Some more statistics, I just wanted to call out looking at alcohol use and opiate use side by side, just another reminder that even though the prevalence of opiate use disorders really high, 5,500,000 in this slide on that second line. There's a fivefold multiple of people who have alcohol use disorder, and this isn't just people using alcohol in a problematic way, but they actually have a diagnosis of alcohol use disorder. So just keep that in perspective.

Next slide. So what can we do as primary care providers and as behavioral health clinicians? It's important that we familiarize ourselves with the resources that are available and also become comfortable administering screening tools. The beauty of screening tools is that (we) they're designed to uncover problems before any obvious symptoms or signs appear. So it's a really great thing to kind of build into your, your regular practice so that we're asking questions of everybody, not just people that we think might have a problem. A lot of times people, people come in asking for help saying, hey I have a problem with my drinking, or I have a problem with opiates, but a lot of times it will be something else will come in with a medical symptom or a medical complaint that's related to their misuse of alcoholic drugs, whether it's insomnia or anxiety, shaking hands, that kind of you know handshaking, and that's the kind of thing where we need to be vigilant. And of course, we want to make sure that we leave our biases at the door and we come into the room with unconditional positive regard and a really supportive approach for our patients. They'll be more honest and more, they'll share more, share more with you when they know you're, you're being genuine and helpful.

Next slide. So there are dozens of screening tools available out there, I wanted to include the first two, the DAST 10, and the audit because they're among the most commonly used tools in the primary care setting and in the emergency rooms and in behavioral health clinics. And I want just for completeness, just to let people know that there are tools available for screening for cannabis used disorder. There's so much of that around now that it's legal both recreationally and medically and you know it's in this state it's actually pretty easy to get. So there's a lot of people that are using it and we're seeing more people that are not just using marijuana but demonstrating problematic use. Next slide.

43-46 "Steven Descoteaux" (1252077824)
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So the DAS 10 is the drug abuse screening test tool. It has 10 questions, they're all yes/no questions, and depending on how many yeses a person answers for these questions, we're able to stratify people into risk groups about whether or not they may have a substance use disorder, and what the urgency might be in terms of like going the next step and providing an intervention versus an urgent referral to treatment. This is, this test is intended for drug abuse, not so much alcohol or cigarettes. So keep that in mind. Next slide.

AUDIT 10 is the alcohol use disorder identification test. Ten questions, they're not yes/no questions. Each question, you rate your answer is 0, 1, 2, 3, or 4. And depending on what your numbers add up to, that similarly can, can help providers stratify patients into risk groups, like who's at a low risk for having an alcohol use disorder versus who's a very high risk of dependents, as well it will help us decide what kind of intervention, how urgent the intervention needs to be for these patients. Next slide.

47-49 "Steven Descoteaux" (1252077824)
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Just real, quick on the Cannabis abuse tool I just wanted to let people know that there, there are two types of people, I don't want to be so simplistic, but there's people that smoke pot at the end of the day just to relax or take the edge off or to unwind. But there are many other people that use marijuana to make their minor decisions throughout the day, and they have other problematic signs and symptoms that go with it. People might be asking them, you know, about their use. A person might have promised themselves to cut down, but they're not able to I'm not able to do it. So doing a test like this is sometimes helpful, particularly if you work in the substance use space where a lot of times we think of cannabis use as really the least of somebody's problems if they're, you know, working, if they're working to get clean from opiates or alcohol, but let's make sure that we're aware that cannabis use can have its own, come with its own set of problems. Next slide.

50-54 "Steven Descoteaux" (1252077824)
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Alright, so there are CPT codes available for us to use in order to do a screening and brief intervention or referral to treatment. These codes, the top 99408 and 99409 depending on how much time you spend doing it can be administered by behavioral health clinicians or medical providers. It could be its own freestanding visit where that's all you talk about there and whether that visit and whether you do 15 to 30 min or 30 plus minutes, that's how you bill it. And we want to make sure that you include a reference to evidence-based tool like a DAST or AUDIT so that you can reference that you did that and include the score in your (in) your note. Similarly, if you if your patient's there for something else, whether it is outpatient primary care, emergency department or they're your doc in an inpatient settings, you can see them for what they're there for and then also do a screen brief intervention referral to treatment, expert assessment and use a modifier 25 to kind of upcode the, the complexity of your visit.

Next slide. Smoking cessation has a couple of CP code CPT codes that we can use for counseling sessions. These 99406 and 99407 can be done by themselves or also tacked onto another visit. They're counseling sessions just to kind of remind people of what the options are to help them quit, but also to let them know that we think it's important that they continue to work on this. We can do this up to eight times in a one-year period with our patients. Next slide.

55-57 "Steven Descoteaux" (1252077824)
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There are meds available for smoking, helping our patients with smoking cessation. Varenicline and Bupropion are tablets. Varenicline used to be called Chantix, but that was taken off the market in 2021 because it was a possible, very small amount of an ingredient that might have been carcinogenic, but they've reformulated it. There are several generic forms available that are safe, they're not thought to be containing trace amounts of something that's cancerous. The way that tablets work is that you start it on day one, you pick a quit day usually about a week later and then you double the, the, the dose, meaning taking twice a day instead of once a day and then in for

Varenicline, you can actually increase the dose further. And on that day you quit and people are seeing some success with that.

58-62 "Steven Descoteaux" (1252077824)
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Nicotine replacement, sort of speaks for itself. Next slide.
A little bit more side by side comparison because I wanted to point out that there are treatments available for alcohol use disorder and opioid use disorder, but we're not offering it frequently enough. Particularly as it pertains to alcohol use disorder, with 28 million people carrying the diagnosis in 2023, fewer than 2 % were offered MAT for alcohol use disorder that year. This is a very small number. but for opioid use disorder, we're doing better. About 25% of people with opioid disorder are currently on MAT and 50% received treatment before they leave detox. I think that's what that was supposed to say. And we know both of them work. We know that people on MAT for alcohol use disorder have better outcomes in 12 months, they're less likely to go to the emergency room or inpatient mental health stay, and they have better adherence to their psychiatric medications. And MAT for open use disorder definitely reduces overdose deaths. It's very highly effective and patient satisfaction is really high. We need to do better at connecting with older adults, racial minorities, people in rural areas, and in Boston. Next slide.

63-64 "Steven Descoteaux" (1252077824)
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So for alcohol use disorder, there are three meds available that we can use in the outpatient setting. We can prescribe this right out of the office. Naltrexone and Campral are the ones that I like to lead with. The middle one and is Antabuse has been around since the fifties, but we don't usually advocate for people to take that. When people are on it, it's usually because they're really motivated to be on something that makes them sick if they have a slip up but a lot of us see that as kind of cool and even barbaric to put a patient through that from having a relapse. Naltrexone comes in tablets and a monthly injection called Vivitrol.

65 "Steven Descoteaux" (1252077824)
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Most people start with 50 mg a day for three to five days before getting the injection, and it works really well reduces cravings, and it puts a cap on, puts a lid on the amount of euphoria or the amount of buzz that person can get from, from drinking. Campral is a similar thing, but it's two tablets, three times a day.

66-67 "Steven Descoteaux" (1252077824)
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So, it's big pill burden, but it does reduce cravings, and it does help people stay away from returning to drink drinking alcohol.

Next slide. So, all these medications none of them really requires blood work before you start them. Certainly, you don't need to check blood work before initiating it. For Naltrexone, when it came out 15 or so years ago, we were really careful about, checking for deliverer enzymes making sure that transaminases weren't three to five times greater than the apple limit of normal. But the current thinking is that if somebody's in your office and they're interested in starting treatment,

68 "Steven Descoteaux" (1252077824)
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Don't wait for blood work to write the prescription. You can do the prescription and get the blood work later. There's very little in terms of somebody's liver health that will disqualify somebody from taking Vivitrol.

Next slide please. And for opioid use disorder, we have two medications that can be prescribed out of the primary care office setting.

69 "Steven Descoteaux" (1252077824)
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Methadone also exists but that currently can only be accessed by a patient going to the local OTP, local methadone clinic. But now Naltrexone just like with alcohol use disorder can be written out of the office, start with tablets and go to injections monthly, buprenorphine/naloxone.

70 "Steven Descoteaux" (1252077824)
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That's Suboxone by its brand name, this brand name being Suboxone. Works really well. Thankfully, there's NO more requirement for an X waiver. Up until last year, prescribers were required to do eight to 12 hours of targeted training for treatment of opioid use disorder and then apply for an X waiver, and permission to treat 30 patients only. And then after a year you could apply to go to 100 patients.

71 "Steven Descoteaux" (1252077824)
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Thankfully all that has gone out the window. Currently all you need is a Massachusetts controlled substance registration and a DEA certificate that permits you to write for schedule three medications. So, so many fewer barriers this year than existed a year ago. Next slide.

72-73 "Steven Descoteaux" (1252077824)
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So as far as like initiating you don't have to feel alone. If you have a patient that's interested in this or a group of patients that you're thinking about, starting on, there are online references that you can go to, but there's also, there are people within Carelon that can help you find the best fit, find the best treatment for the patients so you don't have to feel like you're doing it alone. That's been one of the barriers that people have identified and their decision to not put somebody answer, they just feel like they're not an expert, they're in out of their expertise and they want to make sure that they have people supporting them. So we do have people that can help support with this.

74 "Steven Descoteaux" (1252077824)
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No blood work is needed for suboxone. Although it's prudent to check for liver enzymes and the hepatitis viruses and HIV. We don't need to have that be a reason for delay. Somebody comes in needing treatment, we can give them suboxone on the same day. Of course, we want to do drug screens and make sure that they're not using too much of long-acting opioids.

75 "Steven Descoteaux" (1252077824)
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Methadone, just FYI, when people go to the methadone clinic, they have to have labs drawn first in some cases in EKG, everybody has to have a biopsychosocial assessment and there's a really lengthy orientation process, a thorough orientation process for every patient, as well as clinical hours provided per patient. So that it's a bit of a heavier commitment for people to go to the methadone clinic.

76-77 "Steven Descoteaux" (1252077824)
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But FYI.
Next slide please. Buprenorphine also exists in injectable form. Sublocade has been around longer and the way Sublocade is used, it's intended for people that have been on Suboxone for weeks or months or even years and they don't want to take a tablet or a film once a day or twice a day or three times a day anymore.

78-82 "Steven Descoteaux" (1252077824)
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Sublocade the dosing is the same for, you know, regardless of somebody's on 8 mg or 32 mg of suboxone or Naloxone, and people tend to really like it. It has a super long half-life, that one. People have had their 7th or 8th or 9th injection. If they stop going for more injections. because the half-life is so long, that person remains with therapeutic levels of buprenorphine in their blood for four to six months. So, it's a great strategy for somebody that's ready to taper off or ready to go off of buprenorphine because the self-taper of this long-acting medication makes it far less uncomfortable to get off of it. Brixadi is a newer addition to the market. It comes in both a weekly and a monthly preparation. You might see some of your patients coming out of the emergency room getting, having had a 1st dose off the weekly prep, and kudos to the emergency rooms that are adopting this. You might also get patients coming out of the business room with suboxone tablets or films and with instructions to follow up with you or the primary or with an opiate treatment clinic. Both of the injectable med, Sublocade, they're a little bit complicated that you have to have a pharmacy that has an affiliation with a specialty pharmacy, you have to order the med patient-specific, the med gets delivered to you at your office and you have to keep it count it, store it, and dispose of it if the patient never comes back. You can't reuse a patient specific dose of Sublocade on a, on the next patient that comes in because it's a controlled med. So there's a little bit of red tape that goes along with using these medications, but the pharmaceutical reps are usually really good at connecting you with who you need to be connected with to get the, the medication ordered. Down the bottom, just for completeness. GLP one inhibitors, so like the Ozempics, have been studied for helping people to address their problems with alcohol use disorder. So be prepared if people come in asking for Ozempic to help them with their alcoholism.

83-85 "Steven Descoteaux" (1252077824)
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Next slide. Alright, so for methamphetamines, Psychedelics, and Marijuana, , there isn't as much available in terms of FDA approved medications to treat it. Certainly, we have medications that can keep people comfortable as they're going through withdrawal or detox from these medications. For methamphetamine users, we've been using off label the combination of Wellbutrin/bupropion and Vivitrol which works pretty well about half the time people report that they have a decreased urge to go back to using method and it works pretty well. You have to make sure they're not taking opiates or they're not taking suboxone, methadone, because the Naltrexone will make them sick.

The others like Marijuana and psychedelics, it's like team centered approach - cognitive behavioral therapy, motivational enhancement therapy and contingency management. Next slide.

86-89 "Steven Descoteaux" (1252077824)
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So the takeaways for my section here, it's really important that we do screening for a substance use disorder in our primary care and behavioral health clinics because we're, going to uncover some problems that we can help with. There's many treatment options that can be initiated in the office setting, and also here's plenty of help available if you're unsure of what to do with the patient, there are things online that you can check like up-to-date Medline or SAMHSA website for clues or hints or advice on how to get these medications started. And then what we're going hear more about in a later part of this presentation is that we have care managers and recovery support navigators that are available to help. We'll let you know how to get in touch with them. And MCSTAP, the Massachusetts Consultation Service for the Treatment of Addiction and Pain is available for all Massachusetts providers and all Massachusetts patients where a provider medical provider can call and request to speak with an addiction specialist, and the turnaround time is really quick. They try to get it within a half an hour. So if you call on a Friday morning, they're going to connect you with somebody within a half an hour, they can review a case with you or give you some, some feedback, some suggestions and some guidance. And in some cases, even provide some ongoing mentorship.

90 "Steven Descoteaux" (1252077824)
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And that's, that's it for, for me. Thank you.

91 "Tracey Nicolosi" (2046545920)
00:32:55.641 --> 00:33:07.709

Thank you so much, Dr. Descoteaux, and thank you to MBHP for inviting me to speak about the work that makes me most passionate.

92-96 "Tracey Nicolosi" (2046545920)
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I started my career many, many years ago. I'm certainly not going to put out what my age is, but when I first started in the field, I worked in what used to be called a methadone clinic. And when we heard about an individual abusing Fentanyl, it was the duragesic patch, and it was individuals consuming the active ingredients in the duragesic patch. So fast forward to today, the prevalence of fentanyl in the illicit drug supply right now overdoses that involve fentanyl are probably 94 or 95 %.

Next slide please.
Today I'm going to do a brief overview of the different types of services that MassHealth pays for when we're talking about the treatment of substance use disorders and addiction treatment.
Next slide please. MassHealth is proud to be able to say that we offer a full continuum of care for the treatment of substance use and addictive disorders. The continuum of care that we have aligns with the principles of the American Society of Addiction Medicine, otherwise known as ASAM. We align with the criteria to help practitioners figure out what is the type of treatment and where is that treatment that increases the likelihood of an individual success in achieving recovery as they define it.

97 "Tracey Nicolosi" (2046545920)
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The continuum of care includes both 24-hour levels of care and non-24-hour levels of care. And the continuum includes specialty and population specific treatment.

98-100 "Tracey Nicolosi" (2046545920)
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Next slide, please. I'm going to start with the most intense levels of care as part of the SUD continuum. The most intense level of care is what we call level four which is a, it's a high, it is the highest level of care. It is in a hospital setting and individuals who either currently present with complex withdrawal symptoms or individuals that have a history of complex withdrawal symptoms are best suited to have care done in a hospital setting such as this. The care that is provided is under the direction of a physician.

101-102 "Tracey Nicolosi" (2046545920)
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And it is also situated very often in med surge units, which means that there is 24/7 nursing care. The next level of detox I think most people are familiar with as being identified as detox. In terms of the ASAM continuum, we refer to this as a 3.7. In Massachusetts, we refer to Detox as Acute Treatment Services or ATS.

103-104 "Tracey Nicolosi" (2046545920)
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These programs are also under the direction of a physician and have 2047 nursing availability to manage less complicated withdrawal symptoms. The purpose of a 3.7 is to help manage withdrawal. When we talk about detox, we have moved away from identifying this level of care as detox. And the reason is, when you think about the process of detoxification, that's what our livers do.

105-108 "Tracey Nicolosi" (2046545920)
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Our livers detox our systems. When we talk about treatment, we're talking about managing withdrawal in treating the symptoms of withdrawal. The next level of care below 3.7 or detox is what we refer to in Massachusetts as Clinical Stabilization Services or CSS. Treatment here again is under the direction of a physician. There is nursing staff that's available, but it's not 2/47. When an individual enters CSS level of care, by and large, the symptoms of withdrawal have largely resolved. The focus of this level of care really is about skill building, about psychosocial services such as group counseling or individual counseling and management of Post-Acute Withdrawal Syndrome, otherwise known as PAWS. When we talk about pause, what we are referring to are the feelings and emotions that start to come up when an individual is NO longer abusing substances.

109-110 "Tracey Nicolosi" (2046545920)
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Next slide, please. The next two levels of care, I I'd like to call out as being very specific to Massachusetts. The first level of care known as individualized treatment and stabilization services. This specific level of care serves members who have been involuntarily committed by the court to treatment due to the severity and level of impairment caused by their SUD.

111 "Tracey Nicolosi" (2046545920)
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Section 35 is it's a legal process. Section 35 is not a level of care. Understanding that this population requires different types of clinical intervention in a safe environment.

112-113 "Tracey Nicolosi" (2046545920)
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What we've done in Massachusetts is we have combined two levels of care into a single unit in a single location, which allows for individuals to decrease the number of transitions that they have to make when we're talking about different levels of care. These are specialized units that have higher staffing ratios than some of the other services that MassHealth pays for. These programs are licensed and contracted by BSAS as are all of the different levels of care.

114 "Tracey Nicolosi" (2046545920)
00:40:24.600 --> 00:40:42.990

That I'm describing today. The next Massachusetts specific level of care is youth withdrawal and stabilization services. This is a very specialized type of program that again combines

115 "Tracey Nicolosi" (2046545920)
00:40:42.990 --> 00:40:58.350

withdrawal management, with stabilization and it treats males and females 12 through 16 and transitional aged youth 17 through 20 years of age.

116 "Tracey Nicolosi" (2046545920)
00:40:58.350 --> 00:41:17.280

It's a short-term program and it currently there is only one specialized unit across the state. We're hoping that provider interest in serving this population increases.

117 "Tracey Nicolosi" (2046545920)
00:41:17.280 --> 00:41:33.150

But right now, there's only one specific program in the state. The next level of care, which folks maybe familiar with is what we call residential rehabilitation services,

118 "Tracey Nicolosi" (2046545920)
00:41:33.150 --> 00:41:53.150

or RRS. This matches to ACM Level 3.1 where we're continuing to decrease the amount of supervision and structure, and we're starting to help folks use the new skills that they've

119 "Tracey Nicolosi" (2046545920)
00:41:53.150 --> 00:42:20.030

acquired to maintain recovery and to be able to reintegrate back into the community. When we talk about residential rehabilitation services, Massachusetts has a variety of flavors that treat specialty populations. Some of the populations that are specifically treated in these specialized

120 "Tracey Nicolosi" (2046545920)
00:42:20.030 --> 00:42:44.000

programs include family residential, youth adolescent, and transitional aged residential programs. And we also have what's known as a co-occurring enhanced residential program. These are programs that are staffed and structured in a way to be able to help manage

121 "Tracey Nicolosi" (2046545920)
00:42:44.000 --> 00:43:08.750

individuals that have moderate too severe mental health issues alongside with the substance use disorder issues. There's nursing that's available. There are physicians that are available and there is clinical programming that's designed to help individuals manage both the mental health needs as

122 "Tracey Nicolosi" (2046545920)
00:43:08.750 --> 00:43:31.050

Well as the substance use disorder needs. Next slide please. I'm now going to talk about the outpatient levels of care or the non-24-hour levels of care. The next level of care is what's known as SOAP.

123 "Tracey Nicolosi" (2046545920)
00:43:31.050 --> 00:43:49.170

or Structured Outpatient Addiction Program. We also have what's known as an enhanced soap. What SOAP is, is it's at least 9 hours a week, but NO more than 20 hours a week of treatment.

124 "Tracey Nicolosi" (2046545920)
00:43:49.170 --> 00:44:09.170

Treatment is, the majority of treatment is grouped counseling. There's also individual counseling available as well as case management. Each unit of care for either soap or the enhanced soap is three

125 "Tracey Nicolosi" (2046545920)
00:44:09.170 --> 00:44:26.220

and a half hours a day. This is a level of care for individuals that don't require the medical detox or the withdrawal management. Individuals can maintain responsibilities.

126 "Tracey Nicolosi" (2046545920)
00:44:26.220 --> 00:44:46.220

like, family care taking, employment, volunteering, being a student, they can maintain those responsibilities while they engage in treatment. The next level of care down from soap. Oh I'm sorry. Let me let me go back to

127 "Tracey Nicolosi" (2046545920)
00:44:46.220 --> 00:45:02.670

new Enhanced SOAP. Enhanced SOAP is designed for three very specific populations. Number one is individuals that are homeless or at risk of homelessness.

128 "Tracey Nicolosi" (2046545920)
00:45:02.670 --> 00:45:22.670

The second population is adolescents, and the third population is pregnant in postpartum individuals. These are SOAP programs with some specialized services such as OBGYN, and some additional

129 "Tracey Nicolosi" (2046545920)
00:45:22.670 --> 00:45:39.810

contact to help folks with homelessness or be able to treat adolescents as well. The next level of care is what we generally refer to as outpatient treatment.

130 "Tracey Nicolosi" (2046545920)
00:45:39.810 --> 00:45:59.810

Outpatient treatment is similar to what you would see in a community mental health center. Treatment can be up to 9 hours a week if needed. Individuals appropriate for this level of care have less acute substance

131 "Tracey Nicolosi" (2046545920)
00:45:59.810 --> 00:46:17.670

use in addictive disorders. It's often used as a step down for more intensive services and outpatient can provide long term continuum care that's focused on relapse prevention.

132 "Tracey Nicolosi" (2046545920)
00:46:17.670 --> 00:46:35.190

The next level of care which Dr. Descoteaux mentioned in his presentation are opioid treatment programs. Opioid treatment programs are what used to be called methadone clinics.

133 "Tracey Nicolosi" (2046545920)
00:46:35.190 --> 00:46:50.850

Opioid treatment programs are actually the most regulated type of treatment based on the nature of the medications that they provide to individuals.

134 "Tracey Nicolosi" (2046545920)
00:46:50.850 --> 00:47:08.310

These are treatment services that are ambulatory, they are required to provide outpatient medical and rehabilitation services in conjunction with dispensing medication.

135 "Tracey Nicolosi" (2046545920)
00:47:08.310 --> 00:47:28.310

The medications that opioid treatment programs can dispense include methadone, buprenorphine, and also injectable naltrexone. Outpatient clinics, as Dr. Descoteaux referenced earlier, can also prescribe.

136 "Tracey Nicolosi" (2046545920)
00:47:28.310 --> 00:47:48.450

Buprenorphine and naltrexone, especially with the relaxation of the requirement for the X waiver to be able to prescribe. The last group of services that I want to talk about are peer recovery coaching

137 "Tracey Nicolosi" (2046545920)
00:47:48.450 --> 00:48:03.690

and recovery support navigators. These services while they seem like they are the same, they're actually very different. These are non-clinical peer and paraprofessional services.

138 "Tracey Nicolosi" (2046545920)
00:48:03.690 --> 00:48:20.400

The important thing to understand about recovery coaching and recovery support navigators is that they are mobile. So when we're talking about ensuring an individual has a recovery coach

139 "Tracey Nicolosi" (2046545920)
00:48:20.400 --> 00:48:38.400

that recovery coach can go with the individual throughout the container continuum of care. They can be provided in an emergency department. They can be provided across medical levels of care as well as behavioral health levels of care.

140 "Tracey Nicolosi" (2046545920)
00:48:38.400 --> 00:48:57.180

With peer recovery coaching, the requirement for peer recovery coaches is lived experience. It's a very different interaction with an individual when you've been through what they have been through.

141 "Tracey Nicolosi" (2046545920)
00:48:57.180 --> 00:49:13.530

Peer recovery coaches will help individuals identify what their ambivalence might be about actually seeking treatment and offer some coaching and some suggestions

142 "Tracey Nicolosi" (2046545920)
00:49:13.530 --> 00:49:33.530

to help them move across whatever path to recovery they think that they need. Recovery Support Navigators is a specialized typed type of case managers that are very knowledgeable

143 "Tracey Nicolosi" (2046545920)
00:49:33.530 --> 00:50:01.399

in understanding how to navigate the SUD system. If the SUD system is confusing for the general public, imagine how confusing it might be for individuals that aren't really sure where they need to go and what type of treatment they need. And I believe that is my final slide. Thank you very much.

144 "Heather Towers" (2248702208)
00:50:01.399 --> 00:50:33.290

Good afternoon, everyone. I am going to talk with you all today to share some resources on how to truly navigate the system, right? As Tracy noted, it, (it) can be challenging. We're, we're certainly very thankful to be in a time where we have plus resources, but we have to know how to navigate them in order to be able to use them for folks.

145 "Heather Towers" (2248702208)
00:50:33.290 --> 00:50:37.260

Next slide, please.

146 "Heather Towers" (2248702208)
00:50:37.260 --> 00:50:53.400

So I'm going to talk through ways to connect into MBHP, our Massachusetts Behavioral Health Help Line, our community Behavioral Health Centers, and last but not least, our consultation line mixed staff.

147 "Heather Towers" (2248702208)
00:50:53.400 --> 00:51:13.400

So next slide please. So I wanted to start here. Tracy has done a fantastic job of highlighting all of the ASAM levels of care. So I wanted to incorporate this information to note that MBHP covers the full range of ASAM

148 "Heather Towers" (2248702208)
00:51:13.400 --> 00:51:32.520

substance use disorder services for all of our Members. We are inherent to chapter 258 and therefore any service that a provider deems medically necessary for up to the first 14 days of treatment would not require prior authorization.

149 "Heather Towers" (2248702208)
00:51:32.520 --> 00:51:49.140

Beyond that 14 days, the MBHP clinical team would collaborate with our providers to complete an ASAM review, focusing on developing an effective treatment plan that's individualized for that Member

150 "Heather Towers" (2248702208)
00:51:49.140 --> 00:52:09.140

and encouraging step downs through the continuum of services. This is also where we'd be able to connect in some of those resources that you've heard Tracy and Dr. Descoteaux talk of, our case management programs, our certified peer support workers, our connections into providers

151 "Heather Towers" (2248702208)
00:52:09.140 --> 00:52:38.060

for resource navigators and recovery coaches. So our goal is to collaborate with providers to engage Members in community tenure to reduce any need for readmission to a higher level of care and to utilize the continuum of community services in their recovery. Next slide please. The Massachusetts Behavioral Health Help Line is a 24/7

152 "Heather Towers" (2248702208)
00:52:38.060 --> 00:53:03.920

payer or blind, (so insurance does not matter) front door service that's reachable via call, text and chat to anyone in the Commonwealth. The Massachusetts Behavioral Health Help Line is answered by very skillful, resource and referral specialists who will complete a brief assessment with any call text or chatter in order to

153 "Heather Towers" (2248702208)
00:53:03.920 --> 00:53:26.900

determine what that individual's needs are, what they are looking for, and then develop together the next best step in their journey to recovery. Some of the ways that the Massachusetts BHHL does this is in connecting into Community Behavioral Health Centers. Our community behavioral health centers are also

154 "Heather Towers" (2248702208)
00:53:26.900 --> 00:53:47.610

available 24/7, for crisis intervention needs. So they would be able to meet with folks either on site if they're brick and mortar or at their home or anywhere else that they would prefer that is safe in the community to be able to complete that initial intervention for crisis.

155 "Heather Towers" (2248702208)
00:53:47.610 --> 00:54:07.610

Not only are they available for crisis interventions, but they're also available for same and next day urgent access appointments. So if someone is in need of more acute service but not necessarily a crisis intervention, they would be able to get that same or next day

156 "Heather Towers" (2248702208)
00:54:07.610 --> 00:54:25.230

appointment. That would also include a triage for a connection into psychopharm, which would include any medication assisted treatment as well. The CBHCs also offer outpatient services.

157 "Heather Towers" (2248702208)
00:54:25.230 --> 00:54:44.610

These services have extended hours in evenings and on the weekends to help support folks in in their lives and the other things that they need to attend to. The Massachusetts BHHL also connects into our Behavioral Health Urgent Care Centers.

158 "Heather Towers" (2248702208)
00:54:44.610 --> 00:55:04.610

Similar to some of the services that you would get at a CBHC, the BH urgent Care Centers also have access to same and next day appointments. They also have evening hours, they also have weekend hours, and they too have access to prescribers for psychofarm needs, as well as

159 "Heather Towers" (2248702208)
00:55:04.610 --> 00:55:22.230

medication assisted treatment. The other ways that the BHHL connects folks who are on their journey for recovery are connecting them directly into a Detox program. This is often the first step and incredibly hard to do.

160 "Heather Towers" (2248702208)
00:55:22.230 --> 00:55:38.460

Our team will do a warm handoff. So we will call directly with someone, and work with them to do their self-referral for a Detox program. This takes time. It can often be

161 "Heather Towers" (2248702208)
00:55:38.460 --> 00:55:55.140

really challenging, hard when maybe the first place you call doesn't have a bed. And we'll stay on with someone and support them through making that connection. We also utilize our relationship with the BSAS helpline.

162 "Heather Towers" (2248702208)
00:55:55.140 --> 00:56:13.110

The BSAS helpline is also available 24/7. They too maintain as a public resource for finding substance use treatment. They are there to support recovery and also problem gambling.

163 "Heather Towers" (2248702208)
00:56:13.110 --> 00:56:33.110

They also have a specialized support line that specifically services pregnant and postpartum women. And this too, the BSAS line is also a place where we would connect folks in as a warm handoff to be able to kind of guide and not have folks have to

164 "Heather Towers" (2248702208)
00:56:33.110 --> 00:57:05.960

share their story repeatedly. That can often be a deterrent for folks connecting into resources. So we're there to help support folks in navigating that and get where they need to be.
Next slide, please. The Massachusetts BHHL also maintains a resource tool. This is a snap of it here. It is the Massachusetts BHHL Resource Directory , cleverly named, and this is an

165 "Heather Towers" (2248702208)
00:57:05.960 --> 00:57:25.960

online support tool for all again in the Commonwealth so anyone can use this on finding any mental health, substance use disorder, or social determinant of health need resources. The tool is very similar to other online search engines where you would just utilize filters to narrow down what you're looking for

166 "Heather Towers" (2248702208)
00:57:25.960 --> 00:57:36.540

and obtain information and then be able to, you know, choose what is best for you and then make your calls for connection from there.

167 "Heather Towers" (2248702208)
00:57:36.540 --> 00:57:56.540

Next slide, please. So this dives a little bit more into the Community Behavioral Health Centers and what they're offering. So CBHCs integrate crisis and community-based treatment by utilizing mobile crisis teams, crisis stabilization programs.

168 "Heather Towers" (2248702208)
00:57:56.540 --> 00:58:23.280

Items which are their 24/7 programs. Urgent care and outpatient care for mental health and substance abuse needs. As I noted, the CBHC mobile crisis intervention teams are available 24/7 to see folks in the community and connect them directly to other providers or all or intervene in the community on support and next steps.

169 "Heather Towers" (2248702208)
00:58:23.280 --> 00:58:43.280

The crisis stabilization units, which are their 24/7 unlocked placements, are able to provide acute care for both mental health and dual diagnosis needs. These programs are not able to complete, you know, a more complicated detox protocol per se, though they can support

170 "Heather Towers" (2248702208)
00:58:43.280 --> 00:59:02.310

dual needs in recovery, and they certainly could be considered as an option for individuals who are having dual diagnosis needs and detox, you know, may not be their primary need, but would be, would need support in their recovery at large.

171 "Heather Towers" (2248702208)
00:59:02.310 --> 00:59:22.310

And then the CBHCs also have, as I noted, the same and next day access appointments, including that connection to MAT induction and then ongoing, either ongoing treatment at the CBHC or linkage to other MAT programs.

172 "Heather Towers" (2248702208)
00:59:22.310 --> 00:59:41.160

Within the community. CBHCs are truly available in immediate time of crisis as well as being able to then transition to ongoing services for continued stabilization in recovery and support. Next slide, please.

173 "Heather Towers" (2248702208)
00:59:41.160 --> 01:00:03.290

So this next slide highlights a bit more of the CBHC core services. So these are the same and next day appointments, the ongoing outpatient needs, and they also include support in prescribing medications and connecting

174 "Heather Towers" (2248702208)
01:00:03.290 --> 01:00:26.000

to other SUD resources. This would be the next step that would happen after completing an emergent or urgent or triage appointment. So the CBHC team would first triage an individual. That might be someone who walks in, could be someone who calls over the phone, could be someone who had been seen

175 "Heather Towers" (2248702208)
01:00:26.000 --> 01:00:46.000

by their mobile crisis team, and then they're able to connect that individual to pharmacological resources within 72 hours of that triage. So if you are walking into a CBHC or calling, you would be able to get that triage and screening, and then if appropriate, make that connection

176 "Heather Towers" (2248702208)
01:00:46.000 --> 01:01:06.810

in for, prescribing and to be able to meet with a prescriber within 72 hours. The CBHC prescribers would also then be able to coordinate with PCPs or other specialty providers based on the appropriate needs and what transitions of care would look like.

177 "Heather Towers" (2248702208)
01:01:06.810 --> 01:01:27.890

Next slide, please. This is our consultation program. I think you've heard a little bit about this from Dr. Descoteaux. This is a service for prescribers to support their work in order to increase the capacity for and comfort with

178 "Heather Towers" (2248702208)
01:01:27.890 --> 01:01:49.710

using evidence-based practices in screening for diagnosing, treating, and managing care for all patients with substance use needs and/or chronic pain needs. This is a real time phone consult, which is again is free across the state to anyone.

179 "Heather Towers" (2248702208)
01:01:49.710 --> 01:02:09.710

The program is available Monday through Friday, nine to five. As Dr. Descoteaux noted earlier, typically the outreaches are very quickly responded to, often within 30 min, and a request for a consult from a doctor can be made either by phone or online.

180 "Heather Towers" (2248702208)
01:02:09.710 --> 01:02:29.900

You're going to be connected to a physician who has experience and expertise in treating addiction in pain. The goal is to be able to assist with evidence-based practices when prescribing medication for treating chronic pain and substance use disorders. You will get consultation on any questions in managing

181 "Heather Towers" (2248702208)
01:02:29.900 --> 01:02:53.400

medications, chronic pain, support on prescribing of buprenorphine or naltrexone. You'll get support on considerations that you're making for making medication changes or in titrating meds. If you're wanting to review your overall management plan for a more challenging and complex Member that you're working with.

182 "Heather Towers" (2248702208)
01:02:53.400 --> 01:03:10.140

You may want to outreach because you want to review a change that you're considering prior to having that patient come in and visit. You may be working with someone who is pregnant, or another special need population could have complex medical conditions.

183 "Heather Towers" (2248702208)
01:03:10.140 --> 01:03:25.440

We offer coaching on complex cases with really a goal of building clinician practice care capacity for patients across the state with chronic pain and substance use.

184 "Heather Towers" (2248702208)
01:03:25.440 --> 01:03:45.440

I started by saying that, there are a lot of resources out there and often the challenge can be navigating through them all. You'll see in the appendix in later slides that there are also some additional pieces of information on ways to connect in different links, different phone numbers

185 "Heather Towers" (2248702208)
01:03:45.440 --> 01:04:03.990

to both local and national supports, but the one thing that I want to emphasize is that whenever you are in doubt, please feel free to outreach for support to the Massachusetts Behavioral Health Help Line, and we will work to connect you and get in the right direction for where you need to be.

186 "Heather Towers" (2248702208)
01:04:03.990 --> 01:04:23.990

The Massachusetts Behavioral Health Help Line again is available 24/7. The phone number is also in the appendix, but to share it here, it's 833-773-2445. So that's also 833-773-BHHL.

187 "Heather Towers" (2248702208)
01:04:23.990 --> 01:04:35.577

Thank you, and I believe I will be passing it over to Dr. Descoteaux again.

188 "Steven Descoteaux" (1252077824)
01:04:35.577 --> 01:05:00.620

Hello. Thank you, Heather. So, I had a couple of cases I pulled together just to kind of illustrate how different patient situations might be managed with some help from our teams. Let's go to the next slide. So case one, this is a person that I encountered in real life in the outpatient

189 "Steven Descoteaux" (1252077824)
01:05:00.620 --> 01:05:20.130

setting a couple years ago. He's a 51-year-old man. He came in with his spouse, he had a cast on his left foot, having recently injured himself at work during some episode that may have been related to his drinking. He had surgery, he is now in the recovery

190 "Steven Descoteaux" (1252077824)
01:05:20.130 --> 01:05:40.130

phase is for his foot to heal his ankle to heal, but his job told him, hey, let's get your alcohol use under control before you come back to work. So he comes in actually asking for help. He reports that his hands shake in the morning before he has his first drink

191 "Steven Descoteaux" (1252077824)
01:05:40.130 --> 01:06:00.260

and that he's unable, he's trying to stop, but he gets even more uncomfortable if he doesn't or even if he cuts back on his drinking. So, it's helpful to ask of course you know how much it is that he's drinking. He said it's about a 12 pack during the day and some heavier alcohol, closer to bedtime.

192 "Steven Descoteaux" (1252077824)
01:06:00.260 --> 01:06:22.850

So this is something that clearly needs medically supervised withdrawal. People that are drinking this heavily can't just stop because they're going run into potential issues with seizures and DTs. So this is something we take very seriously. He has a couple options. Inpatient, there are inpatient levels of

193 "Steven Descoteaux" (1252077824)
01:06:22.850 --> 01:06:40.350

care that are 3.7 detox type facilities that people can go to and of course we have the Massachusetts Behavioral Health Help Line available to connect you or with somebody that can help you navigate this very

194 "Steven Descoteaux" (1252077824)
01:06:40.350 --> 01:06:56.400

convoluted and complex system. We're lucky that we have a lot of resources available in Massachusetts, but it's, it's hard to navigate and the Behavioral Health Help Line can help you identify the best fit for, for any given patient.

195 "Steven Descoteaux" (1252077824)
01:06:56.400 --> 01:07:13.770

I also wanted to include that there is an outpatient option for him that for providers that feel comfortable prescribing evidence-based protocols that are found on up to date and Medline that are written for primary care physicians.

196 "Steven Descoteaux" (1252077824)
01:07:13.770 --> 01:07:30.300

Behavior the written for family practice and internal medicine physicians or tapering doses of valium or Ativan or Librium and it's the kind of thing that you have to have a comfort level of doing it. MCSTAP will be a great

197 "Steven Descoteaux" (1252077824)
01:07:30.300 --> 01:07:50.300

resource that if you wanted to talk with a doctor about, you know, is this person maybe appropriate to have a home-based detox or I'll write a prescription for four days of tapering doses of valium to help them through it. Cause there are certain things you have to watch out for before you initiate a home-based protocol.

198 "Steven Descoteaux" (1252077824)
01:07:50.300 --> 01:08:10.730

So the patient actually went with this protocol, he gave him a four day dose of Librium. His wife was able to manage his meds, check his vital signs and hold a dose in case he was not fully alert. And he did really well. He was sleepy the on day two, and then as the doses were tapered, he was feeling much better by

199 "Steven Descoteaux" (1252077824)
01:08:10.730 --> 01:08:42.830

day three and four he was super grateful. Both to not have to go to an inpatient program with his cast and his, you know, his other medical issues and just to be out of his home for it. We ended up extending in another four days, so we got a total of like eight or nine days of valium just to kind of make sure that he did not go back into, you know, withdrawal. And he did really well. I want to, for this case, I also want to remind people that it's really important to let people know that there are medications available to keep people from returning

200 "Steven Descoteaux" (1252077824)
01:08:42.830 --> 01:09:02.830

to drinking, so the MAT medications of Vivitrol or naltrexone or acamprosate are widely available. It's never too early to bring those up in conversation. It could be the first visit that you mentioned it briefly just to plant the seed, but then when they come back, it's good to remind people that a chance of relapse is

201 "Steven Descoteaux" (1252077824)
01:09:02.830 --> 01:09:23.940

or returning to drinking is really super high after you get through the detox phase. Alright, so next case, this is a patient who's presenting with a medical concern, but the medical concern that she raises brings up a number of concerns

202 "Steven Descoteaux" (1252077824)
01:09:23.940 --> 01:09:43.940

about her treatment course. She's 32 years old, she's known to the practice. She's been doing well on a pain contract, for chronic knee pain for four years. She shows you she has an absence on her forearm in here that's, that's draining and she's wondering about antibiotic.

203 "Steven Descoteaux" (1252077824)
01:09:43.940 --> 01:10:14.240

management. There's some redness surrounding it, it's already draining by itself so you don't have to drain it. And her vital signs are pretty stable. So there are a number of issues going on at the same time with this person and sometimes an abscess is just an abscess, maybe she bumped into something and she got an infection under her skin, but it's possible that she has turned to injecting either her pain pills or going to the streets for Heroin or Fentanyl to supplement what she's been getting.

204 "Steven Descoteaux" (1252077824)
01:10:14.240 --> 01:10:48.770

So this is a good time to kind of take a step back and ask her, just ask her about, you know, is this intravenous drug use? This is something that we're concerned about when we see these kinds of wounds, and you could lead with a drug abuse screening test like the DAST 10 to determine, you know, is, are there problematic signs that she's going to admit to? And we have to deal with, you know, how to manage her chronic pain. She's on a chronic pain contract and it's really hard to just take somebody off of it if they

205 "Steven Descoteaux" (1252077824)
01:10:48.770 --> 01:11:21.380

broke the rules, like there has to, but there has to be some sort of an intervention. So, MCSTAP can be super helpful for this as well to kind of navigate what the options are. In this case the patient admitted that she had she's been running out of her prescription payments within the first two to three weeks and then to get her to her next appointment, she's been buying things off the streets, whether it's oxycodone pills or even heroin/fentanyl. And she's exhausted like she knows that something has to change.

206 "Steven Descoteaux" (1252077824)
01:11:21.380 --> 01:11:43.610

She knows that, that it's not a sustainable way of life for her. And what she, what we ended up talking about was going on suboxone for maintenance or going to the methadone clinic to get initiated to treatment there or just tapering her pain meds altogether. But for somebody who has real pain

207 "Steven Descoteaux" (1252077824)
01:11:43.610 --> 01:12:06.720

and an addiction problem, it's really hard to, hard to imagine tapering off altogether. So, yeah, so she ended up going on suboxone. She most people who are abusing opiates out in the streets have tried suboxone one way or another, whether it's injecting it or snorting it or taking it, you know, sublingually. So, people

208 "Steven Descoteaux" (1252077824)
01:12:06.720 --> 01:12:26.720

you know, we used to have to give the first dose in the clinic and watch them, but now since it's out there, it's been out there for so long that most people are able to just go right on it. And since she was using short acting opioids in the recent week or so, she's a safe candidate to go on. Somebody asked a question earlier about

209 "Steven Descoteaux" (1252077824)
01:12:26.720 --> 01:12:50.060

about whether you know vivitrol is appropriate for patients like this. And the short answer is probably NO because they're used to being on opioids for so many years. It's really hard to go from there to being opiate free and really locks you into an opiate free state and people don't feel right if they've, if their brains have been exposed to opioids for so long. So methadone

210 "Steven Descoteaux" (1252077824)
01:12:50.060 --> 01:13:14.239

might be the best fit for her. Suboxone might be a good fit for her. Vivitrol is probably a less reasonable offer for her. Option for her. Alright, so let's, that's it for the cases. I think we're going to go to the question-and-answer session next.

211 "Maria Yerstein" (1578761472)
01:13:14.239 --> 01:13:41.820

Okay, alright, so we got a lot of very good questions, so I'm going to ask our speakers since we want to be mindful of time here to try to answer briefly as possible so we can get through some of these questions. All right. Tracy, could you speak to where the youth withdrawal and stabilization service is located in Massachusetts and comment on whether or not parents need to be involved with those services?

212 "Tracey Nicolosi" (2046545920)
01:13:41.820 --> 01:14:12.917

Ok so the one youth withdrawal management and stabilization program is actually in the central part of the state. It is the program name is MYIR, which stands for Motivating Youth in Recovery and Community Healthlink operates the program. It's a small program.

213 "Maria Yerstein" (1578761472)
01:14:12.917 --> 01:14:16.962

And in general, do parents need to be involved?

214 "Tracey Nicolosi" (2046545920)
01:14:16.962 --> 01:14:29.550

It's best if parents are involved. There may be situations where, you know, the relationship between parents and children maybe isn't

215 "Tracey Nicolosi" (2046545920)
01:14:29.550 --> 01:14:49.550

all that positive, but treatment especially for kids in adolescence with substance use disorders, it's generally better when the family is involved. Thank you.
And just to add very briefly that the number of adolescents that are overdosing is ticking up. So when we're talking about youth and we're talking about adolescents and substance use, we're not really talking about the occasional joint here and there anymore.

217 "Maria Yerstein" (1578761472)
01:15:06.522 --> 01:15:19.258

Thank you. This is a related question for you, Heather. Can you speak to about whether the resources you discussed such as CBHCs, mixed up, BHHL et cetera, are also helpful with minors.

218 "Heather Towers" (2248702208)
01:15:19.258 --> 01:15:39.863

Yes, they all would be helpful for minors. The CBHCs, as well as the Behavioral Health Help Line can support anyone from zero to 105 in the mixed-up consultation line would, you know, be able to do that same thing in supporting prescribers. So absolutely.

219 "Maria Yerstein" (1578761472)
01:15:39.863 --> 01:15:48.542

This one I think Steve might be right for you.
What might make somebody a good fit for a home-based detox?

220 "Steven Descoteaux" (1252077824)
01:15:48.542 --> 01:16:21.376

Well, the things that we want to make sure that they're not pregnant, they're not on multiple psychiatric medications, that they have a safe place to have their medications stored at home, maybe somebody to be with them to kind of monitor for oversedation, and also vital signs that are really way out of range for not just elevated blood pressure and heart rate, or if they're starting to experience hallucinations or have ever had hallucinations associated with detoxing from alcohol.

221 "Maria Yerstein" (1578761472)
01:16:21.376 --> 01:16:33.438

Another one for you - if a person is starting now Naltrexone or Vivitrol and - they don"t they need a time period to stop using before it can be administered?

222 "Steven Descoteaux" (1252077824)
01:16:33.438 --> 01:17:07.380

The issues that can happen withdrawal. Yes, they do. There, there are some protocols that have been put together with micro dosing of like tiny little bits of naltrexone starting even as methadone is being added. It's strange, but for the majority of our patients that we come in that are we're considering for naltrexone to vivitrol, it's usually people that have had a period of having the detox and they're free of the opiates for a long time. People that are using fentanyl are experiencing longer

223 "Steven Descoteaux" (1252077824)
01:17:07.380 --> 01:17:22.879

wait times for the fentanyl to wash out of their bodies. So even if you're testing for it till it goes away, it can be a long wait for it to go away. That's why vivitrol is not always the best option for people, particularly if they're going to relapse and, you know, overdose.

224 "Maria Yerstein" (1578761472)
01:17:22.879 --> 01:17:29.980

Thank you. Tracy, is IOP the same as SOAP?

225 "Tracey Nicolosi" (2046545920)
01:17:29.980 --> 01:17:45.140

So according to ASAM, SOAP is IOP, but what we do in terms of services here in Massachusetts is we separate out IOP.

226 "Tracey Nicolosi" (2046545920)
01:17:45.140 --> 01:18:12.378

and SOAP which is structured outpatient addictions program. They are - the difference is SOAP is for primary SUD and co-occurring disorders and IOP is really the opposite where it is behavioral health or mental health is primary with SUD as being the co-occurring disorder.

227 "Maria Yerstein" (1578761472)
01:18:12.378 --> 01:18:31.830

Thank you. We also did receive a question about providing a list of facilities that offer the levels of care that Tracy addressed, and I did want to let everyone know that we will try to pull that together and send it out after the program.

228 "Maria Yerstein" (1578761472)
01:18:31.830 --> 01:18:49.081

Steve or whoever we can offer an answer to this. Aside from consultation services, are there any assessment tools that individual providers could use to assess for the most appropriate level of care?

229 "Tracey Nicolosi" (2046545920)
01:18:49.081 --> 01:18:54.450

I can take a stab.

230 "Tracey Nicolosi" (2046545920)
01:18:54.450 --> 01:19:12.810

When we talk about ASAM and we talk about assessments, there are very specific questions that assessments are designed to parse out.

231 "Tracey Nicolosi" (2046545920)
01:19:12.810 --> 01:19:32.810
I think back to where we started with Dr. Descoteaux I think screening before assessment really is the first intervention. When we start to talk about assessments, we're talking about biopsychosocial assessments. We're talking about

232 "Tracey Nicolosi" (2046545920)
01:19:32.810 --> 01:20:10.847

what are the medical issues that are going on? What are the behavioral health issues that are going on? What is, the safety situation at home? What kind of situation is someone going to be leaving treatment to? So a real full comprehensive assessment takes much longer than screening. So it could be that the screening is done initially and then the full assessment can be done like by the CBHCs that are very well versed in assessing across a variety of different domains.

233 "Maria Yerstein" (1578761472)
01:20:10.847 --> 01:20:29.100

Thank you, and I think that makes sense. You're reflating to the fact that you need a holistic assessment to figure out what is the right treatment option for people because it is so individualized based on the full biopsychosocial assessment.

234 "Maria Yerstein" (1578761472)
01:20:29.100 --> 01:20:46.653

Okay, here's one for you Steve. Somebody reported that they provide behavioral health support telephonically and they asked how do you suggest getting patients to agree to do a brief preventative substance use disorder screening by phone if they do not have a diagnosis?

235 "Steven Descoteaux" (1252077824)
01:20:46.653 --> 01:21:06.214

Well, I think you've just normalized the practice of, hey, I ask all my patients what's going on with their lives and they're so prevalent with, you know, drinking the opiates and marijuana use like I just have decided to ask everybody and just normalize it and make sure that people feel comfortable answering honestly.

236 "Maria Yerstein" (1578761472)
01:21:08.490 --> 01:21:27.973

Thank you. A few more very specific questions. I think Steve you may be able to answer these. All right. If a person came in for an intake such as a 90791, and then the testing was done to determine if substance use disorder was present, can you then add the modifier code 25 to the billing?

237 "Steven Descoteaux" (1252077824)
01:21:27.973 --> 01:21:34.753

Yes, the 90791, you're able to do a modifier 25 on top of that.

238 "Maria Yerstein" (1578761472)
01:21:34.753 --> 01:21:43.877

Can BH clinicians such as licensed independent clinical social workers or LICSWs bill for tobacco counseling?

239 "Steven Descoteaux" (1252077824)
01:21:43.877 --> 01:21:59.132

Yes, they can. In fact, Medicare, Medicaid and many commercial insurance companies will cover tobacco, youth disorder treatment, and it can be done by medical providers or behavioral health providers.

240 "Maria Yerstein" (1578761472)
01:21:59.132 --> 01:22:19.015

There was another question, which is, is MCSTAP consulting for patients with impactful chronic pain only available to those who also have substance use disorder or, or when providers are worried substance use disorder maybe present? And I believe I or Heather, you have an answer for this one?

241 "Heather Towers" (2248702208)
01:22:19.015 --> 01:22:28.375

So it's actually for substance use disorder or chronic pain. So it can be and or both.

242 "Maria Yerstein" (1578761472)
01:22:28.375 --> 01:22:43.652

Perfect. Okay. Can you speak a bit Steve, to the point where you would consider section 35 applying for section 35 for a patient? What might, might be the signs you're looking for that that's the right next step?

243 "Steven Descoteaux" (1252077824)
01:22:43.652 --> 01:22:59.010

I mean the strict criteria is imminent harm to self or others based on their use of drugs and or alcohol. It's a really restrictive intervention that needs to be done, but for some people it's the right

244 "Steven Descoteaux" (1252077824)
01:22:59.010 --> 01:23:18.900

bit for it. Ordinarily, it's a spouse, a parent, sometimes a doctor, sometimes a probation officer that will partition the court and before somebody gets brought to a section 35 program, they get assessed in court by a court clinician and then a judge will sort of ask the people that are in the room and also the patient

245 "Steven Descoteaux" (1252077824)
01:23:18.900 --> 01:23:36.938

what what's been going on and is and the judge makes the decision about whether an inpatient level of care sometimes against the, the will of the patient is indicated. So it's a pretty high barrier, but it's to answer it more shortly is that if they're at imminent risk of harm to self and others.

246 "Maria Yerstein" (1578761472)
01:23:36.938 --> 01:23:50.810

Alright, we'll try to fit one or two more in. Heather, could you speak to the question of how could somebody find substance use disorder research resources for patients in their area?

248 "Heather Towers" (2248702208)
01:23:53.070 --> 01:24:13.070

So there are a couple of different ways, so we could help support that at the Massachusetts Behavioral Health Help Line. So you could call in to us. It's probably easier if you're a provider looking for resources. We do have text and chat options, right? But I do think as a provider calling in, is probably easier. And then there's also the Resource Directory

249 "Heather Towers" (2248702208)
01:24:13.070 --> 01:24:33.070

online, there are links to that in the app, appendix as well. So you could also go online to the resource directory, put in what area you're looking for, what specialty you're looking for, and also be able to get resources. And then the last thing I would suggest is connecting into your, areas Community Behavior Health Center, right?

250 "Heather Towers" (2248702208)
01:24:33.070 --> 01:24:46.715

Connecting into who your CBHC is. That might be something that we could send out as well, the CBHCs in their catchment areas, but I think those three ways would be great ways to connect in and get additional resources.

251 "Maria Yerstein" (1578761472)
01:24:46.715 --> 01:25:02.752

Thank you.
This will be the last question, and I think it's a very important one. So Steve, can you speak again - and I know you did before about how prescribing requirements have changed in the past year and who can prescribe MAT now?

252 "Steven Descoteaux" (1252077824)
01:25:02.752 --> 01:25:17.930

Any provider that has a mass-controlled substance certificate and a DEA registration who are also press able to prescribe any

253 "Steven Descoteaux" (1252077824)
01:25:17.930 --> 01:25:44.095
schedule three drug can prescribe suboxone now. There used to be a requirement that you do 8 hours of opioid related training online and apply for an X waiver to be permitted to prescribe suboxone in limited numbers, but since all of that has gone away, it's really anybody who's licensed and has controlled substance licenses and certificates.

254 "Maria Yerstein" (1578761472)
01:25:44.095 --> 01:26:03.660
You can do it.

And I also want to emphasize that if people are seeking guidance or help in learning that process, many of the resources we listed today, like the MBHP or the BHHL can assist with that too. Alright, that will conclude our question-and-answer portion.

255 "Maria Yerstein" (1578761472)
01:26:04.860 --> 01:26:24.860

So I would like to close this forum with some heartfelt things. And first I'd like to thank our planning committee members, Andrea Royo, and Amy Rosenstein for their tremendous amount of work over the past several months to make this forum happen. I want to thank our speakers for sharing their knowledge with us all, and I want to thank the volunteers

256 "Maria Yerstein" (1578761472)
01:26:24.860 --> 01:26:43.170

who have made sure this form has gone off without a hitch today. I also want to thank our state partners who support allowed this form to happen. Lastly, I want to thank you all for attending, and my sincere hope is that something we covered today will support you in the important work you are doing every day to improve people's lives.

257 "Maria Yerstein" (1578761472)
01:26:43.170 --> 01:27:03.170

Lastly, please submit feedback through the form provided in the chat. We take it very seriously when we consider the work we do throughout the year and when we plan for this forum for next year. So thank you again and with that, we'll conclude the forum.