Joe Alviani: Hello everyone this is Joe Alviani from O'Neil Associates and this is OA on Healthcare today we're trying something new in the way of Healthcare in addition to continuing to record remotely as a result of the coronavirus, we also have with us two distinguish guests: They are leaders at the American Academy of Addiction Psychiatry and knowledgeable in providing treatment in substance use and other addiction disorders it is appropriate that we focus attention on the issue of substance use disorders and behavioral health today since this week has been designated national Prevention Week by the Substance Abuse and Mental Health Services Administration of the United States (SAMHSA)- a time to recognize the important work done in communities throughout this year to inspire action and prevent substance use and mental disorders.

Joe Alviani: Our guests today are Dr. Kevin Sevarino of the Yale University School of Medicine and currently President of the American Academy of Addiction Psychiatry (AAAP) and Dr. Karen Drexler, Medical Director of the Academy and faculty member at Emory University School of Medicine. Doctors, welcome to OA Healthcare, and thank you so much for taking the time from what I know are very busy schedules to be with us.

Drs. Drexler and Sevarino: Thank you, Joe.

Joe Alviani: AAAP is the National Professional Organization for addiction psychiatrists, physicians, and allied health professionals, dedicated to education, research, and policy in the field of substance use disorders and co-occurring mental disorders. It promotes high-quality evidence-based screening, assessment and treatment in substance use disorders and focuses on translating and disseminating evidence based research into clinical practice and public policy.

Joe Alviani: Doctors we're going to focus in the moment on the number challenges and opportunities that the COVID-19 pandemic has created in treating substance use disorders and mental health but first I'd like to ask since each of you has been heavily involved in the AAAP if you would briefly describe the focus and on treatment in addiction psychiatry.

Dr. Sevarino: So, the primary focus is actually education to try and bring evidence-based practice to the field. We do a lot of that through grants with SAMHSA. Substance use disorders are heavily stigmatized and one thing that we try to do is bring a scientific basis to that treatment- to have people understand that there is an evidence-base to the treatment and that we have effective treatments for substance use disorders that we see as medical diseases and not as any sort of moral failing. It's very important to try and destigmatized and bring substance use disorders into the realm of medical diseases and medical treatment and that's why since about 1985 I believe it is, AAAP has been heavily involved in promoting fellowships or specialty trainings and subspecialty trainings in addiction psychiatry. More recently, addiction medicine has come into the fold and included other specialties such as internal medicine, pulmonology and pain medicine etc., but we are very passionate about trying to bring specialty treatment to pretty much at the head of a very large pyramid of treatment that includes not only of course

MDs and DOs but psychologists, social workers, peer specialists, LPCs etc., all of whom interact with our patients.

Joe Alviani: Thank you. Dr. Drexler, do you have anything that you'd like to add to that?

Dr. Drexler: Yes, I agree with everything Dr. Sevarino just said, and I would just like to say that we share a passion for treatment and recovery of substance use disorders with other national healthcare organizations interested in addiction treatment we partner, as Dr. Sevarino said, with other physician organizations like ASAM and other treatment organizations like ATTOD with national nurses organizations interested in addiction treatment as well as other mental health professionals. I think the unique niche that AAAP has is a very important one. About half the patients with substance use disorder, according to national surveys, also have a co-occurring mental illness and as Dr. Sevarino said, we now understand that substance use disorders are chronic brain diseases that benefit from ongoing care management like other chronic diseases like hypertension and diabetes, so having that medical perspective is important but the frequency of co-occurring mental health illnesses like depression or post-traumatic stress disorder - just to name two - is also important to be able to treat those co-occurring disorders effectively and simultaneously to promote sustained recovery. So, I think our unique niche in AAAP is having expertise in both and promoting evidence-based care for those co-occurring disorders, as well as for primary substance use disorders.

Joe Alviani: Thank you. That's really helpful in explaining the particular niche that addiction psychiatry has. I'm going to segue way now to the issue of the special challenges during the coronavirus. The demand for social distance, forced isolation and loneliness as a result of the coronavirus seems a perfect storm for depression and, I assume, an increase in cases of substance use disorders. What are you seeing in that respect and your own experiences? Dr. Drexler if you would start in that regard.

Dr. Drexler: Sure. It's been a real privilege to be in this position as Medical Director at AAAP because I get to work with colleagues who are struggling with these very issues. So, the things that I've heard from addiction psychiatrists and other healthcare providers across the country are concerns about being able to keep staff safe and well at their programs. Oftentimes, addiction treatment programs have small waiting rooms and small group rooms where it's impossible to keep social distancing guidelines. Folks have had to get very creative. I'm impressed at the creativity and the innovation that I've been able to see across the country. I've also been privileged to hear concerns from people in recovery and, particularly some of the addiction counselors that participate in our webinars, have talked about the importance in their own recovery of fellowship with others in recovery and how they appreciate the virtual touches but how it's not quite the same as seeing folks in person. So, I think there are both some blessings in the innovations of how to touch folks frequently and effectively virtually but also some curses that really, in order to keep folks safe from contracting the virus, we do have to implement risk-mitigation strategies, and sometimes that has decreased our ability to see folks in person. Particular challenges are new intakes, and I've heard heart-wrenching stories - to me - about practices that have decided during shelter-in-place that they are not accepting new

patients. That is heartbreaking. During especially stressful times, substance use disorders go up. It's also a time that folks may be motivated, and there's a short window of opportunity to engage them while they're motivated. It's heartbreaking to pass these opportunities up. I'd like pause and give Dr. Sevarino a chance to talk.

Dr. Sevarino: I think I agree with everything Dr. Drexler has said. It's an interesting time with COVID in that I think many providers are actually going outside their comfort zone and learning how to use telehealth to deliver care and in many ways but not as well as we had hoped. I agree with Dr. Drexler that many of our patients and providers are finding it not completely the same as a face-to-face. Here in Connecticut, it's been interesting that one of our largest providers of agonist and partial-agonist (medication) treatment for opioid use disorders are finding increases in the number of people seeking treatment with buprenorphine but decreases in the number of people being inducted onto methadone- these are both about 20%. So it's having an impact, and I have to say I've been very impressed with the response by SAMHSA, CMS, and DEA in how they've changed regulation to allow induction to buprenorphine and relaxed the rules for providing take-home bottles for methadone. Although you can't induct somebody just by telehealth onto methadone, you can induct buprenorphine by phone. So, I think some of the things that we are learning will last and that we are going to learn new ways for telehealth to rural areas for those that can't get into programs, but it's been stressful.

I think another unfortunate curse - as Dr. Drexler called it - is this is a very stressful time for our patients and for people in general. They lose employment they lose income, they have the stress out of trying to both be a mother or be a parent at home as they work from home, and I think it's going to have a lasting impact. It's going to be a traumatizing event for our population. And so besides recurrences and the effects of COVID itself, I think we're going to see, unfortunately, a wave of an increase in mental illness- depression and especially PTSD but also substance use disorders. Now, do we have the numbers to support that yet? Not quite but I would be very surprised if we didn't see an increased need for treatment after this in terms of mental health and substance use disorders.

Joe Alviani: Yes. I'm sorry - I'm going to get into the Telehealth question in a bit more detail but you anticipated my follow-up question with respect to COVID-19 issue because many of the healthcare professionals have anticipated that there's going to be a resurgence, if there's a premature economic and social activity going forward. But others in the behavioral health field are certainly concerned about the surge in substance use and mental health cases because of it, and I guess in light of your answer to that question, you seem to be concerned about that occurring as well

Dr. Sevarino: Yes. I am concerned about the long-term impacts of not just national but international mental health which we will see all sorts of things which we can't predict now due in part to long-term economic health. Just yesterday the CEO of Boeing predicted it would take three to five years for the airline industry to fully recover, so in those cases we may be facing cases similar to the mental health impact that the great depression had. But I think we're getting

a little beyond my personal expertise but in day-to-day I definitely see patients in my hospital that I do consult work on facing the stress of just not having any visitors.

Joe Albiani: Are you seeing any cases of substance use disorder in…let me put it this way: a disproportionate number of substance use disorder in younger people as a result of a disruption of their normal routines because of the fact that we have school closings and you know just basically the normal kinds of function that younger people they are just not able to participate in.

Dr. Sevarino: Personally, I'm not in my particular environment which is mostly inpatient and consult liaison work I am not seeing that yet but it wouldn't surprise me. I don't know if Dr. Drexler wants to comment?

Dr. Drexler: I don't have any personal experience either, and I think it could be really interesting to see what happens because as all us shelter-in-place, motor vehicle accidents are going down some of us have received rebates on our auto insurance premiums. It may be that the stress as you mention increases the risk for substance use disorders but on the other hand maybe we have less access to substances, so it may have an unexpected positive benefit. I think it just remains to be seen which way it goes

Joe Albiani: So, let's go back to the use of telehealth and telemedicine. Obviously it's played an increasingly important role in treating both physical and behavioral health during the pandemic, and it certainly has received a lot of attention, and I'm sure that both during the pandemic and afterwards, we are going to see an increase in the use of telehealth in a different approach to how it's reimbursed and used going forward. And it does have its limitations some of which you refer to. One of the shortcomings that had been raised about telemedicine is that it creates disparities between low economically disadvantaged groups given differences and people's access to technologies and their financial status and geography. Have you experienced any of that issue in your own practices or have you heard about that kind of concern?

Dr. Sevarino: I definitely have. At the state level in Connecticut, we are very concerned about the homeless without a particular place to access the internet as well as the fact that owning things like iPad makes access difficult. And the idea has been floated that something like a public library or something like a shelter might become a place where people might be able to go to access those services here in Connecticut. We don't have anything like that set up yet. I'm certain that it is more difficult for those that have accessed our public sector treatment, so it's more difficult for them to access care.

Dr. Drexler: I agree with everything Dr. Sevarino 's said, but I'll also provide the other side of the coin which is that many providers have reported that there is an advantage to seeing their patients in their home environment. That they get a window into their day-to-day functioning that they don't usually see in a 15- or 30-minute appointment in a clinic. And I recently retired from the VA where there was a national initiative before the COVID epidemic to provide telehealth so that we can reach veterans who do not live close to or have transportation to get to a VA Medical Center. And we had a limited number of pilot programs for issuing tablets to the

veterans so that they could access their care from home and that's something that other healthcare systems should consider. And also in my personal practice with veterans I'm very grateful to be able to touch the veterans by just old-fashioned telephone if they weren't able to make it into the visit. I would usually use that time to outreach them by telephone and cover many of the same issues and concerns and make complex medical decisions together even though we weren't in the room together. And I hope that one silver lining to this crisis is that more providers become comfortable with that and that third-party payers become comfortable supporting them.

Joe Albiani: That's a really good point. I've long been an advocate of increased use of telemedicine, and I do think that the positives that we've learned as lessons during this are incorporated into the longer run and that some of the obstacles that have been placed in the use of telemedicine are removed as we go forward after this pandemic. Some states and the federal government have temporarily modified rules for healthcare services during the emergency. For example, relaxation of privacy and security rules, payments for telemedicine, virtual visits, parity and payments for behavioral health treatment just to name a few. Do you think some of these changes should be made permanent? Dr. Sevarino, I will ask you to comment first.

Dr. Sevarino: I think we're going to learn from this pandemic that in fact we could deliver care in ways, for example by telephone as opposed to requiring contact…that we are able to deliver in an effective way. I think AAAP and other organizations will be pushing to try to make these changes permanent. I also think that one sticky issue is the idea that many of the legislation and regulations around telehealth are state-based. And so, the federal government has left it up to the states to determine particular rules about whether a prescriber from outside their state boundaries could prescribe within their states. I think if we could - at a national-level - develop guidelines that basically allow a prescriber in one state not to have to worry about whether he is providing expertise or care in other states. I think if that could be expanded, we would…I think…we wouldn't see a roadblock in making people feel comfortable about extending their practices. I think that's something that in the future I hope can be developed.

Joe Albiani: Dr. Drexler?

Dr. Drexler: I agree with everything Dr. Sevarino said and I'd just like to elaborate a little on that point. We have disparity in access to substance use disorder treatment particularly for life-saving medications for opioid use disorders or alcohol use disorders and tobacco. And we tend to have a concentration of those medical experts who can prescribe in urban areas and suburban areas and throughout the opioid crisis we have a disproportionate number of affected individuals in rural areas that don't have this access. If we could come out of this crisis with some national standards that would allow providers to practice safely across state-lines we could reduce some of that disparity. So, I share Dr. Sevarino's optimism, and I hope that we've learned some lessons from this that help us to increase access to treatment.

Joe Albiani: The AAAP has advocated in a very measured way for legislation in Congress that training should be required for all healthcare professionals in diagnosing and prescribing

treatments for substance use disorder particularly in opioid use disorders. Conflicting legislative proposals seem to have provoked some confusion in that regard. Would you please describe the specific policy decision of AAAP and why is important? And Dr. Drexler, if you would start with that?

Dr. Drexler: Sure. So opioid use disorder is a chronic brain disease and exposing one's brain to enough opioids over time can lead to long-lasting changes such that the individual is unable to safely use opioids or control opioid use and they continue to use despite mounting obvious problems related to opioids. It's especially become a problem over the last couple of decades. As a health care system, we have been more liberal in prescribing opioids for chronic non-cancer. Non-end-of-life pain and more of our population has been exposed to opioids over longer periods of times and unfortunately many of those folks that have been exposed to those opioids have developed a dependence and is not so easy for them to just stop these medications. Part of how this perfect storm happened is that we haven't had good education of all of our healthcare professionals about the pathophysiology of substance use disorders, what are the risk factors for developing dependence to opioids and other addictive drugs, and we haven't provided practical clinical experiences for healthcare professionals about how to diagnose and treat. So it created a situation in which many of us physicians really just didn't know, and so we were vulnerable to some of the marketing messages about how opioids were safe and how they wouldn’t be addicting in folks who are at low-risk for addiction. So we feel that is very important for all healthcare professionals - all physicians and nurses, all other healthcare professions - to get some basic training in what is addiction, the pathophysiology behind it, the signs and symptoms, and the robust evidence that treatment works and saves lives. So that is our position as you mentioned we’ve been advocating and working with others to promote that position and our hope. We know that there will probably never be enough addiction psychiatrists to treat every individual with substance use disorder. But just like there's not enough endocrinologists to treat every person with diabetes. Most diabetes is managed effectively in primary care and it's only those most complex patients that are sent to the specialist for stabilization and then usually returned back to their primary care providers for managing them optimally. Optimally, we see a healthcare system in which that happens for substance use disorders as well. We have effective screening tools in primary care and primary care providers can effectively manage less complex and stable patients in their practices. And then we need to develop the mechanism for seamlessly stepping patients up to specialists when it is indicated and then seamlessly stepping them back to their primary care providers for ongoing management once they are stabilized.

Joe Albiani: That was really helpful and very articulate description of the issue and I really appreciate it. Dr. Sevarino?

Dr. Sevarino: I just wanted to reiterate some of their points that Dr. Drexler pointed out. About 15% of our population has some sort of substance use disorder within a prior year. And when you see patients presenting to primary care or specialty psychiatry, that number is much higher. And yet the amount of time a psychiatrist spends in required training for addictions is only about 4% of their hours. This is even worse in their medical school and in many medical schools

where, unfortunately, since there are so many competing interests on what to treat, provide very little education on the treatment and recognition of substance use disorders. So we really do advocate from medical school and on up for at least medical training, including Doctor of Osteopathy (DO) training, for much more emphasis on substance use disorder training because that's what physicians are going to see in their practices. And in fact, medical students these days are much more interested in taking electives and wanting more training in substance use disorders. So, education is very important. And I think there is also this question about once one is a practicing physician, what do they have to do to maintain their training? And I've always felt very strongly that we have to have continuing medical education and continued good, valuable training for physicians in the field to stay up-to-date. I think this would have helped us in the opioid crisis and would have helped guide our treatment and it's something that was lacking. We have faced a controversy about whether specialized training, for example for waiver training for prescription of buprenorphine, is something that should be continued and I think the important point is that we actually should expand our training for physicians and other prescribers of controlled substances rather than reduce the training.

Joe Albiani: Well thank you very much. And thank you very much for answering that question so thoroughly. There has been confusion, and I think it's helpful to get such a specific answer to it.

Joe Albiani: I want to thank you both for taking the time to join us today and my sincere gratitude for all you do in the community and at the American Academy of Addiction Psychiatry for addressing the growing concern of substance use and other addiction disorders especially given the added challenges and impacts of the coronavirus.

Joe Albiani: Our guests today have been Drs. Kevin Sevarino, President, and Karen Drexler Medical Director of the American Academy of Addiction Psychiatry.

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We're just a few days from the start of Governor Baker's phased in restart of certain economic and social activity in Massachusetts. Making it work will demand self-discipline from all of us, as well as strict adherence to the governor's rules. As we increase our public interaction, we must act responsibly to protect the health of all our fellow citizens especially those on the front lines that are in the hospitals, are first responders, are business owners and workers of those businesses. There's already ample evidence of what results if people act prematurely to return to a normalcy not yet as possible. And let's be clear: until we have a vaccine that works, something approaching normalcy is simply not possible. So be smart and be safe and keep others safe. We are truly all in this together. This is Joe Alviani of O'Neill Associates and this is OA on Health Care.