Navigating the Opioid Crisis: Expert Insights & Evolving Strategies

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So thank you, everybody for joining us today. We are really excited to offer you this featured session today. We are going to talk about navigating the opioid crisis. We're going to focus in specifically on opioid use disorder, because it is a chronic, treatable brain disease. And then Indivior is really focused on helping educate people on the access to medications that can be life saving for these patients. Before we get into the presentation, I do have to make a disclaimer, this program is being presented on behalf of Indivior. So this program is going to be in accordance with all applicable regulations and guidelines of the US Food and Drug Administration, as well as our company policies. The speakers you're hearing today have received compensation from end of year, but all of the information that is included in this deck is the property of end of year. So we would ask that you don't take any photos or any recordings or any pictures of it. They are going to be speaking specifically to their experience in what they do every day.

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So without further ado, I'd like to introduce you to both of the speakers. I cannot do them justice, so I will start with you. Dr Keough, would you mind introducing us, introducing yourself, and telling us a little bit about your background and personal experiences in addiction medicine? Sure. Thanks so much. I'm an internist and addiction medicine specialist, and I've been caring for people with substance use disorders for about 25 years, first integrated within my primary care practice, and then I became the medical director of a low barrier, rapid access addiction treatment program called the Bridge clinic at Mass General Hospital for which I was the medical director for about eight years. And alongside that, I also am the medical director of several opioid treatment programs in the Boston area, and I'm part of the addiction medicine fellowship program one of the supervising attendings at Mass General Hospital.

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Excellent. Thank you. And Dr Santoro, would you mind introducing yourself to the audience? Sure,

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I was first trained in family medicine and was board certified in family medicine in 1985

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and I quickly added addiction medicine to my practice. For a long time, I did both family medicine and addiction medicine, but then, in beginning in about 2012

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I started a transition to

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more Addiction Medicine as an outpatient as well as an inpatient treatment and a completely stopped doing family medicine in 2016

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I am the I was the chief of Addiction Medicine

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at Tower health for eight years, program I began, and it encompassed treating patients, doing inpatient consults, running the drug and alcohol detox rehab, as well as taking care of outpatient

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programming as well. Excellent. So we'll stay with you. Dr Santoro, what was it about addiction medicine that drew you to the space?

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It actually was a single patient I was covering as a family doctor for another doctor who was a family physician and doing addiction medicine. And I saw one patient, and I was reviewing her chart, and she had listed her goals, and she listed goals for today, just for today

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was I would like to not trade sex for drugs. And I thought, what kind of life does somebody have to live to put that down, not as a long term goal, but just as a goal for today, and that got me interested in addiction medicine, and just made it my goal to add addiction medicine into my practice, never realizing it would take it over completely within a few years. Thank you. Thank you for sharing that. And Dr tiho, what was it about the space that you were you to it?

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Well, I went into medicine to care for patients who were historically underserved by the medical community. And I found very quickly as a medical student that really nobody knew anything about how to

treat people, not only to welcome people, but how to treat people with substance use disorders. And at that time, the opioid crisis was well underway, well before it was even named in the mid 2000s

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and all I knew was to kind of empathize with patients and refer them to peer support and maybe methadone, which clearly did not meet their needs. And as a person who specialized in chronic disease management. This was clearly a chronic, recurring, very treatable illness that I found in like Doctor Santoro said I had several patients who I had worked with, and at that time, it was the early it was 2003

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so data waiver had just come out in.

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I was salivating to be able to actually treat my patients where they were coming to see me, and buprenorphine was, I'll never forget, the first patient I treated was like nearly miraculous. It was like no other medication that I had been able to treat patients with for any other chronic condition, and very quickly saw my patient, you know, break the cycle of severe withdrawal and ongoing compulsive use, despite all these horrible things happening to her in her life. And got to walk with her along the journey and partner with her to her health. And then, you know, I was sold, you know, the safety of this medication, the increasing access, and so I became one of the first providers in the community at my hospital system, and then quickly became kind of a referral source

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and fell in love with it, and then that kind of continued to the positive reward of seeing people get better and really navigating substance Use Disorder and keeping them healthy along the way as they navigated that. Wow, excellent. So this, this question will be for both of you. We can, we can start with Dr Santoro here, since you've started to where you are today, how have you seen this disease evolve?

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Well, years ago, as Dr Keough had just mentioned, you know, when we started using Bucha orphan sublingual It was miraculous, and that's because we were dealing with heroin, and I long for the days of treating patients who were just using heroin, that was the dominant opiate. But today, you've got fentanyl, high potency, other opioids, you've got adulterants like xylazine, and that has really changed the way we start and use buprenorphine.

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This we also see a change in the system. Years ago, we had people come into an inpatient program, and you go through detox, maybe rehab, and then send them out the door. And I used to say it was a

revolving door, because they would get treated, and then they would go out, they would relapse, they'd come back in, get another 28 days, and go out and, you know, wash, rinse, repeat, and with today, we now recognize that we have to do more. We've the use of medication for opiate use disorder has really come to light.

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And many of us who have been doing this, I suspect Dr Cao as well that we were, we have long believed in

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medication management for years, but our colleagues in the patients in the and society treated this as an acute problem, rather than a chronic disease. Chronic Disease, you don't cure chronic disease you maintain this does not strep throat, that I'm going to give you 10 days of a medication and prove that you're fine, because after the 10 days, you no longer have the problem. That's the exact opposite when you're treating a chronic disease. Chronic Disease, proof that it works is that when you stop the medication, the disease returns. That's proof That your treatment of your chronic disease was working, and that is the evolution that I have seen. Yeah, Dr keel, anything else to add on to that? Yeah, I mean echoing exactly what Bill said, and I would just say this is the only treatable condition where the patients with the disorder, the disorder and the incredibly life saving medications are all vilified and completely misunderstood, even by treatment professionals. And so I would say, going back to the initial question of what we've seen as this drug crisis has evolved, is that it has really gone from the days of this very, very effective, easily administered medication with this kind of neat, oh, it's, you know, heroin addiction, we can manage it as awful as it was to a full on drug crisis, as we said, in adults rated very dangerous, drug supply multiple substances. It's not just opioids as well, stimulant use disorder, alcohol use disorder, benzodiazepine use disorder, you name it. And so there's this real urgency. There was an urgency then, but it's even more urgent now that we get people onto medication, and we get them on quickly into the right levels to actually treat this brain disorder, and,

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you know, control their symptoms and take them a step back and understanding that that doesn't happen overnight, and that while people are working toward that goal, which is not just about them working harder, it's also about the medications us, getting the dose right us, you know, looking at the other issues that are impacting their health, social determinants of health.

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Health and keeping them safe along the way. So really

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doubling down on harm reduction interventions as well, which is the scaffolding of all chronic disease management. But in the addiction space, it's, for some reason, controversial, but we do it for every other illness. So I would say that's one thing we've learned a lot over the years and and also that we can't do this care without incorporating the voice of our patients, because they're teaching us a lot alongside the science. Great. So I think you guys have talked a lot about the patients, and I love that, because the focus of this should be on the patient, but I'd be curious to know, and we'll start with you. Dr Kehoe, you guys both have experience working within the health system. What are the ways that this disease can impact the health system as a whole, when we think about this at another layer up? Yeah, absolutely. So this is, you know, the number one cause of death in people, you know, under 50. So it's, you know, you don't get much scarier than that and impacting the health system, then what that means it's not just about overdose deaths and for a treatable illness in 2025

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in the United States. I mean, that says something about how well we're doing here, that so many people are dying of treatable illness, but also the costs otherwise. So as Bill had mentioned, you know, we still have detox facilities where we are putting people in, tapering them down for chronic disease, and then they have a return to use, and they're blamed for that. And so the cost of this cycle of in and out, so financially to the healthcare system, the the emotional toll on on that it that you can't even put a number on to families and to the patient and feeling demoralized, and that this is their fault, when, in fact, the system is not set up. So the health care system is is not meeting the needs. It's broken. And then we also know emergency rooms are flooded with people with a chronic illness, with very severe, acute

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complications of untreated opioid use disorder, hospitalizations, etc. So the whole health care system is really impacted by this. And there's, you know, we'll probably talk about kind of finances and how do we support kind of innovative programs and lower barrier programs, and it really is about taking a look and a step back at hospitalizations. If we can decrease emergency room visits, we can decrease length of stay in hospital, or even admissions as we get people to the outpatient setting. This is a disease that should be managed in the outpatient setting,

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and that, right there is a cost saving. So that will probably come up a lot for hospital systems to say, well, how are we going to fund this? This seems costly, but it's, it's clearly something that will be a cost saving if we treat this illness the way we know how to treat it. Great. Yeah, you're kind of leading me to something else I wanted to ask about. And I'll, I'll start with you. Dr Santoro on this one. So in a space that seems to be driven so much by fee for service and volume, if you were to reshape it, or you were to move the mindset on this to be focused on outcomes, what are the kinds of outcomes that a system should strive for? What should they be looking towards to try to achieve? In your opinion?

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Well, couple of things. First, I think they need to look at engagement. Is the patient engaged in the treatment?

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When you talk about cost, if you don't want the patient engaged, you're going to elevate your cost. What Laura was mentioning, I just want to touch back on the cost of to the health system. I look at it as there are two costs. There's a cost to the patient, and then there's a cost to the health system, the cost of the patient, and they're in opposite

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opposite they're moving in opposite directions when it is extremely costful to the patient. Is very cheap for the health system, the cost of the patient is their life. And frankly, the cheapest way for the health system to deal with this, if a patient overdoses and dies, because it costs the health system nothing, and it costs the patient everything their life. And the reverse then also happens. The cheapest for the patient is the most expensive for the health system. And I often get people who they'll say, Well, look at the cost of, say, the long acting injectables. They're quite high. Even I used to get that when the when there were only brand names for the sublingual buprenorphine. Now they're generics, but it's still a cost. But if you look at the cost of a person going to an emergency room, as Laura was pointing out, cost of one ER visit with a cost of one overdose and an admission to an intensive care unit for a week, compare that cost to a year's cost or even a lifetime.

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Cost of either the long acting injectables or the sublingual products, and you can see that it is cost effective to treat these people. So how do we look at what is considered success? What measures I look at the social determinants of care? Number one, are they engaged? Number two, do they have a job or? Number three, are they involved with their family? These, to me, are much more important measures than simply, does a person have a negative urine drug screen? Because how do you then define failure if this, if we were talking about another chronic disease, such as diabetes, so a person has one elevated blood sugar in a year, does that mean they're not well controlled? We'll say the same thing in our field, if a person has one positive urine drug screen in a year, does that mean they failed? No, I think success needs to be defined more broadly than simply a measure of a urine drug screen or a measure of

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if they've made every appointment, if they miss one appointment, that doesn't mean they fail. That means they missed one appointment. So engagement, as well as these other factors, are what I would be looking at Excellent. So thank you. Both have now talked about a couple of different settings, and I've heard emergency department come up in your experience. And we'll start with you, Dr Kehoe, what typically? Where do you first typically see oud patients? What settings are you first coming into contact with them? Yeah, so right now I see them mostly just because of where I work, I work very closely partnered with our emergency department, so patients coming straight out of the emergency room to our bridge clinic, or people walking into bridge clinic self referral, referral from the inpatient setting after a

hospitalization. So I see them in a slightly different setting. I also see them at the opioid treatment program in methadone, when patients have been referred for that.

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And then I, you know, before I was really, as Bill is doing, really primary, primarily focusing on addiction clinics only, I was seeing them in my primary care clinic. But I think that's, that's the key is patients with this condition are inter are interfacing in all touch points of the health care system in this highly treatable, highly lethal condition, therefore should be treated in all of those settings. And that you know, obstetrics, urgent settings, outpatient settings, inpatient settings, so all health care professionals who touch them should be able to treat. That's interesting, so I'll go to you, Dr Santoro, are there settings that you're aware of where they are not able to access treatment? And what do you think could be done to change that?

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There are multiple places that they can't access treatment. In fact, I have recently shifted my focus

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and changed jobs. I mentioned earlier that I was the chief of the section of Addiction Medicine. I've recently left that position happily and left with a on good terms, because I want to try something new, and it's something that you and Laura have just touched upon. I have a different vision for addiction medicine. Moving forward, I successfully created an addiction practice. I successfully created a section of Addiction Medicine within a health system. Now what I want to do is I've joined a health system that has said, take the ball and run with it. I don't want to set up a practice where I see addiction patients, substance use disorder patients. What I want to do is go from one primary care provider to another, whether that primary care provider is OB GYN, pediatrics, internal medicine, family doctor, emergency room, I want to work side by side with those people to teach them to do what I do, what Laura does, because I really believe that. Always say that I don't think I'm smarter than any other doctor, and from what I know of Laura, Laura, I think she would agree with me. We are just regular doctors. We can do this. It doesn't take anything special. It just takes a little bit of dedication, no different than treating any other disease. And it can be done, and it should be done in all these different settings. So if I can then teach multiple doctors to do this and then walk away and retire. I've accomplished something greater than just simply creating a practice for

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my now my sign off on my email says we build bridges, not silos, and that's what I want to do, is I want to build bridges to these different providers and different.

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Practices who can also do what we do? Awesome. So I'll start with you. Dr Kehoe on this. Let's say a patient arrives and they are actually looking for treatment. What does that conversation sound like? Like? What are they asking? What information are you sharing? I'd like for the audience to get a better understanding. You know, if they aren't in addiction medicine, if somebody comes with this disease, what some of those initial conversations could or should sound like? Yeah, it's, I think the first thing is always welcoming someone that you're so happy that they've come this is great, and starting with, what are their goals? And upfront, I think also taking a step back, as I said earlier, this is the only illness in medicine where people are conditioned not to trust us, because the problem is with us. It's with the healthcare system. Why people don't seek care, why they may not engage in care, they don't feel that they can there's they're highly ashamed. They're conditioned to be ashamed that they have this illness, and that's on us. So first and foremost, to understand that it might take a while, even if you're the most welcoming, most you know, lovely person, that it might take a while for people to trust us,

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but starting with making people feel comfortable that you're there, to start with what their goals are, and sometimes even validating if they say, Well, I just, I just don't, I might not even know to start with how we can start with engaging them, as Bill said, because if people don't engage, we can't work with them. And so that may be for for one person, I don't know what I want to do. I just want to kind of check this place out. I know that I don't like how things are going. I'm not sure I'm ready to stop this has been a real coping skill for me, but I know that I want to start thinking about it. So starting with what they want to do, versus somebody else says, I want to stop right now. I just overdose. Please give me medication right away.

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But one of the one of the challenges is that this, this kind of the approach has been, as Bill said, that it's, you know, you stop using the minute you walk in the door. And there's no other condition that we expect this huge life change to happen the minute people come in. And that's really we've seen that in our studies, too. The studies are all about what the toxicology negative or positive, rather than quality of life measures. So incremental changes in starting with the patient, excellent. So I'll ask you a similar question, Dr Santoro, let's, let's think about a patient who would come into an emergency department with an opioid related event. They may not necessarily be seeking treatment. Is there something that you or another doctor or the health system should be doing at that point in time? If there's a kind of an assumption that there's an opioid related event. You're reviewing their history, you think this person likely has oud, and maybe they've been diagnosed, maybe they've been not. What should that kind of transition of care look like in a best demonstrated practice? Well, I've gotten into I took a a one seminar on motivational interviewing, and it really opened up my eyes when I put motivational interviewing in practice into addiction medicine. What it turns out to do is exactly as Laura had mentioned, we need to reduce the stigma. So the first thing I would do walking into a patient in an emergency room is the same thing I do when I walk into a patient for the first time in my office, ask them, What can I do to help and and then I ask them questions like, if, if they have decided to get into treatment, I start asking them questions like, Well, what do you think you can do? You know, I know what I can do. I'm getting in my head things already of what I can do to help you, but what I really want to know is, what do you think you can do to help you? And ask them, What do you think your the odds are, on a scale, say, of from one to 10, that you're going to be successful at this? And I realize these are strange questions. They're very open ended.

And I tell the patient, I promise you, after I get through a bunch of these, I'll tell you what I'm doing and why I want to get through the questions, I then explain to them that what I what I don't want to do is be somebody who comes in with the answers. You know, I, I one time, was

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involved in community theater, and I got pigeon holed as a I was casted as a physician in the 1700s

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and my one was to say to the sick King, I walked up to the king and I said, your problem is your kidneys. Now, tell me your symptom.

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Okay. And of course, they laugh, but I don't want to be that doctor here, be quiet. Here's the answer to your problem. Now I'm telling you, I'm going to treat you with these, with these medications, and by the way, what are your symptoms? I don't want to do that. I want to come in first find out about you. What are your goals? What do you consider success? What are you going to do to help? Uh.

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In getting to that successful point. Now I've got the patient on my side, then I can say them, okay, you're going to do this. When I ask them, what can you do? They often say, Well, I can go to counseling. Okay, I can go to meetings. I can delete contacts in my phone. These are things they can do. And then I turn and say, Okay, you do those things. Here are the things I can do. I can prescribe medicine. I can guide you to get a primary care physician. So we're in this together, rather than a me versus you, which often happens in this field. As Laura pointed out, it's the only field where they feel like it's me against them. I get patients in the beginning, they'll say, Well, if you didn't find that my urine was positive, then it didn't happen. No

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whether I find out whether it happened or not it happened. That's

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so that's the way I approach the patient. That's great. Just

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add one other thing. The other thing that I do is I make sure that patients understand their diagnosis. This is one thing. Again, people say, Yeah, I know that I have this addiction, but nobody ever really explained medically what that means. And then again, through the lens of other illnesses, that they can make an informed decision about treatment options. And that's where the discussion about making sure that they

know that we could do medication right away, what their options are, not forcing it on them, but ensuring that they actually have informed decision because there's a lot of misunderstanding about the medications, as we said, or they may have lived experience with not a great experience with that. And so this is an option and an opportunity to really explain to them and what the evidence base is and what they can how we can provide them with first line treatment. Can I jump in and tell you if what Laura and I are saying, if they do that, I want to give you an example of what happens when people are and patients are treated by doctors in the manner that Laura and I are talking about. I had a patient a couple of weeks ago came in and he plopped down in front of my desk and he said, Dr santar, I gotta tell you, I screwed up. I relapsed. The buddy from high school came over and we started talking. The next thing you know, I used and

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you know, I just at that point, my nurse walked in and handed me his urine drug screen. And I said, Well, Josh, that's interesting, because your urine drug screen is perfect. Now, Josh has known me for years, and he said, So now he's joking with me. He says, you know, Doc, you just don't listen to me. Of course, my urine drug screen is negative. That's why I said to you, I have to tell you, that's because I relapsed two weeks ago. And if I didn't tell you that I relapsed, you would never know. So that's why I said and opened the conversation with, I have to tell you.

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And he knew my head wasn't going to explode. He knew I wasn't going to say, Well, Josh, that's the third strike, so you're out. We're not playing baseball here. He knew the only way he could get help for me was to be honest and to tell me. And he felt

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I was not going to berate him or demean him, or throw him out of the practice because he had a positive urine drug screen. I don't believe that we should be tossing patients out of care for having the disease that they came in asking us to treat. And I really believe that if people, if, if physicians do what Laura and I have been saying, they will have a lot more interactions like that.

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Yeah, I appreciate you sharing that story. That's excellent. I think we've talked a little bit about what you both have done over the last couple of years to evolve. And Dr Santora, you talked about how you're taking a new approach, and you're trying to create access through education of others. And Dr Kehoe, I know that the bridge clinic is, is actually kind of it's not standard across health systems. It's a more unique approach. So if you want to both chime in on that, that's fine. But I'd also be curious to know, has your treatment approach in terms of the medications you're using, evolved over the last several years? So we can start with you first, Dr Kehoe, if give us some insight onto that. Yeah, absolutely so. As I said, I have been treating people with buprenorphine products, initially sublingual, for many, many years, really right when it came out early, 2000

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and flash forward, and all medications for opioid use disorder, I would say agonist treatment, including methadone, because there are some patients where partial opioid agonist is not sufficient and they need full agonist, or that's their choice. But as far as buprenorphine products, when extended release, long acting injectable came out, this was also at the height of, again, high potency synthetic opioids and.

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Had were clearly well seated in the drug supply. We were seeing real challenges with people getting on to medication. And we were also seeing or sublingual buprenorphine. We're also seeing that not only was it challenging for many people to take or that it wasn't holding their their cravings, and that opioid debt was not being met, and so extended release buprenorphine really allowed us to get higher serum blood levels. And for patients who preferred not having to take something every day, it was really a life saving tool. So our clinic very quickly adopted using extended release buprenorphine, and we did do, in my experience, we did some innovation. Again, we're in an urgent care setting where many of our patients could not necessarily take sublingual medication right away, so we started rapid initiation with long acting injectable. In my experience, doing that, that's

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an off label intervention. And, you know, flash forward, we our clinic provides. We do buy and bill because we're a hospital based clinic, so we're very, very high volume during the pandemic, the COVID pandemic, we were very anxious that pharmacies might run out of trans mucosal product, or patients wouldn't be able to get there, and so we almost stockpiled the long acting injectable. And as I said earlier, we have learned so much about the delivery mechanism, options of care, how patients respond, the patients giving us on the ground clinical experience, and also really,

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real admiration for the patients who come in for this. I mean, this is a it's an injection that is, you know, it's uncomfortable, and people keep coming back because they feel so well, and they find that it really sustains their recovery

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and their remission. So my experience with the buprenorphine products is really remarkable in seeing people get their lives back. I said earlier about really embracing harm reduction. And you know, it can take a while, as I said, for people to get safer, but every day, somebody is on a partial agonist or full agonist treatment for opioid use disorder, that's a day they're less likely to overdose and die. So for those patients who are really ambivalent about what their goals are, but they know they want to, you know, start engaging and getting better. We use this as a rapid overdose prevention tool as well. So that's been an exciting option. Excellent. And Dr Santoro, how has your treatment approach and the use of medications evolved? Well, I was a very early adopter of medication

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for opiate use disorder. I was a medical director to a methadone clinic for 22 years, and that started before buprenorphine came out. And I remember the director of the methadone clinic I was at was very concerned when I told him that I was going to be using buprenorphine in my private practice, because he felt that

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Bucha orphan was going to be a competitor to methadone. I looked at it as there is room for both. So I was an early user of buprenorphine. I was an early user of the injectable one of the things that and I continue to recommend people to go to methadone, because not one drug is going to always work on every person. So more tools, the better. The other thing, though, that I do is I tell people that we've got to stop, and it's starting, but I've been saying this for 20 some odd years. We've got to stop separating medication from, quote, abstinence based treatment. I put abstinence based treatment in quotes, because I do believe that people who are on medication are abstinent. They are abstinent from at least illicit drugs. But I send every one of my patients, or recommend every one of my patients to go to 12 step meetings even though they're on medication, because at 12 step meetings. That's where you're going to learn how to live life. Medication isn't going to teach you what 12 Steps teach you. Normal 12 steps be able to stop the craving and the withdrawal that medications can do. So the combination of both 12 step and medication, to me, is where we need to go. Excellent. So we are coming up on time. So I have one final question I want to ask both of you. It this is going to be if you had your crystal ball or, you know, let's say you were in charge of the world. If we think about health systems in today's space, what is the one thing they need to solve for or get right today that would take.

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One of the biggest gaps in treatment. What is your big, big blue sky option? And I'll start with you. Dr Keough,

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yeah, I think prioritizing, when we look at the urgency of the crisis and statistics, this is a one of the leading causes of death and morbidity and mortality in our morbidity and mortality in our country. And so this should be prioritized across all health systems. And what that means is looking back at the standard of care. The standard of care is for patients with moderate or severe opioid use disorder, and that is who we're seeing are offered immediate access to buprenorphine or methadone. And it should be across all places where people present in healthcare systems. Thank you. And Dr Santoro,

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Laura took the down in the weeds approach, which is excellent, because you're going to save a lot of lives. So I'm going to take the 30,000 foot level and say, in order to get to what Laura is saying, I think the

primary thing we need to do is two things. Number one, we have to work on the stigmatization of this disease. This has got to be accepted as a disease, not using terms like addict, drug addict,

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clean and dirty urines. And the other thing we need to do is it needs to be accepted as a chronic disease. This is not something we're going to cure. This is something we're going to control. Once we get the fact that this is controllable, it's a disease and it is not a moral failing, then we can get down into the weeds of what Laura is saying of getting the actual treatment, but you're not going to get through the treatment if you can't get rid of the stigma. Yeah, and I would say that there too, it's chicken or egg. I think also by normalizing and providing that treatment, that is the best way to reduce stigma. So you know, and it can both. They don't have to be mutually exclusive. We can do them all at the same time, and I would say there are health systems like Bill is part of and our practice, and there are programs across the country that have been doing this. So there are blueprints and how hospitals can can do this, and there are supports as well. One thing, our Department of Public Health in Massachusetts has a hotline for primary care providers. And I actually do that on Fridays, which is really fun, where you can get at the elbow support. So if you have a PCP in the clinic who says, I have somebody here, it's a Friday they have opioid use disorder, what do I do? How do I start buprenorphine? They can call we can walk them through it in the moment, so they don't have to wait to kind of, well, I'm going to refer you to a bridge Clinic, and I'm going to refer you here. They have the patient there, so things like that, kind of installing, kind of experts at the elbow, if people are anxious about that, but really empowering people to dive in that. This is, this is not as complicated as they think. Most people already have the tools. They're managing chronic illnesses with acute presentations every single day. This is really no different, other than it's more urgent,

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excellent. Well, I'll just say this. I can't thank you both enough for your time today. We're not going to take questions, but what I would say to the audience is Dr Kehoe and Dr Santoro will be at the front of the room before the next session comes in. So if you want to grab them and exchange contact information or ask them questions, I'm sure they'd be happy to meet with you. The final thing I'll say is opioid use disorder. It's a chronic, treatable brain disease. And the unfortunate thing is, it's it's an equal opportunity infector we all know, and somebody in this audience, I bet you you all know someone who struggles with this, whether it's in your family or within your community, and having conversations like this are going to help us further the cause of reducing stigma and providing medication that can be potentially life saving. So hopefully you learned a lot today. I did thank you again to our wonderful speakers, and I hope you all have a wonderful rest of your day. You.