



**MINUTES FOR THE MEETING OF THE BOARD OF THE  
BOSTON PUBLIC HEALTH COMMISSION  
Wednesday, September 21, 2016**

A meeting of the Board of the Boston Public Health Commission ("Commission") was held on Wednesday, September 21, 2016 in the Hayes Conference Room, 2nd floor, 1010 Massachusetts Avenue, Boston, MA 02118.

**Board Members Present:**

Francis J. Doyle, Esq., Chair  
Monica Valdes Lupi, JD, MPH, Executive Director  
Harold Cox  
Tyrék D. Lee  
Myechia Minter-Jordan, MD, MPH

**Also Present Were:**

Tara Sicellon, Ali Ragan, Martha Farlow, Rick Winterson, Grace Connolly, Stephanie Knight, Gerry Thomas, David Pia, Osagie Ebekozi, Dr. Huy Nguyen, Debra Paul, Debbie Allen, Catherine Cairns, Brad Cohen, David Susich, Ilyitch N. Tábor, Dr. Ed Bernstein, Jen Tracey, Devin Larkin, Ché Knight, Marjorie Nesin, Anita Barry, Lia Beltrame, Ludy Young, Steve Stephanou, Tim Harrington, PJ McCann, Mimi Brown, Chuck Gagnon, and Kathy Hussey.

**Proceedings:**

**Chairman's Comments**

*Francis J. Doyle, Esq.*

- The meeting of the Boston Public Health Commission's Board of Health was called to order by Mr. Doyle at approximately 4:05pm. Welcome to everyone here. Before getting started on anything else, Mr. Doyle introduced our newest board member, Tyrék Lee, who fills the final open seat that was on the Commission and was recently vacated by Celia Wcislo, who was also from SEIU1199. We very much welcome Tyrék Lee our new colleague. Tyrek is the Executive Vice President of the SEIU's Local 1199. Tyrek has a lot of experience. He's been working for many years, starting over at BMC. Tyrek joined the union in 2002 as a telephone operator at Boston Medical Center and made history as the first African American man to lead a major statewide union in the Commonwealth. Tyrek has played a key role in the union's organizing, political, and coalition building efforts.
- He helped to advance the "Fight for \$15", leading 1199SEIU members who have secured new contracts at Lynn Community Health Center, South Boston Community Health Center, and Whidden Hospital.
- As part of the national "Fight for \$15" movement, Tyrek recently helped lead negotiation teams that secured all workers at Boston Medical Center a starting minimum wage of \$15/hour. That announcement coupled with other \$15 victories secured the 1199SEIU members have triggered a domino effect within the industry, prompting other major employers to adopt or pledge a pathway to a \$15/hour minimum starting wage for employees.
- Tyrek has been a leader and is the up-and-coming of the next generation of Union leaders. We're very proud of that. We're very proud to have him with us now and have him engaged here, influencing and teaching us a lot from the Union side and perspective of public health, particularly because he has so many members that are working in the public health system both in Boston and throughout Massachusetts. Welcome very much, Tyrek.
- As you can see from our Agenda today, we are continuing along, as Monica had explained before, on trying to make these meetings of the Commission pertinent to the daily topics of interest in the public health spectrum. Whether or not they've hit us for decision making or not, they are certainly critical to what is happening in the public health of the people of Boston. Today, we continue that new tradition, if you will, that was established for these meetings with delving into opiates and opioid abuse crisis that we are facing nationally, state-wide and locally.

- Mr. Doyle was thrilled that Monica has put together with her team a terrific presentation on that which is extremely timely. Inevitably all of this will come together for Board action on different aspects at some point in the future as we all know, but it also edifies us. He believes it also accomplishes a second goal that we have as your new, if you will, Commission advised by our elder statesmen. We want to make these Commission meetings both topical with what's going on and also what's of interest to the public. Monica is working with her staff to work more on engaging the public with these meetings so that we can engage with them and also so that the public has the opportunity to see the presentations that have been so substantive, particularly over the last few months.
- We have been talking about some of the major issues over the last few months. At some of those meetings of the Board, there have been questions and there have been follow-ups requested of staff. You have in your board packet now on the left-hand side is a Board Follow-up that includes the major issues that were raised during those prior meetings. Monica and the staff will be updating that regularly so that you know that all of us are paying attention to what we talk about and follow-up and continue to pursue those subjects that are so important, like Zika, like Lead, and others that we've had over the last few months. Thank you Monica very much for that.
- Also, just underneath that on the left-hand side of your packet, one of the things that did come up in a meeting, about three (3) months ago, was the whole issue of the funding of Zika and the problems that were going on in Congress. You may remember that our former Executive Director of the Commission, John Auerbach, was on the phone with us that day from the CDC where he is now responsible for the Zika activities nation-wide. We asked John what might we do that would be helpful to him. He certainly thought supporting the funding in Congress would be something that would be worth our while to pursue. You have a letter there that's been drafted to our Congressional delegation, not that any of them need to be introduced to the subject, they're all very supportive. I think it's always good to let them know how important it is to the local board of health that they address these issues that become nationally stuck in the mud, if you will, and to show them our support for their activity. Thank you again staff for following up on that.

#### **Acceptance and Approval of Minutes from July 20, 2016 Board Meeting**

- Without pursuing any of that further, I'd like to entertain a Motion to accept the Minutes, which you have also in your packet, from the meeting of July 20th. Dr. Minter-Jordan seconded the Motion. May I ask for a vote, for all those in favor say "Yea." The Minutes from the July 20, 2016, meeting have been unanimously approved by the Board members in attendance. Thank you very much. I will now turn things over to our Executive Director.

#### **Report from the Executive Office**

*Monica Valdes Lupi, JD, MPH*

*Executive Director, Boston Public Health Commission*

- Monica thanked Mr. Doyle and welcomed her fellow Board members. Welcome again to Tyrek. We're really excited that we have a full slate now on the Board. Monica had a chance to talk with Tyrek last week and get to know him a little bit better. She learned that they do share something in common, in terms of a personal history/journey is that they both spent some time in Ohio. Tyrek spent time in Cleveland; she spent her first couple of years here in the States growing up in Youngstown. We're really happy that Tyrek is with us because it really does round out the membership of the Board.
- Monica wanted to highlight a couple of ways BPHC has been in the news, some updates on grants we've received and some grants we have going out, and then round that out with some updates on the Government Relations front. This is a feature that she plans on doing on a routine basis as part of the Executive Director Report to the Board.
- As you may have heard last night, we have a new case of West Nile Virus that was confirmed. The patient was diagnosed with West Nile Virus by testing that was completed yesterday by the MA State Department of Public Health. They reached out to Dr. Barry, who is present, and Dr. Nguyen. Our Communications team quickly worked together to pull together a health advisory to underscore the prevention efforts that we have to promote, in terms of using mosquito repellent and being aware of the risks around West Nile Virus particularly. This is the time of the year when we'll see cases. This is the first case in Boston. We can share information offline about where to receive the materials from Dr. Barry's staff which is available in multiple languages.
- Monica wanted to also highlight that in the news, we've been very busy with Jen Tracey, our Director for the Mayor's Office of Recovery Services and Devin Larkin, our Bureau of Recovery Services Director. They are working with our colleagues at City Hall and other partners throughout the City on Recovery Month events. We did a launch with the Mayor last week for the new partnership with the Mayor's 311 Line and our PAATHS Program. We'll hear more about that later. We were also part of a group of department heads that joined the Mayor at the Recovery Day events on the Boston Common and the March to Faneuil Hall. There are a series of upcoming weekend events throughout the rest of the month. Monica wanted to flag that with all of you.

- Monica had the opportunity to attend a press event last Saturday with Mayor Walsh, Chief Arroyo, and Ilyitch Táborá, who is Chief Arroyo's Chief of Staff, colleagues from the Office of Immigrant Advancement and Councilor Wu and Councilor Campbell at the Timilty Middle School where the Mayor signed a new Ordinance. The Ordinance is aimed at residents throughout the City who speak any language other than English who have some visual and/or hearing impairment are accessing City services through proper translation, interpretation and assisted devices. This is really exciting. It's actually work that the Commission has been leading in with our residents. With our materials we were able to inform the process by participating in a working group. We look forward to sharing more about how that Ordinance will be implemented City-wide across all departments with the Board.
- In terms of grants we have received, Monica wanted to let the Board know really exciting news, that from the Department of Public Health, Bureau of Substance Abuse Services ("BSAS") recently notified the Commission that we received continuing funding for Family Residential Substance Abuse Treatment Services. These services are provided through the Entre Familia program at Mattapan. This is actually a grant that we had received in the past and was put out for a competitive re-bid by the State. We're really excited that we were selected as one of the eight (8) grantees. We learned about our award just this week. The award is for a little over \$1million annually.
- We released the Neighborhood Trauma Team RFP last Friday (Sept. 16, 2016). During the late spring-early summer months, the BPHC worked on organizing a series of Listening Session throughout the City. We were able to hear from a community assessment process that engaged over 350 individuals, including youth, parents, and service providers, in Roxbury, Dorchester, Mattapan, Jamaica Plain and East Boston. We partnered with community health centers and other community-based groups to organize these Listening Sessions.
- We took the information that we heard, worked with colleagues at City Hall: Chief Arroyo, Commissioner Morales (BCYF), Dan Mulhern (Public Safety Director for the Mayor), and Conan Harris (Deputy Director of Public Safety Initiatives/Director of My Brother's Keeper Boston) to develop a new RFP. The letters of intent are due next week. We'll be holding bidders' conferences and taking on questions as they come in. The deadline for the applications is October 14, 2016. More to follow on the development of those new grants. Monica is looking forward to a wonderful opportunity of working with the Board to make those announcements later in October.
- It's a very busy time for our team in Government Relations working with our bureau directors and programs. There are many proposed regulations that have been released by our colleagues at the Massachusetts Department of Public Health. Monica just wanted to flag a few of those for the Board members. Today, our colleagues at the Department held public hearings on the proposed changes to the DoN (Determination of Need) Regulation. The staff is working on submitting formal comments by the October 7, 2016 deadline.
- We are also reviewing a Request For Information that MassHealth has posted to seek feedback on the development of its Community Partner program. This is related to the work MassHealth is doing to establish Accountable Care Organizations as part of their 1115 Waiver, ensuring that those new models of care are contracting with, partnering with Community Partners. The staff will be working to develop comments for that RFI.
- Tomorrow, DPH is holding a hearing on the proposed regulations on Mobile Integrated Health and Community EMS programs. We are developing comments and Chief Hooley will be testifying on behalf of the Commission and Boston EMS to present some perspectives on the proposed regulations. Monica thinks that this is an interesting evolution in terms of the work that EMS has been doing here locally and bring some examples and practices from other parts of the country to really look at access to care in the role of emergency medical services.
- On Halloween, Monday, October 31, 2016, DPH will be holding a hearing on the proposed amendments to the reportable diseases surveillance isolation and quarantine requirements. Dr. Nguyen and Dr. Barry are taking the lead in working with our team to review the proposed changes and develop comments and testimony.
- Finally, in terms of proposed regulations, you might have also heard recently that DPH has proposed some amendments to their Medical Marijuana Regulations. The staff is going to be reviewing those and considering whether we'll weigh in and develop some comments.
- Monica also wanted to extend an invitation, on behalf of Ilyitch Táborá and Chief Arroyo, to the Health and Human Services Staff Appreciation Event that Chief Arroyo is holding this Sunday. We'll get the invitation to both of you. Mayor Walsh's Chief of Staff, Dan Koh will be attending. It really is an opportunity for Chief Arroyo, Chief Koh and the Mayor's Staff to thank all of the really hard working committed staff across the seven (7) departments that Chief Arroyo leads under the Health and Human Services cabinet. He wanted Monica to make sure that we shared that invitation with all of you to help us celebrate and thank the staff from the Commission along with staff from other sister agencies. That was a lot, but we haven't met since July and Monica wanted to provide the Board with those updates.
- Frank asked if there were any questions. Tyrek asked the time of Chief Arroyo's event on Sunday. Monica told him it was at Noon.

- Frank had a comment before giving the floor back to Monica. We're trying to keep the focus of the of the Board meetings on those things most pressing in the City. There's a wide variety, nationally, state-wide, but particularly in this City as leaders in the response to the substance abuse and opioid crisis that we have been facing. We have so many activities at the community level, at the city level, at the state level in trying to address this. You all know, and I hope share my pride, when the Mayor got up in front of a national audience on national television and declared himself an alcoholic to the nation. You know that this is an extremely important subject to him personally and that he's been involved with for a very long time. We have not made the kind of progress any of us would like to have made during this period. It seems that we finally have all levels of government in a strong focus on this. The challenge now is to coordinate all of those resources from the Dimock shelter's detox beds, to our own shelters, and the substance abuse programs that we do run, to coordinate with the state and even with some of the federal programs that are, at least, funding change locally. I'm very pleased that the staff has put together a robust presentation for today. I'll let Monica introduce the staff that will be speaking to you.
- Thank you. I want to thank Frank for helping us shape the panel for this afternoon. And also want to recognize that we carved out enough time on the agenda so that you all have an opportunity to engage in the discussion. I think we're really fortunate on our Board to have leaders, both locally and nationally, with Dr. Minter-Jordan, with work that's happening at BMC that Kate and her team are leading and others in this work. We all see it in our neighborhoods. I want to thank you all.
- As Frank said, we have a really exciting panel that we pulled together. I wanted to let you know we did extend an invitation to our state colleagues, but as I rattled off all the amendments to proposed regulations, they weren't able to join us. In their place, I think we'll have some good presentations and discussions. The Board heard some updates in January. This is will be new information on work since the staff and our colleagues at BMC have been here.
- We'll start with Chief Hooley from Boston EMS who will share with us some information about the work they are leading on the Narcotic Related Illness data surveillance work. You may have seen this in the Herald today. Chief Hooley will be followed by Dr. Bernstein from Boston Medical Center and Lia Beltrame who's from our PAATHS program and will highlight the work they are doing in collaboration under the Opioid Urgent Care Center at BMC. Thank you very much for joining us this afternoon, Dr. Bernstein.
- We also have Jen Tracey and Devin Larkin who'll talk with us and share some updates on the work they're doing through the Office of Recovery Services and PAATHS, and some expanded outreach that we're doing as a cross-departmental team at City Hall. Frank informed the audience that after each of the presentations, he'll open the panel to questions from the Commission and after that, would welcome any questions they may have. As the presentations are being made, feel free to jot a note to yourself and we will open that up for questions from the audience. Monica asked that we hold those questions until the end of the panels. Thanks, Chief.

**Presentation: Opioid Crisis: Briefing on Local, State, and Healthcare Partnerships**

*Chief Jim Hooley, Boston Emergency Medical Services (BEMS)*

*Dr. Ed Bernstein, Boston Medical Center (BMC)*

*Lia Beltrame, Director, PAATHS Program, Bureau of Recovery Services (BRS)*

**Updates and Questions:**

*Jen Tracey, Director, Office of Recovery Services*

*Devin Larkin, Director, Bureau of Recovery Services*

**Chief Jim Hooley, Boston Emergency Medical Services (BEMS)**

- Chief Hooley stated the NRI (Narcotic Related Illness) information may seem familiar to some of you from past presentations. Chief Hooley reviewed the use of Narcan (Naloxone CHL) in Boston. It began in 1978 when Boston EMS Paramedics began administering it. Boston EMS was granted a Special Project Waiver: BLS Narcan in 2006. The following year, 2007, BPHC issues Narcan to Friends/Family. In 2012, BEMS proves BLS Narcan concept which resulted in a change in standard statewide protocols. The First Responder Narcan Program was launched in 2013.
- BEMS has developed a four-point NRI Methodology: 1) Documentation - all patient encounters are documented in the electronic Patient Care Report; 2) Data Query - an automated query is run searching clinical impression, cause and free text fields; 3) Manual Review - all records with one or more of the identified key words/text strings is manually reviewed by a department paramedic/analyst to determine if they meet the case definition for NRI; and 4) NRI Classification - the analyst categorizes NRI calls as either Heroin Observed (HO), Heroin Mentioned (HM), or Other Abuse ( OA), as well as type of opioid/opiate. Of the 2,601 NRI calls in 2015, the vast majority (83%) were coded as HO. EMS personnel who cared for the patient may be contacted for additional information.

- Chief Hooley explained the BEMS NRI data terminology. **Narcotic Related Illness (NRI)** - a Boston EMS clinical incident identified as suspected to be related to narcotic use (including opiates and opioids) after review. Potential NRI cases are identified based on information entered in patient care reports by on scene EMTs or Paramedics, with confirmation of pinpoint pupils and altered mental status. It does NOT include: cocaine, meth, benzos, or marijuana. **Cardiac (CARD)** - Patient with identified NRI (based on presence of narcotic paraphernalia or verification by a first-person witness) determined to be in cardiac arrest, without vital signs, by Boston EMS. **Heroin Observed (HO)** - Heroin drug use identified based on presence of altered mental status, myosis, patient's admission of heroin use, evidence of recent/chronic venipuncture, possession of narcotic injecting/insufflating paraphernalia, and/or eye witness report of heroin use. **Other Abuse (AO)** - When a patient admits to an opioid source other than heroin. **Heroin Mentioned (HM)** - A case where the patient admits to narcotic use as part of their medical history, but is unrelated to presentation. **Narcan Given** - A narcotic-related incident in which patient's condition required administration of Narcan. **Referred to Medical Examiner (RME)** - a patient with identified NRI (based on presence of narcotic paraphernalia or verification by a first-person witness) determined to be non-viable on scene and referred to the Medical Examiner by Boston EMS.
- A chart was shown depicting an historical perspective of BEMS NRI incidents from 2010 through 2015. *NRI* cases increased from 1,013 in 2010 to 2,601 in 2015. *Narcan Administered* incidents went from 232 in 2010 up to 1,196 in 2015. *Cardiac Arrest* incidents in 2010 totaled 9 and rose to 31 by 2015. Incidents *Referred to Medical Examiner* totaled 10 in 2010 rising to last year's total of 67.
- Another chart with a weekly NRI Snapshot of results was shown which included: Total Cases of NRI, RME, Narcan Given, Heroin Cases, Heroin Mentioned, Other Abuse, Cardiac Arrest/Transported to a Hospital. The results are then compared to the same time period for the prior year; the same comparison is made for year to date results. For example; during the week of Sept. 12, 2016 to Sept. 18, 2016, there were 57 Total NRI Cases. During that same timeframe in 2015 there were 47. From Jan.1, 2016 to Sept. 20, 2016, there were 2,193 cases; in 2015 from Jan. 1st to Sept. 20th, there were 1,914 reported cases.
- According to BEMS, of the 2,193 suspected NRI incidents from January 1, 2016 through September 19, 2016, 73% were male and 27% female; 53% were given Narcan (1,161). Lastly, Chief Hooley showed a graph of NRI incidents year-to-date by Zip Code. It's sort of misleading because there are hot spots on maps where it's a portion of a zip code that drives up the numbers disproportionately. If you count a lot of people within a quarter mile circle around an area, it can hit 2 or 3 different zip codes. Also, this only tells you where we encounter the incidents. It doesn't tell you where they live. Some of the highest numbers were for Roxbury and Dorchester, but still would take the zip code information with a grain of salt.
- What do we do with this information? Historically, for years we share it with the Addictions bureau, now the Bureau of Recovery Services, where we are referring people out, are we talking to clients to see if they need Narcan and/or Narcan training. Everyone taken to the hospital gets a copy of their chart with a detailed history of what we saw on scene. We share the information with others involved in treating our patients, including inside hospitals. We do that with trauma as well.
- We work with the BPD and the Boston Regional Intelligence Center (BRIC), the intelligence unit up there. We're very careful about patient information. We work with their drug unit. If there are deaths, that's a legal matter and the police are involved. If we start to see a spate of calls somewhere, there are always questions that come up. You see it in the media all the time. We can share that information or if we have suspicions we can share it with the BPD and they may use it for law enforcement efforts.
- We also get information from DEA in New Mexico, New Jersey, and Rhode Island. What are providers there saying? Is there something else going on? Things that may alert us to trends that may affect our area. We're starting to work with the courts on the sequential intercept for the whole jail diversion to treatment and see how we can share information without compromising patient information. We met with DPH last week to get better information sharing with them around their efforts to coordinate this. The good news is there are a lot of players willing to help because we all have information. Now we're tackling ways to better seamlessly share the information so that we can, in real time, make a difference.
- Monica and the Board thanked Chief Hooley and introduced Dr. Bernstein and Lia Beltrame.

**Dr. Ed Bernstein, Boston Medical Center (BMC)**

- Dr. Bernstein is the Program Director at the Faster Paths to Treatment Opioid Urgent Care Center. This program is a collaboration of Boston Medical Center, the Boston Public Health Commission and the MA Department of Public Health Bureau of Substance Abuse Services. Dr. Alex Walley is the Assistant Program Director. Lia Beltrame is the Director of the PAATHS Program at BPHC.
- Dr. Bernstein stated he started at Boston City Hospital in 1988. He was here with Judith Kurland and Al Plough at the time when the hospitals were called to task because of the high rate of infant mortality. He really is a firm

believer that the hospitals have something really important to offer during the opioid crisis. At this stage, he will report on what his hospital has been doing in this partnership.

- When we started, we were all in Room Five which was right in our Emergency Room Department. Under the leadership of Judith Kurland and Al Plough, we were able to bring to the attention that we were somehow powerless as nurses and physicians to deal with, in an appropriate way, to finding treatment for people with addiction. They had a target cities grant at that time, at three intake centers: Fruit Street at Mass. General, one at Dimock and the one in our Emergency Department Room Five. We went to them and said we were interested in doing something more. So we applied to SAMHSA for a grant Al Plough backed us up and we got a grant for practical services. What are practical services? It was bringing people from the community to do "inreach" and who themselves had been or were in recovery, knew the resources and they could help us do a better job of taking care of our patients. Those are some of the roots of our collaboration that's been over the last 25 years. And I'd just like to speak to that and how important it is.
- Dr. Bernstein commented that a big part of their collaboration is the importance of data and knowing where the "hot spots" are. He then presented a chart comparing BEMS patient transports to Boston Hospitals and Medical Examiner for NRI's in 2014 and 2015. NRI includes many categories such as heroin-related, and/or Narcan given in both fatal and non-fatal ODs or transports where clients were in cardiac or respiratory arrest from opioids. In 2015, BMC transports increased by 228 over 2014. MGH increased from 388 to 488 in 2015. NEMC transports increased by 74 to 397 in 2015. Carney, Faulkner, BIDMC, and St. Elizabeth also had increased transports. BWH actually decreased by 1 from 2014 to 96. Overall in 2015, there were an additional 564 transports in 2015; an increase of 34%.
- Dr. Bernstein noted that the one thing Naloxone interventions have not been able to address fully is the Fentanyl addiction and Fentanyl adulteration and counterfeiting. We hear about people in Connecticut who think they're getting Cocaine or "white powder" and it turns out to be Fentanyl. We were very happy to see a report that just came out from Michael Botticelli and the President that they were going to try and get to the source. There needs to be work done on that, especially the major sources of some of the Fentanyl that's come into this country. We don't have sufficient access to treatment in this state or in the community even though there's high demand.
- BMC's Emergency Center has Project ASSERT which is very active and hands-on referral system. Dr. Bernstein presented data from January to December 2015 which showed there were a total of 2,250 patients seen for detox placement. Of those patients 1,723 requested detox and 56% (960) were placed; 763 patients were denied detox; and 527 patients were not interested in detox. Their data also shows that between 2010 through Jan.-June 2016, at total of 1,085 Naloxone Rescue Kits had been distributed. The distributions were done via Project ASSERT to patients, Project ASSERT to Patient Social Network, and/or Physician Rx to Patient.
- Over the last two decades, Boston Medical Center has developed and implemented a wide range of programs to address substance use disorders in the emergency department (Project ASSERT), clinics (OBAT) and inpatient hospital setting (ACS). BMC launched a new program on August 1, 2016, *Faster Paths to Treatment (FPT)* funded through a MA DPH Bureau of Substance Abuse Services' Opioid Urgent Care Center grant.
- Faster Paths brings together and enhances existing services through coordination, economy of scale, increased resources, and active collaborations with existing community agency partners and the Boston Public Health Commission (BPHC). Our Vision is to provide respectful, supportive, and effective pathways for patients with unhealthy alcohol and drug use to improve health and quality of life for themselves, their families, and their communities. Our Mission is to integrate, enhance and fill the gaps in the existing continuum of substance use disorder patient services.
- Faster Paths to Treatment / Opioid Urgent Care Center (OUCC) rapidly evaluates, motivates, and refers patients with substance use disorders to a comprehensive care network of inpatient and outpatient detoxification, treatment, and aftercare services integrated with mental health and medical care. We will incorporate and build upon the existing addiction services provided by Boston Medical Center (BMC) and Boston Public Health Commission (BPHC), filling the gaps in care to create a seamless continuum. We will provide weekday access to Medication Assisted Treatment (MAT) in the Faster Paths Outpatient Unit: on-site Pharmacy with liaison to facilitate Prior Authorization and on-site Lab and drug testing with 1-2 hour turn around.
- Faster Paths to Treatment /OUCC considers patient safety a priority. We are working to enhance current BMC network of providers. We want to serve as a central for intake medical, substance use, and behavioral health assessment center concentrating on Essex, Suffolk, Middlesex, and Norfolk Counties. We will ultimately accommodate 1,000 estimated patient visits per month by July 2018.

- We've added the Medication Assessment Unit (MAU) will provide Buprenorphine/naloxone Induction/Stabilization and Naltrexone and Methadone access. The unit will be staffed Monday to Friday: an addiction MD will be available 8a.m. to 12p.m. and an addiction RN will be available 8a.m. to 4:30p.m. Our goal is to transfer people to more definitive care, but they have to be stable beforehand. We've had 45 patients that are now getting medications in this unit. (We estimate 100 referrals monthly). We have this system in place to make sure that people are safe and, as much as possible, are not being reverted back into the streets. The MAU will provide maintenance referrals to OBAT, Adolescent Clinic/CATALYST, HIV Clinic, Family Medicine, Addiction Psychiatry, Project Respect, and FQHC.
- PAATHS: Recovery Specialist/Coaches provide: Case management support and referrals to community-based housing, education, employment support; Medical and social service navigation - accompanying patients to pharmacies, social services, and medical or behavioral health appointments; Chronic disease self-management support - home visits for health education and medication adherence support; Provide support needed to initiate and engage in treatment - transportation to Acute Treatment Services (ATS); MAT and other Outpatient appointments; assist in obtaining government IDs and money; conduct support group meetings - AA/NA and connecting with sponsors.
- We have a wonderful external referral network: ATS/CSS - Lahey Health Behavioral Services, Dimock Center/Women's Renewal Program at Bournewood Hospital; Adcare Hospital, Highpoint, Phoenix House, Andrew House/Shattuck, Community Healthlink/TSS, Transition BPHC, Specrum Health Services, Inc., Baldpate Hospital, St. Elizabeth's Comprehensive Addiction Program (SECAP), NORCAP Lodge, Stanley Street Treatment and Resources (SSTAR), BEST Team, ARBOR, MAT - CSAC, Habit Opco, New Horizons Buprenorphine Program, Health Care for the Homeless; South Boston Collaborative, BPHC's Men's Health Recovery, BPHC's AHOPE, Mom's Project/MORE Program, Hope House, Gavin House, Victory Program, and BPHC's Entre Familia.
- Dr. Bernstein asked Ms. Beltrame to speak about their relationship with the Bureau of Recovery Services. Ms. Beltrame stated she would talk more about PAATHS afterwards. They are very happy to be partner with BMC. They've been working closely together for a number of years and since this grant, even more so. BMC has been able to refer to PAATHS. We've been able to refer to Faster PATHS which has been very helpful in getting people the help they need. It's been a great relationship.
- Dr. Bernstein commented that one of the patients that came to them told him that if it weren't for the Peer Recovery Support, he would have been using that day. A person came right out and asked where he was going and physically brought him over to our clinic and the next day he was on a maintenance program.
- We've done a lot of community outreach. People need a lot more than just medication. They need housing and actual services that will help stabilize them. Perhaps Ludy would like to talk about our work for a minute.
- Ludy Young introduced herself. I am a supervisor with Project ASSERT at Boston Medical Center. As Dr. Bernstein pointed out, we're approaching our 20th anniversary. It's taken us two (2) decades to build our resources in communities, such as Dimock for example, our Primary Care Family Medicine within BMC, and also with our suburban partner s outside the Metropolitan area that help us get people to detox. Also, that includes some of our private facilities, Adcare for example, and some of the new ones that have come into play. It's beneficial for our patients because oftentimes they'll say they want to get out of Boston. For me to have that opportunity for them is a wonderful thing because a lot of them can use a geographical change. They're entitled to go outside of Boston if they're able to do so. We are partnering with a company that will provide transportation for our patients. We're also working on getting Commuter Rail passes for the weekends.
- Project ASSERT's acronym stands for Alcohol, Substance Abuse, Education, Referral and Treatment. In our Emergency Department at BMC, we've been doing just that and also partnering with the old Room 5, now Faster Paths Program, where we've been referring patients, not only to detox but for primary care. We do a "cold call", going from room to room to visit our patients in the ED and offer them services, such as primary care, health insurance, and referrals. For those who are seeking detox, whether in-house or elsewhere, we can make that happen at the bedside. Our patients do appreciate the visits. The one-on-one attention that they get, even the 5-minute interventions that we do, are important. Patients come back and report that that brief intervention was meaningful for them. Even those struggling with addictions, the chronic relapsers, know they can always come back to Project ASSERT and/or PAATHS and will be accepted just the way they are and will be treated with respect.
- Monica thanked Dr. Bernstein and Ms. Young for giving us the history. It is a great reminder about how so many of the innovations we're hearing about now with SBIRT, Narcan and Naloxone, really have been pioneering for other healthcare systems across the country. We're all looking forward to seeing how this Faster Paths Program develops for you in your continued partnership with us and the Board and continue to be national leaders in this work. Thank you for sharing that. We'll round out with Lia first, then Jen and Devin.

***Lia Beltrame, Director, PAATHS Program, Bureau of Recovery Services (BRS)***

- Lia introduced herself as the Director of PAATHS and explained that PAATHS stands for: **Providing Access to Addiction Treatment Hope and Support**. A variety of treatment options exist for individual seeking treatment for drugs and alcohol use. This presentation will navigate this continuum, and help to understand the types of treatment available and appropriate level of care can be challenging. The levels of care include: MAT, Detox, CSS, TSS, HWH, Sober House, Recovery support programs and outpatient counseling programs.
- There are common barriers for people seeking treatment: co-occurring medical issues and SUD; co-occurring mental health and SUD; insurance coverage; medication, unstable housing/homeless; program availability (no beds); transportation; restriction from programs. A typical case scenario: 31yr. old single white male; homeless staying in shelter, presenting to PAATHS; needs help accessing post-detox services; history of heroin use 10 years; 5 ODs in the past 2 months; suffers from depression, bipolar and taking Lithium; also has asthma, diabetes, high blood pressure - lost all medications for medical issues. Current encounter: patient was discharged from ATS to the street due to no bed availability at CSS/TS; he has no ID and no primary care provider.
- PAATHS provides: walk-in services; assessment, referral, case management, advocacy; helps facilitate access to all levels of care; remove barriers that hinder access to care; coordinates treatment with medical and mental health providers; provides information and resources to families and friends; provide community support/TA; and Hotline/311.
- Lia provided a chart with data collected for the period January 1, 2016 through September 1, 2016: Walk-In visits totaled 5,444; an average of 641 walk-ins a month. The Hotline received 3,298 calls; an average of 392 calls a month. Over 1,500 people were placed in treatment programs. Services requested by levels of care: 50% detox, 35% CSS/TSS (post detox inpatient programs), and 15% OPC/MAT. PAATHS averaged 90 new clients every month.
- Lia presented case scenarios for discharge planning: Patient is admitted into ER and needs detox. Provider calls detox facilities and there are no beds available. Patient is admitted into ER/hospital after an overdose. Provider offers treatment but patient does not want to go to treatment; Patient comes in with family and/or friends and family and friends are the ones asking for resources/information. PAATHS discharge planning involves a Safety Plan: do you have a safety plan? Where are you going to stay tonight? (if the option exists, always give patients the option to leave in the morning as opposed to evening or night). Is there anyone you can or need to call? Do you need me to call the shelter for you? We provide overdose prevention education and where to access services (e.g. AHOPE, PAATHS). **\*\*\*If a patient is being referred to PAATHS, please call us and let us know before he/she is discharged.**
- PAATHS is located at 774 Albany Street, Boston, MA 02118 (across from Boston Medical Center.) Patients are seen on a first come, first served basis and early registration is encouraged. **The Hotline is: 1-855-494-4057 or call 311 if in Boston.** The walk-in hours are: Monday: 7:30am - 3:30pm / Tuesday: 7:30am - 3:30pm / Wednesday: 7:30am - 1:30pm / Thursday: 7:30am - 3:30pm / Friday: 7:30am - 3:30pm.

**Updates and Questions:**

***Jen Tracey, Director, Office of Recovery Services***

- Jen introduced herself and stated she's been here a couple of times talking about their services. She's taking this opportunity to reiterate the innovative program of initiating the 311 Line for Boston residents. It is probably the first municipal referral line that's 24/7. We are able to utilize the constituent service line in the Mayor's office with 311 for people to call. Then we have worked with partners. The state is partnering with us on some off-hours. We have some community partners that are helping us with overnight as well as we try to figure out the resources necessary to cover this 24/7 with other community providers or within the Commission itself.
- If you're in the field, or have had a family member or loved one that has had a question or needed services, you know that people still did not know who to call or what to do, at least on the City level. We knew that we have services: Dimock, providers, PAATHS, BMC, to start, that are doing this work every day. However, unless you're "in the know", you didn't know about it. We think the 311 will certainly work as we work through the kinks in the system going forward and after only being a week into it. We welcome your feedback if you have any problems. We hope to have some sort of public awareness media campaign in the future to really spread the word through our networks. Jen wanted to take this opportunity to reiterate that part and thank everyone for their partnerships.

***Devin Larkin, Director, Bureau of Recovery Services***

- Devin introduced herself and shared an update with everyone about their new Outreach Team. She believes most of us have seen in the press about this area being the "Methadone Mile." We are working to rename it "Recovery Road." Local news and newspapers have been coming out with some pretty harsh articles about things that have been happening in this neighborhood.
- We know there's a lot of very innovative care being delivered in the neighborhood. We also realize that's not always evident to people when they're driving by on the street. What people are seeing on the street is really hard right now. People are very sick. There are a lot of crowds out on the street that appear to be in need of treatment and/or support services.
- The City of Boston has reallocated funds for 4 FTEs that have been assigned to our bureau. They will be on the street 7 days a week from 8:00a.m. to 4:00p.m. They'll be out on the street in our neighborhood, Melnea, Mass. Ave., Albany Street, up to the Southampton Shelter and Clifford Park, the hot spots areas. They'll be engaging with folks and asking what they can help them with. If they want to be connected to treatment, they'll be happy to walk them to either our building, BMC or any of the other treatment providers.
- They will also be introducing themselves to all the treatment providers. They have networks in both the Methadone clinics; with Project ASSERT; with Hope House; with Victory Programs, one of the largest providers in the area. They're a way to kind of loop the network together during the day if somebody needs help. If we're worried about someone and they need a walk to the next appointment they have, they can call the Outreach Team and they will walk the person. If a person is anxious about walking by themselves, Outreach Team is there to do that. If somebody appears impaired on the sidewalk and it's not a medical emergency, or needs EMS at this point, but we're worried about them and want them to go inside, we can take them to a safe place. It may be AHOPE. It may be PAATHS. It may be Healthcare for the Homeless. It may be Project ASSERT. We can get them to that place where they can be medically evaluated or, within a safe space, be observed; not out in the street where they're at risk for an overdose, a victim of theft or being caught up in traffic.
- The idea of this Outreach Team is really to: get a sense of what is going on in the neighborhood; what would be useful to the clients - what do they want to see more of; and how to get people from spending their day on the street corner to maybe having more places to be during the day. This has only been going for about 5 weeks. We're doing a 90-day pilot and will report back on the results, hopefully in a few months.
- Monica thanked Jen and Devin for their time and updates and apologized they were abbreviated, but we needed to make time for panel questions. She also thanked the other presenters for coming.
- Frank commented that he would like to deal with the audience as a kind of panel of respondents because there is such a wealth of information and activity in this area. He asked a question to get things started and open it to his fellow Board members. He is very cognizant, being with Boston HealthNet at BMC, of the difficulty sometimes in communicating just how much is out there. Or coordinating it so we're not tripping over each other doing the same thing in one area and totally missing a gap in some other area. Now that there are new funds from the State and others. Even with private foundations like GE coming into this space, it's all the more important that we use those most efficiently so that we hit all those gaps and don't continue to have everybody trying to attack everything at once. Thank God for all of you and the work that is being done and for the leadership at City Hall and here at the Commission that is helping to drive that public policy. It's the responsibility of the Commission to help make that a unified effort and a coordinated effort.
- I did hear from Ed that those seeking detox, he was only able to provide it to 56% of those that requested detox. Taking that, then asking the question about within BMC the capacity in the new Urgent Care Faster Paths program and what's happening over at PAATHS, what are you experiencing as far as with all this robust activity in this area? No matter how much we try, if we don't have that 44% gap better filled, a lot of this activity is going to go unresolved for the individual patients that need the detox. So let me just throw that out for discussion to ask all of you as a group to think about.
- Maybe we could start with the new Urgent Care. Do you see a capacity issue yet? I think you said you've seen 45 patients. Dr. Bernstein said it's 45 patients on medication and have had visits and other visits associated with PAATHS. There are assessments and other types of visits associated with ASSERT. It's not the solution because we still have to move people from the Medication Assessment Unit to maintenance. There are areas to maintenance programs and patients must be stabilized in order to get into these programs. The big problem is that we need more providers. Mr. Doyle asked: do you feel within the Urgent Care Faster Paths program that you have additional capacity to handle more through the new 311 program that may pass some people over to Urgent Care in order to connect them with treatment? Dr. Bernstein replied it would be a small capacity increase.
- Ms. Larkin spoke of how they handle the wait at PAATHS. There is not always a bed on demand for detox. It's much harder for step-down services CSS and TSS. What we do with people at PAATHS is to try and help them manage the wait as best we can. We have a waiting room where they are welcome to stay all day. We have a TV,

coffee, and snacks because people are often not feeling so well. So we provide those things to really help them manage their anxiety around the wait. When we get that phone call, they want to be nearby because people might want to interview them before going into the bed. We try to make that wait as comfortable as possible.

- If we don't have a bed by the end of the day when we close, we do safety planning. We talk about how they're going to stay safe tonight. Some people have families that will help them bridge that gap before getting treatment. Other people don't and they're staying in the shelters longer. So we may do a warm handoff to some of our colleagues at the shelters; Fran and others that work at the shelters that we know. We ask them to keep an eye on this person tonight. They're trying to get into detox. We'll be back on the phones tomorrow at 7am and we're going to get them in tomorrow. Sometimes we know already that we can get them in, they have a bed for tomorrow, but they just have to get through the night. So helping people make it feel less overwhelming to manage the wait goes really far. They need to know that ok, we didn't get it today, but tomorrow we're going to get right back on this and make it happen and you can still keep coming back while we're working on referrals. It does mean that people will use that day, that night, they don't want to be ill because there's some risk involved.
- With CSS/TSS the wait can actually be several days. So we encourage them to wait with us in our meeting room everyday if that's what they want to do. Some clients really like to do that because they want to be off the street. Other clients will talk about using a recover center that might be nearby. We'll talk about things they can do during the day to manage the wait. We just started a peer lead drop-in group for these kinds of clients in our building at the recovery center. We're doing a 9:30am peer group for people who are waiting for post-detox because they're not impaired like pre-detox. We're just trying all sorts of things to manage the wait and stick with us and that we'll really get them in. The bed will be there, it's just a matter of when that bed comes up. We're going to need you right there and we're going to put you in that slot and then we're going to put you in the van and get you to where you need to go.
- For some people that are really complex, it gives us time to manage the medications they're on. People have to go into treatment with 30 days of their medications. So that means coordinating with usually a few doctors for our clients and getting those meds refilled, explaining why those meds need to be refilled this month, they need more refills because their bag got stolen, sometimes they need labs. Sometimes we'll have assignments of things they can do with phone calls. We're going to do the phone calls and you're going to do your labs and med work at BMC and we're going to be checking all day. Then we get back together at the end of the day. Frank commented this is very critical foundation for the coordination being done every day.
- Frank asked Jen, thinking that now we're into the 311 just being introduced, I know any new system takes a lot of kink work to get through. What's your first hurdle that you see as a major hurdle? Is it either of capacity in the sense of waiting, or capacity in the ultimate goal of getting a detox a bed? Or is it structural? I was thinking with Jim, as far as information exchange from the point of identification of heroin addiction or whatever, through the connection that was being spoken of by Lia with PCP connection or whatever. How do we? What ways? I don't want to throw all the answers out and then ask you to pick one. Jen what do you say?
- Jen replied that framing 311, she thinks that we've been really lucky to get additional staff to help man just this 311. I'm confident already in the work that PAATHS does, that's been described to you and with our partners that we actually have a really good system set up. Not everybody knew about it. 311 is going to allow the folks to do the work that they've been doing and keep on doing what they've been doing. 311 also the vision of it should be not just for the acute client, a family that has someone in acute stage. It should be where can I get a support group? We should move a little bit, not further down the continuum, but a little bit earlier so that people can reach out and ask questions. The vision for 311 really is essential access for questions. It could be about resources. It could be about better placement. We actually have a pretty well-oiled machine, I think coming from a state perspective that PAATHS and building on PAATHS is going to help that.
- I think it's about options too. People don't know about the options. They don't know that detox isn't necessarily the only option for folks. We have to have folks that know there are different options and different community providers. You're in East Boston. You're in South Boston. You're in Roxbury. This is what we have for you in your community. Is that going to work for you? And just continue to work with community providers and really build the City's partnership. It's beyond the Commission. It's with our big hospitals and with community providers. When you opened up talking about the 1115 Waiver, and stuff that the state is doing right now, this is a really pivotal time for us and an opportunity to do something thinking together. I hope to be calling on you all and our partnerships to figure out how are we going to make sure that we get through whatever the state decides they're going to do around that. So that we and the folks we know out there are going to continue to get care step by step. Frank commented that we're here as your partners both individually because we're all in this business too and obviously because the Commission is a part of it too.

- Harold asked for a couple of clarifications. First, Jim, you talked about the number of incidents that we are experiencing. Could you talk about that in terms of number of cases of unduplicated cases? We've got a number of incidents that occur, but I'm wondering about the number of unduplicated count of individuals who are involved in those incidents.
- Chief Hooley said that certainly some of the incidents that we respond to could be a repeat patient. I don't have that on there. I know we have looked at that from time to time. It's interesting when you look at some of the cases, anecdotally say, it has to be twice in one day if you really want to trigger a look and say what's really going on here. It could be they're at Tufts in the morning and BMC in the afternoon and they're not talking to us or even talking to each other. But something's got to get done. We'll look back at the history of a patient, at least the history that's in our Boston EMS system. We don't know anything else outside of that. We could have an individual that we saw and transported 17 times in the last four (4) years. Or we could have somebody who this is their first encounter.
- I don't have it with me, but in 2014, 2015, I think that less than 50% of the interactions we had with patients, were people who gave a Boston address or self identified as a Boston resident. There are a lot of homeless and a lot who lived outside of Boston. That's why I said the "Zip Code" thing is misleading because that's the point where we picked them up. The actual percentage of repeats off the top of my head, I don't know. Harold thought it would be interesting to understand what that number looks like.
- Ludy, you also mentioned that individuals, when people are interested, you assist them in going outside of Boston for care and for the services. Are there sufficient services outside of Boston? Ludy replied that seems to be the premise around the patients. The treatment is good. The grass is always greener. I know there have been some patients who have reported back that this place was nice. I go by their reports; I listen to their requests. I like to say I'm like that old commercial "an educated consumer is our best customer." They get first pick. If they say they want to try a place in Worcester, it's my job to at least avail them of that chance. It's not totally realistic that it will happen. One of the facilities, Serenity Summit, sends a vehicle to pick up the patients, just as Adcare does. That is absolutely imperative for our patients who cannot access the railways or have the means to get there. It's a big plus. Sometimes, a patient will say I need to get out of the City for a while. As I said earlier, sometimes a geographical change for these folks is therapeutic for them as well. They have been able to find their way and if they relapse again they'll go back there or come back local. Of course our local partners here in Boston, who I call our family, is Dimock, Boston Medical, Woods Mullen and all the rest of them, are always my first choice. What's available here is just as good as what's out in the western suburbs. I always go with that first because I like to induce a kind dose of reality, if you will. The treatment is just as good at McLean's, at Dimock, Adcare and here across the street, and to reassure them we are going to be here. This is for: (1) get you off the street; and (2) get the treatment you need. If treatment is across the street, then let's make it happen.
- Harold thanked Ludy. He just wanted to make one more comment then a question. First, thank you for the presentation. Thank you for the work that all of you do. It's a hard job and I appreciate you coming to talk with us and helping us to understand this. But, we're seeing an increase in the numbers. We are seeing better collaboration of projects and something's missing. We talked a moment ago about the business about capacity as being one issue and maybe the entry point. I'm wondering what's missing from the conversation. This is a really big conversation and a really complicated one. It's great that we've got services and it's good to hear about the things you're doing, but something's missing from the conversation. And I don't know what that is. I'm wondering if you have just a couple of inklings of things that you'd say "if I had my druthers, I would prefer if we were talking about".... And I'm wondering what that would be.
- Jen responded that she thinks the rest of the world is catching up on us. We are in a position where, as you know, for years, those that I've been working with in the field on addictions and substance abuse, we have been doing it alone. The opioid epidemic has brought many people to the table which is a good thing. Things are, systems are changing because of that, but there is still a lot of educating that we are doing to the medical field, to other fields around the disease particularly. That's what I would like to continue those sorts of conversations that have started now about medical schools getting training on addiction. It's stuff that wasn't happening, isn't happening in a lot of our schools, the medical schools, nursing schools, dental schools. In order to do a lot of the work we're doing, that PAATHS is doing and other programs, is really educating other systems. Obviously, we're very lucky because we're here in Boston because BMC has been with us for a long time. That isn't true nationally and even state-wide.
- Frank exercised his Chairperson prerogative announcing that we have an Executive Session we need to get into to discuss a real estate matter. However, I know that Tyrek had a question before we do that. Tyrek said he'd follow up later on the others, but with the "zip code" slide, does the data show the actual geographical locations? For example, Franklin Park is 50 of the 300 that happened in one year. Or Washington and Columbia Road? Is there any of that data within that Zip Code available? Chief Hooley said it was available. We do report out to large groups just the Zip Code, but we do have the ability to dot some maps and do overlays, so yes.

- Tyrek realized that we're out of time. He said the last thing he'd say was that if folks were willing to reach out to him or he'll reach out to folks to try and figure this out, the one thing he's been looking for in Boston is a preventative piece. We have a lot of treatment. We have a lot of recovery. I know our resources are limited, but I would love to partner with folks to get around before the point where they begin using the drugs. That's sometimes going to our kids and really talking to them a little bit. I don't know if you can email Monica or if you have my contact info. If there's a large group of Boston that's really focused on the preventative before you even actually take the drug, if you could let me know that would be awesome.
- Myechia had a quick request. For future conversations around this, she would love to understand the disparities in those accessing treatment and how we are administering Narcan just so we can get a slice of that in future reports.
- Frank commented he had about 47 questions he'd love to ask because we have great group of people here today that could make this almost a day-long activity. What I will do is put mine on paper and send them in and Monica can share it with all of you and let's continue the discussion offline, if you will. I would encourage, and I apologize again like I did at the last meeting, that I told the audience we would engage the audience with question time too, but we really do have to get to this Executive Session. So I apologize for that, but like us, please, if you did write down a question or two, send them in to Monica or anyone at the Commission with those questions and we will address those as well.

### **Executive Session for the Purpose of Discussing a Real Estate Matter**

- Harold called for a motion that we move into Executive Session to discuss pertinent real estate business among the members. Myechia and Tyrek seconded the motion. Frank stated for the record we had a motion that was made and seconded. In the discussion phase of that motion, he wanted put on the public record that this is a discussion of real estate issues which need to be addressed by the Board. But, I have, in an excess of caution, if you will, determined that, at least at this time in this discussion phase, I may have a conflict or could be interpreted or perceived that I might have a conflict. In some ways today, the perception is even more important than the legality as far as moving things forward. So, just to publicly put it on the record, I'll be recusing myself from that Executive Session. I've asked Dr. Jordan if she would act as the leader of that Session from the Board's perspective. On that, I will ask for a vote of all those in favor of going into Executive Session say "Yea"; the members present said "Yea". Those opposed; none. The vote is so ordered. Thank you very much all of you. We'll continue this discussion for a long, long time, I'm sure, but it's wonderful to know all that's being done. Thank you.

### **Adjournment**

Mr. Doyle adjourned the regular meeting of the Board at approximately 5:45p.m.

Respectfully submitted by:

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Kathy Hussey, Board Secretary