Grayken Addiction Medicine Fellowship 2023-2024

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Revised June 19, 2023

1. Goals and Objectives

General Goals:

The mission of the Grayken Fellowship in Addiction Medicine is to prepare physician leaders for careers in Addiction Medicine who will improve the health and wellness of people who use substances through clinical care, research, education, advocacy, and public health. The program is invested in Boston Medical Center's commitment to provide "exceptional care without exception," which includes intentionally addressing the health and wellness inequities faced by people due to discrimination by race, ethnicity, poverty, age, gender, sexual orientation, disability and stigmatizing illness.

Educational Goals

The Addiction medicine Fellowship aims to:

1) Train physicians to be clinical and academic addiction medicine leaders in patient care, research, and education.

2) Train physician leaders to integrate high quality evidence-based addiction medicine care with general and specialist health delivery systems.

3) Train physician leaders to innovate addiction medicine programs that will fill gaps in the healthcare system.

4) Train physician leaders that will improve wellness and healthcare by addressing inequities faced by people vulnerable due to race, ethnicity, poverty, age, gender, disability and stigmatizing illness.

Overall Program Structure: Fellows, all of whom have completed another clinical residency, can complete a single clinical training year or the two (or more) years of combined longitudinal research and clinical training. Fellow experiences are tailored to the individual's interests and fellows are guided by the interdisciplinary BMC Addiction Medicine Fellowship faculty. The program faculty members draw from multiple relevant disciplines (Internal Medicine, Family Medicine, Psychiatry, Emergency Medicine, Preventive Medicine, Obstetrical Medicine, and Pediatrics) and have established relationships with relevant teaching sites. These include Boston Healthcare for the Homeless, which provides community-based health care services that are compassionate, dignified, and culturally appropriate; VA Boston Healthcare System, home to an existing addiction psychiatry program and major leader in substance use treatment in the northeast, and Boston Children's Hospital Adolescent Addiction Program, one of the preeminent research and training sites for teen addiction nationally. The two-year program combines the resources of the BU School of Medicine and Public Health as well as local training institutions to offer a comprehensive training program that includes both clinical and research experience.

The BMC Addiction Medicine Program curriculum is organized around four areas, **1) Clinical Addiction Medicine; 2) Analytic and Research Skills on Addiction Epidemiology and Health Services Delivery; 3) Leadership, Teaching and Administrative Skills for Addiction Medicine; and 4) Identity as an Addiction Medicine Physician.** A central focus on health disparities in urban, impoverished and minority populations infuses the entire curriculum described below.

I. GOALS- CLINICAL ADDICTION MEDICINE

The program's goal is to give trainees a strong foundation in the components of clinical addition prevention and treatment through a variety of supervised clinical experiences in a wide range of inpatient and outpatient settings, but grounded in a longitudinal experience caring for patients with addiction. There are numerous required clinical rotations to help the resident obtain basic skills in addiction medicine, as well as elective experiences to delve deeper in areas of personal interest. Each rotation is supervised by appropriate clinical staff, and include addiction medicine physicians and interdisciplinary experts matched to the educational goals of the rotation. In addition, there is an ongoing didactic lecture series on clinical addiction medicine given by program faculty.

A. *Maintain a longitudinal practice.* Each fellow will maintain the equivalent of ½ day per week in an ongoing longitudinal setting that matches the prior clinical training. Primary care trained fellows will maintain a continuity primary care practice within one of the ambulatory clinics at Boston Medical Center, an affiliated health center, or at the VA Boston Healthcare System. Patients will include a broad range of clinical diagnoses but will be enhanced with patients with addiction issues. Faculty supervisors will be trained in both the underlying discipline as well as addiction medicine. For non-primary care specialists, such as Emergency Medicine, the longitudinal experience may reflect ongoing EM practice shifts.

B. *Public Health delivery sites*. Fellows will participate in needle exchange and other public health department administered outpatient and residential programs to learn addiction preventive counseling, education, and brief intervention skills as well as harm reduction strategies.

C. *Outpatient*. Fellows will rotate through multiple outpatient experiences, which will include dedicated substance use treatment (e.g. opioid treatment programs- Methadone and Buprenorphine, or obstetrical care for pregnant people with substance use disorder), as well as general treatment settings in which addiction assessment and treatment constitute an important element (e.g. Emergency Department, low barrier substance use disorder clinic). These rotations will offer the foundational skills in assessment, pharmacological treatment, behavioral counseling, interdisciplinary team work, triage and referral, evaluation of comorbid medical conditions and treatment outcome monitoring.

D. *Intensive Outpatient and Partial Hospitalization*. Fellows will rotate through intensive outpatient and partial hospitalization programs to obtain skills in medical management of acute withdrawal as well as formulating and administering treatment plans for patients requiring level II care.

E. *Inpatient/Residential.* Fellows will rotate on the inpatient addiction consult service in which medical, and surgical patients are evaluated for addiction related issues- including diagnosis of addiction, management of withdrawal, evaluation and referral for treatment, and management of comorbid conditions. They will also rotate through residential treatment with the public health department sponsored programs.

F. *Didactic Lecture Series***.** Fellows attend the following didactics:

Day	Time	Lecture Series
Tuesday	9-12	Academic Primary Care Series (ex. academic seminars, journal club, fellows work in progress, QI) when available
Wednesday	12-1	Addiction Fellow Case Conference
Thursday	1-2	Brown BU TUFTS Addiction Fellow Didactics

II. GOALS – ANALYTIC AND RESEARCH SKILLS ON ADDICTION EPIDEMIOLOGY AND HEALTH SERVICES DELIVERY
Research training occurs though curricular offerings by the Addiction Medicine Fellowship faculty. The research and analytic competencies are developed and solidified through individual mentored research projects. One year clinical addiction fellows will be expected to pursue a single scholarly project, limited in scope. The specific goals are described in detail below.

1. ***Participate in Scholarly activities****.* Fellows, with the help of program faculty, can choose projects from ongoing research projects, submit case reports, or other scholarly work. The program directors meet to help steer fellows to potential project advisors. One-year fellows are expected to have one project which is limited in scope. Trainees in the two year program (year 1 ACGME accredited, year two non-accredited) obtain in-depth analytical and research skills through the Boston University School of Public Health (SPH) Master's degree programs, and are expected to conduct at least two research projects over the course of their program.

2. ***Attend Research-in Progress Meetings****.* Fellows participate in research-in-progress seminars, which are conducted in conjunction with the Academic Primary Care fellowship. The trainee-focused seminar meets twice a month and is attended by all the post-doctoral fellows in primary care, infectious diseases and cardiovascular epidemiology as well as 3-4 research faculty members. A second Research-In-Progress meeting is a twice monthly meeting organized by the Section of General Internal Medicine. The objectives are similar to the trainee-only meeting but attended by a much larger audience with primary care and public health research faculty, staff and trainees present. *Each fellow is expected to present at least two times each year in the trainee-focused research in progress.*

2. *Present research at national meetings and publish research projects results in peer-reviewed journals*. At the conclusion of each research project, the fellow is expected to submit written abstracts to regional and national professional meetings and submit and publish projects in peer-reviewed publications (actual publication may occur after completion of fellowship). Fellows are required to apply for travel awards to attend the meeting.

B. *Complete a Master's Degree at the School of Public Health*. Two-year Addiction Medicine (AM) fellows enroll at the school as part-time students and may elect to pursue either a Masters of Science in Epidemiology (MS Epi) or a Masters of Science in Translational & Implementation Science. The MS programs require a core series of coursework, electives, and culminate in a capstone project.

III. GOALS-LEADERSHIP, TEACHING, AND ADMINISTRATION SKILLS FOR ADDICTION MEDICINE
Our program's goal is train future leaders in academic and public health addiction medicine. The clinical rotations, didactic sessions and teaching seminars of the program prepare the trainees for this role. Fellows:
*A. Attend the Combined Brown-BU-TUFTS Addiction Fellows Didactic Lecture Series***.** Fellows are required to attend a weekly interdisciplinary didactic lecture series aimed at ensuring that all fellows (addiction medicine and addiction psychiatry) are exposed to a comprehensive range of topics and issues in Addiction Medicine. Topics related to leadership and administration include those geared towards increasing the understanding of public health systems, leadership in public health, advocacy and policy.
B. Attend the Addiction Medicine Fellows Case Conference Series. Fellows are required to attend a weekly case conference series aimed at ensuring that all fellows can discuss current cases confidentially with the PD and APDs. ***Fellows are expected to attend a minimum of 75% of the sessions.***

C. Become familiar with legal processes governing public health. Fellows may achieve familiarity with the legal processes governing addiction by identification of legislation and funding mechanisms governing substance use treatment, including the criminal justice system.
D. Attend Academic Seminars. The Academic Seminar is a series of professional development didactics specifically designed to develop professional skills that will help graduates succeed in their career choices. The seminars focus on skill building to promote career development and draw on the expertise of faculty across the institution. All seminars are conducted in a small group format alongside fellows in the academic primary care fellowship program.
*E. Attend Teaching Methods Seminars***.** Training in clinical teaching methods is an important component of the Program. During the first half of the academic year, six 90-minute seminar sessions cover a core of topics that relate directly to teaching in academic and clinical Addiction Medicine environments. Core topics include Promoting a Learning Climate, Large Group Lecturing Skills, and Outpatient Teaching Skills.

IV. IDENTITY AS AN ADDICTION MEDICINE PHYSICIAN
Identity as an addiction medicine physician is nurtured in three ways: 1) the clinical addiction rotations and 2) Board certification in general Addiction Medicine.

A. *Clinical Addiction rotations.* The fellow should develop confidence in addiction medicine skills by virtue of successful completion of the required and elective addiction medicine rotations.
B. *Obtain Board Certification in Addiction Medicine*. It is expected that graduates of the program take the board certification exam upon graduating the program. To support certification, fellows will take an in-service examination (ADEPT through ACAAM membership) and faculty will encourage fellows to attend national board review courses.
C. *Attend a national addiction meeting.* AM fellows are expected to attend AMERSA and ASAM during the program to shape understanding of the larger context of the Addiction Medicine profession and promote creation of an identity as an Addiction Medicine professional. Fellows are required to apply for travel awards to attend the meeting.

V. Addiction Medicine Fellowship Clincial Competencies
1. Patient Care: By the end of training, the Addiction Medicine Fellow will demonstrate competence in medical care of persons with SUD across a diverse spectrum of drugs, stages of use, and presentations, including care directed at reducing SUD-related harm. They shall be able to render patient care that is compassionate, appropriate, and effective for the prevention and treatment of problems related to the addiction disorders.

Specifically, the physician will be able to:

- Screen for and diagnose common problems related to the addiction disorders including:
    - Recognize psychological, social and functional indicators of subclinical addiction disorders
    - Use common standardized screening instruments and interview questions to assess use
    - Routinely screen for addiction when patients present with commonly associated medical problems, including trauma or other injuries
- Conduct an accurate patient history
    - Conduct a clinical interview to collect a substance use history and addiction treatment history in a structured and non-judgmental manner

    - Assess stages of change and use motivational interviewing strategies to promote change in persons with problematic substance use
- Perform an appropriate physical examination and detects physical signs of
    - acute use, intoxication, and withdrawal
    - chronic use and sequelae of use for
        - tobacco
        - alcohol
        - sedative-hypnotics
        - opioids
        - intravenous drug abuse
- Order appropriate diagnostic tests
    - Routine laboratory tests
    - Toxicology
    - Diagnostic imaging
    - Interprets laboratory findings for diagnostic purposes
- Formulate a diagnosis and an appropriate management plan
    - Use standard diagnostic criteria to diagnose addiction disorders
    - Formulates an abstinence-oriented treatment plan when appropriate
    - Formulates a maintenance-oriented treatment plan when appropriate
- Explain diagnosis to the patient and explains rationale for treatment
    - Able to provide brief intervention
    - Able to make referrals for treatment
    - Able to direct the medical management of
    - Syndromes of withdrawal
        - Outpatient treatment programs
        - Inpatient treatment programs
        - Residential treatment programs
        - Addiction disorders in acute care settings
        - Ongoing recovery (i.e., “aftercare”)

2. Knowledge: By the end of training, the Addiction Medicine Fellow will understand addiction as a chronic medical condition, and Substance Use Disorders (SUD) as important and prevalent public health issues. They will understand the established and evolving biomedical, clinical, and cognitive sciences and apply this knowledge to the care of patients with SUD.

Specifically the physician will be able to:

- Understand the core knowledge for the addiction disorders including:
    - Epidemiology
    - Prevalence and patterns of alcohol and other drug use
    - Demography of drug use and misuse: social, national, religious, ethnic, cultural contexts
    - Etiology of drug misuse and addiction
    - Neurobiology of reward and addiction
    - Genetics of reward and addiction
    - Psychosocial issues shaping drug use and misuse
    - Drug and drug misuse effects

    - Pharmaco-dynamics of common drugs of reward
    - Actions and features of acute intoxication
    - Patho-physiology of chronic misuse
    - Neuropsychological effects of chronic misuse
    - Common secondary medical problems associated with drug misuse
    - Fetal and neonatal effects of commonly misused drugs
- Formulate a reasonable differential diagnosis related to:
    - Signs and symptoms of drug use, intoxication, and withdrawal
    - Standard diagnostic criteria for Addiction Disorders
    - Other Substance-Related Disorders
- Manage significant withdrawal from commonly used drugs
    - alcohol
    - tobacco
    - sedative-hypnotics
    - opioids
- Treat medical emergencies associated with commonly misused drugs
    - alcohol
    - opioids
    - sedative-hypnotics
    - cocaine, methamphetamine, other stimulants
- Provide appropriate general medical care for persons in recovery
    - Select indicated treatment medications
    - Use Motivational Interviewing to support recovery
    - Follow indicators of recovery
- Objective physical and psychological findings
- Biological markers (e.g., laboratory values)
    - Pharmacologic interventions to support recovery
    - Basic psychosocial strategies to support recovery
    - Awareness of specialty treatment approaches and resources
    - Awareness of self-help and peer group approaches and resources
    - Complementary/alternative health approaches
- Provide medical management of persons with addiction disorders in special contexts
    - Pre and post operative care
    - Pain management
    - Peri-natal period (mother and child)
    - Problems related to intravenous drug abuse

3. Practice-based learning and improvement: The Addiction Medicine specialist will stay current with evolving science and clinical practice relevant to the prevention and management of SUD and complications. They will be a life-long learner of patient care and will be able to appraise and assimilates new scientific evidence in the care of patients. Specifically, the physician will:

- Be able to access needed resources and information on substances and addiction
- Consult with other treatment resources as appropriate

- Be able to supervise and teach other health care professionals
- Access scientific and clinical information from the medical literature
- Know avenues for specialization/concentration/continuing education in the field
- Continuously improve skills through practice assessment

4. Interpersonal skills and communication: The Addiction Medicine specialist will consistently use respectful and effective communication with SUD patients, their families and other health care professionals, in order to optimize medical care. Specifically, the physician will:

- Communicate with patients based on medical and public health understanding of drug use and addiction, in a manner that is:
  - Respectful and non-judgmental
  - Based on accurate and non-stigmatizing nomenclature
  - Structured and firm as appropriate
- Routinely use motivational strategies to support change
- Understand the importance of families/significant others in addressing substance issues and communicate with them effectively as appropriate
- Understand him/herself to be a member of a care team and communicate effectively and respectfully with co-care providers
- Recognize and address potential barriers to effective communication
  - Health literacy limitations
  - Jargon
  - Language and cultural differences

5. Professionalism: The Addiction Medicine specialist will engage in care of persons with SUD in a professional, health-oriented, responsible and proactive manner, in order to reduce substance-related harm, promote health and address co-existing medical problems. They will manifest a commitment to carrying out professional responsibilities, an adherence to ethical principles, and sensitivity to a diverse patient population. Specifically the physician will:

- Maintain an appropriate appearance
- Be consistently punctual and reliable
- Demonstrate respect and sensitivity to patients' culture, age gender, and disabilities.
  - Provide care of persons with substance use problems based on a medical and public health paradigm of drug use and addiction
  - Recognize and actively address stigma towards persons with substance misuse and/or addiction
  - Not discriminate, or tolerate discrimination towards, persons with substance misuse and/or addiction
  - Address addiction as a chronic medical illness and harmful drug use as a personal and public health problem in all contexts
- Provide or arrange for ongoing care of persons with substance use problems, to address:
  - Substance use problems
  - Other medical problems

- Effectively address substance use issues among colleagues
- Recognize signs of harmful substance use in colleagues
  - Pro-actively intervene when concerned about a colleague or his/her patients well- being
- Know available help resources for self and colleagues
- Practice self-awareness and self-care
- Continuously seek balance in professional and personal life
- Proactively manage personal substance risks
- Engage in personal self-care
- Avoid potentially harmful substance use
- Assess personal substance risks
  - Be aware of how the physicians' own experiences may affect their relationship with patients with addictions

6. Systems based practice: The Addiction Medicine specialist will demonstrate an awareness of and responsiveness to the larger context and system of health care. They will recognize the multi-dimensional components of the system required to reduce SUD. They will be able to effectively access, navigate and engage the system to optimize care.

Specifically the physician will:

- Work as part of a treatment team
- Engage other members of the health care team in a respectful manner including:
  - Primary care and specialty physicians
  - Mental health professionals (e.g., psychologists, social workers, counselors)
  - Pharmacologists /pharmacists
- Anticipate errors/lapses in care and take steps to prevent them
- Help patients utilize resources to overcome obstacles to care
  - Clinical resources within the healthcare system in which he/she works
  - Self-help groups
  - Community based treatment and recovery resources
  - Schools and Student Assistance Programs (SAPs)
  - Employers and Employee Assistance Programs (EAPs)
  - Governmental entities (Licensing Boards, DEA, etc.)
  - Private organizations (professional societies, peer advocates, etc.)

1a. BMC's Addiction Medicine Fellowship & Faculty Wellness Policy

The Addiction Medicine Fellowship recognizes that the psychological, emotional, and physical well-being are critical in the development of competent, caring, and resilient physicians and requires attention spent developing this balance between work and personal life. All physicians are at risk for burnout and depression, and we understand the responsibility of looking after the well-being of both fellows and faculty members in the unit. Self-care and responsibility to support other members of the health care team are skills that must be modeled, learned, and nurtured in the context of other aspects of training in professionalism and patient care. We seek to establish a unit culture that is marked by mutual respect, openness, and support for one another.

Components of Wellness:

- **Learning and working environment**: We strive to provide a healthy learning and working environment for fellows and faculty with a culture of respect and accountability. This includes offering protected time for didactics and minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships. We pay special attention to scheduling, work intensity, and work compression that impact fellow and faculty well-being. We regularly evaluate workplace safety data and address the safety of both fellows and faculty. See below for reporting mechanisms.

- **Physical wellness**: We recognize that a sense of well-being includes physical wellness. We encourage the fellows to have a personal primary care physician and we provide them time to go to these appointments. They are given the opportunity to attend medical, dental, optical and any mental health appointments as needed. We encourage them about the importance of a healthy diet, exercise, and adequate rest.

- **Social wellness:** Spending time away from work with family and friends and finding support and purpose outside of medicine is also important. We also encourage regular fellow group activities outside of work.

- **Mental health:** Special attention is paid to the possibility of fellow and faculty burnout, depression, and substance use. Using resources available to us through BMC, we educate faculty and fellows in the identification of the symptoms of burnout, depression, and substance use, including the means to assist those who experience these conditions. Fellows and faculty are educated to recognize these symptoms in themselves and how to seek appropriate care. We encourage them to alert the Program Coordinator, Program Director, or DIO when they are concerned that another fellow or faculty may be displaying signs of burnout, depression, substance use, suicidal ideation, or potential for violence, whether to themselves or others. We provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24/7, to ensure that fellows and faculty have access at all times to a mental health professional. Financial cost is not a barrier to obtaining care.

- **Time-off/ Leave:** There are circumstances in which fellows or faculty may not be able to attend work, such as fatigue, illness, family emergencies, and parental leave. We allow leave of absence for each fellow and faculty unable to perform their patient care responsibilities, as assessed on an individual basis. We have policies and procedures in place to ensure coverage of patient care that are implemented without fear of negative consequences for the fellow or faculty who is unable to perform their patient care responsibilities.

- **Creating Calm in Crosstown-C3**: The Section of General Internal Medicine in which the Addiction Medicine Fellowship is housed has an employee wellness program. Each week there are a variety of options for trainees to participate in including : a walking group, mindful meditation, "jam" sessions, gaming sessions, chair massage and reiki to name a few (some have been put on hold while others have transitioned to Zoom during the pandemic).

- **Faculty mentor**: At the beginning of a fellows' training, they are assigned a faculty mentor. The goal of assigning the mentor at the beginning of the training is that the fellow can connect and grow with the faculty member over their course of training. Mentors and mentees formally meet at least monthly to check in and offer any needed support, both personally and professionally. The program director is also expected to meet with all of the fellows as a group throughout the year for both social events and team building. Additional wellness resources available are a list of books, web-based modules, and articles. The list is reviewed and updated every few years for relevancy.

Wellness Resources

BMC Employee Assistance Program
BMC's Employee Assistance Program (EAP) provides employees and their families with confidential short-term counseling and referral services for a wide range of concerns including mental health, alcohol/substance use disorder, smoking cessation, depression, anxiety, career concerns, elder care support, and more. They are available 24/7. Call 833-306-0107. More information, as well as addiction and mental health assessments, are available online at guidanceresources.com (register with Web ID: BMC).

Your call will be answered by a clinician, who may help you by:

- Responding to a mental health or substance use emergency
- Evaluating your problem or concern
- Providing telephone counseling
- Referring you directly to an EAP clinician for a face-to-face visit
- Locating, qualifying, and referring you to a local clinician

The EAP provides you and each of your eligible dependents with up to five in-person counseling sessions per each different presenting problem with an EAP clinician at no cost to you and your eligible dependents per calendar year. If additional counseling services are needed, the EAP will work with your medical provider to ensure you receive the care you need. The EAP is not part of your health insurance and is a separate service that does not require health insurance to participate. However, an EAP counselor may recommend extended services beyond the scope of the EAP, at which time your EAP counselor would assist you in accessing your health insurance plan for further coverage.

Employee Assistance Clinicians
If you are looking for mental health or substance use disorder treatment programs for yourself or a family member and you don't know where to start, or are having difficulty getting a timely appointment, you can contact our **Employee Assistance Clinician**, Beth Milaszewski, LICSW. Beth provides the following services:

- Care Navigation: Beth can assist with navigating and triaging services to help you find the most appropriate site/providers for your specific needs, both at BMC and elsewhere. This includes referrals for long-term counseling and substance use disorder treatment programs.
- Social Support Resources: If you have social support needs such as housing, food, and family issues, Beth can help find available resources to address these needs.

Beth can be reached by email: **Beth.Milaszewski@bmc.org**, phone: 617-414-4357, or pager: 8010.

Roopa Mathur, DO: Dr. Mathur is available to treat or to help employees find psychiatric and therapy services. Contract Dr. Mathur at roopa.mathur@bmc.org.

Izzy Berenbaum, MD: Dr. Berenbaum is available to see residents and attendings for therapy and/or psychiatric medication needs, using medical insurance. Please note that medical and behavioral health notes are not kept in Epic. You may contact him by paging 0196 or emailing bbq@bu.edu.

Physician Health Services (PHS)
Consultation and support services for physicians, residents, and medical students. Call 781-434-7404 or 800-322-2323 x7404.

Sleepio
Research shows that people who suffer from chronic sleep problems have more difficulty managing emotions, are at double the risk of developing depression and respond less to treatment for mental health disorders. The sleep experts at Sleepio can help you get the best sleep possible. This six-week personalized sleep program uses Cognitive Behavioral Therapy (CBT) to teach you techniques to get your sleep schedule, thoughts, lifestyle and sleep environment into shape. Discover your Sleep Score and how to improve it at www.sleepio.com/bmc.

Daylight
Daylight is a digital therapy program designed to help you build your resiliency so you can feel better when facing life's tough challenges. It was created with evidence-based research and uses Cognitive Behavioral Therapy to teach you ways to manage your daily stress, worries, and anxiety, based on your specific needs. Register at www.trydaylight.com/bmc.

Doctor on Demand: Telemedicine Services
If you are enrolled in a BMC employee medical plan with Health Plans, Inc. you can receive convenient and confidential behavioral health visits through online video chat with licensed practitioners. Conditions treated include depression, anxiety, addiction, trauma, and loss.
You can select a mental health appointment with a psychologist for talk therapy for 25 or 50 minute sessions. You may also schedule an appointment with a psychiatrist for an initial assessment and medication management, including prescribing/renewing prescriptions (45 minutes). Subsequent 15-minute follow-up sessions are available for ongoing medication management. Medications that the psychiatrist prescribes can be called into a local pharmacy, including BMC. The cost for each visit is typically $5, but all copays are being waived during the COVID-19 pandemic. To find out more and register, visit www.doctorondemand.com/health-plans-inc.

Domestic Violence Program
Provides support and resources for employees and patients with suspected or known domestic violence situations. Contact Joanne Timmons at 617-414-5457 or view the BMC Domestic Violence Program site for more information.

Spiritual Care
Provides immediate support and pastoral counseling for employees and patients. Contact:
Chaplain Samuel Lowe, PhD, Mdiv, at pager #3658
Rev. Jennie R. Gould, Ph.D., BCC, at pager #4578
Spiritual Care main pager #4578 or #3658

What to do when a patient dies

- Notify program director/mentor
- Call family and send a condolence card from the program
- Notify staff as soon as possible

- Cancel future appointments in the scheduling system
- Clinician to document death in the medical record
- Notify medical records
- File an incident report, QA/QI meeting
- Contact chief's of service
- Notify department of public health

www.Acgme.org/what-we-do/initiatives/physician-well-being

1b. Jeopardy (Fatigue, Illness and backup coverage)

In the event that a fellow is ill or too tired to come to work, the program office will be notified and the backup system initiated. If a fellow is sent home during their shift, the program office will do its best to find coverage, and will let the attending know that there may not be a fellow on that day. It is the expectation that faculty monitor fellows for fatigue and burnout, and send fellows home when necessary.

1c. Confidential Reporting & Workplace Safety

Anonymous Reporting of Resident Issues
This form allows an anonymous report by anyone with concerns regarding the work or treatment of Boston Medical Center trainees. In addition to residents and fellows, any BMC employee or a resident's family member can make the report

Examples for using this report:
•instances of coercion to exceed duty hours involving the person reporting the violation or observed coercion of others.
•observation of evidence for excess fatigue and sleep deprivation in residents who continue to engage in active patient care.

When this form is used, we guarantee that no demographic information such as IP address, workstation ID, or any other identifying information is captured, and you will remain anonymous. The secure information you provide in this form will be immediately routed to the Designated Institutional Official (DIO) Jeffrey Schneider, MD, for investigation and implementation of corrective action as warranted. When submitting the below form, please indicate the department, the date of the violation/incident (if applicable), and the nature of the violation/incident.

RL Incident Reporting System
BMC commits to fostering a work environment that is professional, respectful, and supportive of all personnel to provide optimum patient care and a safe, supportive work environment. BMC expects all employees, regardless of position, to support this aim, and BMC has a zero-tolerance policy for behaviors that undermine our culture of safety. Behaviors that are not tolerated include but are not limited to: aggression/bullying, inappropriate communication, destructive behavior, discrimination, harassment, physical abuse, and retaliation.

Gaps in communication (lack of, ineffective, disruptive) are cited as a root cause in the vast majority of all preventable patient harm events. The effect of destructive behaviors on others can result in anxiety, depression, health issues and ineffective teamwork; ultimately, they can have a negative impact for both staff well-being and patient safety. BMC leadership has prioritized a strong culture of safety in which all employees, licensed independent practitioners (LIP) and patients feel safe.

It is understood that BMC employees and staff are human beings and that we all may need the occasional thoughtful reminder for behavioral mindfulness. Ideally, missteps in communication and professional conduct can be addressed and resolved in the moment through de-escalation and respectful discussion or escalated through employee/provider chain of command. However, there may be times when this is not a viable solution, or when a negative pattern continues. In these cases, the event should be reported in RL. In order to facilitate reporting of more serious or problematic behavior, the employee/LIP

professional conduct icon has been added to the RL incident reporting system. As with entering patient safety events, respectful, factual descriptions with sufficient detail for the reviewer will expedite event review and intervention. A standardized, non-punitive process has been developed to optimize confidentiality, timely review, and intervention. Limited, specific designated leaders will be assigned to event review for each discipline.

Professional Resource Services

The Professionalism Resource Service (PRS) promotes the development of professional attitudes, behaviors, and practices at Boston University School of Medicine (BUSM) and Boston Medical Center (BMC) in order to support a learning environment where all are treated with respect, humility, and compassion.

A confidential, independent, non-adjudicating service available at no cost, PRS can assist individuals, groups, and departments at BUSM and BMC in developing remediation strategies that preserve relationships and careers. PRS also monitors and reports on professionalism within the learning environment, supporting education activities and assessments.

BMC Human Resources

Fellows can reach out to BMC Human resources at 617-638-8585 to speak to the Human Resource Business Partner for residents for issues regarding BMC employees.

BMC Compliance

BMC Compliance covers the following areas: prevention of fraud, waste, and abuse; protection of patient privacy and HIPAA; research compliance; billing compliance audit; disclosure and management of conflicts of interest; pharmacy compliance; and monitoring of workforce relationships with industry vendors.

Compliance receives reports of concerns, questions and other inquiries via the Compliance Hotline (800-586-2627) and through other means such as telephone calls and in-person visits. Every report received by Compliance is investigated and resolved. We actively work to prevent retaliation against any workforce member who makes a report to Compliance or who participates in the investigation of a report.

DG-ComplianceHelp@BMC.org: for anyone who'd like to report concerns, leave tips, and have questions regarding compliance

BU Human Resources

Fellows can reach out to the BU HR Service Center at 617-353-2380 or email hr@bu.edu for issues regarding BU employees (faculty).

BU Ombuds

The Office of the Ombuds is an independent, impartial, informal problem-solving resource serving faculty, staff, and students on the Charles River and Medical Campus. The Office maintains strict confidentiality, and provides a safe place for you to have off-the-record conversations on issues related to life, work, or study at Boston University. Talking to the Ombuds can be a good first step if you have a concern and you don't know where to turn for help.

Solomon Carter Fuller Building
85 East Newton Street, Suite 818
(617) 358-7645
ombuds@bu.edu

1d. Racial and Ethnic Diversity, Equity, and Inclusion Curricular Plan

- *Acknowledgement, education and action on racism and discrimination into required curricula*
    - Dedicated, required curricula –
        - BMC's Health Equity Rounds https://www.bmc.org/medical-professionals/education/health-equity-rounds HealthEquityRounds@bmc.org
        - Racism, Mass Incarceration, the Drug War, and Addiction care lecture
        - Bystander Intervention Training (LIFT) during orientation
        - Implicit Bias Rounds/Health Equity Rounds – partner with existing efforts on campus and/or incorporate into existing
            - e.g. Jen Brody and Sonja Spears case presentation at BHCHP
            - www.healthaffairs.org/do/10.1377/hblog20170717.060993/full/
    - *ACAAM sessions focused on anti-racism: Require for fellows not on consult service Wednesday afternoon 2-4pm*
        - Mandate that they listen to the recordings.
- *Support and encourage fellows to pursue analyses of racism and discrimination in their scholarly work*
    - Highlight examples and connect with mentors
    - Skills to do a disparities analyses as a leader
- *Publishing and highlighting existing curricula available*
- *Recruit diverse fellows*
    - Holistic review with explicit and transparent values of racial ethnic diversity, equity, and inclusion
    - Work with GME to set and achieve URG recruitment targets (20% or greater)
    - Targeted outreach to BMC BIPOC/URG residents
    - Stipended rotation for URiM rotating residents
- *Highlight, celebrate and promote addiction medicine faculty of color as teachers and mentors*
- *Encourage/require that addiction medicine faculty all complete Bystander Intervention Training (LIFT) presented by BUMC FDD*
- *Longitudinal QI project handed from fellow to fellow each year*
- *Partner with Elena Mendez-Escobar and the BMC Equity Center/Grayken*
- *ACGME Equity Matters Toolkit: https://dl.acgme.org/learn/learning-path/acgme-equity-matters-equity-practice-toolkit*

2. Rotation Goals and Objectives

Inpatient

Inpatient Rotation Name	Addiction Consult Service
Site	Boston Medical Center
Length of Rotation	14 weeks
Name(s) of Supervising Faculty Member	Zoe Weinstein, MD, MS
Revised	May 2022

As a member of a multi-disciplinary team (nurse practitioner, social worker, peer, physician), the fellow will provide addiction medicine consultation to inpatients on the internal medicine, family medicine, obstetrics/gynecology, and surgical services, including history and physical assessments and addiction treatment coordination for medical and psychiatric co-morbidities. The fellow reviews each case with his or her faculty supervisors and have full consultative responsibility for assigned cases. Faculty are always available for consultation.

Setting
The population seen on the Addiction Medicine Service will mirror the population admitted to the inpatient services at Boston Medical Center with substantial proportions of racial and ethnic minorities and socio-economically disadvantaged. Interpreter services are available in many languages. There is a broad range of patient acuity, from acute ICU cases to tertiary care. Most patients are diagnosed with substance use disorders, particularly alcohol, opioid, stimulants or benzodiazepines. They frequently require major medical interventions related to alcohol withdrawal, opioid withdrawal, intravascular and soft tissue infections from injection drug use, chronic pain, burn/trauma care, pregnancy or treatment for orthopedic trauma. Services provided include substance use disorder diagnosis and psychosocial assessment, linkage and referral to outpatient treatment and services provided by the peer and social work team member. Ongoing treatment and management recommendations are made for medical/surgical patients in collaboration with the medical/surgical service, for pregnant addicted patients in collaboration with the OB Service, and for patients referred by the Pain Service.

Learning Objectives
At the end of rotation fellows will be able to:
Patient Care
1. Take an appropriate substance use specific history
2. Diagnose substance use disorders, recognizing co-occurring medical and psychiatric conditions
3. Diagnose patients with alcohol and opioid intoxication and withdrawal
4. Develop and execute short and medium term treatment plans for the medical management of withdrawal, substance use disorders and any medical and psychiatric comorbidities, including transition to longer term inpatient and outpatient treatment

Medical Knowledge
1. Recognize different classes of opioids, interpret urine drug screening, and understand equianalgesic dosing
2. Provide consultation services for patients with clinical problems requiring basic risk assessment

Practice Based Learning & Improvement
1. The fellow will identify and acknowledge gaps in personal knowledge and skills in the care of patients with substance use disorders and will use supervision effectively to explore gaps in knowledge and skill sets.
2. The fellow will develop and implement strategies for filling gaps in knowledge and skills and will demonstrate the capacity to research topics and identify needed resources in the medical literature.

Systems Based Practice

1. The fellow will work effectively in complex health care systems to insure the successfully delivery and coordination of multidisciplinary substance use disorder treatment plans.
2. The fellow will collect, synthesize and understand data from diverse sources about patients.
3. The fellow's treatment plans will include cost-effective and evidence-based strategies for the treatment of the substance use disorders.

Professionalism

1. Understand the value of multi-disciplinary team rounds with MD (IM and Psych), SW, CM and primary team
2. Counsel patients using non-judgmental approach and encourage rapport-building with SUD patients

Interpersonal & Communication Skills

1. Counsel patients on use, risks, and benefits of medication for alcohol use disorder
2. Counsel patients on use, risks, and benefits of opioid agonist therapy and naltrexone for opioid use disorder
3. Counsel patient on harm reduction strategies, including overdose prevention, HIV post and pre-exposure prophylaxis, and safer syringe use practices
4. Appreciate complex interplay of pain, medication tolerance and addiction, with importance of managing pain on opioid agonist therapy (OAT)
5. Manage pain in patients with concurrent opioid use disorders

Evaluation Methods

Global assessment by clinical supervisor
Evaluation by other professional staff on the consult service.

Faculty Qualifications

Attending physicians on the Addiction Consult Service clinic are board certified in either internal medicine or family medicine and are also board certified in addiction medicine.

Inpatient Rotation Name	SECAP: St. Elizabeth's Comprehensive Addiction Program
Site	St. Elizabeth's Hospital
Length of Rotation	4 weeks
Name(s) of Supervising Faculty Member	Fariba Miryousefi , MD
Revised	May 2022

The fellow will provide clinical care at SECAP which is a comprehensive and multi-dimensional care program for individuals with Substance Use Disorder (SUD) particularly opioids, alcohol and benzodiazepines. SECAP programs include inpatient detox, inpatient addiction consult service, outpatient addiction treatment and outpatient psycho-social support. Fellows' training and work will include admission history and physical assessments, progress assessments, participation in psychotherapy sessions, and treatment coordination for medical and psychiatric co-morbidities.

During the SECAP rotation the addiction medicine fellow will acquire and demonstrate competence in the medical care of patients with substance use disorders, including medically-managed withdrawal, medications for substance use disorders, group and individual psycho-therapy, and management of co-morbid medical and psychiatric disorders. They shall be able to render patient care that is compassionate, appropriate, and effective for the prevention and treatment of problems related to opioid dependence.

Learning Objectives

Patient Care

1. Perform a comprehensive physical and history that includes:
    a. Completing a comprehensive addiction assessment.

b. Performing a physical examination to evaluate the patient's general health status with special attention to physical manifestations of substance use disorders, including intoxication and withdrawal.
c. Integrating multiple sources of data into a diagnostic assessment.
d. Making a complete diagnosis of all substance use disorders present, and note pertinent negatives.
e. Conducting an appropriate risk management assessment of each patient, including suicide and self-harm risk and risk to others, and refer to a higher level of care if indicated.
f. Provide patient care that is safe, effective, compassionate, and appropriate with regard to acute withdrawal syndromes that require inpatient or residential level of care such as ASAM Level IV or Level III Inpatient Care.

2. Demonstrate the following as part of performing a comprehensive assessment:
   a. The ability to perform a physical exam that documents physiological disturbances due to acute withdrawal from alcohol, sedatives, opioids or other classes of drugs.
   b. The ability to perform a mental status exam that documents perceptual, cognitive, emotional and behavioral disturbances due to acute withdrawal from alcohol, sedatives, opioids or other classes of drugs.
   c. The ability to conduct appropriate risk assessment of the patient during withdrawal, including suicide and self-harm risk, aggression risk, elopement risk, and fall risk.
   d. The ability to complete a comprehensive addiction assessment addressing the six assessment dimensions of the ASAM Patient Placement Criteria (PPC) and to make an appropriate diagnosis of all substance use disorders present (as well as 'pertinent negatives' regarding addiction to various classes of drugs).
   e. The ability to use diagnostic criteria and rating scales (e.g. DSM – 5, COWS, CIWA) to assist in the formulation of a diagnosis.
   f. The ability to integrate other sources of data into diagnostic assessment, including review of medical records of previous health care encounters, and interviews of family members and other relevant collaterals to confirm or refute patient self-reports and come to the most accurate diagnosis.
   g. The ability to appropriately assess the patient's motivational level/stage of change, using rating scales if necessary.
3. For post-withdrawal care, be able to:
   a. Manifest skill in conducting follow-up patient interviews for diagnostic and treatment recommendation purposes when the initial examination was conducted during a state of intoxication or withdrawal or otherwise altered mental status that could have affected the validity of the patient's responses.
   b. Demonstrate the ability to recommend the appropriate level of care, which could be in accord with the ASAM PPC, for addiction treatment services to follow the detox encounter.

Medical Knowledge

1. Demonstrate the ability to assess withdrawal, including the ability to:
   a. Perform a history and physical exam to identify medical/surgical co-morbidities that can complicate or intensify withdrawal syndromes, that can mimic intoxication and withdrawal syndromes and which should be included in the differential diagnosis, and that must be managed concurrently during inpatient withdrawal management.
   b. Use laboratory tests and other diagnostic procedures and consultations to appropriately provide medical management of electrolyte disturbances and other general medical complications of intoxication, withdrawal, and chronic drug/alcohol use/addiction.
   c. Appropriately classify the Stage of Alcohol Withdrawal (Stage I, II, III, IV) and appropriately manage each stage, including the care of advanced stages such as delirium tremens.

2. Have competencies in the pharmacologic management of withdrawal, and demonstrate:
    a. The ability to use appropriate pharmacotherapy to manage withdrawal syndromes.
    b. The ability to interact with patients and mentor non-physician staff in the appropriate non-pharmacologic management of intoxication and withdrawal (e.g., environmental adaptations, interpersonal interactions, 'talking down', and safe/effective alternatives to seclusion and restraint) whenever possible.
    c. The ability to integrate data from multiple sources and appreciate the progression and resolution of symptoms of withdrawal over several days.
3. Demonstrate the ability to:
    a. Make appropriate recommendations for the initiation or continuation of addiction pharmacotherapies during/at the end of the detox encounter.
    b. Make appropriate recommendations for the initiation or continuation of psychopharmacotherapeutic agents during/at the end of the detox encounter.

4. During the SECAP clinical rotation, the Addiction Medicine fellow will understand addiction as a chronic medical condition, and Substance Use Disorders (SUD) as important and prevalent public health issues. He/she will understand the established and evolving biomedical, clinical, and cognitive sciences and apply this knowledge to the care of patients with SUD. Specifically, the addiction medicine fellow will demonstrate *knowledge of:*

a) The signs and symptoms of alcohol, sedative, opioid, and other drug withdrawal syndromes, as well as their neurobiology and pathophysiology.
b) The medical/psychiatric conditions that can mimic intoxication or withdrawal and must be included in an appropriate differential diagnosis.
c) The neurophysiology of withdrawal syndromes.
d) Spontaneous and precipitated withdrawal and the actions of pharmacological antagonists in circumstances of intoxication or withdrawal.
e) The use of anticonvulsants and other agents for alcohol withdrawal management and the rationale/indications for use of each.
f) Key features of management of alcohol/sedative withdrawal delirium.
g) The use of methadone and buprenorphine in the management of opioid withdrawal--clinical, legal and regulatory aspects.
h) The use of nicotine replacement therapies and other approaches in the management of nicotine withdrawal.
i) The theories supporting the use of various other pharmacotherapies for other drug withdrawal syndromes, e.g. stimulant and cocaine withdrawal.
j) The diagnostic criteria for substance use disorders and various intoxication and withdrawal states per the most recent edition of the DSM.
k) The detox levels of care in the ASAM Patient Placement Criteria and the admission, continuing care, and discharge criteria for such levels of care.
l) The levels of care for addiction treatment in the ASAM Patient Placement Criteria and which level to recommend based on patient need and motivational level.

Practice-Based Learning and Improvement

1. The fellow will identify and acknowledge gaps in personal knowledge and skills in the care of patients with substance use disorders and will use supervision effectively to explore gaps in knowledge and skill sets.
2. The fellow will develop and implement strategies for filling gaps in knowledge and skills and will demonstrate the capacity to research topics, utilize web-based data sets, and identify needed resources in the medical literature.

Systems-Based Practice

1. The fellow will work effectively in complex health care systems to insure the successfully delivery and coordination of multidisciplinary substance use disorder treatment plans.
2. The fellow will collect, synthesize and understand data from diverse sources about patients.
3. The fellow's treatment plans will include cost-effective and evidence-based strategies for the treatment of the substance use disorders.

Professionalism

1. demonstrate administrative and leadership skills, including:
    a. The ability to prioritize patient needs and manage multiple patients with varying disease severities and even in varying levels of detox care, simultaneously.
    b. The ability to work with nursing personnel in the use and interpretation of standardized withdrawal rating scales.

Interpersonal and Communication Skills

1. Demonstrate the ability to:
    a. Engage the patient and enhance his/her motivation, as necessary, to secure his/her acceptance of recommendations for post-detox care.
    b. Provide evidence-based psychotherapies, such as motivational interviewing, cognitive behavioral therapy, and relapse prevention.

Evaluation Methods

Perform satisfactorily in global assessment by clinical supervisor.

Mentor Qualifications

Physicians at BHCHP are board certified in internal medicine and addiction medicine.

Outpatient

Outpatient Rotation Name	CATALYST Clinic
Site	Boston Medical Center
Length of Rotation	8 weeks
Name(s) of Supervising Faculty Member	Sarah Bagley, MD, MS
Revised	May 2022

The CATALYST program is an outpatient clinic that supports teens and young adults who are affected by substance use by providing multidisciplinary care, including primary care, behavioral health, and support resources for patients up to age 25 and their families.

The CATALYST providers are a multidisciplinary team consisting of physicians, social workers and nurses, all overseen by a program manager and medical director. All providers have been trained in addiction medicine and are adept to working with young patients struggling with substance use.

Services provided include:

- Assessment and diagnosis of substance use disorders (SUDs)
- Counseling
- Treatment of SUDs with medications (such as buprenorphine and naltrexone)
- Assessment and treatment of co-occurring mental health disorders
- Hepatitis C screening and treatment
- Primary Care
- Harm reduction counseling including overdose prevention, HIV post and pre-exposure prophylaxis, and safer use practices
- Monitoring with urine drug testing

Schedule

Rotating fellows will conduct history, physicals, and addiction assessments, precepted by a supervising

faculty member, for 4-hour weekly sessions for at least 8 weeks. Fellows will also attend the weekly multidisciplinary clinical practice conference during the rotation.

Learning Objectives

At the end of this rotation fellows will be able to diagnose and treat substance use disorders in adolescents and young adults in a developmentally appropriate manner, accounting for family and social network dynamics. By the end of the rotation, fellows will:

1. Assess, diagnose and propose treatment (including pharmacotherapy) for adolescents and emerging adults with substance use disorder.
2. Understand how interdisciplinary care coordination for adolescents and emerging adults is critical for successful treatment.
3. Describe differences between delivering substance use care for adolescents and emerging adults as compared to older adults, including how to involve caregivers, guidelines around confidentiality and consent, and how young people's social networks impact treatment.

Patient Care

Goal

Fellows must be able to provide patient care that is compassionate, appropriate, and evidence based for assessment and treatment of adolescents and young adults with opioid and other substance abuse problems. Fellows are expected to:

Objectives

Objective

- Gain proficiency obtaining a detailed substance use screening history
- Gain proficiency identifying patients at risk for substance misuse or addiction
- Develop an appreciation for the scope of drug addiction presenting complaints
- Understand that alcohol and drug addictions are chronic, relapsing conditions that are: 1)Preventable with early intervention via screening and brief intervention 2)Treatable with effective medical and behavioral treatments 3)Addressable with risk reduction strategies, such as syringe access and overdose prevention

Medical Knowledge

Goal

To increase fellow's knowledge of substance abuse disorders and prevention and mitigation of complications of such disorders, including the factors that are implicated in etiology and options for management

Objectives

- Understand strategies used to prevent complications of addiction
- Understand the pharmacologic treatment options available to treat opioid addiction
- Understand co-morbidities associated with opioid addiction
- Understand the risks and benefits of treating opioid addiction using the various modalities

Practice- Based Learning and Improvement

Goal

Fellow must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. Fellow are expected to develop skills and habits to be able to :

Objectives

- Identify strengths, deficiencies and limits in one's knowledge and expertise;
- Incorporate formative evaluation feedback into daily practice
- Use information technology to optimize learning

Systems Based Practice

Goal

Fellow must demonstrate an awareness of and responsiveness to the larger context and system of health care, related to the evaluation and treatment of substance abuse and dependence. Fellow are expected to:

Objectives

- Understand resources available to patients and clinicians for prevention and management of opioid and other substance use disorders

Professionalism

Goal

Fellow must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Fellow are expected to demonstrate:

Objectives

- Compassion, integrity, and respect for others
- Responsiveness to patient needs that supersedes self-interest

Interpersonal and Communication Skills

Goal

Fellow must demonstrate interpersonal and communication skills that result in the effective exchange of information and teaming with patients, their families, and professional associates. Fellow are expected to:

Objectives

- Communicate effectively with patients and families across a broad range of socioeconomic and cultural backgrounds
- Communicate effectively with physicians, other health professionals, and health related agencies

Evaluation Methods

Perform satisfactorily in global assessment by clinical supervisor.

Mentor Qualifications

Physicians in the CATALYST clinic are board certified in either internal medicine or pediatrics. The medical director and addiction medicine faculty are also board certified in addiction medicine.

Outpatient Rotation Name	Faster Paths Urgent Care
Site	Boston Medical Center
Length of Rotation	20 weeks
Name(s) of Supervising Faculty Member	Jessica Taylor, MD,
Revised	May 2022

Faster Paths is a low barrier access clinic that is focused on initiating medications for substance use disorders, providing harm reduction services, and linking patients to community programs. Patients include individuals referred directly from the BMC Emergency Department, the Addiction Consult Service, the local syringe services program, and individuals walking in off the street.

Consultations may include: assessing patients for the presence of a substance use disorder using DSM criteria, determining the optimal treatment plan, optimizing safety for patients who continue to actively use or who are at risk of return to use, assessing risk for HIV, HCV, and other infections, delivering HIV prevention service, assessing for opioid analgesic appropriateness, setting treatment goals, defining appropriate monitoring strategies, and assessing patient progress toward these goals. All referred patients will be assessed using standardized, validated instruments.

Fellows will be precepted and supervised by an addiction medicine board certified faculty member and work as part of a multi-disciplinary team.

Learning Objectives

Patient Care

Goal

Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows are expected to learn how to safely and effectively diagnose and manage patients with substance use disorders, including optimizing safety among those who continue to use substances or who are at risk for return to use.

1. Use electronic prescription drug monitoring program databases to verify patients' medication history during the history-taking process.
2. Perform a physical exam that evaluates the patient's general medical status, evaluates for complications of substance use (e.g., abscess), and assesses signs/symptoms of intoxication and/or withdrawal.
3. Perform a mental status exam and collect a psychiatric review of systems to rule out or rule in the presence of significant co-morbid psychiatric conditions that should be addressed along the individual's substance use disorder; this includes assessment of self-harm, suicide, and harm-to-other risk.
4. Use laboratory tests, including urine drug testing, and other diagnostic procedures and consultations to appropriately asses' patients' disease and/or medical complications of chronic drug/alcohol use/addiction.
5. Integrate other sources of data into diagnostic assessment, including review of medical records and (with appropriate permission) interviews of family members and other relevant collaterals to confirm or refute patient self-reports and come to the most accurate diagnosis.
6. Demonstrate competence in assessing and managing withdrawal syndromes as they appear in the ambulatory setting.
7. Form a relationship with the patient that includes acceptance of the patient, regardless of the severity of his or her primary disease or its complications, and which may include the patient's inability to adhere to recommendations regarding abstinence from alcohol or drug use.
8. Proficiently devise a message and a manner of message delivery, which the patient and family can reasonably integrate, based on their unique socio-cultural identifiers, and the unique obstacles existent in patients and families dealing with substance use disorders.
9. Develop and execute written treatment plans for addiction medicine outpatients and, as indicated by accreditation and licensure bodies, participate in multidisciplinary team review of treatment plans and discharge plans.
10. Initiate, continue, and discontinue methadone for opioid withdrawal management under the provisions of the 72-hour-rule.
11. Perform the unique medical and procedural skills encompassed in the care of persons with substance use disorders, including screening and diagnostic tools, medical withdrawal and medication induction protocols, medication management, abscess and wound care, HIV prevention, family planning, and long-term monitoring and care management.
12. Be aware of the evidence for methadone and buprenorphine maintenance during pregnancy and be able to address this with the patient and her family.

Medical Knowledge

Goal

Addiction Medicine fellows will understand addiction as a chronic medical condition, and Substance Use Disorders (SUD) as important and prevalent public health issues. Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows are expected to learn how to safely and effectively manage patients with substance use disorder.

Competencies and Educational Objectives

Specifically, the addiction medicine fellows will demonstrate:

1. Knowledge of the diagnostic criteria for substance use disorders and various intoxication and withdrawal states per the most recent edition of the DSM.
2. Knowledge of the pharmacology of pharmacotherapeutic agents for substance use disorders, proper dosing, and ongoing management using them.
3. Knowledge of non-pharmacologic treatments for substance use disorders, including their evidence base, effectiveness, and accessibility.
4. Knowledge of the levels of care for addiction treatment in the ASAM Patient Placement Criteria and which level to recommend based on patient need and motivational level.
5. Knowledge of the scope of substance use during pregnancy: tobacco, alcohol, opioids and opiates, stimulants, sedatives and hallucinogens.

Practice- Based Learning and Improvement

Goal
Fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.

Competencies
Fellows are expected to develop skills and habits to be able to:

- Identify strengths, deficiencies and limits in one's knowledge and expertise;
- Set learning and improvement goals
- Identify and perform appropriate learning activities
- Systematically analyze practice, using quality improvement methods, and implement changes with the goal of practice improvement
- Incorporate formative evaluation feedback into daily practice
- Locate, appraise and assimilate evidence from scientific studies related to their patients' health problems
- Use information technology to optimize learning
- Participate in the education of patients, families, students, fellows and other health professionals, as documented by evaluations of a fellows' teaching abilities by faculty and/or learners

Systems Based Practice
Goal
Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

Competencies
Fellows are expected to:

- Work effectively in various health care delivery settings and systems relevant to their clinical specialty
- Coordinate patient care within the health care system relevant to their clinical specialty
- Incorporate considerations of cost awareness and risk-benefit analysis in patient care
- Advocate for quality patient care and optimal patient care systems
- Work in inter-professional teams to enhance patient safety and improve patient care quality
- Participate in identifying systems errors and in implementing potential systems solutions

Professionalism
Goal
Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

Competencies
Fellows are expected to demonstrate:

- Compassion, integrity, and respect for others
- Responsiveness to patient needs that supersedes self-interest
- Respect for patient privacy and autonomy
- Accountability to patients, society, and the profession
- Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation

Interpersonal and Communication Skills
Goal
Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and teaming with patients, their families, and professional associates.

Competencies
Fellows are expected to:

- Communicate effectively with patients and families across a broad range of socioeconomic and cultural backgrounds.
- Communicate effectively with physicians, other health professionals, and health related agencies.
- Work effectively as a member of leader of a health care team or other professional group.
- Act in a consultative role to other physicians and health professionals
- Maintain comprehensive and timely medical records.

Evaluation Methods
Perform satisfactorily in global assessment by clinical supervisor.

Mentor Qualifications
Physicians in the Faster Paths clinic are board certified in emergency medicine, family medicine, or internal medicine. They are also board certified in addiction medicine.

Outpatient Rotation Name	Office-Based Addiction Treatment Clinic
Site	Boston Medical Center
Length of Rotation	10 weeks
Name(s) of Supervising Faculty Member	Zoe Weinstein, MD, MS Emily Hurstak, MD, MPH
Revised	May 2022

Fellows will assess new patients for appropriateness for OBAT including documenting a substance use disorder diagnosis, educating patients about the effectiveness and safety of medications for substance use disorder, obtaining informed consent, developing addiction treatment plans, overseeing medication management, referring to other addiction treatment including outpatient counseling, monitoring for treatment adherence and communicating with nurse care managers, patient navigators and other outpatient team members. In this rotation you will gain experience with patients in long term recovery.

Setting
The Office Based Addiction Treatment program in BMC's primary care clinic, provides addiction treatment using evidence-based medications to over 800 patients annually, the majority of patients treated within the OBAT program have opioid use disorder. OBAT patients are predominantly male (64%) and white (67%); 68% of patients are 40 years of age or younger. 22% of the patient population in OBAT is homeless and co-occurring physical and psychiatric illness is common. At time of intake, past year injection drug use is common (45%); as is past year use of opioids (95%), alcohol (45%), cocaine (42%) and marijuana (39%). Eighty-five percent report a history of inpatient detoxification, 44% past opioid agonist maintenance treatment, and 69% some form of residential treatment.

Learning Objectives

Patient Care

1. Assess patients for appropriateness of OBAT and intake evaluations
2. Supervise induction and stabilization (buprenorphine dose adjustments during days 1-7)
3. Maintenance of buprenorphine treatment with monitoring for treatment goals

Medical Knowledge

1. Knowledge of the pharmacology of pharmacotherapeutic agents for substance use disorders, proper dosing, and ongoing management using them.
2. Knowledge of non-pharmacologic treatments for substance use disorders, including their evidence base, effectiveness, and accessibility.
3. Knowledge of the levels of care for addiction treatment in the ASAM Patient Placement Criteria and which level to recommend based on patient need and motivational level.

4. Knowledge of the scope of substance use in the primary care settings, including tobacco, alcohol, opioids, stimulants, and sedatives.

Practice Based Learning & Improvement

1. The fellow will identify and acknowledge gaps in personal knowledge and skills in the care of patients with substance use disorders and will use supervision effectively to explore gaps in knowledge and skill sets.
2. The fellow will develop and implement strategies for filling gaps in knowledge and skills and will demonstrate the capacity to research topics, utilize web-based data sets, and identify needed resources in the medical literature.

Systems Based Practice

1. The fellow will work effectively in complex health care systems to insure the successfully delivery and coordination of multidisciplinary substance use disorder treatment plans.
2. The fellow will collect, synthesize and understand data from diverse sources about patients.
3. The fellow's treatment plans will include cost-effective and evidence-based strategies for the treatment of the substance use disorders**.**

Professionalism

1. Understand the value of multi-disciplinary teams
2. Counsel patients using non-judgmental approach and encourage rapport-building with SUD patients

Interpersonal & Communication Skills

1. Counsel patients on use, risks, and benefits of opioid agonist therapy and naltrexone for opioid use disorder
2. Counsel patient on harm reduction strategies, including overdose prevention, HIV post and pre-exposure prophylaxis, and safer syringe use practices
3. Appreciate complex interplay of pain, medication tolerance and addiction, with importance of managing pain on opioid agonist therapy (OAT)
4. Manage pain in patients with concurrent opioid use disorders
5. Counsel patients on medications for alcohol use disorder and management strategies

Evaluation Methods

Perform satisfactorily in global assessment by clinical supervisor.

Mentor Qualifications

Physicians in the OBAT clinic are board certified in internal medicine and addiction medicine.

Outpatient Rotation Name	Project Respect & Newborns
Site	Boston Medical Center
Length of Rotation	8 weeks
Name(s) of Supervising Faculty Member	Kelley Saia, MD Emily Rosenthal, MD Erica Holland, MD
Revised	June 2022

During the Project Respect rotation fellows will manage addiction medications and other addiction care in pregnant and post-partum people, observe the assessment, management, and prevention of neonatal abstinence syndrome, and enhance linkage and engagement of newborn and mother to post-partum/delivery medical and addiction treatment services.

Learning objectives:

Patient Care

1. Take an appropriate substance use specific history.

2. Diagnose substance use disorders, recognizing co-occurring medical and psychiatric conditions.
3. Manage addiction medications and other addiction care in pregnant and post-partum people.

Medical Knowledge

1. Knowledge of the pharmacology of pharmacotherapeutic agents for substance use disorders, proper dosing, and ongoing management using them.
2. Knowledge of non-pharmacologic treatments for substance use disorders, including their evidence base, effectiveness, and accessibility.
3. Knowledge of the levels of care for addiction treatment in the ASAM Patient Placement Criteria and which level to recommend based on patient need and motivational level.
4. Knowledge of the scope of substance use during pregnancy: tobacco, alcohol, opioids and opiates, stimulants, sedatives and hallucinogens.
5. Knowledge of physiologic changes of pregnancy and how they impact medication management.

Practice Based Learning & Improvement

1. The fellow will identify and acknowledge gaps in personal knowledge and skills in the care of patients with substance use disorders and will use supervision effectively to explore gaps in knowledge and skill sets.
2. The fellow will develop and implement strategies for filling gaps in knowledge and skills and will demonstrate the capacity to research topics, utilize web-based data sets, and identify needed resources in the medical literature.

Systems Based Practice

1. The fellow will work effectively in complex health care systems to insure the successfully delivery and coordination of multidisciplinary substance use disorder treatment plans.
2. The fellow will collect, synthesize and understand data from diverse sources about patients.
3. The fellow's treatment plans will include cost-effective and evidence-based strategies for the treatment of the substance use disorders.

Professionalism

1. Understand the value of multi-disciplinary teams
2. Counsel patients using non-judgmental approach and encourage rapport-building with SUD patients

Interpersonal & Communication Skills

1. Describe the process of DCF evaluation for families through the peri-partum period.
2. Understand the role of the multi-disciplinary team of a newborn and birthing person through labor, delivery, and post-partum inpatient care.
3. Provide guidance to pregnant patients with substance us disorders and addiction treatment programs on the assessment, management, and prevention of neonatal abstinence syndrome and the care of substance-exposed newborns.
4. Enhance linkage and engagement of newborn and parent to post-partum/delivery medical and addiction treatment services.

Evaluation Methods

Perform satisfactorily in global assessment by clinical supervisor.

Mentor Qualifications

Physicians in Project Respect are board certified in obstetrics and gynecology, with addiction specific expertise.

Outpatient Rotation Name	Healthcare for the Homeless
Site	Boston Healthcare for the Homeless Program
Length of Rotation	8 weeks
Name(s) of Supervising Faculty Member	Jessie Gaeta, MD Joanna D'Affliti, MD
Revised	

This rotation will provide the fellow with outpatient and inpatient addiction treatment patient care experiences to individuals who are homeless, marginally housed or high risk for homelessness, including inpatient respite unit at Barbara McInnis House, the Supportive Place for Observation and Treatment (SPOT), shelter and health center-Based Addiction Treatment in primary care, and mobile low barrier access addiction treatment and harm reduction services.

Learning Objectives

1. Diagnosing substance use disorders
2. Recognizing co-occurring medical and psychiatric conditions
3. Developing and executing short term treatment plans for the medical management of withdrawal and any medical and psychiatric comorbidities
4. Initiating and continuing patients onto medications for substance use disorders
5. Developing long term treatment plans for the management of substance use disorders
6. Medical management of withdrawal from opioids, benzodiazepines, alcohol and other substances of abuse
7. Transitioning patients from acute inpatient hospitalization to respite care to medium and longer-term care.
8. Harm reductions services will include safer substance use practices, HIV post and pre-exposure prophylaxis, and overdose prevention and response.

Patient Care

The fellow will develop skills in the diagnosis, evaluation, management, and treatment planning of patients with substance use disorders through the continuum of acute, crisis stabilization and transitional care. These skills will include accounting for medical and psychiatric co-morbidities in management and treatment planning. These skills will be assessed by direct supervision of the rotation attending, as well as other members of the care team, at multiple venues.

Medical Knowledge

Knowledge with regard to diagnosis, evaluation, management, and treatment planning of patients with substance use disorders will be obtained via didactic and practical training elsewhere in the fellowship and will be enhanced and bolstered through clinical experience and background reading during this rotation. Reading will occur in a patient-focused fashion. Medical knowledge will be assessed by direct supervision of the rotation attending.

Interpersonal and Communication Skills

The fellow will present patient histories and care plans to the patient being treated, rotation attending, other members of the care team, and to collaborating care providers involved in transitions of care from one setting to another. These patient presentations will be succinct and complete. Competence in communication will be assessed by direct supervision of the rotation attending. All communication will promote the dignity of patients and incorporate patient goals.

Practice-Based Learning and Improvement

The Addiction Medicine fellow is responsible for tracking the number and diagnoses of cases seen during the rotation. These data are used to ensure that an adequate educational experience is obtained.

Professionalism

The highest standards of professionalism must be maintained at all times, including interactions with patients, social networks and other care providers. Competence in professionalism will be assessed by direct supervision of the rotation attending.

Systems-Based Practice

Patients with substance use disorders require coordination of the health care system in order to continue needed care beyond acute stabilization. The addiction fellow will learn about the barriers that

exist and how to work within these constraints and how to address these barriers to provide the best care. Competence in system-based practice will be assessed by direct supervision of the rotation attending.

Evaluation Methods
Perform satisfactorily in global assessment by clinical supervisor.

Mentor Qualifications
Physicians at BHCHP are board certified in internal medicine and addiction medicine.

Outpatient Rotation Name	ASAP Clinic
Site	Boston Children's Hospital
Length of Rotation	4 weeks
Name(s) of Supervising Faculty Member	Sharon Levy MD Patricia Schram MD Jennifer Ross, MD, MPH
Revised	May 2022

During this rotation the addiction medicine fellow will acquire and demonstrate competence in the medical care of adolescents with substance use disorders. He/she shall be able to render patient care that is compassionate, appropriate, and effective for the prevention and treatment of substance use disorders. Primarily you will observe counselling sessions. You will also interact with a different patient population.

Patient Care

- The ability to recognize the effects of parental substance use and addiction upon the child and adolescent and identify resources available in the community for children of parents with substance-use disorders.
- The ability to evaluate and manage the child or adolescent who is intoxicated or withdrawing from psychoactive substances and provide non-pharmacological and pharmacological interventions to stabilize the patient.
- The ability to utilize office based opioid treatment for the child and adolescent with opioid addiction.
- The ability to evaluate the impact of child and adolescent developmental status and problems upon the diagnosis of and management of adolescent substance use and addiction.
- Demonstrate an understanding of the socio-cultural influences that might affect alcohol and other drug use in communities.
- Demonstrate an understanding of risk and protective factors that contribute to the initiation, maintenance and escalation of alcohol, tobacco, and other drug use in children and youth.
- Demonstrate an understanding of the characteristics of evidence-based prevention programs and the individual, family, school and community-level characteristics that these preventive interventions are based upon.
- Demonstrate an understanding of the role of the family, environment and community in prevention and treatment.
- Demonstrate an understanding of the differences between universal, selective and indicated prevention programs.

Medical Knowledge

- Demonstrate an understanding of available treatment options including differences in treatment philosophies, modalities, and settings appropriate for youth.
- Identify the appropriate treatment resources to meet the needs of the child, adolescent or affected family member.

- The ability to evaluate the impact of child and adolescent developmental status and problems upon the diagnosis of and management of adolescent substance use and addiction.
- A familiarity with normal growth and development, including physical and psycho-social stages, and the impact of pre-natal, parental and environmental exposure and substance use by the child.

Practice Based Learning & Improvement

- The fellow will identify and acknowledge gaps in personal knowledge and skills in the care of patients with substance use disorders and will use supervision effectively to explore gaps in knowledge and skill sets.
- The fellow will develop and implement strategies for filling gaps in knowledge and skills and will demonstrate the capacity to research topics, utilize web-based data sets, and identify needed resources in the medical literature.

Systems Based Practice

- The fellow will work effectively in complex health care systems to insure the successfully delivery and coordination of multidisciplinary substance use disorder treatment plans.
- The fellow will collect, synthesize and understand data from diverse sources about patients.
- The fellow's treatment plans will include cost-effective and evidence-based strategies for the treatment of the substance use disorders.

Professionalism

- The ability to communicate with and engage the family of the child and adolescent with substance use disorder and addiction during assessment and treatment.

Interpersonal & Communication Skills

- Provide anticipatory guidance and basic general information on the impact of and the effects of alcohol and other drugs of abuse to individual patients and their families.
- Be able to support the child, adolescent and family throughout the treatment process and following its completion, including identifying realistic treatment goals and expectations of treatment outcome; identifying potential factors contributing to relapse during treatment and strategies for preventing or minimizing it; and, finally, providing appropriate referrals for follow up or aftercare.
- Understanding of effective substance use screening tools applicable to the child and adolescent and teach physicians and non-physicians how to utilize them.

Evaluation Methods

Perform satisfactorily in global assessment by clinical supervisor.

Mentor Qualifications

Physicians at BCH are board certified in pediatric medicine and addiction medicine.

Outpatient Rotation Name	Intensive Day Treatment Program
Site	Edith Norse Rogers Memorial Veterans Hospital
Length of Rotation	4 weeks
Name(s) of Supervising Faculty Member	DC Park, MD
Revised	May 2022

Description of Rotation or Educational Experience

During this four-week rotation, fellows will be involved in assessing and managing patients in transition between different levels of care, with emphasis on the intensive day treatment program (residential/partial hospitalization level). Fellows will be tasked with evaluation for the appropriateness of the program, including the addiction psychiatry intake and managing their addiction and psychiatric medications. They will also evaluate patients in the transition after an acute detox hospitalization, and to a longer-term residential program. They will also participate in case discussions and evaluation for intensifying (to a higher level of care) services from residential programs and VA community programs like Crescent (supported housing program) and Step-Down program. Fellows will also observe and participate in Cognitive-Behavioral Therapy, Contingency Management, and Motivational Interviewing counseling and behavioral programming.

Patient Care

Goal

The fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of substance use disorders and co-occurring psychiatric disorders.

Objectives

1. The fellow will be able to correctly and effectively diagnose, develop, and implement treatment plans for substance use and psychiatric disorders in adults.

2. The fellow will complete initial substance use disorders and psychiatric assessments.

3. The fellow will work with a multidisciplinary team in the development and implementation of a clinically sound plan for diagnosis and treatment.

4. The fellow will communicate effectively with patients' primary care physicians and ancillary service providers and will demonstrate knowledge of the interaction between medical, psychiatric and substance use disorders.

5. The fellow will collect, synthesize and understand data from diverse sources about patients.

6. The fellow will establish and maintain therapeutic relationships with patients and demonstrate and describe the basic dynamics of the doctor-patient relationship, including concepts such as the therapeutic alliance, transference and countertransference, denial, and resistance, particularly as they relate to patients with substance use disorders.

7. The fellow will discuss the different theoretical frameworks for and treatment approaches to the substance use disorders and co-occurring psychiatric disorders.

8. The fellow will make effective treatment decisions based on a firm knowledge of psychopharmacology in adult patients.

9. The fellow will effectively utilize each of the following classes of medication: anti-craving medications, medications for opioid use disorders, detoxification medications, antidepressants, mood stabilizers, anxiolytics, psychostimulants, and antipsychotic medications.

10. The fellow will describe the potential interactions between common drugs of abuse and those classes of medication identified in item #9 above.

11. The fellow will describe the contributions of medical illnesses, psychiatric illnesses, and substance use disorders to the psychopharmacologic decision-making process in substance use disorder patients.

Medical Knowledge

Goal

The fellow must demonstrate knowledge of established and evolving neurobiological, clinical, epidemiological, genetic and behavioral sciences, as well as the application of this knowledge to patient care.

Objectives

1. The fellow will expand knowledge of the basic and clinical science underlying the care of patients with substance use disorders and co-occurring psychiatric disorders.
2. The fellow will access and critically evaluate current medical information and scientific evidence relevant to patient care.
3. The fellow will describe the mechanism of action, indications, interactions, and common side effects of common psychopharmacologic interventions.
4. The fellow will describe the potential interactions between common drugs of abuse and common treatment medications.
5. The fellow will discuss the different theoretical frameworks for and treatment approaches to the substance use disorders and other major co-occurring psychiatric disorders.

Practice- Based Learning and Improvement

Goal

The fellow will demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

Objectives

1. The fellow will identify and acknowledge gaps in personal knowledge and skills in the care of patients with substance use disorders and psychiatric illness and will use supervision effectively to explore gaps in knowledge and skill sets.

2. The fellow will develop and implement strategies for filling gaps in knowledge and skills and will demonstrate the capacity to research topics, utilize web-based data sets, and identify needed resources in the medical literature.

Systems Based Practice

Goal

Fellow must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system and in the community related to the evaluation and treatment of substance use disorders.

Objectives

1. The fellow will utilize the multidisciplinary resources necessary to optimally care for patents.

2. The fellow's treatment plans will incorporate the full range of multidisciplinary resources necessary for effective treatment of substance use disorders.

3. Wherever appropriate, the fellow's treatment plans will include participation in community-based self-help programs.

4. The fellow will collaborate with other members of the health care team, and community resources, to ensure comprehensive patient care.

5. The fellow will work effectively in complex health care systems to insure the successfully delivery and coordination of multidisciplinary substance use disorder treatment plans

6. The fellow will collect, synthesize and understand data from diverse sources about patients.

7. The fellow's treatment plans will include cost-effective and evidence-based strategies for the treatment of the substance use disorders, such as cognitive behavior therapy, motivational enhancement treatment, twelve-step facilitation, brief interventions (including SBIRT), contingency management, and medications for substance use disorders.

Professionalism

Goal

Fellow must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

Objectives

1. The fellow will acquire the skills, attitudes, knowledge and standards of professionalism necessary for their development of a sense of identity as an addiction medicine physician.

2. The fellow will present patient information succinctly and coherently.

3. The fellow will attend and utilize supervision for clinically-focused, patient-oriented learning.

4. The fellow will be punctual and professional, and will attend required meetings.

5. In their appearance and behavior, the fellow will adhere to accepted professional standards.

Interpersonal and Communication Skills

Goal

Fellow must demonstrate interpersonal and communication skills that result in the effective exchange of information and teaming with patients, their families, and professional associates.

Objectives

1. The fellow will communicate effectively with patients and families and will implement treatment plans that reflect the participation of patients and families.

2. The fellow will communicate effectively with physician colleagues at all levels and with all non-physician members of the health care system team to assure comprehensive and timely care of patients.

3. The fellow will present patient information concisely and clearly, verbally and in writing.

4. The fellow will teach colleagues effectively.

5. The fellow will assist members of the multidisciplinary team to identify and manage countertransference issues and will assist them in maintaining professional behavior in relationship to substance use disorder patients.

Teaching Methods

What teaching methods are you using on this rotation or educational experience?

- Case presentation and discussion with supervisor
- Three times-a-week clinical practice meetings (On Mon-Wed-Fri)

Assessment Method (Fellow)

How do you measure the fellow's performance on this rotation or educational experience?

- Supervisor review of medical record documentation
- Clinical supervisor global ratings

Assessment Method (Program Evaluation)

How do you evaluate whether this educational experience is effective?

- Yearly fellow evaluation of program
- Scores on the ABPM board exam

Level of Supervision

How is the fellow supervised on this rotation?

- Clinical supervisor
- Clinic administrator

Educational Resources

List the educational resources

- UpToDate Online
- Boston University Alumni Library, including electronic journals, databases, Cochrane collection, complete medline
- VISN 1 Veterans Affairs Library, including electronic journals and databases
- 4 online modules http://www.bu.edu/act/mdalcoholtraining/slides/index.html.
- Principles of Addiction Medicine
- Weekly fellows case conferences
- Providers Clinical Support System
- BMC Grayken Center for Addiction TTA

Electives

Elective Name	Rural Health: Franklin Addiction Medicine Rotation
Site	Franklin, MA
Length of Rotation	2 weeks
Name(s) of Supervising Faculty Member	Ruth Potee, MD

The goal of the Franklin Addiction Medicine Rotation is to provide the fellow with outpatient and inpatient addiction treatment patient care experiences that serve rural communities, including inpatient Acute Treatment Services, inpatient Clinical Stabilization Services, facilitation of addiction treatment for incarcerated patients, and Office-Based Addiction Treatment.

Learning Objectives

Specific objectives include the acquisition of clinical skills in the assessment and treatment of adult patients with substance use disorders who are seeking inpatient treatment, including medically managed withdrawal from opioids and/or alcohol, stabilization, and/or transition to longer term inpatient and outpatient treatment. These skills include diagnosing substance use disorders, recognizing co-occurring medical and psychiatric conditions, developing and executing short term treatment plans for the medical management of withdrawal and any Specific objectives include the acquisition of clinical skills in the assessment and treatment of adult patients with substance use disorders who are seeking inpatient treatment, including medically managed withdrawal from opioids and/or alcohol, stabilization, and/or transition to longer term inpatient and outpatient treatment. These skills include diagnosing substance use disorders, recognizing co-occurring medical and psychiatric conditions, developing and executing short term treatment plans for the medical management of withdrawal and any medical and psychiatric comorbidities, inducing and initiating patients onto medications for substance use disorders, developing long term treatment plans for the management of substance use disorders, and working with a multi-disciplinary care team that includes nursing and addiction counselors. Specific areas of addiction treatment include medical management of withdrawal from opioids, benzodiazepines, alcohol and other substances of abuse, transitioning patients from acute services to medium and longer-term care, and overdose prevention and response. Medical and psychiatric comorbidities, inducing and initiating patients onto medications for substance use disorders, developing long term treatment plans for the management of substance use disorders, and working with a multi-disciplinary care team that includes nursing and addiction counselors. Specific areas of addiction treatment include medical management of withdrawal from opioids, benzodiazepines, alcohol and other substances of abuse, transitioning patients from acute services to medium and longer-term care, and overdose prevention and response.

Patient Care:
The fellow will develop skills in the diagnosis, evaluation, management, and treatment planning of patients with substance use disorders through the continuum of acute, crisis stabilization and transitional care. The fellow will develop skills for treatment-seeking patients including accounting for medical and psychiatric co-morbidities in management and treatment planning. These skills will be assessed by direct supervision of the rotation attending, as well as other members of the care team, at multiple venues.

Medical Knowledge
Knowledge with regard to diagnosis, evaluation, management, and treatment planning of patients with substance use disorders will be obtained via didactic and practical training elsewhere in the fellowship and will be enhanced and bolstered through clinical experience and background reading during this rotation. Reading will occur in a patient-focused fashion. Medical knowledge will be assessed by direct supervision of the rotation attending.

Interpersonal and Communication Skills
The fellow will present patient histories and care plans to the patient being treated, rotation attending, other members of the care team, and to collaborating care providers involved in transitions of care from one setting to another. These patient presentations will be succinct and complete. Competence in communication will be assessed by direct supervision of the rotation attending. All communication will promote the dignity of patients and incorporate patient goals.

Practice-Based Learning and Improvement
The Addiction Medicine fellow is responsible for tracking the number and diagnoses of cases seen during the rotation. These data are used to ensure that an adequate educational experience is obtained.

Professionalism
The highest standards of professionalism must be maintained at all times, including interactions with patients, families and other care providers. Competence in professionalism will be assessed by direct supervision of the rotation attending.

Systems-Based Practice Patients with substance use disorders require coordination of the health care system in order to continue needed care beyond acute stabilization. The addiction fellow will learn about the barriers that exist and how to work within these constraints and how to address these barriers to provide the best care. Competence in system-based practice will be assessed by direct supervision of the rotation attending.

Evaluation Methods
Perform satisfactorily in global assessment by clinical supervisor.

Mentor Qualifications
Dr. Potee is a board certified Family Physician and Addiction Medicine physician at Valley Medical Group in Greenfield, MA. She is currently the Medical Director for the Franklin County House of Corrections, the Franklin Recovery and Treatment Center and the Pioneer Valley Regional School District as well as the Chair of the Healthcare Solutions of the Opioid Taskforce of Franklin County.

Other Electives & Observation Sites:

The following electives are available:

Scope of Pain with Dr. Dan Alford

Project Trust with Dr. Simeon Kimmel

Street Medicine with Dr. Avik Chatterjee and Dr. Morgan Younkin

OBSERVATION OPPORTUNITIES

Boston Medical Center Observation Sites

Buprenorphine-Based Shared Medical Appointment Program (Family Medicine Department, 11 Melnea Cass Blvd): A shared medical appointment is a group visit where patients with similar diagnoses are seen together with one or more healthcare providers. The Department of Family Medicine's Shared Medical Appointment Program meets for an hour weekly and focuses on buprenorphine treatment, patient education, and peer support for those with substance use disorders.

Community Crisis Stabilization Unit (85 East Newton Street, Fuller Building): The Community Crisis Stabilization Unit (CCSU) serves persons 18 years of age and older, providing short-term crisis intervention over a three-to-five day stay. The CCSU is a 24/7 program with intensive patient work involving group therapy, nurse practitioner consults, medically-managed alcohol detox, and medication stabilization. Approximately 80-90% of individuals at the BMC CCSU have a secondary diagnosis of a substance use disorder alongside a psychiatric diagnosis.

FAST PATH (Shapiro Center, 9th floor, Suite 9B): The FAST PATH program in Infectious Disease provides integrated addiction care in conjunction with HIV primary care. The program provides diagnosis and management by addiction specialists who also provide HIV primary care, office-based medication for addiction treatment, clinic-based counseling, and case management.

FAST PATH Support Group (Shapiro Center, 9th floor, Suite 9B): This weekly support group is led by a licensed social worker and includes patients from the FAST PATH Clinic as they address substance abuse-related issues (e.g. housing, employment, relationships), share stories, and discuss pathways to recovery.

Opioid Addiction Treatment ECHO (Crosstown Center, 801 Massachusetts Ave, room 2061): ECHO is an opioid addiction treatment training for health centers that utilizes videoconferencing technology. Actual patient cases, in a de-identified format, are presented during the training for specialty input and feedback by professional experts in substance use disorders.

Project ASSERT (Menino Pavilion, 1st floor, Suite 1210): The trainee can spend an afternoon session with the staff of Project ASSERT in the BMC emergency department observing health promotion advocates doing universal alcohol and drug screening with brief interventions and referrals to treatment on the Boston Medical Center campus. Availability in Project ASSERT is limited.

Supporting Our Families through Addiction and Recovery (SOFAR) (Crosstown, 7th floor, Department of Pediatrics): SOFAR is a multidisciplinary team of physicians, social workers, patient navigators, nurse practitioners, and coordinators who provide high-quality, coordinated medical and psychosocial care for families to maximize their ability to successfully navigate parenting and substance use recovery. Availability in SOFAR is limited.

Self-Management and Recovery Training (SMART) Group (Shapiro Center): SMART Recovery groups are mutual support meetings for those seeking recovery from addiction. These weekly meetings, led by a facilitator, focus on self-empowerment, stages of change, and cognitive behavioral therapy (CBT).

External Observation Sites

***Please note that depending on availability, you may not be able to observe at some of these sites**

AIDS Action Committee Access Program (359 Green Street, Cambridge): The Access Program is a state-sanctioned and state-funded syringe exchange program in Cambridge. It provides risk reduction supplies, risk reduction counseling and education, HIV/HCV/STI testing, and information and referrals to service providers.

Boston Public Health Commission AHOPE Needle Exchange Program (774 Albany Street, 1st floor, Boston): Access, Harm Reduction, Overdose Prevention and Education (AHOPE) provides a range of service to active injection drug users, including: integrated HIV/Hepatitis/STI testing, free and anonymous needle exchange, overdose prevention education, and risk reduction counseling. Availability in AHOPE is limited.

Hope House (8 Farnham Street, Boston): Hope House is residential treatment program for adult males with substance use disorders. Residents receive education and support allowing them to pursue their life interests with families, employers, and be self-sufficient members of their communities.

Southampton Men's Clinic (Meet at 780 Albany Street to walk over as a group to the shelter): The trainee can observe an evening clinical session at the Southampton Street Shelter which serves men ages 18 years or older. Because the clinic only has an affiliation agreement with BMC and not BU, only BMC accredited individuals (e.g. residents, fellows) will be allowed to observe at this site.

Boston University Medical Campus Lectures of Potential Interest

Transformative Training Program in Addiction Science (TTPAS) (Usually held in Evans Building, Room E201): Hosted monthly by the Boston University TTPAS Program, these lectures are interdisciplinary within the field of addiction medicine, and topics range from neuroscience to psychiatry to novel treatments for addiction. If you would like to be added to this listserv, please contact haungvn@bu.edu

3. Rotation Guides

3a. Addiction Consult Service

PC1: Take an appropriate substance use specific history[1]

- conduct interviews and exams in a private setting
- use substance use interview questions that focus on gaining an accurate assessment of the quantity and frequency of use
- start substance use assessment by asking about alcohol and more commonly used substances and then proceed to questions about injection drug use
- ask about early drug use in a patient's youth or early adult years and then proceed up to questions about current use
- perceive substance addiction as any other chronic disease
- assess safety risk (ie: using harm reduction techniques)
- use EPIC dot phrases for notes: **.acsnoteayw ; .acsdailynoteayw ; .csacparaayw**

PC2: Identify patients with substance use disorder

Substance Use Disorder (SUD)[2] "A cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems." The DSM-V refers to 10 separate classes of drugs: alcohol; caffeine; cannabis; hallucinogens (with separate categories for phencyclidine [or similarly acting arylcyclohexylamines] and other hallucinogens); inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants (amphetamine-type substances, cocaine, and other stimulants); tobacco; and other (or unknown) substances.

Criteria:

Impaired Control

Criterion 1: The individual may take the substance in larger amounts or over a longer period than was originally intended
Criterion 2: The individual may express a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or discontinue use
Criterion 3: The individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects
Criterion 4: The individual may express a craving, or an intense desire or urge for the drug
Criterion 5: Recurrent substance use may result in a failure to fulfill major role obligations at work, school, or home
Criterion 6: The individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
Criterion 7: Important social, occupational, or recreational activities may be given up or reduced because of substance use *Risky Use*
Criterion 8: This may take the form of recurrent substance use in situations in which it is physically hazardous
Criterion 9: The individual may continue substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
Criterion 10: Tolerance, signaled by requiring a markedly increased dose of the substance to achieve the desired effect or a markedly reduced effect when the usual dose is consumed.
Criterion 11: Withdrawal, a syndrome that occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged heavy use of the substance

Severity:

Mild SUD – 2-3 criteria met; Moderate SUD – 4-5 criteria met; Severe SUD – 6 or more criteria met

PC2: Identify patients with alcohol and opioid intoxication and withdrawal[2]

Alcohol intoxication:

Diagnostic Criteria

- Recent ingestion of alcohol.
- Clinically significant problematic behavioral or psychological changes that developed during, or shortly after, alcohol ingestion.
- One (or more) of the following signs or symptoms developing during, or shortly after, alcohol use: Slurred speech,
  Incoordination, Unsteady gait, Nystagmus, Impairment in attention or memory, Stupor or coma.

The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.

Alcohol Withdrawal

Diagnostic Criteria

- Cessation of (or reduction in) alcohol use that has been heavy and prolonged.
- Two (or more) of the following, developing within several hours to a few days after the cessation of (or reduction in) alcohol use: Autonomic hyperactivity, Increased hand tremor, Insomnia, Nausea or vomiting, Transient visual, tactile, or auditory
  hallucinations or illusions, Psychomotor agitation, Anxiety, Generalized tonic-clonic seizures

The signs or symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

Opioid Intoxication

Diagnostic Criteria

- Recent use of an opioid.
- Clinically significant problematic behavioral or psychological changes (e.g., initial euphoria followed by apathy, dysphoria, psychomotor agitation or retardation, impaired judgment) that developed during, or shortly after, opioid use.
- Pupillary constriction (or pupillary dilation due to anoxia from severe overdose) and one (or more) of the following signs or symptoms developing during, or shortly after, opioid use: Drowsiness or coma, Slurred speech, Impairment in attention or memory

The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.

Opioid Withdrawal

Diagnostic Criteria

- Cessation of (or reduction in) opioid use that has been heavy and prolonged (i.e., several weeks or longer).
- Administration of an opioid antagonist after a period of opioid use.
- Three (or more) of the following developing within minutes to several days after cessation: Dysphoric mood, Nausea or
  Vomiting, Muscle aches, Lacrimation or rhinorrhea, Pupillary dilation, piloerection, or sweating, Diarrhea, Yawning, Fever, Insomnia.

The signs or symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

PC2: Recognize different classes of opioids, interpret urine drug screening, and understand equianalgesic dosing

Different Classes of Opioids[3]

Types	**Chemical Name**	**Routes** (selected)
Naturally-derived	Opium, morphine, codeine	
Semi-synthetic	Diacetylmorphine (Heroin), oxycodone, hydrocodone, oxymorphone, hydromorphone	Heroin: smoked, injected, inhaled/"snorted"
Synthetic	Methadone, meperidine, propoxyphene, fentanyl	
Partial Agonists	Buprenorphine, pentazocine	Buprenorphine: sublingual, oral, injection
Non-opioid mu agonist	Tramadol, tapentadol	

[4]Urine Toxic Screen at BMC includes: **amphetamines, barbiturates, benzodiazepines, cocaine metabolite, and opiates***.

Expanded opioid panel at BMC includes: **methadone, oxycodone, fentanyl and buprenorphine**

6-monoacetylmorphine (6MAM – specific for heroin) and cannabinoids are available but must be specifically requested.

Other substances worth checking at times and available by send-out by GC-MS are: Gabapentin (Neurontin), 7-aminoclonazepam (specific for Klonopin), methamphetamine

*Opiates here refers specifically to naturally occurring opiates, including morphine, and heroin (metabolite is morphine). Oxycodone is not detected with this assay, nor are tramadol, naltrexone, or methadone.

Drug Class or Drug	Duration of Positive Result after use
Amphetamines	1-2 days
Barbiturates	2-20 days
Benzodiazepines	1-14 days
Buprenorphine Codeine Hydrocodone Naltrexone	2-4 days
Cannabinoids	2-7 days; up to 1 month in chronic use
Cocaine	2-3 days
Methadone	5-7 days
Opiates: 6-monoacetyl morphine codeine hydromorphone morphine hydrocodone (at high doses)	2-3 days
Oxycodone	1-4 days
Phencyclidine (send-out for PCP)	10-20 days

Equianalgesic conversions[5]

Drug	**Equianalgesic Dose Parenteral (mg)**	**Equianalgesic Dose Oral (mg)**
Morphine	10	30
Oxycodone	--	20
Hydromorphone	1.5	7.5
Fentanyl	0.1	--
Meperidine	75	300

Risk of overdose increases with oral morphine equivalent doses greater than 50mg per day.[6]

PC2: Manage alcohol and opioid withdrawal in the hospital CIWA: Clinical Institute Withdrawal Assessment for Alcohol[7]

1. Initial Dosing followed by as needed dosing
    a. Diazepam 10-20 mg PO q 1-2 hrs until symptom resolution, THEN q4h PRN s/s of w/d
    b. Lorazepam 2 mg PO q 1-2 hrs until symptom resolution if elderly, severe respiratory impairment or hepatic synthetic dysfunction (i.e., elevated INR or low albumin) OR Lorazepam 2 mg IM/IV q 1-2 hrs until symptom resolution if oral route not accessible THEN Lorazepam 2-4mg PO/IM/IV q4 hrs prn signs and symptoms of withdrawal
2. Reassessment
    a. Q1h x 4 hrs, then q2h until score < 8, then q4h
    b. If score > 8, resume q2h assessment
    c. If score > 20 at any point or > 15 for ≥ 4 hours, primary team should be notified
3. Treatment of Complications
    a. Seizures
        i. No specific drug treatment, other than benzodiazepines as mentioned above, is recommended.
        ii. Patients with alcohol withdrawal seizures should be monitored with seizure precautions
    b. Delirium tremens
        i. Diazepam 5-10 mg IV OR Lorazepam 1-2 mg IV q 5 minutes until the achievement of a calm, awake state
        ii. Continuous monitoring; reassessing symptoms every 5 minutes until calm but awake, then every 30 minutes for 48 hours
    c. Hallucinations
        i. If concurrent with DT, treat as DT, otherwise treat as symptomatic withdrawal and consider anti-psychotics.

COWS: Clinical Opioid Withdrawal Scale[8]

Goal: To manage opioid dependence (addiction) and alleviate acute opioid withdrawal signs and symptoms

Hospital day #1:

- **Assess for acute opioid withdrawal** either based on a Clinical Opioid Withdrawal Scale (COWS) score of at least 5 or by assessing withdrawal based on the following clinical signs and symptoms: *symptoms*: yawning, sweating, anxiety, restlessness, insomnia, chills, nausea cramping, abdominal pains, muscle aches; *signs*: lacrimation, rhinorrhea, dilated pupils, piloerection, tachycardia, hypertension, diarrhea, vomiting.
- Regardless of amount of opioid (e.g. heroin) reported by history, start with:
    - Methadone 20 mg **solution** PO X1 dose
      OR
    - Buprenorphine/naloxone 4/1mg **tablet** under the tongue (sublingual) x 1 dose
        - CAUTION – buprenorphine/naloxone SHOULD NOT BE GIVEN within 48 hours of prior methadone administration, 24 hours of prior long-acting opioid analgesic (eg. MS Contin) or 12 hours of prior short-acting opioid analgesic (e.g. oxycodone) or illicit heroin/fentanyl because of the risk of precipitating opioid withdrawal. Be sure to review the patients MAR for other opioids prior to starting buprenorphine
        - Discuss specific treatment (e.g., methadone or buprenorphine/naloxone dose) and goals openly with the patient.
        - If concerns about safety (e.g., precipitated withdrawal) with starting buprenorphine/naloxone, page Addiction Consult Service #6226
        - If withdrawal symptoms worsen (precipitated withdrawal) with first dose of buprenorphine/naloxone, page Addiction Consult Service #6226.
    - With either methadone or buprenorphine/naloxone treatment, expect some opioid withdrawal relief within 2 hours.
- Order naloxone PRN for hypoxia or unresponsiveness.
- Reevaluate the patient every 2-3 hours.
    - For patients started on **methadone**, give additional doses of methadone in increments of 5-10 mg per dose of solution orally every 2-3 hours until withdrawal abates, COWS < 5 to a maximum of 40 mg.
    - For patients started on **buprenorphine/naloxone**, give additional doses of buprenorphine in increments of 4/1mg per dose sublingually every 2-3 hours until withdrawal abates, COWS < 5 to a maximum of 12/3 mg.
    - Assess and document with the COWS scale at each re-evaluation
- DO NOT exceed 40 mg of methadone or 12/3mg of buprenorphine/naloxone in the first 24 hours of admission.
    - Consult Addiction Consult Service #6226 if considering methadone doses >40mg or >12/3 mg of buprenorphine/naloxone in the first 24 hours
- DO NOT give additional methadone or buprenorphine/naloxone doses if the patient is sedated or has respiratory depression (RR < 8 breaths per minute). For patients with significant sedation and respiratory depression, consider naloxone administration if patient does not respond to physical stimuli.

Hospital day #2:

- On the morning of the following day:
- For methadone, give the amount of methadone given over the previous 24 hours at one time or split into two doses, but do not exceed 40mg.
    - Doses may exceed 40mg a day with guidance and approval of the Addiction Consult Service
- For buprenorphine/naloxone, give the amount given over the previous 24 hours at one time or split into two doses, the dose can be increased to 16/4 mg if the patient continues to experience opioid withdrawal, but do not exceed total daily dose of 16/4 mg.
    - Doses may exceed 16/4 mg a day with guidance and approval of the Addiction Consult Service
- Discuss the following options with the patient:
    - Option A: Maintenance (recommended)
        - Continue daily methadone or buprenorphine/naloxone with last dose given on day of hospital discharge.
            - If the patient is interested in continuing methadone or buprenorphine/naloxone after discharge, please consult the Addiction Consult Service #6226 as soon as possible during the hospitalization
    - Option B: Taper

    - For methadone, taper by 5-10 mg/day with last dose given on day of hospital discharge.
    - For buprenorphine/naloxone, taper by 2/0.5 mg – 4/1 mg/day with last dose given on day of hospital discharge.
    - Discharge should not be delayed in order to complete a taper.
- DO NOT write an outpatient prescription for methadone
- Refer the patient to addiction treatment by contacting your social worker. This should not delay discharge plans. You can also refer your patient to the MA Statewide Helpline 1-800-327-5050 or www.helpline-online.com

PC5: Provide consultation services for patients with clinical problems requiring basic risk assessment

Providing Effective Consultation[9]

- Elicit clearly framed consultation question
- Provide recommendations verbally whenever possible
- Bulleted or numbered recommendations preferred to paragraphs
- Make simple, concise recommendations along with rationale
- Provide recommendations for future steps depending on outcomes of more proximal decisions or actions

MK1: Appreciate complex interplay of pain, medication tolerance and addiction, with importance of managing pain on opioid agonist therapy[8]

ACUTE PAIN MANAGEMENT ON METHADONE: The patient's methadone maintenance dose or daily methadone dose used to treat acute withdrawal in patients not enrolled in a methadone maintenance program DOES NOT provide adequate analgesia for acute pain. If acute pain requires opioid analgesia, larger and more frequent doses are often required. Continue methadone maintenance dose in addition to the opioid analgesic. Avoid using mixed agonist/antagonist opioid analgesics (i.e. Butorphanol (Stadol), Nalbuphine (Nubain), buprenorphine) as they may precipitate withdrawal.

ACUTE PAIN MANAGEMENT ON BUPRENORHINE: The patient's buprenorphine maintenance dose DOES NOT provide analgesia and may prevent opioid analgesics from working. If pain requires opioid analgesia, it is prudent to use nonopioids (e.g., NSAIDs, acetaminophen) along with one of the following 2 options based on the anticipated pain acuity and duration:

- For Moderate or Severe Pain

    - Divide the buprenorphine daily dose to q8 hour dosing to take advantage of buprenorphine's analgesic properties.

    - Either increase usual buprenorphine maintenance dose by 2-4 mg per dose to achieve increased analgesia up to a maximum dose of 32 mg per day **OR** use concurrent short- acting opioid analgesics. Larger and more frequent opioid doses are often required due to opioid cross-tolerance with the patient's usual buprenorphine dose. Avoid using mixed agonist/antagonist opioid analgesics (i.e. Butorphanol (Stadol), Nalbuphine (Nubain) as they may precipitate withdrawal. NOTE: it is SAFE to add opioids on top on buprenorphine if the patient has been continuously receiving buprenorphine in past 24 hours

    - Convert patient to usual daily buprenorphine maintenance dose and dosing when acute pain resolves.

    - For patients with uncontrolled pain on buprenorphine, contact Addiction Consult Service #6226

SBP1: Understand the value of interdisciplinary team rounds with MD (IM and Psych), SW, CM and primary team

Daily IDT rounds at 1pm with social worker, nurse practitioners, peer recovery coach, case managers, Project ASSERT to discuss patients Discuss appropriate referrals to the consult service from SW Regularly meet with other services, such as Psychiatry C/L

Triage substance use disorder patients to appropriate inpatient resources (Project ASSERT, floor SW, Addiction Medicine)

Project ASSERT: ASSERT = Alcohol & Substance Abuse Services, Education, and Referral to Treatment

- Based in BMC ED
- Health promotion advocates (HPAs) offer screening, brief intervention, and resources
- "in-reach" as opposed to community "outreach"
- facilitate detox admission
- Hours: 8am to 12:30 am
    - 7 days a week and holidays
- Contact: 617-414-4388
- Facilitate inpatient and outpatient detox admission

- Plan strategies to reduce readmissions for high risk patients
- Motivational interviewing
- Barbara McInnis House referrals
- Inpatient medication management

- Opioid agonist therapy (OAT) initiation
- Pain management in OAT patients

PROF1: Counsel patients using non-judgmental approach and encourage rapport-building with SUD patients

Discussing addiction with and about patients – Stop Talking "Dirty"[10]

Recommended	Not recommended
People with substance use disorder	Substance abusers, addicts
Harmful/hazardous use	Abuse
Positive UDT	Dirty
Negative UDT	Clean

SBIRT: Screening, Brief Intervention, and Referral to Treatment[11]

Screening: identifies unhealthy drug and alcohol use

Brief Intervention: provides feedback about unhealthy substance use

Understand the patient's views of use

Give information/feedback

Enhance motivation to change

Give advice and negotiate goal

Referral to Treatment: helps facilitate access to addiction assessment and treatment

MA Substance Abuse Information and

Education Helpline

800-327-5050 *(Interpreter services available)* TTY 888-448-8321

Website: www.helpline-online.com

Adolescent Central Intake Care and Coordination

617-661-3991 *Toll free:* 866-705-2807 TTY: 617-661-9051

Website: www.mass.gov/dph/youthtreatment

Smokers' Helpline

800-QUIT-NOW (800-784-8669)

ICS1: Counsel patients on use, risks, and benefits of pharmacotherapy for alcohol use disorder; Counsel patients on use, risks, and benefits of pharmacotherapy for opioid use disorder

Pharmacotherapy for alcohol use disorder[12]

Indications:

Patients with alcohol use disorder, moderate to severe subtype, who also

- Have current heavy alcohol use and ongoing risks from use
- Are motivated to reduce alcohol intake
- Prefer medication in addition to or instead of psychosocial intervention

Goals:

- Abstinence OR
- Reduction of heavy drinking

	Mechanism	Dose	Common Side Effects	Notes
Naltrexone	Blocks mu opioid receptors	50mg PO qd OR 380mg IM q4weeks	Nausea, headache, dizziness	1st line; cannot give if on concurrent opioid therapy
Acamprosate	Unclear; decreases cravings	666mg PO tid	Diarrhea	1st line; dose adjust in renal impairment
Disulfiram	Blocks aldehyde dehydrogenase	500mg PO qd x 1-2 weeks, then 250mg PO qd	Drowsiness, metallic taste, headache	2nd line; avoid in CAD, pregnancy

Pharmacotherapy for opioid use disorder

Goals[13]

- reduction or cessation of illicit opioid use
- reduction or cessation of injecting and associated risk of bloodborne virus transmission
- reduction of overdose risk
- reduction of criminal activity

Opioid Agonist Therapy: Methadone Maintenance v OBOT/Buprenorphine-Naltrexone[14,15]

	Methadone	Buprenorphine
Schedule	II	III
Mechanism of action	Agonist	Partial agonist
Regulation	Prescribed from licensed program	Prescribed by certified and specially trained physicians
Trade names	Dolophine	Subutex Suboxone (+naloxone)
Advantages	Programs provide structure and support groups Close monitoring Eases cravings Blocks euphoric effects of concurrent illicit opioid use	Can take at home Low hazardous use potential with naloxone combination Low intrinsic activity & slow dissociation rate Acts as antagonist at high doses
Disadvantages	Stigma Difficult to get "take homes"	Easily diverted
Side effects	QTc prolongation/arrhythmias Constipation Sweating	Headache Sweating Liver complications
Contraindications	Patients at risk for QTc prolongation	Severe liver impairment
Notes	Majority of patients require 80 – 120 mg/d of methadone	When dissolved under tongue, buprenorphine effects predominate; when crushed and injected, naloxone predominates. Patient should be in withdrawal at initiation

Opioid Antagonist Therapy

Naltrexone: a complete opioid antagonist, available as Revia (oral tablet) or Vivitrol (IM injection). Advantages of naltrexone include the absence of addicting or sedating effects as well as little to no potential for hazardous use or diversion; however the primary disadvantage is relatively little effect on opioid cravings. Adverse events include precipitation of opioid withdrawal symptoms, liver injury, headache, stomach pain, nausea and fatigue. Naltrexone is used as a maintenance agent in patients who have undergone opioid management withdrawal and are not receiving opioid replacement therapy with methadone or Suboxone

ICS1: Counsel patient on harm reduction strategies

Injection Drug Use Harm Reduction[16]

- Choose an appropriate injection site: somewhere patient is unlikely to be interrupted (by police or others), with access to water, and sheltered from wind/weather
- Use small gauge needles (27-28) and medium length needles (1/2"-5/8")
- ONE SHOT = ONE NEW NEEDLE AND SYRINGE
- Used needles are DULL (causing unnecessary trauma) and NOT STERILE, with high risk of transmitting infection
- Use clean cotton to inject and don't use twice
- Wash hands thoroughly prior to using

It is important to consider the following in all of your patients:

Checklist to optimize health and safety in people who use drugs:[17]

- Take an addiction history
  - Triggers, coping skills, recovery supports
  - Previous treatment experience
  - Polysubstance – polypharmacy
- Assess readiness for treatment
- Offer treatment options
  - Opioid agonist therapy
  - Opioid antagonist therapy
- Overdose prevention
  - Risk reduction plan
  - Response plan
  - Naloxone rescue kit
  - Safe storage and disposal
- Infection prevention
  - Safer injection techniques
  - STI screening
  - TB screening
  - Vaccines
  - PrEP consideration
  - Hepatitis treatment
- Account for mental health needs
- Case management for concrete needs/bolstering supportive services

PEARL: Thinking of initiating suboxone for your patient?

You should:

1) Determine their last use of opioids (ie: are they are in withdrawal?) AND
2) Determine if you anticipate them needing opioids for pain or other indications (ie: intra-op and post-surgical)

Appendix A: CIWA[7]

Score: 0-7 = No withdrawal; 8-15 = mild withdrawal; 16-20 = moderate withdrawal; > 20 = severe withdrawal

NAUSEA AND VOMITING **Ask: "Do you feel sick to your stomach? Have you vomited?"** **Observation** 0 no nausea and no vomiting 1 mild nausea with no vomiting 2 3 4 intermittent nausea with dry heaves 5 6 7 constant nausea, frequent dry heaves and vomiting	**TACTILE DISTURBANCES** **Ask: "Do you have any itching, pins and needles sensations,** **burning, numbness or do you feel bugs crawling on/ under** **your skin?"** **Observation** 0 none 1 very mild itching, pins and needles, burning or numbness 2 mild itching, pins and needles, burning or numbness 3 moderate itching, pins and needles, burning or numbness 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations
TREMOR **Arms extended and fingers spread apart** **Observation** 0 no tremor 1 not visible, but can be felt fingertip to fingertip 2 3 4 moderate with patient's arms extended 5 6 7 severe, even with arms not extended	**AUDITORY DISTURBANCES** **Ask: "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?"** **Observation** 0 not present 1 very mild harshness or ability to frighten 2 mild harshness or ability to frighten 3 moderate harshness or ability to frighten 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations
PAROXYSMAL SWEATS **Observation** 0 no sweat visible 1 barely perceptible sweating, palms moist 2 3 4 beads of sweat obvious on forehead 5 6 7 drenching sweats	**VISUAL DISTURBANCES** **Ask: "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything** **that is disturbing to you? Are you seeing things you know are** **not there?"** **Observation** 0 not present 1 very mild sensitivity 2 mild sensitivity 3 moderate sensitivity 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations continuous hallucinations
ANXIETY **Ask: "Do you feel nervous? "** **Observation** 0 no anxiety, at ease 1 mildly anxious 2 3 4 moderately anxious, or guarded, so anxiety is inferred 5 6 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions	**HEADACHE, FULLNESS IN HEAD** **Ask: "Does your head feel different? Does it feel like there is a band around your head?"** **Do not rate for dizziness or lightheadedness. Otherwise, rate severity.** 0 not present 1 very mild 2 mild 3 moderate 4 moderately severe 5 severe 6 very severe 7 extremely severe

AGITATION	**ORIENTATION AND CLOUDING OF SENSORIUM**
Observation 0 normal activity 1 somewhat more than normal activity 2 3 4 moderately fidgety and restless 5 6 7 paces back and forth during most of the interview, or constantly thrashes about	**Ask: "What day is this? Where are you? Who am I?'** 0 oriented and can do serial additions* 1 cannot do serial additions or is uncertain about date 2 disoriented for date by no more than 2 calendar days 3 disoriented for date by more than 2 calendar days 4 disoriented for place and/or person 5 * Serial additions-ask patient to add by 7s.

Appendix B: COWS[8]

Enter scores at time zero, 30min after first dose, 2 h after first dose, etc.

	Times: _____	_____	_____	_____
Resting Pulse Rate: beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120				
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face				
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds				
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible				
Bone or Joint aches *if patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny nose or tearing *Not accounted for by cold -symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks				
GI Upset: *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting				

Tremor *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching				
Yawning *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute				
Anxiety or Irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh skin 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection				
Total Score The total score is the sum of all 11 items				

References

1. Taking Patients' Sexual and Substance Use Histories. 2002. at http://www.hiv.va.gov/provider/tools/sexual-substance-use-history.asp - S3X.)
2. APA. Substance-Related and Addictive Disorders. Diagnostic and Statistical Manual of Mental Disorders. 5th ed: doi:10.1176/appi.books.9780890425596.dsm16; 2013.
3. Hopper JA. Chapter 234. Opioids. Principles and Practice of Hospital Medicine: The McGraw-Hill Companies; 2012.
4. TABLE 3: URINE TOXICOLOGY TESTING AT BOSTON MEDICAL CENTER (BMC) 2010. at http://internal.bmc.org/laboratory/documents/UrineDrugs010810.pdf.)
5. Opioids - Equianalgesic Dosages. 2015. at http://www.globalrph.com/narcotic.htm.)
6. Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. Annals of internal medicine 2010;152:85-92.
7. Alcohol Withdrawal and Treatment BMC Medication Guideline #1.35 2010. at http://internal.bmc.org/pharmacy/guidelines/documents/mdg_alcoholwithdrawal.pdf.)
8. Management of Inpatient Opioid Withdrawal and Opioid Dependence (Addiction) in Non-Pregnant Adult Patients BMC Medication Guideline. 2014. at http://internal.bmc.org/pharmacy/guidelines/mdg_opioidwithdrawal.pdf.)
9. Boulware DR, Dekarske AS, Filice GA. Physician preferences for elements of effective consultations. Journal of general internal medicine 2010;25:25-30.
10. Kelly JF, Wakeman SE, Saitz R. Stop talking 'dirty': clinicians, language, and quality of care for the leading cause of preventable death in the United States. The American journal of medicine 2015;128:8-9.
11. SBIRT: A Step-By-Step Guide. 2012. at http://www.masbirt.org/sites/www.masbirt.org/files/documents/toolkit.pdf.)
12. Pharmacotherapy for alcohol use disorder. Wolters Kluwer Health, 2014. at http://www.uptodate.com/contents/pharmacotherapy-for-alcohol-use-disorder.)
13. Guidelines for the Psychosocially of Opioid Dependence. 2009. at http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf.)
14. Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. 2004. at http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf.)
15. Management of Patients with Opioid Dependence: A Review of Clinical, Delivery System, and Policy Options. 2014. at http://cepac.icer-review.org/wp-content/uploads/2014/04/CEPAC-Opioid-Dependence-Final-Report-For-Posting-July-211.pdf.)
16. Getting Off Right: A Safety Manual for Injection Drug Users. 2011. at http://harmreduction.org/wp-content/uploads/2011/12/getting-off-right.pdf.)
17. Thakarar K, Weinstein Z, Walley A. Optimizing Health and Safety in People Who Inject Drugs: Case Study and Clinical Checklist (under review). 2015.

MAT Clinical Protocols:

**Please see documents in the Google Drive in addition to the information in this section:

- Management of Inpatient Opioid Withdrawal and Opioid Use Disorders (Addiction) in Non-Pregnant Adult Patients
- Perioperative Management of Non-Pregnant Patients on Maintenance Therapy for Opioid Dependence
- ACS Curriculum

1.) Withdrawal prevention and management

Alcohol Withdrawal Diagnostic Criteria

- Cessation of (or reduction in) alcohol use that has been heavy and prolonged
- Two (or more) of the following, developing within several hours to a few days after the cessation of (or reduction in) alcohol use: autonomic hyperactivity, insomnia, nausea or vomiting, transient visual, tactile, or auditory hallucinations or illusions, psychomotor agitation, anxiety, generalized tonic-clonic seizures

The signs or symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

CIWA: Clinical Institute Withdrawal Assessment of Alcohol:

1.) Initial Dosing followed by as needed dosing
    a. Diazepam 10-20 mg PO every 1-2 hours until symptom resolution, then every 4 hours as needed for signs and symptoms of withdrawal
    b. Lorazepam 2 mg PO every 1-2 hours until symptom resolution. If elderly, severe respiratory impairment or hepatic synthetic dysfunction (i.e. elevated INR or low albumin) OR Lorazepam 2 mg IM/IV every 1-2 hours until symptom resolution if oral route not accessible, then Lorazepam 2-4 mg PO/IM/IV every 4 hours as needed for signs and symptoms of withdrawal
2.) Reassessment
    a. Q1h x 4 hours, the q2h until score < 8, the q4h
    b. If score > 8, resume q2h assessment
    c. If score >20 at any point or > 15 for ≥ 4 hours, primary team should be notified
3.) Treatment of Complications
    a. Seizures
        i. No specific drug treatment, other than benzodiazepines as mentioned above, is recommended
        ii. Patients with alcohol withdrawal seizures should be monitored with seizure precautions
    b. Delirium tremens

i. Diazepam 5-10 mg IV or Lorazepam 1-2 mg IV every 5 minutes until the achievement of a calm, awake state
ii. Continuous monitoring; reassessing symptoms every 5 minutes until calm but awake, then every 30 minutes for 48 hours

c. Hallucinations
i. If concurrent with DT, treat as DT, otherwise treat as symptomatic withdrawal and consider anti-psychotics

Opioid Withdrawal Diagnostic Criteria

- Cessation of (or reduction in) opioid use that has been heavy and prolonged (i.e., several weeks or longer
- Administration of an opioid antagonist after a period of opioid use
- Three (or more) of the following developing within minutes to several days after cessation: dysphoric mood, nausea or vomiting, muscle aches, lacrimation or rhinorrhea, pupillary dilation, piloerection, or sweating, diarrhea, yawning, fever, insomnia

The signs or symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

COWS: Clinical Opioid Withdrawal Scale

Goal: To manage opioid dependence (addiction) and alleviate acute opioid withdrawal signs and symptoms

Hospital day #1:

- Assess for acute opioid withdrawal either based on a Clinical Opioid Withdrawal Scale (COWS) score of at least 5 or by assessing withdrawal based on the following clinical signs and symptoms: *symptoms*: yawning, sweating, anxiety, restlessness, insomnia, chills, nausea cramping, abdominal pains, muscle aches; *signs*: lacrimation, rhinorrhea, dilated pupils, piloerection, tachycardia, hypertension, diarrhea, vomiting.
- Regardless of amount of opioid (e.g. heroin) reported by history, <u>start with:</u>
  - <u>Methadone 20 mg **solution** PO X1 dose</u>
    OR
  - <u>Buprenorphine/naloxone 4/1mg **tablet** under the tongue (sublingual) x 1 dose</u>
    - CAUTION – buprenorphine/naloxone SHOULD NOT BE GIVEN within 48 hours of prior methadone administration, 24 hours of prior long-acting opioid analgesic (eg. MS Contin) or 12 hours of prior short-acting opioid analgesic (e.g. oxycodone) or illicit heroin/fentanyl because of the risk of precipitating opioid withdrawal. Be sure to review the patients MAR for other opioids prior to starting buprenorphine
    - Discuss specific treatment (e.g., methadone or buprenorphine/naloxone dose) and goals openly with the patient.
    - If concerns about safety (e.g., precipitated withdrawal) with starting buprenorphine/naloxone, page Addiction Consult Service #6226

        - If withdrawal symptoms worsen (precipitated withdrawal) with first dose of buprenorphine/naloxone, page Addiction Consult Service #6226.
    - With either methadone or buprenorphine/naloxone treatment, expect some opioid withdrawal relief within 2 hours.
- Order naloxone PRN for hypoxia or unresponsiveness.
- Reevaluate the patient every 2-3 hours.
    - For patients started on methadone, give additional doses of **methadone** in increments of 5-10 mg per dose of solution orally every 2-3 hours until withdrawal abates, COWS < 5 to a maximum of 40 mg.
    - For patients started on **buprenorphine/naloxone**, give additional doses of buprenorphine in increments of 4/1mg per dose sublingually every 2-3 hours until withdrawal abates, COWS < 5 to a maximum of 12/3 mg.
    - Assess and document with the COWS scale at each re-evaluation
- DO NOT exceed 40 mg of methadone or 12/3mg of buprenorphine/naloxone in the **first 24 hours of admission**.
    - Consult Addiction Consult Service #6226 if considering methadone doses >40mg or >12/3 mg of buprenorphine/naloxone in the first 24 hours
- DO NOT give additional methadone or buprenorphine/naloxone doses if the patient is sedated or has respiratory depression (RR < 8 breaths per minute). For patients with significant sedation and respiratory depression, consider naloxone administration if patient does not respond to physical stimuli.

Hospital day #2:

- On the morning of the following day:
- For **methadone**, give the amount of methadone given over the previous 24 hours at one time or split into two doses, but do not exceed 40mg.
    - Doses may exceed 40mg a day with guidance and approval of the Addiction Consult Service
- For **buprenorphine/naloxone**, give the amount given over the previous 24 hours at one time or split into two doses, the dose can be increased to 16/4 mg if the patient continues to experience opioid withdrawal, but do not exceed total daily dose of 16/4 mg.
    - Doses may exceed 16/4 mg a day with guidance and approval of the Addiction Consult Service
- Discuss the following options with the patient:
    - Option A: Maintenance (recommended)
        - Continue daily methadone or buprenorphine/naloxone with last dose given on day of hospital discharge.
            - **If the patient is interested in continuing methadone or buprenorphine/naloxone after discharge, please consult the Addiction Consult Service #6226 as soon as possible during the hospitalization**
    - Option B: Taper
        - For methadone, taper by 5-10 mg/day with last dose given on day of hospital discharge.
        - For buprenorphine/naloxone, taper by 2/0.5 mg – 4/1 mg/day with last dose given on day of hospital discharge.

    - **Discharge should not be delayed** in order to complete a taper.
- DO NOT write an outpatient prescription for methadone
- Refer the patient to addiction treatment by contacting your social worker. This should not delay discharge plans. You can also refer your patient to the MA Statewide Helpline 1-800-327-5050 or www.helpline-online.com

ACUTE PAIN MANAGEMENT ON METHADONE: The patient's methadone maintenance dose or daily methadone dose used to treat acute withdrawal in patients not enrolled in a methadone maintenance program DOES NOT provide adequate analgesia for acute pain. If acute pain requires opioid analgesia, larger and more frequent doses are often required. Continue methadone maintenance dose in addition to the opioid analgesic. Avoid using mixed agonist/antagonist opioid analgesics (i.e. Butorphanol (Stadol), Nalbuphine (Nubain), buprenorphine) as they may precipitate withdrawal.

ACUTE PAIN MANAGEMENT ON BUPRENORHINE: The patient's buprenorphine maintenance dose DOES NOT provide analgesia and may prevent opioid analgesics from working. If pain requires opioid analgesia, it is prudent to use nonopioids (e.g., NSAIDs, acetaminophen) along with one of the following 2 options based on the anticipated pain acuity and duration:

- For Moderate or Severe Pain
    - Divide the buprenorphine daily dose to q8 hour dosing to take advantage of buprenorphine's analgesic properties.
    - Either increase usual buprenorphine maintenance dose by 2-4 mg per dose to achieve increased analgesia up to a maximum dose of 32 mg per day **OR** use concurrent short-acting opioid analgesics. Larger and more frequent opioid doses are often required due to opioid cross-tolerance with the patient's usual buprenorphine dose. Avoid using mixed agonist/antagonist opioid analgesics (i.e. Butorphanol (Stadol), Nalbuphine (Nubain) as they may precipitate withdrawal. NOTE: it is SAFE to add opioids on top on buprenorphine if the patient has been continuously receiving buprenorphine in past 24 hours
    - Convert patient to usual daily buprenorphine maintenance dose and dosing when acute pain resolves.
    - For patients with uncontrolled pain on buprenorphine, contact Addiction Consult Service #6226

2.) MAT initiation and titration

Pharmacotherapy for alcohol use disorder

Indications:
Patients with alcohol use disorder, moderate to severe subtype, who also

- Have current health alcohol use and ongoing risks from use
- Are motivated to reduce alcohol intake
- Prefer medication in addition to or instead of psychosocial intervention

Goals:

- Abstinence OR

- Reduction of heavy drinking

	Mechanism	Dose	Common Side Effects	Notes
Naltrexone	Blocks mu opioid receptors	50 mg PO qd OR 380 mg IM q4weeeks	Nausea, headache, dizziness	1st line; cannot give if on concurrent opioid therapy
Acamprosate	Unclear; decreases cravings	666 mg PO tid	Diarrhea	1st line; dose adjust in renal impairment
Disulfiram	Blocks aldehyde dehydrogenase	500 mg PO qd x 1-2 weeks, then 250 mg PO qd	Drowsiness, metallic taste, headache	2nd line; avoid in CAD, pregnancy

Pharmacotherapy for opioid use disorder

Goals:

- Reduction or cessation of illicit opioid use
- Reduction or cessation of injecting and associated risk of bloodborne virus transmission
- Reduction of overdose risk
- Reduction of criminal activity

Opioid Agonist Therapy: Methadone Maintenance vs. OBOT/Buprenorphine-Naltrexone:

	Methadone	Buprenorphine
Schedule	II	III
Mechanism of Action	Agonist	Partial agonist
Regulation	Prescribed from licensed program	Prescribed by certified and specially trained physicians
Trade Names	Dolophine	Subutex Suboxone (+naltrexone)
Advantages	Programs provide structure and support groups Close monitoring Ease cravings Blocks euphoric effects of concurrent illicit opioid use	Can take it home Low hazardous use potential with naloxone combination Low intrinsic activity & slow dissociation rate Acts as antagonist at high doses
Disadvantages	Stigma Difficult to get "take homes"	Easily diverted
Side effects	QTc prolongation/arrhythmias Constipation Sweating	Headache Sweating Liver complications
Contraindications	Patient at risk for QTc prolongation	Severe liver impairment
Notes	Majority of patients require 80-120 mg/d of methadone	When dissolved under tongue, buprenorphine effects predominate; when crushed and injected, naloxone predominates. Patient should be in withdrawal at initiation

Naltrexone: a complete opioid antagonist, available as Revia (oral tablet) or Vivitrol (IM injection). Advantages of naltrexone include the absence of addicting or sedating effects as well as little to no potential for hazardous use or diversion; however the primary disadvantage is relatively little effect on

opioid cravings. Adverse events include precipitation of opioid withdrawal symptoms, liver injury, headache, stomach pain, nausea and fatigue. Naltrexone is used as a maintenance agent in patients who have undergone opioid management withdrawal and are not receiving opioid replacement therapy with methadone or Suboxone.

3.) OD prevention education and naloxone distribution

Please see http://prescribetoprevent.org/ for information on OD prevention and naloxone distribution. Below are two pages from the site. The first is a table showing naloxone product comparison. The second is a page that provides information on an online continuing education program called "Overdose Prevention and Naloxone Rescue Kits for Prescribers and Pharmacists".

- http://prescribetoprevent.org/wp2015/wp-content/uploads/Naloxone-product-chart.17_04_14.pdf
- https://www.opioidprescribing.com/naloxone_module_1-landing

**Note: Naloxone kits should be available at all bridge clinic sites in case of an overdose.

3b. Fellows' Guide to Faster Paths

Welcome to Faster Paths, Boston Medical Center's low-barrier substance use disorder bridge clinic! At Faster Paths you will have a unique opportunity to work with people with problematic substance use in need of rapid access to medications for substance use disorders, overdose prevention, harm reduction counseling, HIV prevention, and linkage to community services. You will also be part of an interdisciplinary team providing comprehensive, non-judgmental harm reduction and addiction services.

Faster Paths Contact Information

Faster Paths (main line)	617-414-4580	
Faster Paths (fax)		
James Evans, RN *Nurse Care Manager (M-F)*		
Merida Brimhall, RN Elyssa Williams, RN Danielle Greenaway, RN Deb Almeida, RN *Nurses (weekends, per diem)*		
Sandy Gonzalez *Program Manager*		
Jennifer Ruidiaz Fowzia Abdi Grace Neville *Patient Care Coordinators*		

BMC and Community Partners

Rapid ACCESS *Recovery coaches and counseling services (also refer in EPIC)*	617-638-5500
Roundhouse TCC *Rapid access to medications for SUD (similar to FP)*	617-638-0613
Roundhouse SCC *24-hour stabilization unit for management of intoxication and withdrawal*	617-638-0613
Inpatient Addiction Consult Service	Pager 6226
OBAT *Office-based addiction treatment program in GIM primary care*	617-414-4123
PAATHS: *Post-detox residential treatment placement*	855-494-4057
Project Assert *Detox and post-detox residential (TSS, CSS) placement, overdose prevention*	617-414-4388
Project TRUST: *Drop in center for STI testing, harm reduction, PEP/PrEP, HCV treatment*	617-414-4495
FAST PATH *OBAT clinic within CID HIV Clinic, Shapiro 9*	617-414-4755
CATALYST *Integrated primary care for young people with SUD up to age 26*	617-414-6655
Addiction Psychiatry Treatment Program (APTP) *OBAT clinic within Psychiatry Department (also refer in EPIC)*	617-414-1948
Community Behavioral Health Clinic (Psychiatry Bridge Clinic) *Urgent outpatient consults for serious mental illness (also refer in EPIC)*	
Briana Baker, CPT	Flag in EPIC

Pharmacy liaison for prior authorizations (e.g., for Sublocade)	
BMC Central Pharmacy *Contact for Pyxis restocking needs*	617-414-7687 *Option 2*
Yawkey Pharmacy	617-414-4883
Boston Health Care for the Homeless Program *(*BHCHP appt line)	857-654-1605
BHCHP OBAT	857-654-1628

Timing:

- Faster Paths Clinic is open from 8am-4:30pm, 7 days/week. We are often closed on outpatient hospital holidays.
- Resident continuity clinics occur during one 3- or 4-hour session during ambulatory weeks
- Fellow clinics are 3 hours, typically 9am-12pm or 1pm-4pm

Schedule Changes

- Residents: Please contact your preceptor directly and copy the Chief Residents
- Fellows: Because of our precepting model, coverage is needed when you are away. **Please provide 3 months' notice for any planned vacations.** For any requests < 2 months out, you may be asked to find coverage from co-fellows or other FP providers.

Preparation

- Please review the charts of any patients scheduled in advance.
- At the beginning of each session, we will huddle with the RN case manager to review scheduled patients. Most patients will be seen by the provider. Depending on patient needs and capacity, sometimes the RN will see patients on their own. We will also often see walk-ins. Flexibility and willingness to chart review on the fly are key!
- Check out the BMC "Words Matter" Pledge and plan to use person-first, medically accurate, non-stigmatizing language in all presentations and documentation: https://www.bmc.org/sites/default/files/Patient_Care/Specialty_Care/Addiction-Medicine/LANDING/files/Words-Matter-Pledge.pdf
- Review the 11 DSM V criteria for diagnosing a substance use disorder. This is embedded in the intake note template (see below) and is an important part of our initial assessment.
- Check out the review articles included below and other background articles on Box (*https://bostonmedical.account.box.com/login*)

What Treatments Do We Provide?

- **OUD and opioid withdrawal:**
    - Sublingual and monthly injectable buprenorphine (including low-dose bupe initiations – see protocol and patient handout)
    - Injectable and oral naltrexone
-
    - Opioid withdrawal: We are able to administer schedule II medications (e.g. methadone) for emergency opioid withdrawal management for up to 72 hours with linkage to ongoing care, including linkage to opioid treatment programs (OTPs) (see protocol). We also use non-opioid medications to treat withdrawal.
    - Naloxone kits for overdose response

- **Alcohol use disorder:** FDA-approved medications for AUD: naltrexone, acamprosate, disulfiram.

- **Alcohol withdrawal**: outpatient benzo taper, typically with diazepam
- **Benzodiazepine withdrawal:** intensive outpatient benzo taper for select patients (see protocol)
- **Stimulant use disorders:** currently no FDA approved medications; we will occasionally offer off-label medications like topiramate (cocaine UD) and mirtazapine (amphetamine UD)
- **Smoking cessation:** nicotine patch/gum/inhaler, varenicline, bupropion
- **Harm reduction supplies:** safer injection use kits, safer smoking kits, fentanyl and xylazine test strips
- **HIV prevention:** PEP, PrEP (condoms also available) – **high priority with HIV outbreaks in Boston, and we have rapid HIV tests (finger stick sample) for patients who decline phlebotomy**
- **Bacterial STI testing and treatment:** vaginal, throat, and rectal GC/CT swabs available in clinic. Urine GC/CT also available. Ceftriaxone, azithromycin, and bicillin available in clinic.
- **Skin/soft tissue infections:** wound care, antibiotics, abscess I&D
- **Reproductive health:**
    - Contraception: OCP, patch, ring; emergency contraception and depo-provera available in clinic. **Refer to Jordy Laks and/or Cecily Barber, OB/GYN/Addiction attending, for Nexplanon in Faster Paths.** Can also page OB Family Planning fellow for urgent LARC access.
    - Refer to Thurs PM FP Sexual Health clinic for preconception counseling, pap smears, other sexual health or gynecologic needs.
- **HCV Treatment:** direct acting antiviral medications; coordinate with Pharmacy
- **Vaccines**: HBV, HAV, influenza regular and hi-dose (all available in Pyxis)
    - We have the following medications in our Pyxis for urgent administration:
        - Ketorolac 30 mg vials
        - Diazepam
        - Clonidine
        - Azithromycin
        - Ceftriaxone
        - Bicillin
        - Buprenorphine/naloxone (8/2 mg and 2/0.5mg sublingual films)
        - Methadone 10 mg/mL oral syringes
        - Long-acting morphine
        - Oxycodone 5 mg tablet
        - Ulipristal (ELLA emergency contraception)
        - Medroxyprogesterone (Depo-Provera)
        - Nexplanon device
        - Naloxone intranasal
        - Lidocaine with Epi 1:100,000
        - Lidocaine without Epi (use to reconstitute ceftriaxone)
        - Acetaminophen
        - Ibuprofen
        - Ondansetron
        - Hydroxyzine
        - Dicyclomine

What Don't We Prescribe?

- With some exceptions (e.g., patients entering detox/residential facility, short-term use during bupe initiations), we generally do not prescribe outpatient psychiatric medications, including sleep aids, mood stabilizers, antipsychotics, gabapentin, and benzodiazepines (unless part of a structured taper), as our goal is to connect patients to long term care.
    - Discuss with your preceptor if a bridge prescription is warranted

    - Gabapentin is very rarely prescribed in Faster Paths – discuss with preceptor
- Likewise, we generally do not prescribe other primary care medications (e.g., antihypertensives, diabetes medications) unless there is a clinically urgent reason
- Methadone: In select circumstances, we can administer (but not prescribe) methadone for emergency opioid withdrawal management for up to 72 hours while linking to ongoing care. We are not an OTP and therefore refer to local programs for methadone treatment for OUD

How Long Are Our Prescriptions?

- We generally see patients 1-2x/week until they stabilize and have a clear transition plan.
- Patients treated with methadone are seen for up to 3 consecutive days (maximum 72 hours) and linked to an OTP or inpatient level of care. Patients should be encouraged to return to address other SUD-related needs and ensure linkage to primary care if needed. Consider booking a follow up appointment for these patients to address issues such as HIV prevention and HCV treatment.
- Prescriptions are written to last until the next visit.
- Urine tox testing is not required for all patients if it will not change management with the following exceptions:
    - Urine tox testing is required prior to methadone administration and for OTP referral.
    - Benzo GC/MS is required for outpatient benzo tapers

Precepting and Follow-Up

- We are a small space with just 1 MD exam room, so most resident precepting is at the bedside. Let your preceptor know if a patient would benefit from precepting outside the exam room.
- We use the following smartphrases:
    - .FASTERPATHS (initial visit, includes DSM V criteria)
    - .FASTERPATHSFOLLOWUP (follow-up)
    - .FASTERPATHSMEDCLEARANCE (medical clearance for detox visits)
    - .FPMETHADONE (smart phrase for patients receiving methadone under 72h rule)
- When writing a medical clearance letter, we use the following smartphrase:
    - .FASTERPATHSLETTERMEDCLEARANCE
- The "Faster Paths" order set includes standard intake labs (encouraged but not required for every patient)
- At the beginning of the year, most fellow precepting is also at the bedside. As time goes on, fellow precepting can happen by phone on a standing- and then as-needed basis. <u>However, calling to discuss complex cases in real time is always expected.</u>
- Please **finalize notes and route them to your preceptor by the end of the clinic day** (i.e. same day as the visit). This expectation may be different than your other clinics but it is a requirement in Faster Paths, where patients are seen frequently by an interdisciplinary team.
- Results:
    - Ask the patient how they would prefer to receive results (e.g., by phone, MyChart, return in person)
    - Please call patients with lab results (calling about expected UDS results is not necessary) and document a phone note
    - Talk to your preceptor with any questions about results first

Other Tips and Tricks

- Patients referred from the Addiction Consult Service may not have had the standard intake lab panel, which includes screening for HIV and STIs. Strongly encourage these labs. Swabs are available in the provider room cabinet for GC/Chl testing of throat, rectal, vaginal sites (these swabs must be

done in clinic, not in the lab), and for vaginal trichomonas testing. You can tube completed swabs to the lab in the phlebotomy suite next door.
- POCT hCG testing can be completed in the Radiology holding area by trained personnel (ask Jimmy Evans, RN Manager). Serum hCG quants are also an option. We are in the process of acquiring home pregnancy tests to offer patients who would benefit from low-barrier self-testing for pregnancy.
- For patients with benzo UD, including those considering or on a benzo taper, order both the standard urine tox screen and the benzo GC/MS ("Pain management, benzodiazepines, quantitative"). Clonazepam does not reliably cause a positive benzo result on the standard urine tox screen. Likewise, consider urine gabapentin levels when results would change management.
- For patients on benzo tapers, work with your preceptor to outline a clear taper plan that other providers can follow for consistency (see protocol).
- We have a breathalyzer, which can be used when there is uncertainty about recent alcohol use (do not use during COVID pandemic)
- Include the plan for post-Faster Paths transition of care in every note
- Include assessment and plan for nicotine cessation/management in every note, if appropriate
- Include HIV risk assessment and prevention plan in every note, if appropriate
- For patients who are intoxicated and need safe monitoring, consider referring to the Roundhouse Stabilization Care Center (SCC).

Background Reading

SUD Bridge Clinics

- Taylor, Wakeman, Walley, Kehoe. Substance use disorder bridge clinics: models, evidence, and future directions. *Addiction Science & Clinical Practice.* 2023; 18(23).

- Taylor, Laks, Christine, Kehoe, Evans, Kim, Farrell, White, Weinstein, Walley. Bridge clinic implementation of "72-hour rule" methadone for opioid withdrawal management: Impact on opioid treatment program linkage and retention in care. *Drug and Alc Depend.* 2022 Jul 1;236:109497.

- Snow, et al. Patient experiences with a transitional, low-threshold clinic for the treatment of substance use disorder: A qualitative study of a bridge clinic. *J Subs Abus Treat*. 2019; 107: 1-7.

OUD Treatment

- Taylor, Johnson, Cruz, Gray, Schiff, Bagley. Integrating harm reduction into outpatient opioid use disorder treatment settings. *JGIM*, 2021.

- Cohen et al. Low Dose Initiation of Buprenorphine: A Narrative Review and Practical Approach. *J Addict Med* 2022 Jul-Aug;16(4):399-406

- Jakubowski, Fox. Defining Low-threshold Buprenorphine Treatment. *J Addict Med*. 2020; 14(2): 95-98).

- Walley, Wakeman, Eng. Case Records of the Massachusetts General Hospital: A 29-year-old woman with nausea, vomiting, and diarrhea. *NEJM.* 2019; 380: 772-9.

- Martin, et al. The next stage of buprenorphine care for opioid use disorder. *Annals of Internal Med*. 2018; 1-9.

- Thakarar, Weinstein, Walley. Optimising health and safety of people who inject drugs during transition from acute to outpatient care: narrative review with clinical checklist. *Postgrad Med J.* 2016; 0:1-8.

Overdose and Drug Supply

- Kariisa et al. Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics — 25 States and the District of Columbia, 2019–2020. *MMWR* 2022; 71(29);940–947

- Gupta, et al. Xylazine – Medical and Public Health Imperatives. *NEJM* 2023. 10.1056/NEJMp2303120

Alcohol Withdrawal

- Muncie, et al. Outpatient management of alcohol withdrawal syndrome. *Am Fam Physician*. 2013;88(9):589-595.

HIV Prevention

- Bazzi, et al. Limited knowledge and mixed interest in pre-exposure prophylaxis for HIV prevention among people who inject drugs. *AIDS Patient Care STDs*. 2018; 32:529-37.

- Taylor, Walley, Bazzi. Stuck in the Window with You: HIV Exposure Prophylaxis in the Highest-Risk People who Inject Drugs. *Subst Abus*. 2019; https://doi.org/10.1080/08897077.2019.1675118.

Other Faster Paths Research:

- Laks et al. Methadone initiation in a bridge clinic for opioid withdrawal and opioid treatment program linkage: a case report applying the 72-hour rule. *Addict Sci Clin Pract.* 2021 Dec 28;16(1):73.

- Harvey, et al. Sexually Transmitted and Blood-borne Infections Among Patients Presenting to a Low-barrier Substance Use Disorder Medication Clinic. J Addict Med 2021 Nov-Dec;15(6):461-467.

- Harris, et al. Low Barrier Tele-Buprenorphine in the Time of COVID-19: A Case Report. *J Addict Med*. 2020 Jul/Aug;14(4):e136-e138.

- Roy, Choi, Bernstein, Walley. Appointment wait-times and arrival for patients at a low-barrier access addiction clinic. *J Subs Abus Treat*. 2020; 114: epub ahead of print.

3 c. I-PASS Handoff and Transitions of Care Policy

The method in which patient information is communicated between caregivers during a hand-off is vital to overall patient safety. An organizational structure that comprises a standardized patient hand-off process ensures that all pertinent information is communicated between caregivers at the time of patient transfer from one caregiver to another. These handoffs or transfers of responsibility occur hospital-wide and include examples such as:

· Resident to Resident transfer of on-call responsibility
· Attending to Attending transfer of on-call responsibility
· Admission from ED to Medical/Surgical Physician Team
· Nurse to Nurse change of shift reports
· Transfers of patient from Unit to Unit
· Nurse to physician reports/hand-offs
· Transporter to Ancillary Services

In complying with The Joint Commission National Patient Safety Goal 2E, the following characteristics comprise effective hand-offs:

· Interactive and allow the opportunity for questioning between the caregivers (giver and receiver) of patient-related health information.
· Include accurate information regarding the patient's care, treatment, services, condition, medical history, and anticipated changes.
· In an area where there are limited interruptions to ensure all information is communicated clearly.
· Include a process for verification of the information received such as repeat back.

Fellows should review Handoff (if need help viewing this section or printing list this way – ask Zoe or an NP!) or charts prior to first day. As always it is critical that NPs, fellows, residents, med students or attendings (when no fellow) update Handoff on patients at the **end of every day.**

Please prioritize Walking Rounds and at the 1pm meeting Card flip should be as brief as possible - discussing patients who WON'T be seen by the attending and go over Emily/Theresa updates.

As a reminder the NPs will leave rounds to complete their notes approx. 1 hour prior to time they need leave for the day (Jason leaves at 5, other NPs at 6).
Boston Medical Center has adopted "IPASS", which stands for **I**llness Severity, **P**atient Summary, **A**ction List, **S**ituation Awareness & Contingency Planning, and **S**ynthesis by Receiver as a method of standardized hand-off communication. The format acts as an acronym for ensuring that all pertinent information is exchanged during the hand-off process. Guidelines include:

I	Illness Severity	• Flag if pt sick/unstable/needs daily fu • Primary ACS team member following (optional)
P	Patient Summary	• One liner • Hospital course- especially timeline of important meds e.g. history of methadone dose titration • Ongoing A/P
A	Action List	• To do list (especially methadone referral needs, bridge rxs, titration or taper plans and when pt next needs to be seen by team) • Timeline and ownership
S	Situation Awareness and Contingency Planning	• Important FYIs for anyone covering pt • PRNs and parameters (or reasons NOT to give more meds)
S	Synthesis by Receiver	• Receiver summarizes what was heard • Asks questions • Restates key action/to do items

3 d. Key Contacts & Services

BMC Services

CATALYST (adolescent and young adult clinic)	617-414-6655 Or pager 2283
Domestic Violence Program	Safety and Support Advocates' line at 617-414-5457 or page 2590 during business hours
Faster Paths (urgent care/bridge clinic)	617-414-4580 Epic message to: Jimmy Evans Nurse; Jennifer Ruidiaz/ Grace Neville ASRs
OBAT	Nursing Line: 617-414-4107 Epic message to: P BMC GIM OBAT NURSING
Project ASSERT (Alcohol & Substance abuse Services, Education and Referral to Treatment) ED program	617-414-4388
Project RESPECT (Recovery, Empowerment, Social Services, Prenatal care, Education, Community and Treatment)	For questions about your pregnancy or medications: Call 617-414-4165 For prenatal care, social work & mental health appointments: Call 617-414-6376 After 4:30 PM and weekends call: 617-414-2000
SOFAR Clinic (Supporting Our Families through Addiction and Recovery)	Patient Navigator 617-414-5988
Project Trust (Drop-In Center)	617-414-4495

Description of Substance Use Treatment Services (Levels of Care)

Inpatient/Residential Level of Care

ATS (Acute Treatment Services (Detox)	• Level IIIA Detoxification is a 24-hour, seven-day-a week, medically supervised addiction treatment that provides evaluation and withdrawal management. Detoxification services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning. Acute Treatment Services are provided to those experiencing, or at significant risk of developing an *uncomplicated* withdrawal syndrome as a result of an alcohol and/or other substance use disorder. • Level IV Detox (acute-level detox) typically requires hospital level of care due to complicated withdrawal symptoms (EtOH and/or benzodiazepines). Individuals require the medical and clinical intensity of a hospital-based detoxification service (see HBATS below). • Special programs are available for youth under the age of 21 (see Youth Stabilization Services) and for adults with co-occurring conditions (see E-ATS on the Mental Health Services).
CSS (Clinical Support Services)	24-hour treatment, usually following Acute Treatment Services (ATS) for substance use, and including intensive education and counseling regarding the nature of addiction and its consequences, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction. CSS provides nursing support, case management, education, counseling, and aftercare. These programs provide multidisciplinary treatment interventions and emphasize individual, group, family, occupational, and other forms of therapy. Linkage to aftercare, relapse components, and self-help groups, such as AA and NA, are integrated into treatment and discharge planning. Special programs are available for youth under the age of 21 (see Youth Stabilization Services).
TSS (Transitional Support Services)	Very similar to CSS. Residential program that is typically two-four weeks. Oftentimes an individual will call it "a holding." TSS offers structure and support in a residential facility for adults ages 18 and older with substance use disorders. TSS is provided 24 hours per

	day and provides nursing support, intensive case management, education, and aftercare planning.
E-ATS (Enhanced Acute Treatment Services)	24-hour treatment for individuals diagnosed with co-occurring psychiatric diagnoses and substance use issues. Can monitor and treat withdrawal symptoms for a substance use disorder and provide clinical stabilization for psychiatric co-morbidities. E-ATS provides psychiatric consultation, medication review and management, nursing care, and counseling services. *Individuals placed in E-ATS need to be assessed by psychiatry.*
HBATS (Hospital-based Acute Treatment Services)	Also known as Level 4 Detoxification Services, is for adults who are at high risk of severe withdrawal symptoms. HBATS is provided 24 hours a day in a hospital to adults ages 18 and older. The individuals may also have other medical complications
Youth Stabilization Services (YSS)	YYS is a medically-monitored substance use disorder service for adolescents and transitional age youth up to the age of 21. YSS is provided 24 hours per day. YSS includes help with withdrawal and intensive substance use disorder treatment in the same setting. Individuals also receive psychiatric consultations and nursing care.
Residential Rehabilitation Services (RRS)	RRS provides support and assistance to individuals with substance use disorders to get back into the community. RRS is a 24-hour structured, supportive program that happens in a home-like setting. RRS provides ongoing case management, education, and counseling. Programs are available for adults ages 18 and older, adolescents, transitional age youth and young adults, families, and pregnant and post-partum women.
Halfway House	An individual will typically go to a halfway house after they have completed post-detox residential substance use treatment (CSS/TSS). Halfway house is a long-term residential treatment option. Insurance can be used as a payor source. An individual is on "restrictions" the first few weeks. There will be a curfew and daily/weekly urine toxicology screens. May be asked to attend 12-step meetings.
Sober House	An individual has to pay out-of-pocket (usually weekly/monthly rent). He/she will be required to work during the day. Not as restrictive as a halfway house (more freedom to come/go as you please), but will oftentimes have a curfew, daily/weekly urine toxicology screens.

Outpatient Level of Care

Emergency Services Program (ESP)	ESP is a behavioral health emergency service and can be contacted when an individual is having a crisis and needs help right away. The ESP helps individuals of all ages if they are having a behavioral health crisis (see Mobile Crisis Intervention for youth under the age of 21). ESP staff will assess the crisis and help stabilize

	the individual. The ESP is available 24 hours per day, 7 days per week, 365 days per year. The ESP covers all cities and towns in Massachusetts. Some insurance restrictions may apply.
Dual-Diagnosis PHP (Partial Hospitalization Program	Non-residential treatment program that provides clinical, diagnostic, and treatment services on a level of intensity equal to an inpatient program, but on a less than 24-hour basis. Primary focus is psychiatric treatment as well as treating a co-occurring substance use disorder. These services include therapeutic milieu, nursing, psychiatric evaluation and medication management, group and individual/family therapy, psychological testing, vocational counseling, rehabilitation recovery counseling, substance use disorder evaluation, and counseling and behavioral plans.
SOAP (Structured Outpatient Addiction Treatment) A.K.A. IOP (Intensive Outpatient Program)	SOAP is best suited for patients whose primary diagnosis is a substance use disorder. SOAP is a short-term, intensive day and/or evening substance use disorder treatment service. It is for individuals who do not need 24-hour care. SOAP aims to give patients a heightened level of self-awareness about their substance-use disorder, relapse prevention skills and a variety of coping skills to help them become independent individuals in recovery. Typically meets 3-5 days/week for three-four hour sessions (including group, individual counseling/therapy, and psychiatry).
Direct Admission to MMTP (Methadone Maintenance Treatment Program)	An individual is started on methadone in the hospital setting and is not connected to a home methadone clinic in the community. Staff will provide a referral to a methadone clinic and if accepted, the individual will go to the methadone clinic the following day post-discharge to begin dosing.
OPIOID TREATMENT PROGRAM (OTP) is also known as methadone clinic	Individuals with opioid use disorder have their medication given to them and monitored. Medications used are methadone, buprenorphine, naltrexone, or other U.S. Food and Drug Administration (FDA)-approved medications. Individuals can receive counseling, education, and vocational services as needed. OTP is available on a short-term (withdrawal management) or long-term (maintenance) basis.
OBAT (Office Based Addiction Treatment)	Services provided in an outpatient setting, typically in a primary care/community health center setting. MD/NP prescribe medications for addiction treatment including buprenorphine (suboxone), naltrexone/vivitrol (injectable form of naltrexone). OBAT also provides counseling and recovery supports. *You cannot be prescribed and/or obtain methadone at an OBAT clinic.*
Medication-Assisted Treatment (MAT)	MAT supports recovery from substance use disorders. Treatment includes behavioral therapy and medications. MAT may be provided in an Opioid Treatment Program (OTP), Office-Based Addiction Treatment Program (OBAT), primary care, or outpatient behavioral practice.

4. Policy for Supervision of Residents, Resident Duty Hours, Work Environment and Moonlighting

As per ACGME requirements, the Addiction Medicine Fellowship maintains strict requirements governing the supervision of resident trainees. As part of this policy:

1) The attending, resident, and nurse caring for each patient are identified on the Boston Medical Center Addiction Medicine Fellowship Electronic Medical Record (EMR) tracking system. This system is available to all practitioners at Boston Medical Center. The attending physician identified is ultimately responsible for the patient's care.
2) Fellows and faculty members are responsible for informing patients and their family members of their respective roles in each patient's care.
3) With all BMC AM resident patients, there is either *Direct Supervision*, *Indirect Supervision Immediately Available, or Oversight.* Depending on patient acuity and fellow skills, the attending evaluation may occur prior to the fellow evaluation, concurrent with the fellow evaluation, or subsequent to the fellow evaluation. All Boston Medical Center Addiction Medicine patients are seen by an appropriately credentialed Boston Medical Center Addiction Medicine Fellowship attending. The time from patient arrival to attending evaluation is usually within minutes of arrival.
4) The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the Program Director and faculty members (see below).
5) Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows.
6) Fellows should serve in a supervisory role of junior residents in recognition of their progress towards independence, based on the needs of each patient and the skills of the resident.
7) As patients are seen by an attending in immediate proximity to the fellow evaluation, all critical decisions (e.g., end-of-life decision, admission to a critical care unit, etc.) are made with real-time input from attending physicians.
8) Each fellow must know the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence.
9) The clinical responsibilities for each fellow must be based on PGY level, patient safety, fellow education, severity and complexity of patient illness/condition, and available support services.
10) Fellows must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective inter-professional teams that are appropriate to the delivery of care in emergency medicine.

Faculty evaluation of the fellow's abilities is a cornerstone of the BMC AMF and the data generated through a variety of different evaluation processes are critical to their training. Each rotation has specific goals and objectives and the fellowship leadership and faculty utilize these goals and objectives to assess fellows' readiness to assume progressive responsibility, conditional independence, and a supervisory role in patient care.

The program assesses the ability of fellow via several complementary and overlapping methods. Direct observation of patient care, including management plans and procedural skills, is the most important of these mechanisms and time at monthly faculty meetings is set aside to discuss the performance of each fellow as they relate to the Core Competencies. Additional information is gathered via simulation cases, off-service and fellow (self and colleague) evaluations, and nursing and patient feedback.

The criteria on which fellows are judged allowing for their progressive authority and responsibility, conditional independence, and a supervisory role in patient care are presented below (one component of "milestones").

Duty Hours

Duty hours are defined as all clinical and academic activities related to the residency program. This includes clinical care, in-house call, transfer of patient care and administrative activities related to patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. For Call from Home (at-home call), only the hours spent in the hospital after being called in to provide care count toward the 80-hour weekly limit.

Hours spent on activities that are required by the accreditation standards, such as membership on a hospital committee, or that are accepted practice in fellowship programs, such as fellows' participation in interviewing fellowship candidates, must be included in the count of duty hours. Any tasks related to performance of duties, even if performed at home, count toward the 80 hour, such as completion of medical records, submitting orders, reviewing lab tests and verbal orders that can be signed at home. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours.

Maximum Hours of Clinical & Educational Work Per Week

- Work hours must be limited to **no more than 80 hours per week**, **averaged over a four-week period (or the length of the rotation, if shorter than four weeks)**, including in-house clinical and educational activities, clinical work done from home, and moonlighting.

Mandatory Time Free of Clinical Work & Education

- Trainees should have **eight hours off between** scheduled clinical work and education periods.
- Trainees must have at least **14 hours free** of clinical work and education after 24 hrs of in-house call.
- Trainees must be scheduled for a minimum of **1 day (a full 24 hours!) in 7 free** of clinical work and required education, **averaged over four weeks (same as above)**. At-home call cannot be assigned on these free days.
- Clinical & educational work periods must not exceed 24 hrs of continuous scheduled clinical assignments
- Up to 4 hours of additional time may be used for activities related to patient safety (transitions of care, trainee edu, etc.)

Work Hour Exceptions

In rare circumstances, after handing off all other responsibilities, a trainee, on their own initiative, may elect to remain / return to the clinic in the following circumstances:

- …to continue to provide care to a single severely ill or unstable patient
- …humanistic attention to the needs of a patient or family, or
- …to attend unique educational events

These additional hours will be counted toward the 80-hour limit.

Program Directors are responsible for reviewing each submission of additional service and must track both individual fellow and program-wide episodes of additional duty.

Call from Home (at-home call)

Time spent in the hospital by fellows on Call from Home (at-home call) must count towards the 80 hour maximum weekly hour limit. The frequency of Call from Home (at-home call) is not subject to the every third night limitation, but must satisfy the requirement of one-day-in-seven free of duty (when averaged over a four-week period).

Fellows are permitted to return to the hospital while on Call from Home (at-home call) to care for new or established patients. Each episode of this type of care, while it must be included in the 80 hour weekly maximum, will not initiate a new "off-duty period."

Moonlighting

Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program. The fellow and Program Director must comply with BMC's Moonlighting Policy and all relevant provisions in the BMC/CIR Collective Bargaining Agreement.

Time spent by fellows in Internal and External Moonlighting must be counted towards the 80 hour maximum weekly hour limit.

Logging Duty Hours

Reporting of Duty Hours is written into the CIR Union Agreement **Article XIII, Section 15** Trainees must accurately record all work hours worked weekly. No Trainee will be disciplined or retaliated against for accurately recording work hours regardless of whether such hours comply with ACGME regulations. Failure to record work hours will result in a mandatory meeting with the PD to discuss professionalism and determine a plan to ensure future compliance. If a Trainee repeatedly fails to accurately record all hours worked, the CMO will immediately convene a meeting with the Trainee and PD to address the problem and determine a course of action to ensure the Trainee and Program complies with the ACGME.

Fellows shall enter duty hours weekly to the extent practicable. The Work Hour Types used by our program are:

Call from Home (at-home call) - Called In: A call taken from outside the assigned site that requires going into the assigned site. Time in the hospital/medical center counts against the 80 hour per week limit but does not restart the clock for time off between scheduled in-house duty periods.
Call from Home (at-home call) - Not Called In: A call taken from outside the assigned site that does not require going into the assigned site.
Daily Assignment: This covers all patient care, education and research activities assigned
Moonlighting: Voluntary, compensated, medically-related work (not related to training requirements) performed internally or externally to the institution in which the resident/fellow is in training. Privileges can be revoked if you're not logging in this time.
Vacation: You must log vacation time, and should be logged M-F for a 5-day period *only.*

The Addiction Medicine Fellowship Program pre-populates the duty hours for the fellows from the assignment schedule module. **HOWEVER**, your hours are not considered logged until you ***review, edit,*** **and *click* "approve".** You will still deal with Work Hours on a weekly basis… the program did the first step for you, but this is still your responsibility.

Schedule swaps must be approved by the program and must not generate a Work Hour violation.

Oversight
The Addiction Medicine Fellowship programs written policy and procedure is consistent with the Institutional Policy on Duty Hours and the specific Program Requirements for resident duty hours and the working environment. These policies are distributed to the fellows and the faculty. Duty hours are monitored weekly to ensure an appropriate balance between education and service.

Back-up support systems are provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create fellow fatigue sufficient to jeopardize patient care.

Duty Hour Exception
A Review Committee may grant exceptions for up to 10 % or a maximum of 88 hours to individual programs based on a sound educational rationale. Prior to submitting the request to the Review Committee, the Program Director must obtain approval of BMC's Graduate Medical Education Committee and the Designated Institutional Official.

Protocol for episode remaining on duty beyond scheduled hours
Fellows and their supervisors are given instructions to not expand beyond the scheduled hours. In the case that the addiction medicine fellows remain on duty beyond scheduled hours, the fellows are instructed to send an email to the program director and administrator at the time. The email should discuss the circumstances that have caused the fellow to remain on duty. These should be limited to cases of compassion, such as a patient who may be dying and the fellow wishes to spend additional time after the scheduled hours. When the fellows are in their final year of the

program, they may take on responsibilities similar to that of an attending, and thus may need to remain on duty beyond scheduled hours to conduct a family meeting or meet with a trainee to give feedback on their performance. This should be outlined in the email.

POLICY ON ADEQUATE REST

It is the responsibility of the program to:

1) Educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation.
2) Educate all faculty members and fellows in alertness management and fatigue mitigation processes.
3) Adopt fatigue mitigation processes to manage the potential negative effects of fatigue such as on-call rooms, naps, and back-up call schedules.
4) Provide adequate sleep facilities and safe transportation options for fellows who may be too fatigued to safely return home (e.g. the taxi voucher program).

PGY-4 and PGY-5 fellows must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that fellows in their final years of education have 8 hours free of duty between scheduled duty periods, there may be circumstances (required continuity of care for a severely ill or unstable patient, or a complex patient with whom the fellow has been involved, events of exceptional educational value, or humanistic attention to the needs of a patient of family) when these fellows must stay on duty to care for their patients or return to the hospital with fewer than 8 hours free of duty. Circumstances of return-to-hospital activities with fewer than 8 hours away from the hospital by fellows in their final years of education must be monitored by the Program Director.

5. Quality Improvement and Safety Projects

AY 2020	
Kispert	Opioid Modules
Peterkin	Microdosing on the wards
AY 2021	
Laks	Updating BMC's policy on mandated reporting of substance exposed newborns developing benzodiazepine withdrawal protocol revising the pharmacy protocol for inpatient treatment of opioid withdrawal and developing an order set for opioid withdrawal treatment Endocarditis working group Overdose response training at Woods Mullin Shelter Benzodiazepine taper protocol at Faster Paths Resident Harm Reduction Training
Rozansky	Quantify and expand access to PrEP/PEP

	treatment of pain in people on Bup in the observation Unit Resident Harm Reduction Training
Younkin	buprenorphine microdosing at Codman Square Health Center HIV PrEP and PEP for at BMC for patients who inject drugs seen by the Addiction Consult Service Benzodiazepine taper protocol at Faster Paths for ED alcohol withdrawal management
AY 2022	
Barber	led an initiative to provide rapid access to long-acting reversible contraceptives (LARCs) to hospitalized patients on the Addiction Consult Service and patients seen in a low-barrier SUD bridge clinic; Updating withdrawal protocols for pregnant patients
Christine	IV Methadone forpost surgical pain in patients on methadone maintenance: endocaditis working group; evaluating 72-hour methadone program in low-barrier SUD bridge clinic
Pierre	linkage & retention of black men in OBAT
Silva	establish a gender affirming care clinic; harm reduction bags for ACS patients
Winer	Roundhouse Protocols for Buprenophine induction; establish a gender affirming care clinic
AY 2023	
Barber	updated methadone induction protocol in pregnant persons; updated the PRESPECT patient contract
Reed	Harm reduction supplies for inpatient/ER pts
Weisenthal	Harm reduction supplies for inpatient/ER pts; microdosing of bupe in the ED

Potential Projects for fellows to join:

Endocarditis Working Group- 3rd Thursday of the month from 7:30-8:30, contact Dr. Eric Awtry

Harm Reduction in Hospital

Getting medications on formulary (IV buprenorphine, IM naltrexone)

6. Clinical Competency Committee

Policy
Per ACGME Common Program Requirement V.A.1.c)-V.A.1.d)(3), the **Addiction Medicine Fellowship Program** has outlined the responsibilities of the Clinical Competency Committee (CCC). The purpose of the CCC is to review resident performance and make a recommendation to the Program Director for advancement to the next PGY level.

The **Addiction Medicine Fellowship** CCC is expected to monitor resident performance in accordance with ACGME Common Program Requirements and the Boston Medical Center GME policies and procedures regarding promotion and dismissal.

Committee Composition
The Program Director has identified and appointed the members of the CCC. This CCC includes at least 3 members and is composed of core faculty members, appropriate section heads, representation from rotation sites, the department Chair, and a Non-physician member. The Program Director will be on the Committee in a consultative manner to oversee the process. The Chair of the Residency CCC will be the departmental Vice Chair of Research or a similar appointee. CCC membership is for two year term and will be evaluated each academic year.

For the Addiction Medicine Fellowship, the members will consist of a subset of the Executive Committee which meets on a monthly basis. The Program Director will be on the Committee in a consultative manner to oversee the process: Alyssa Peterkin

At least 3 members must make up the committee:
The Chair of the Residency CCC will be the departmental Vice Chair of Research or a similar appointee: Zoe Weinstein
Non-physician member: Linda Neville
Other official members: Sarah Bagley, Jessie Gaeta, Alyssa Peterkin

Committee Responsibilities
The Clinical Competency Committee will participate actively in:

1. Reviewing all resident evaluations by all evaluators semi-annually as well as the resident's learning portfolio, individual learning plan and documented assessment by the Program Director or Associate Program Director.

   Tasks:
   Program Coordinator to compile
   - [] Individual Development Plan
   - [] Resident clinical and other evaluations
   - [] Clinical AM rotations completed (including # of sessions)
   - [] Review fellow meeting attendance (fellows work in progress, academic seminar, etc.)

2. Preparing and assuring the reporting of Milestones evaluations of each resident semi-annually to ACGME.
   - [] Milestone evaluations to be reviewed by the committee

3. Making recommendations to the Program Director for resident progress including promotion, remediation, and dismissal, following all BMC GME and program-specific policies.

Meeting Frequency
In order to meet the ACGME Milestone reporting deadline of May and December, the CCC will meet twice per year in November/early December and April/early May. The exact timing of the meeting may fluctuate depending on the ACGME Milestone Reporting schedule and the number of residents to be reviewed. In addition, the Residency CCC will agree to meet, as necessary, to discuss any urgent issues regarding resident performance.

Meeting Documentation
The Program Coordinator or designated program support personnel will document each CCC meeting held. In addition, the CCC review and recommendation of each resident will be documented in the New Innovations residency management system.

7. Program Evaluation Committee

Policy
Per ACGME Common Program Requirement V.C., the Residency Program has outlined the responsibilities of the Program Evaluation Committee (PEC) as well as defined the process for the Annual Program Evaluation (APE). Each year the PEC reviews the mission, aims, strengths, areas for improvement & threats to the program. The PEC is expected to monitor and improve the quality and effectiveness of the training program.

Committee Composition
The Program Director has identified and appointed the members of the PEC. This includes the Program Director (Chair), Associate Program Director(s), appropriate Section Heads and leadership and core faculty from any rotation sites, core teaching faculty and peer-selected residents from each level are also members of the PEC. Members may be rotated to and from the PEC as deemed necessary. This will be evaluated each academic year.

Scheduled Meeting
The PEC will meet annually in September to conduct the Annual Program Evaluation (APE). The meeting will be held in a half-day session and must be scheduled in January so that all members can attend this single meeting.

Committee Responsibilities
The Program Director will lead the PEC to actively participate in:

1. Planning, developing, implementing, and evaluating all significant activities of the residency program.

2. Developing and reviewing competency-based curriculum goals and objectives

3. Assuring that areas of non-compliance with ACGME standards are corrected

4. Reviewing the results of residents' assessments of the program together with other program evaluation results (internal and external) to improve the program

5. Reviewing, monitoring and tracking progress in each of the following areas:

- resident performance
- faculty development
- graduate performance, including performance of program graduates on the certification examination
- program quality

Data Collection for Review
In order to accomplish the Committee's responsibilities and thoroughly review all aspects of the training program, the following is data that may be used during the APE. This list is not all inclusive and should be viewed as the minimum.

Resident Performance
1. Evaluations – aggregate, program, rotation
2. Results of In-Service Exams including trends and analysis
3. Resident Scholarly Activities

5. Participation in Hospital and Departmental Patient Safety and QI projects

Faculty Development
1. CME activities
2. Didactic conferences, Participation in Journal Clubs and other Residency Activities
3. Experiential workshops
4. Participation in Hospital and Departmental QI/Patient Safety Projects
5. Practice improvement self-study

Graduate Performance
1. Board Pass rates/results
2. Alumni Surveys

Program Quality
1. Case Logs and Summary Statistics, Program vs. National Statistics
2. Resident & Faculty Evaluations of Programs
3. ACGME Faculty & Resident Survey Results
4. Most current Program Improvement Plan
5. Last RRC Notification Letter and status of citation corrections
6. Written action plan from last APE and status of action plan
7. Programmatic concerns

Documentation of the APE

The Education Program Manager will document the formal, systematic evaluation of the curriculum as well as a full, written APE and action plan to document program improvement initiatives. The APE and action plan will be uploaded into the GME residency management system by July 15th of each year. The APE will be reviewed and monitored by the DIO and GME.

The Program Director will present the results of the APE for approval to the teaching faculty and will be documented in meeting minutes. The APE will also be reviewed with all residents in the program.

Reference Material

https://bostonmedical.box.com/s/qzsgbx5l8rpkx8hfpqrpwb43taiz0z4l

1 Douaihy, A., Gold, M., & Kelly, T. (Eds.). (2014). Motivational interviewing: a guide for medical trainees. Oxford University Press.

3. Miller, W. R., & Rollnick, S. (2013). Motivational interviewing: helping people change. Guilford Press.

Rethinking Drinking Homepage - NIAAA (nih.gov)

In Rotation folder:

SOFAR article

Fast Path 2 articles

Listservs

Aodhealth.org

Pcss.org

Slide Decks

1. Addiction BST Mode Cutting Agents: https://www.dropbox.com/s/k9im1ufxthtvupd/Addiction%20BST%20Mode%20Cutting%20Agents.pptx?dl=0

Diversity, Equity, Inclusion & Justice

Quiz to take

https://www.shrm.org/ResourcesAndTools/tools-and-samples/quiz/Pages/quiz-unconscious-bias.aspx

1. https://www.ted.com/talks/valerie_alexander_how_to_outsmart_your_own_unconscious_bias
2. https://www.ted.com/talks/jodi_ann_burey_the_myth_of_bringing_your_full_authentic_self_to_work?language=en
3. "Sexual Orientation and Estimates of Adult Substance Use and Mental Health: Results from the 2015 National Survey on Drug Use and Health," https://www.samhsa.gov/data/sites/default/files/NSDUH-SexualOrientation-2015/NSDUH-SexualOrientation-2015/NSDUH-SexualOrientation-2015.htm#end3
4. "2015 US Transgender Survey," https://transequality.org/sites/default/files/docs/usts/USTS-Executive-Summary-Dec17.pdf
5. "Missed Opportunities: Youth Homelessness in America," https://voicesofyouthcount.org/wp-content/uploads/2017/11/ChapinHall_VoYC_NationalReport_Final.pdf
6. "Sexual and gender minority health in medical curricula in new England: a pilot study of medical student comfort, competence and perception of curricula," https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5933287/
7. Healthypeople.gov, https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health
8. https://www.glaad.org/blog/new-glaad-study-reveals-twenty-percent-millennials-identify-lgbtq

9. AAMC Medical School Graduation Questionnaire, https://www.aamc.org/media/46851/download
10. **"**Sexual and Gender Minority Identity Disclosure During Undergraduate Medical Education: "In the Closet" in Medical School," https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6170061/
11. "GLAAD Accelerating Acceptance 2019," https://www.glaad.org/sites/default/files/Accelerating%20Acceptance%202019.pdf
12. "The dilemma of disclosure: patient perspectives on gay and lesbian providers," https://pubmed.ncbi.nlm.nih.gov/18043983/
13. Gender Identity and Sexual Orientation chart, https://medschool.kp.org/admissions/class-of-2024
14. https://www.statnews.com/2021/04/06/excited-delirium-medicalized-racism-organized-medicine-take-a-stand/
15. https://mededucation.stanford.edu/courses/teaching-lgbtq-health/
16. https://www.drugpolicy.org/about-us/departments-and-state-offices/research-academic-engagement
17. https://structuralcompetency.org/
18. **Title VII à** https://www.eeoc.gov/statutes/title-vii-civil-rights-act-1964
19. Black Feminism & the Movement for Black Lives: Barbara Smith, Reina Gossett, Charlene Carruthers (50:48)
20. Dr. Robin DiAngelo discusses 'White Fragility' (1:23:30)
21. "How Studying Privilege Systems Can Strengthen Compassion" | Peggy McIntosh at TEDxTimberlaneSchools (18:26)
22. Building a Tool Kit for Medical and Dental Students: Addressing Microaggressions and Discrimination on the Wards | MedEdPORTAL
23. Populations and the Power of Language https://nccdh.ca/images/uploads/Population_EN_web2.pdf
24. Gateway to Health Communication Principles https://www.cdc.gov/healthcommunication/Key_Principles.html
25. Gateway to Health Communication Preferred Terms https://www.cdc.gov/healthcommunication/Preferred_Terms.html

Books to read:

1. Dawes, Daniel, the Political Determinants of Health: https://jhupbooks.press.jhu.edu/title/political-determinants-health
2. Gregory, Raymond F. 2001. Age Discrimination in the American Workplace: Old at a Young Age. Rutgers University Press.
3. Hartlep, Nicholas Daniel, Yoon K. Pak, and Robert T. Teranishi. 2013. *The Model Minority Stereotype: Demystifying Asian American Success*. Information Age Pub., Inc.
4. Herek, Gregory M. 1998. *Stigma and Sexual Orientation: Understanding Prejudice against Lesbians, Gay Men, and Bisexuals*. Psychological Perspectives on Lesbian and Gay Issues: V. 4. Sage Publications.
5. Ismail, Suzy. 2011. *Nine to Five: Muslims in the Western Workplace*. Beltsville, Md.: Amana Publications.
6. Kendi, Ibram X. 2019. How to Be an Antiracist. One World.
7. Kermode, Jennie, and Jane Fae. 2017. *Transgender Employees in the Workplace: A Guide for Employers*. Jessica Kingsley Publishers.
8. Stone, Dianna, Donna Blancero, and Lois Tetrick. 2014. *Hispanic and Latin Americans in the Workplace*. Journal of Managerial Psychology: Volume 29, Issue 6: V.29.6. Emerald Group Publishing Limited.
9. Susser, Peter. 2005. *Disability Discrimination and the Workplace*. Bureau of National Affairs.

10. Tulshyan, Ruchika. 2016. *The Diversity Advantage: Fixing Gender Inequality In The Workplace*. CreateSpace Independent Publishing Platform.

Academic articles to read:

11. Bottom, William P., and Dejun Tony Kong. 2012. "The casual cruelty of our prejudices": On Walter Lippmann's theory of stereotype and its "obliteration" in psychology and social science. *Journal of the History of the Behavioral Sciences*, 48, 363-394.
12. Devine, Patricia, Patrick S. Forscher, Anthony J. Austin, and William T. L. Cox. 2012. Long-term reduction in implicit race bias: A prejudice habit-breaking intervention. *Journal of Experimental Social Psychology*, 48, 1267-1278.
13. Ely, Robin, and Thomas, David. 2020. Getting serious about diversity: Enough already with the business case. *Harvard Business Review*, November-December, 115-122
14. Kong, Dejun Tony, and Phillip M. Jolly. 2019. A stress model of psychological contract violation among ethnic minority employees. *Cultural Diversity and Ethnic Minority Psychology,* 25, 424–438.
15. Livingston, Robert W. 2020 (September). How to promote racial equity in the workplace. *Harvard Business Review*. https://hbr.org/2020/09/how-to-promote-racial-equity-in-the-workplace.
16. Ray, Victor. 2019 (November). Why so many organizations stay White. *Harvard Business Review*. https://hbr.org/2019/11/whyso-many-organizations-stay-white
17. Sue, Derald Wing, Sarah Alsaidi, Michael N. Awad, Elizabeth Glaeser, Cassandra Z. Calle, and Narolyn Mendez. 2019. Disarming racial microaggressions: Microintervention strategies for targets, White allies, and bystanders. *American Psychologist*, 74, 128-142.
18. Thoroughgood, Christian N., Katina B. Sawyer, and Jennica R. Webster. 2020. Because you're worth the risks: Acts of oppositional courage as symbolic messages of relational value to transgender employees. *Journal of Applied Psychology.* Advance online publication.
19. Webster, Jennica R., Gary A. Adams, Cheryl L. Maranto, Katina Sawyer, and Christian Thoroughgood. 2018. Workplace contextual supports for LGBT employees: A review, meta-analysis, and agenda for future research. *Human Resource Management*, 57, 193-210.
20. Williams, Monnica T. 2020. Microaggressions: Clarification, evidence, and impact. *Perspectives on Psychological Science*, 15, 3-26.

Articles to read:

21. "America's Racial Contract Is Killing Us" by Adam Serwer | Atlantic (May 8, 2020)
22. Ella Baker and the Black Freedom Movement (Mentoring a New Generation of Activists
23. "My Life as an Undocumented Immigrant" by Jose Antonio Vargas | NYT Mag (June 22, 2011)
24. The 1619 Project (all the articles) | The New York Times Magazine
25. The Combahee River Collective Statement
26. "The Intersectionality Wars" by Jane Coaston | Vox (May 28, 2019)
27. Tips for Creating Effective White Caucus Groups developed by Craig Elliott PhD
28. "Where do I donate? Why is the uprising violent? Should I go protest?" by Courtney Martin (June 1, 2020)
29. "White Privilege: Unpacking the Invisible Knapsack" by Knapsack Peggy McIntosh
30. "Who Gets to Be Afraid in America?" by Dr. Ibram X. Kendi | Atlantic (May 12, 2020)
31. https://www.businessinsider.com/heres-why-reverse-racism-doesnt-actually-exist-in-the-us-2016-4
32. https://www.facultyfocus.com/articles/effective-classroom-management/responding-to-microaggressions-in-the-classroom/
33. https://www.annemergmed.com/article/S0196-0644(20)30259-6/fulltext