Hospital Innovations to Reduce Emergency Department Utilization Among People with Opioid Use Disorders

An Open Society Institute-Baltimore Brief

Open Society Institute-Baltimore was created as a field office for the Open Society Foundations to test approaches for solving some of the most difficult challenges faced by cities and communities around the country. In keeping with that mission, we offer the **OSI-Baltimore Briefs**. The initiatives and projects they describe occurred in Baltimore with multiple partners and stakeholders from both the city and state, but the ideas, insights, and information they contain are useful to people and places across the nation. Our hope is that these examples may be replicated or adapted so that others may benefit from what we have learned about the process, challenges, and successes of addressing some widely shared issues.

INTRODUCTION

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The dramatic rise in opioid use disorders (OUD[4]) has had a profound effect on the nation, Maryland, and Baltimore City. While the burden of OUDs was a new problem in much of the country in 2016 when this Open Society Institute – Baltimore (OSI) initiative was funded, communities in Baltimore have struggled with heroin and other opioids for over fifty years. The dramatic numbers of opioid overdoses and deaths of Baltimoreans could not have been more evident than in the city's crowded Emergency Departments (EDs). Despite advances in evidence-based treatment, these numbers were, and are, increasing unabatedly: Maryland ranks second among states for OUD-related ED visits, with a visit rate of more than nine times the national average.

It should be noted that this project took place in 2017-18, before the rise of COVID-19 and its impacts on hospitals. While the pandemic has changed the realities of ED practices across the country, it has not diminished the need for better ED care of people with OUD. The social distancing and quarantining required by COVID-19 pose many challenges for the drug using population, including making it more difficult to employ harm reduction practices such as obtaining safe supplies and using in the company of others who can respond in the case of an overdose or other emergency. Overdose deaths have risen since the pandemic began, highlighting the need for hospital EDs to do a better job of serving patients with OUD and connecting them with ongoing treatment and other resources in the community.

Until recently, most hospitals were not prepared to engage persons with OUD in treatment. Standard treatment was administration of naloxone, a short-acting drug to rapidly reverse symptoms of overdose, and then releasing the patient back into the community.[5] While naloxone can prevent individual overdose death events, it does not treat the underlying OUD and therefore cannot prevent future overdoses. Thus, many patients treated with naloxone in the ED overdose again after being released, often times leading to death. Maryland ranks in the

[4] Many people living with OUD often also have other substance use disorders, including alcohol and other illicit drugs like methamphetamines. For the purposes of this paper we use the term OUD, recognizing that other substance use disorders may also be present.

[5] "New Opioid Treatment Resources for Emergency Department Clinicians," National Institute on Drug Abuse, published on October 03, 2018, https://www.drugabuse.gov/news-events/news-releases/2018/10/new-opioid-treatment-resources-emergency-department-clinicians.

top five states with the highest burden of overdose deaths, more than half of which occur in Baltimore City.[6, 7]

In recent years, federal, state and city forces converged to compel hospitals to initiate treatment for persons with OUD in the emergency department and to connect these patients with community-based treatment programs, along with other health and social needs. This new approach held promise to decrease the overall burden of treating overdoses in EDs and reduce ED visits among these high utilizers. Maryland's Heroin and Opioid Prevention Effort (HOPE) and Treatment Act of 2017 required all Maryland EDs to have a discharge protocol in place for patients with OUD.[8] Four focus areas were identified:

- Universal screening for OUD in hospital EDs
- Increased naloxone access
- Facilitated referrals to evidence-based opioid treatment programs
- Peer recovery services

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is an evidence-based approach to engaging persons with substance use disorders and has become more widespread in EDs across the country. SBIRT involves[1]:

- **Screening** patients for substance use disorder upon admittance
- **Brief intervention** by a healthcare professional discussing behaviors and potential options
- **Referral** of patients to **treatment** resources and other services

A 2017 randomized control trial found that SBIRT significantly reduced overall drug use in ED patients with substance use disorders compared to the enhanced usual care generally offered to these patients.[8]

Maryland's approach to universal substance use disorder screening in hospital EDs was statewide implementation of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol, which OSI helped bring to Maryland in 2011.[9] OSI's initial investment in SBIRT led to a $10 million federal grant as well as a $1 million grant from the Hilton Foundation to expand access to SBIRT in Maryland. In 2018, the State of Maryland received $2.6 million from the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement and enhance SBIRT practices in health care settings, prioritizing hospital emergency departments. A large portion of this funding was awarded to Mosaic Group, a Maryland-based health management consulting firm, who supported SBIRT implementation in hospitals in 15

[6] "Maryland Opioid Summary," National Institute on Drug Abuse, revised March 2019, https://www.drugabuse.gov/opioid-summaries-by-state/maryland-opioid-summary.

[7] "Baltimore Opioid Death Statistics," LiveStories, accessed February 03, 2020, https://www.livestories.com/statistics/maryland/baltimore-county-opioids-deaths-mortality.

[8] Maryland General Assembly, *Heroin and Opioid Prevention Effort (HOPE) and Treatment Act of 2017*, HB1329 CH0571, http://mgaleg.maryland.gov/mgawebsite/legislation/details/hb1329?ys=2017rs.

[9] "SBIRT," Maryland Department of Health, Behavioral Health Administration, accessed February 02, 2020, https://bha.health.maryland.gov/Pages/SBIRT.aspx.

Medication Assisted Treatment (MAT)

MAT is an evidence-based approach to treating OUD using prescription medications like methadone or buprenorphine to lessen systems and curb opioid cravings. After starting MAT in EDs, patients continue treatment through community-based opioid treatment programs (OTP). According to a 2015 randomized control trial, ED-initiated buprenorphine treatment significantly increased patients' engagement in addiction treatment, reduced self-reported illicit opioid use, and decreased use of inpatient addiction treatment services among patients with OUD compared to SBIRT and referral to treatment.[10]

jurisdictions across Maryland.[10] In Mosaic's model, people in recovery from OUD are recruited and trained by experienced Mosaic staff to be peer recovery specialists (peers) and to work with a team of ED providers to provide SBIRT and manage patients' referrals. The implementation of this SBIRT model coincided with OSI's ED Diversion pilot project.

Another diversion strategy that targets patients with OUD is ED-initiated medication assisted treatment (MAT). Though not identified as a core component in the passing of the HOPE Act, ED-initiated MAT was included as scoring criteria in the 2018 Levels of Care initiative led by the Baltimore City Health Department, which provided Baltimore city EDs with a framework for evaluating and enhancing diversion efforts for patients with OUD.[9]

A 2017 cost effectiveness analysis found that ED-initiated MAT was more cost-effective in the long-term than other ED diversion methods, including SBIRT.[11] However, as of 2017, only 27% of Maryland EDs had implemented MAT initiation. The biggest barrier for implementation is the lack of OTP capacity to meet the need for continued treatment after ED discharge.[12] This is true almost everywhere in Maryland except Baltimore, where community-based OTPs have greater capacity to meet the need for OUD treatment. With Maryland's new focus on cost effectiveness in health care and shift to a value-based payment, innovations in ED diversion strategies targeting high utilizers with OUD and are important not only to provide better care, but also to bend the curve on Maryland's opioid epidemic in a cost effective manner.

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[10] "SBIRT," Maryland Department of Health, https://bha.health.maryland.gov/Pages/SBIRT.aspx.

[8] Frederick C. Blow, et al., "A Randomized Control Trial of Brief Interventions to Reduce Drug Use Among Adults in a Low-Income Emergency Department: The *Health*ER You Study," *Addiction* 112 (2017): 1395-1405.

[9] "Levels of Care for Baltimore City Hospitals Responding to the Opioid Epidemic," Baltimore City Health Department, August 2018, https://health.baltimorecity.gov/sites/default/files/Levels%20of%20Care%20-%20Guide.pdf.

[10] Gail D'Onofrio, et al., "Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence," *Journal of American Medical Association* 313, no. 16 (2017): 1636-1644.

[11] Susan H. Busch, et al., "Cost-Effectiveness of Emergency Department-Initiated Treatment for Opioid Dependence," *Addiction,* (2017).

[12] "Emergency Discharge Protocols for Patients with Substance Use Disorders and Opioid Overdoses in Maryland's Hospitals," Maryland Hospital Association, published December 2018, https://www.mhaonline.org/docs/default-source/transforming-health-care/healthy-hospitals-healthy-communities/behavioral-health/final-ed-discharge-protocol-report.pdf?sfvrsn=fbbbd40d_2.

WHAT DID WE DO

OSI has had a long-standing focus on stemming the burden of substance use disorders in Baltimore. In 2016, it seized the opportunity to help Baltimore's hospitals to implement new policies, data infrastructure, partnerships, and processes to transform the outcomes of emergency department services for persons with OUD by releasing a targeted request for proposals to Baltimore City EDs. OSI sought to fund ED programs that were:

1. Taking a community-based approach
2. Creating multidisciplinary partnerships
3. Engaging local behavioral health providers
4. Supporting ED staff in providing comprehensive screening and assessment
5. Committing to making changes to ED procedures that would be sustainable after the project ended

With these priorities as a guide, OSI aimed to enhance ED diversion efforts to community treatment resources and strengthen the continuum of care for patients with OUDs through real-time data monitoring. Ultimately, OSI awarded three hospitals, Bon Secours, Johns Hopkins Bayview Medical Center, and University of Maryland Medical System, with grants to design ED diversion programs uniquely tailored to each hospital's gaps and needs.

WHAT HAPPENED?

BON SECOURS HOSPITAL (BON SECOURS)

Bon Secours used OSI grant funding to bolster its IT infrastructure and to provide an additional peer recovery specialist to the team established through Mosaic's SBIRT program award. While SBIRT peers focused on behavioral health screening and referrals, the OSI-funded peer screened for patients' social needs and managed referrals to community resources. Bon Secours contracted with the software designer mdlogix to implement BHWorks[13] in the ED. The BHWorks app enabled peers to screen for behavioral health conditions and social needs and provided a link to referral resources that could be tracked in real time. Initially, peers focused on internal referrals to resources in the Bon Secours network, such as Bon Secours Community Works. As external community resources were identified and included in BHWorks, peers referred patients to a broader array of services and resources. To facilitate patients' engagement with these community resources, Bon Secours used OSI funds to provide patients with cell phones or pay for activities like lunch that incentivized patient-peer engagement.

[13] "BHWorks," mdlogix, accessed February 15, 2020, https://mdlogix.com/bhworks-page/.

JOHNS HOPKINS BAYVIEW MEDICAL CENTER (BAYVIEW)

In 2016, most Bayview ED visits were associated with OUD, and about 70% of these led to admission to Bayview's Chemical Dependence Unit (CDU) for a three-day detox period. Bayview aligned SBIRT and OSI funding to create a holistic and coordinated ED diversion program. SBIRT peers focused on patient engagement in the ED while the OSI funded team focused on strengthening linkages between the CDU and community treatment and social resources. Program staff understood that effectively linking patients to community-based treatment, housing and other community resources was more easily accomplished over three days in the CDU than in the short stay in the busy ED. OSI funds provided a dedicated social worker to work with the SBIRT peer recovery specialists. The social worker and peers were trained in motivational interviewing and experienced high rates of success engaging patients in treatment. Peers supported engagement in treatment while the social worker addressed important co-occurring health and social needs. The social worker assessed patients' biopsychosocial needs, access to primary care, psychiatric support, and housing; created individualized care plans; and coordinated patients' linkage with internal and community resources – often walking them to the Addiction Treatment Center at the CDU. Through this work, the social worker identified homelessness and housing instability as one of the main barriers to patients' sustained engagement in treatment. This led to a new partnership with Helping Up Mission to provide up to seven days of housing for homeless persons with OUD while other supports were put in place. OSI funds were also used to enhance the ED's capacity to initiate medication assisted therapy (MAT) and to expand group and individual counseling in the CDU. Another new partnership extended access to MAT in skilled nursing facilities to patients with OUDs.

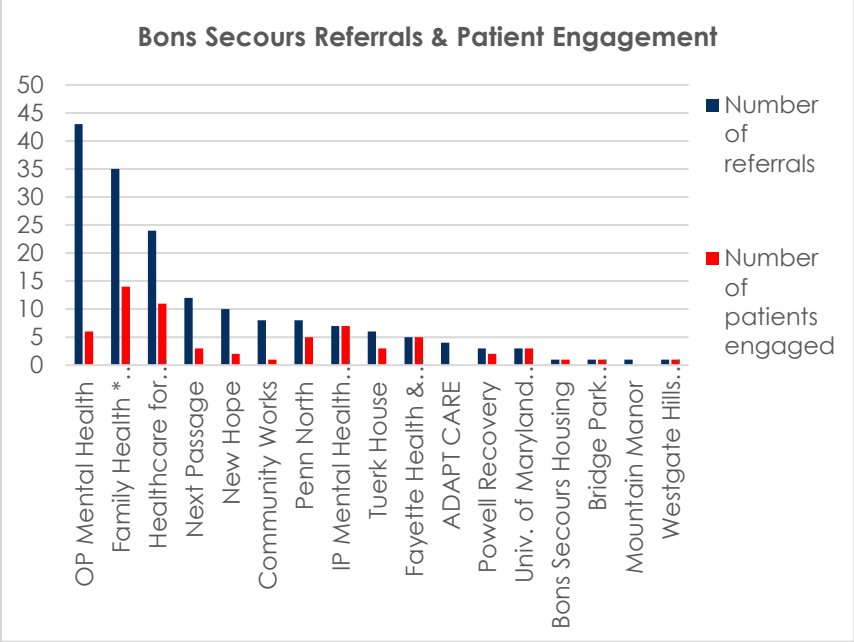
UNIVERSITY OF MARYLAND MEDICAL SYSTEM (UMMS)

Unlike Bon Secours and Bayview, UMMS already had a comprehensive, evidence-based approach to engaging persons with OUDs in place and was a national leader in ED-initiated MAT. As part of this infrastructure, UMMS had created a bridge clinic to provide MAT for ED patients while community-based treatment plans were established. Thus, UMMS used OSI funding to engage ED Directors in other Baltimore and Maryland hospitals to recognize and address stigma in current protocols and to fully embrace SBIRT and MAT initiation in the ED. The psychiatric ED medical director and the overall ED medical director joined forces with Mosaic clinicians to form the Substance Abuse Consultation Services team, which provided technical assistance to six hospitals on ED-initiated MAT. This team developed training modules and learning collaboratives to engage peers and behavioral health and emergency medicine specialists at each hospital, discussing best practices for ED-initiated MAT and challenges to implementation. The team also provided hospitals with a web-based manual of community resources to assist peers in providing next-day patient referral appointments to community resources.

"We recognized that there is a strong interest both on a national level and in the State of Maryland to reduce unnecessary emergency department usage," says Dr. Eric Weintraub of UMMS. "We saw that a large number of our ED admissions were related to opioid use disorder and committed to addressing patients in a medically appropriate manner—while reducing the likelihood of return ED visits."

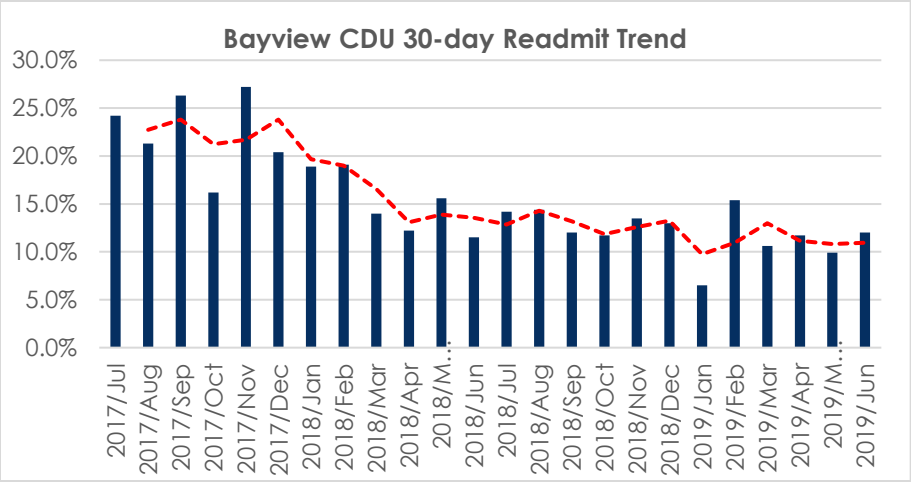
WHAT DID WE LEARN?

Baltimore hospital EDs and EDs across Maryland still have work to do to break the cycle of overdose and to reduce OUD-related ED visits. While there is greater access to community-based OUD treatment in Baltimore than in other parts of the state, internal barriers persist. These include a lack of physician champions for new OUD clinical practices, fragmented staffing models, lack of internal cross-department coordination, and inadequate electronic health records to coordinate medical and social needs.



At the start of the pilot project, Bon Secours identified five outcome goals, including increasing psychiatric and social needs screening of persons with OUDs in the ED, increasing patient referrals, and decreasing ED utilization, 30-day readmissions, and 90-day readmissions.

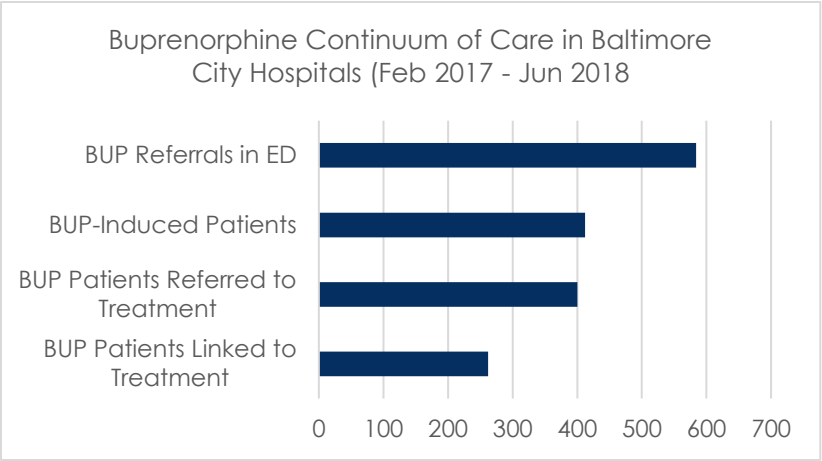
To track these outcomes, Bon Secours measured the number of patient referrals, repeat ED utilization, number of 30-day readmissions, and number of 90-day readmissions. Goals for patient screenings and referrals were surpassed: Bon Secours used BHWorks to screen 80% of high ED utilizers and to provide 172 referrals. The most common referrals were for primary care, mental health services, housing, education, and employment assistance. However, of the referrals provided by ED peers, less than 40% of patients showed up for their appointments. Mental health appointments were the most common no-shows. Patient-peer contact outside of the hospital setting, either through text message and voice call or in-person activities like lunch, was shown to positively impact patients' appointment attendance. Program staff stated that more resources were needed so that peers could follow up with patients in the community after they are discharged from the ED in order to maintain connection and help patients successfully complete referrals. Overall, ED utilization appears to have increased from this pilot program, rather than decreasing as anticipated. The program hypothesized that these surprising results were because peers developed positive relationships with patients, thus patients would return to the ED to engage with the same peers for help with their other social and health needs. Over time, this effect faded out; no difference was seen in 90-day readmissions, where the peer workers were more effective at connecting patients to community-based treatment and social resources.

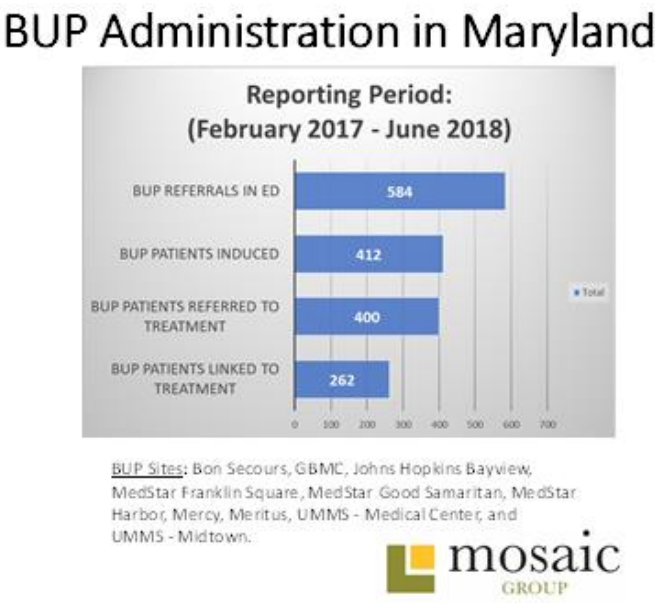


At Bayview, OSI and SBIRT funding together contributed to a dramatic transformation in care for patients with OUD and significantly reduced the number of ED visits for patients engaged by the program. Due to targeted efforts in the ED and Bayview's Chemical Dependence Unit (CDU), 30-day CDU readmissions dropped from 27.2% to 11.5% in seven months. Over time, 30-day CDU readmissions stabilized at under 15%, and hit a record low of 6.5% in January of 2019. This was widely believed to be due to a decrease in OUD-related ED visits. Another key element in Bayview's pilot program was the partnership formed with Helping Up Mission (HUM), a nearby nonprofit providing housing for homeless persons with behavioral health conditions. Through motivational interviewing, the OSI-funded social worker identified homelessness and housing instability as one of the main barriers to patients' sustained engagement in treatment. By partnering with Helping Up Mission (HUM), Bayview linked over 80% of homeless and housing unstable patients with OUD to HUM's Next Step program, which provided seven-day supportive housing and transportation. Recovery coaches worked with patients at HUM to facilitate engagement in recovery treatment services. After the seven day period, patients were encouraged to return to HUM for nonemergency treatment instead of the ED. HUM notified Bayview of all return visits. Of the patients referred to HUM from Bayview, 60% were linked to community treatment programs, and only 5% returned to Bayview for treatment in the ED within 30 days.

At the University of Maryland Medical System, the Substance Abuse Consultation Services team discovered that many ED doctors carried heavy stigma and skepticism about the effectiveness of MAT and peer engagement in supporting patient recovery. Therefore, the team incorporated patient and prescriber input into the training modules to better educate doctors on the benefits and need for ED-initiated MAT for patients with OUD. Additionally, the UMMS-led learning collaborative among hospitals shifted to focus more on how ED doctors could support peers to transition patients initiating MAT in the ED to community-based treatment providers. In the hospitals the UMMS team engaged, 584 ED patients were referred to MAT, and of those, 412

initiated treatment in the ED. Of these, 400 patients were referred to community resources to continue outpatient MAT treatment. However, less than two thirds of those referred to resources were actually linked to community treatment providers to continue MAT, underscoring the importance of continuing peer supportive services in community settings. UMMS is currently increasing efforts to provide doctor support to peers for transition of patients from the ED to community OTPs.





With OSI's financial support, Bon Secours, Bayview, and UMMS expanded their ED services to better engage people with OUD in effective treatment and connect them with needed resources in the community. Joint OSI and SBIRT funding in Bon Secours and Bayview was especially helpful in embedding SBIRT in comprehensive care systems. In all three hospitals, significant effort was directed to better managing patient referrals to internal and external resources. Bon Secours and UMMS expanded the use of technology to facilitate these patient referrals. This enhanced peers' capabilities to coordinate patient screenings, standardize referral resources, and track patients' linkage to care. However, both hospitals still faced challenges in connecting patients to referral services, especially external services, largely due to a lack of funding to support peers to follow up with patients in the community after discharge to ensure that referrals are completed. Instead of leveraging technological aides, Bayview focused on strengthening referral coordination with the addition of the social worker. While patient referrals varied more, the social worker had connections that led to fast tracking referral appointments and ensuring that patients connected with referred services.

Barriers remain in strengthening coordination and standardization of patient referrals and how to leverage technological aides. Research has shown that technology can help EDs link patients to internal and external resources that are specific to each patient's needs, and that linkages to these resources is associated with better long-term health outcomes. However, further work must be done to study the impact technology has on ED diversion specifically for patients with OUD. In continuing to develop high impact programs, emphasis must also be on increasing

sustained patient-peer connections, as this is most effective in increasing patients' engagement with referral services and retention in care.

Another opportunity to continue to make progress in ED diversion is universal implementation of ED-initiated MAT for patients with OUD. While the benefits and long-term cost effectiveness of MAT combined with SBIRT in ED diversion has been well documented, UMMS was the only hospital system in the cohort that used OSI funds to scale up MAT implementation. In doing so, they encountered strong provider stigma against MAT and difficulty in linking ED-initiated patients to community-based treatment. Given that Baltimore is one of the only jurisdictions in Maryland with an adequate supply of outpatient treatment programs to meet the need for outpatient MAT, more energy must be put into to implementation of ED-initiated MAT. To do this, ED doctors, peers, and other behavioral health staff must first be educated on the background and benefits of MAT. More attention must be paid to the continuum of care for patients undergoing ED-induced MAT, especially patients' linkage with community-based programs and potential engagement in bridge clinics, so that patients are able to sustain treatment after discharge. In strengthening their MAT capabilities, Baltimore City hospitals should consider the standards put forth by the city with the Levels of Care initiative, aligning services with the framework that is most appropriate to their individual patient population and structural capacity.

WHERE DO WE GO FROM HERE?

The burden of OUDs in Baltimore is unrelenting. While significant progress was made through these projects, internal gaps in hospital capacity to implement high impact ED diversion projects remain, and the community infrastructure to support long term recovery needs is woefully inadequate. With the ongoing impacts of COVID-19 on both communities in general and hospital EDs in particular, the opioid overdose epidemic in Baltimore and across the country has lost much of the public spotlight. But the increased social isolation of pandemic living challenges harm reduction practices such as accessing safe use supplies and avoiding using alone, increasing the risk of overdose and other poor outcomes among people with OUD. We have already seen an increase in Maryland's overdose deaths in the first quarter of 2020 and expect these numbers to continue rising throughout the year as the full impacts of the pandemic are seen. Even as hospitals deal with the struggles of COVID-19, it is imperative that they continue strengthening services and connections for patients with OUD. More than 70,000 people died from overdose in the US in 2019, and even more died in 2020.

We recommend the following steps to continue to build an effective response to OUDs:

1. **Support hospitals in assessing ED infrastructure and systems to identify remaining gaps.**
2. **Provide technical assistance to address internal hospital gaps.**

3. **Build partnerships among hospitals, the Maryland Department of Health and the Baltimore City Health Department to analyze gaps in community resources to support recovery from OUDs and to collectively invest to expand access to resources.**
4. **Strengthen systems to evaluate progress in building seamless OUD treatment and recovery systems.**

ED INFRASTRUCTURE CHECKLIST

- ✓ ED and Behavioral Health Directors support universal screening and MAT initiation in the ED, and ED physicians are waivered to be able to prescribe buprenorphine
- ✓ Peer recovery specialists are integrated in ED staffing, supported by social workers, and resourced to provide referral linkages in the community after patients are discharged
- ✓ Infrastructure is in place to initiate MAT in the ED (policies, licensing, training, etc.) as well as provide harm reduction resources such as naloxone upon discharge
- ✓ Internal referral and care coordination procedures are in place with psychiatry, hospital outpatient treatment programs, and other departments
- ✓ Referral relationships and procedures are in place with community treatment providers, harm reduction service providers, and housing and other social service providers
- ✓ Social needs screening is integrated into ED intake and referrals relationships are in place with community nutrition, housing, violence, transportation, and other resources
- ✓ Electronic health record links behavioral health, medical and social service information in one platform
- ✓ Quality assessment and improvement processes are in place

Lastly, more research is needed to understand and address the underlying social factors that impact patients' success with treatment and sustained recovery. More research is also needed to ensure that the medical and social needs of pregnant and parenting women, persons with co-occurring mental illness, aging persons and other special populations are met in new care systems. As Bayview found, a large portion of ED patients with OUD suffer from homelessness and housing insecurity. A recent study corroborated that individuals experiencing homelessness had significantly higher risk of OUD and opioid-related ED admission and readmission. Individuals with OUD who were homeless had worse long-term health outcomes than individuals with OUD who were not homeless. Additional social factors, such as poor nutrition, social isolation, and lack of educational attainment have also been identified as key risk factors impacting people living with OUD. As they continue to implement and enhance their diversion strategies, Baltimore hospital EDs must integrate interventions related to the social determinants of health to better serve patients with OUD.

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The Open Society Institute-Baltimore's Addiction and Health Equity Program seeks to generate and promote innovative ideas that improve health equity and lower the threshold to high-quality behavioral health services, reduce stigma, and support community engagement to improve public health in Baltimore.

The program includes the following priorities:

Use the opportunity of health care reforms, including the Affordable Care Act, to reach universal access to a comprehensive, high-quality public addiction treatment system.

The greatest opportunity, and challenge, to the field has been the passage of national health care reform. Although Maryland identified essential health benefits that include substance use treatment, we still have much work to do to ensure that these benefits are actually available to those in need. Health care reform implementation has changed the way health care is provided in this country in substantial ways and created some new challenges for behavioral health providers. To make the most of this changing landscape, providers, hospitals, government officials, and health care advocates have to continue to be nimble and forward-thinking. OSI-Baltimore initiatives support education, advocacy, and demonstration projects to increase meaningful access to substances use disorder services.

Support harm reduction policies and initiatives to reduce the stigma associated with addiction and decrease the negative impact of substance use.

One of the most debilitating negative aspects associated with substance use is the criminalization of addiction. OSI-Baltimore supports programs, such as Law Enforcement Assisted Diversion (LEAD), that work to divert individuals struggling with addiction from the criminal justice system into the public health and social services systems. This work is important to decreasing the stigma associated with substance use and creating a more open environment for individuals who wish to seek treatment. Clearly, one of the most immediate and concerning risks associated with opioid use is the increasing numbers of fatal overdoses. OSI-Baltimore will continue to serve as a local leader in the efforts to identify simple but effective policies that reduce overdose risk.

Strengthen and help sustain a strong, diverse addiction treatment advocacy community, inclusive of those most affected by substances use disorder services policies.

The initiative supports the establishment of a diverse advocacy community that includes directly impacted individuals who have first-hand knowledge of how policies that discriminate against people with substance use disorders lead to the breakdown of families and disintegration of our communities.