Expanding Infectious Disease Testing in MA Opioid Treatment Programs (OTPs) Webinar Transcript

Melissa Schoemmell:

Welcome! I am so excited to see you all today. We are here to talk about expanding infectious disease testing in Massachusetts. OTPs. I'm Melissa Schoemmell, and I am joined here by a wonderful group of colleagues, from JSI Research and Training. The OTP TTA Center is out of JSI, and we are funded by this effort to support all the OTPs in, supporting the person centered, access to MOUD in Massachusetts. And we are joined by our colleagues at JSI who support the the infectious disease side of things, in Massachusetts. And so, what a perfect time for us to all come together and talk about OTPs and infectious diseases as that is part of the new regulatory environment. So I'm Melissa, and I'm going to be kind of kicking us off today, and then I'll hand it over to my colleagues. If we want to go to our next slide, I'll walk through our welcome.

So hello everyone. Thank you for being here. If you want to introduce yourselves in the chat. I would love to hear from you. If you want to say, where you're coming from today? We'd love to know kind of where you're coming from and how you're doing. Please do say hello. I'll walk through our our session objectives. What we want to accomplish today and what we hope you'll walk out of here with, and give a little bit of a structure on the, 42 CFR part eight and how that, includes requirements for infectious disease testing and linking patients to care. We'll talk about the continuum of care, for infectious disease in Massachusetts and best practices, around that. We'll have some discussion with peers, and some questions and answers. And we'll wrap up. Thank you for introducing yourselves. Please continue to do that. We want there to be questions asked. And although we might not have the answers to all of your questions today, we will try our best to to take those down and make sure that we can can get those answered to you, in, in good time.

So, the next slide. I will introduce our presenters. So I'm going to be, kind of guiding us through the whole thing. And also introducing to the 42 CFR part eight in general. I have, our colleagues here, Adelaide Murray from the drug user health team and the infectious disease TA as I mentioned, Molly Higgins-Biddle, also from the infectious disease team at JSI. She co-directs that project, and Sophie Lewis, is here in spirit. She's not able to join us today. Unfortunately, unexpectedly. She's also a part of that infectious disease team and the subject matter expert. And did, actively participate in the slide development and, so we know that her expertise is woven throughout today's

presentation. So we're also joined today by representatives from the Mass DPH Bureau of Substance Addiction Services, BSAS, and the Bureau of Infectious Disease and Laboratory Sciences, and also, mass health. Individuals from those organizations will not participate in the breakout rooms, but will definitely be a part of the the conversation and presentation. So we hope that you all will take a sip of your coffee and get comfortable while our presenters engage you in, what we hope is, some valuable content on infectious disease testing and linkage to care at, OTPs. I'm going to pass to my colleague Adelaide to to walk us through our objectives.

Adelaide Murray:

Thank you so much, Melissa. It's really great to be here with you all today. As Melissa mentioned, I'm Adelaide Murray, and I am the drug user health team lead for a project at JSI called infectious Disease TA at JSI. So very similar to the OTP TTA center on the infectious disease side focused on drug user health. And it's really exciting for us to be able to collaborate and speak with you all today. So I'm going to start off by sharing our objectives. We hope that at the end of our time together today, you'll be able to first explain the importance of infectious disease testing and linkage to care in an OTP setting. Describe federal regulations and best practices related to expanding infectious disease testing and linkage to care in your OTP, and also start to think about preparing your programs to offer or expand infectious disease testing and linkage to care at your OTP. Next slide please.

So I'm going to start out level setting us with some data about infectious disease and substance use here in Massachusetts. You can see the source material which both Melissa and Molly will speak a little bit more about the Massachusetts DPH best practice memo, but I just wanted to highlight some data points that are included in that memo that I think are really pertinent to our conversation today. So about 1 in 5 or 20% of reported HIV infections between 2020 and 2022, in Massachusetts, had injection drug use as a contributing factor. 95% of individuals with hep C who will have had their exposure modes documented reported that they had ever injected drugs, and 90% of people diagnosed with HIV in Massachusetts who have a history of injection drug use also had a hepatitis C co-infection. And then finally, a little note on syphilis, 23% of infectious syphilis cases that were interviewed in Massachusetts reported substance use in the past, excluding alcohol use. So on that point of syphilis, which as you can tell from this data, we're going to be focusing today primarily on HIV, hepatitis C and syphilis. I wanted to draw your attention to a dear colleague letter that was sent out by SAMHSA and shared with you all earlier this year, which was about testing and linkage

to care for syphilis. We're going to throw that into the chat now. But just want to flag that these are three conditions that in Massachusetts, we, nationally are seeing rising numbers of syphilis cases and congenital syphilis cases. And in Massachusetts over the past few years, we have seen, unfortunately, some outbreak incidences of both HIV and hepatitis C. So these three conditions are super applicable and pertinent to think about when serving people who use drugs. And I think these data points are super compelling for us when we think about expanding access to these services. Next slide please.

So now what we're going to do is I am new here. I'm happy to meet you all today, but I would love to learn a little bit more about where you all are with your infectious disease testing and linkage to care in your OTPs. So we're going to get started and put up a few poll questions. There is just about four of them. But let's get the first one up. All right. So the first question is going to be how familiar are you with the infectious disease continuum of care? Not at all. Somewhat very or don't know. Not sure. And I'll give you a few moments to answer that. I see the results are coming in. Great things have slowed down a little bit, but I'll still give folks a few more seconds. If you haven't had a chance to answer the poll, please do. All right, let's close this poll, and I'm going to share the results back. There they are. So it looks like the majority of folks who answered this, about 65% of you are somewhat familiar. We have some folks who are not at all familiar. A few that are very familiar, and then a couple don't know. Not sure. So I'll let you in on a secret. I think that we are. This presentation is going to be very perfect for this audience, I think, for those that are not at all familiar. And for a couple who are very we're I think we're going to hit the right tone. So let's go on to question number two. And this question is going to be how consistently do you provide testing for OTP patients to test for HIV, hepatitis C, STIs and or other infectious diseases? Do you not provide these tests for patients? Do you provide the testing when the patient asks? Do you provide testing for most or all of your patients, or you don't know or you're not sure? And all answers are okay. Answers. Wonderful. They're coming in.

Thank you so much for answering these polls. I'm hoping one more person answers so I can get the same number of people to answer. Question one, just to let you in on on my thought process. There they are. Thank you. All right, let's share this back. So a little bit more of a spread on this one, which is great. So we have about 20% of you saying we do not provide these tests for patients. We have 13% who provide testing when the patient asks, 40% who provide testing for most or all patients, and then 27% don't know. Not sure. Like I said, all super good answers. Love the mix. It's going to make discussions super informative and interesting. So thank you. We're halfway through the polls. Let's throw the next one up there, which, if you don't provide these tests, which is about 20% of you, totally fine. But when you provide testing for HIV, HCV, STIs, and or

other infectious diseases, do you test at your office or do you send the patient somewhere else so you can see it at first? Not applicable. We don't provide those tests. We do them at our office or we send them somewhere else or don't know, not sure. These answers are coming in quickly, I love it. Thank you. Again, waiting for 1 or 2 more folks to answer.

Melissa Schoemmell:

There's a question in the chat about how can I put both? And I don't think we have that option, but it's good to know that there got out there.

Adelaide Murray:

Oh yeah. We didn't make them I think. Select all that apply. Sorry about that, Cynthia. Thank you for for letting us know, though, that that it's both. Let's share these back because super interesting. It's we're seeing almost about a half and half split, with a lot of folks providing the test at your offices and a lot of folks sending the patient somewhere else. So I'm excited to learn more about those processes in the discussion. And then our final question is, and this is applicable really whether you provide testing or not. Right. Because someone might come into the OTP and tell you that they have been previously tested and they know they have HIV, but they're not in care or another condition. So this question is how comfortable are you linking a patient to infectious disease care if they tell you that they have HIV or hepatitis C or an STI that has not been treated? And this will be our last poll or today. Amazing. I think we have the folks that will answer. We can go ahead and share that back. And really awesome. Thank you all for sharing. We have the majority of folks feeling very comfortable and the rest of folks feeling somewhat comfortable. So when we start to talk about linkage today, maybe a good bit of review, but always good to refresh and share best practices amongst each other. So that's what we will do today. Thank you so much, for your engagement in these polls. And I am going to pass it back to Melissa.

Melissa Schoemmell:

Thanks, Adelaide. All right. So I am just going to ground us really quickly. For anyone who, might not be living with their regulatory hat on. So the at the national level, 42 CFR part eight, is a regulation modified, within a final rule, at DHHS, federal DHHS and

SAMHSA. It was finalized in January of 2024. And when they say final rule, it is because it's been modified from a proposed rule, that was proposed in 2022. So they call it the final rule. And as we have mentioned before, that this regulation is supported by evidence based research and draws on lessons learned, from the policy changes that happened. And the regulatory exemptions that happened, and that were initiated during, the, the Covid pandemic. And really is focused on patient centered care, that shared practitioner and patient decision making, using practitioners clinical judgment, being responsible and having flexible services that, are based in evidence and also, updating some stigmatizing language. And, this is huge. It's the first significant change to treatment of, methadone delivery standards in over 20 years. So there was a lot in there. And we have gone through some of the main key points that, that BSAS has, provided guidance for and waivers for to allow for these, this regulatory environment to, to work in Massachusetts. If you want to go to the next slide.

The, the thing we are going to focus on today is that this final rule also expands the provision of counseling services, that are provided by OTPs and will include harm reduction, counseling and linkage to treatment for anyone with a positive HIV, viral hepatitis, or other sexually transmitted infection test results. So, that is what we are here to talk about today and how OTPs can, take that regulation and, implement practices and processes to, to move toward more patient centered care and more centralized care for our patients and better health outcomes. So I am going to pass it back to Adelaide now that we are grounded in that rule and this infectious disease piece. I'm going to pass to Adelaide.

Adelaide Murray:

Thanks, Melissa. It's really exciting for us to have this opportunity to build on all of the work that you all are already doing with these new requirements. I know that, you know, this is a lot of changes that you all are experiencing right now and a lot of things that you're trying to learn and adjust to. Or maybe you were already doing and you're feeling really excited that, you know, now it's aligned with the new rule. So we recognize, you know, the infectious disease is now a part of that. So we wanted to dig a little bit deeper into what Melissa shared. So when SAMHSA is referring to harm reduction, they are going to define that as both practical and legal evidence based strategies that include overdose education and then testing and intervention for infectious disease. And so these interventions include counseling and risk mitigation activities, which form part of a comprehensive integrated approach to address HIV, viral hepatitis, other sexually

transmitted infections, and bacterial and fungal infections. You can head to the next slide, please.

And so this culminates in the language in this regulation, in this final rule that Melissa mentioned, which states that OTPs must provide counseling on preventing exposure to and the transmission of HIV, viral hep, STIs, and then either directly provide services and treatments or actively link to treatment each patient admitted or readmitted to treatment who has received positive test results for these conditions from either their initial or their periodic medical examinations. So it's in there. We're now going to talk about how we do it, and I'm going to pass it over to Molly to start to walk us through some of the Mass DPH best practices.

Molly Higgins-Biddle:

Thanks, Adelaide. And hello everyone. It's great to be here with you all today. So as Adelaide mentioned, we started off kind of at the federal level and some of those regulations and the final rule. We're going to turn now to what this means in Massachusetts. And I'm going to walk through some of the key components of the best practices memo that DPH released. We could go to the next slide.

And I believe Shaivi put the link to that memo in the chat. So you can click on it and view it yourself as well. But here are some of the main pieces. So under 105 Code of Massachusetts regulation, substance use disorder treatment programs must designate an HIV/AIDS coordinator. And that person is responsible for overseeing HIV risk assessment and facilitating access to HIV testing. This expectation applies to HIV and any other laboratory studies as clinically indicated. And because people who use drugs, and inject drugs face an elevated risk for infectious disease acquisition and transmission, the testing for hepatitis C, HIV, and syphilis are all clinically indicated, and their billable services under MassHealth. Next slide.

Okay. So the best practice in the memo, is to offer testing for HIV, hepatitis C and syphilis at intake assessment, in addition to any other clinically appropriate serology site you may be testing for offering testing for. It's also best practice to offer testing follow following a high risk exposure or of course, at the request of the patient. And it's great from our polls that some of you, are already doing this best practice. Next slide.

Okay. So to implement this, if you are starting out, OTPs should establish and implement policies for infectious disease testing, follow all applicable state and federal regulations, including those for individuals covered by Mass Health. Report any positive

cases or positive test results for DPH. And if your OTP is also licensed as a clinical laboratory, you must also adhere to those regulations and standards that are applicable to clinical lab operations for infectious disease testing. Okay, so that's a brief overview of the best practice memo. And we're going to get into the infectious disease continuum. And I'm going to pass it back to Adelaide.

Adelaide Murray:

Thanks, Molly. So me again now filling in for our colleague Sophie, who you heard, was last minute not able to join us, but I hope I do her justice. So as you start to look at this slide and you look at the infectious disease continuum of care, you might notice or I hope you start to notice something which is that these latter three steps, so the gray, the blue and then the darker blue box, are really similar to what you are used to doing right in engaging folks in their substance use treatment. So once someone gets into care, you already know you support their identified goals. You utilize a whole person approach to their care, and you try to keep them engaged in care and meeting those goals through this process. Right. So we're really familiar with that. Even though it's infectious disease and not substance use. You have the tools in the toolbox already. Now, the beginning of the infectious disease continuum of care is a little bit different than what we might be used to with substance use disorder. So that's what we're going to focus on today is that testing, diagnosis and linkage to care peace. Next slide please.

So I'm going to start us off with testing. And we're going to talk about consent which is important always and often right. So individuals need to be informed of all tests that will be performed. And all individuals who are offered testing do have the option to accept or decline. There are some specific requirements around consent for HIV. Those are that verbal consent is required for the test itself. And then written consent is going to be required in order to inform any third party that an HIV test was performed and any results along with that. And again, this is super similar to how you all are used to sharing substance use disorder information, right? We need that specific written consent to share any information about SUD to be in line with 42 CFR part two. And it's the same for HIV information. We're going to need a specific written consent to share any HIV information. So your facility may already have policies in place about HIV informed consent and of course, encourage you to start there and familiarize yourself with that policy if so, next slide please.

So once you've obtained consent and you are getting ready to order the test, if you're not super familiar with this process, you're going to want to order a serum or blood test

for HIV, hepatitis C and syphilis. This is going to be the best practice in order for this type of testing. There are different protocols and guidance around these tests depending on the lab you work with. And of course, you know it's best to talk with your lab and figure out what they require. But an example about some of the specifics around these tests is around hepatitis C specifically, it's recommended that an antibody test for hepatitis C is followed by another test, which is used to detect if the infection is active or if maybe the person has just had hepatitis C in the past. And this additional test may require you to check two different options when you're ordering the labs. But again, just make sure, you know, with the lab you're working with or if you have an in-house lab, what they prefer, in order to make sure that you get the best information to then share back with the patient. So speaking of next slide, please.

When you're preparing to share those results with the patient I have some tips. And again it's all pretty similar I think, to what you guys are used to, you know, from asking someone if they want to be tested to delivering their results and to having conversations about when, where and how they'd like to engage in care. It's important to ask the patient's preference and follow their lead. Molly is going to get a little bit more into how other types of organizations tend to deliver results, but ultimately, it's important to go with what the patient would prefer. Then. It's also important to be aware of privacy and confidentiality laws around HIV. I just mentioned that piece around, you know, written consent. Information about someone's HIV status may have even more heightened security measures than HIPAA and 42 CFR part two, which might feel a little daunting to us. I know it does to me because 42 CFR part two can feel so very strict. But we just want to make sure that we have all the information about security and confidentiality around someone's HIV status. And then we want to always ensure trauma informed care that understands the physical, social and emotional impact of trauma experiences on the person you're talking to. Again, something I think you guys are super used to. And then of course, our trusted tool of motivational interviewing. We love it, we know it, and can and should be used when talking about an infectious disease to ensure a collaborative, goal-oriented style of communication. And now I'll pass it back to Molly.

Molly Higgins-Biddle:

Thanks, Adelaide. All right. So we're going to get into methods for delivering test results. And this is a lot of information on one side. So we're just going to walk through it one step at a time. So for negative results for HIV, syphilis and hepatitis C, those can be delivered via phone call and for negative results, you may also, choose to provide some harm reduction resources to help patients stay negative. For positive results for syphilis

and HCV, those can both be delivered via phone call as well. However, some organizations choose to deliver positive HIV test results in person so that the provider can assess a patient's response, provide support, answer questions, and address any concerns. And this is really especially important because of the elevated stigma associated with HIV. For positive test results, if they've tested positive for HIV or syphilis, let them know that someone from the health department will contact them. This is part of the a partner services program that DPH runs. We're going to talk about that a little bit more on the next slide.

If the patient has tested positive for hepatitis C, let them know that hepatitis C can be cured. And we'll talk a little bit more about that on the next slide. In terms of what, the treatment is about. Okay. So for linkage to treatment, again, a lot of information on this slide, I'm going to start on the right hand side with hepatitis C first. And for treatment, the patient's primary care provider may be able to provide treatment for their hepatitis C. So it's important, to ask, if their PCP can provide it. Or they might need to see an infectious disease specialist. And depending on where you refer patients for treatment, the patient may need to become a patient of the prescribers facility before seeing an HCV prescriber. So it's important to kind of, figure that out with the patient and make sure that they can navigate that, as they, attend their care appointments. If possible, make an appointment on behalf of the patient if they'd like you to, if that's not possible, provide the patient with their name and contact information to make an appointment. It's also really helpful to check back with people the next time you see the patient back, in your facility to see if they were able to attend to their medical care appointment, and receive treatment. It's also, I think there are a lot of, common misconceptions out there about hepatitis C, specifically. So it's important to make sure patients know that the treatment is over 90% successful. There's it's not quite new anymore, but there is a regimen now that's 8 to 12 weeks for treatment. MassHealth and other insurance providers will generally cover treatment more than once in a person's lifetime. And, they don't have a substance use abstinent requirement. For HIV and syphilis. Sorry, the same slide. Lots of information, for HIV and syphilis. Again, as I mentioned, DPH does run this partner services program to help people diagnosed with HIV and STDs get linked to treatment, notify their partners of the exposure, and help partners get access to testing and medical care if needed. And this program is free, voluntary. It's confidential. And so what happens is that when laboratories report positive test results to DPH, DPH field epidemiologist will first reach out to you as the provider for context about the patient and the diagnosis. And then they will actually follow up with the patient directly, and link the patient to treatment. They can also make that appointment on their behalf. And they're

also available to be present when test results are delivered to the patient, if that's helpful. All right. Next slide.

Okay. So this slide is about an out posting model that's currently in use in Massachusetts. As we saw from the poll, some of you are sending folks off site. This is actually a model where an external organization, is contracted to provide infectious disease testing and/or treatment on site at your OTP location. And this can work both for testing and for treatment, particularly with an external treatment provider that can provide care via telehealth. So currently, 21 OTPs in Massachusetts have out posted staff from external agencies to conduct testing. And this is funded by the Bureau of Infectious Disease and Laboratory Sciences. No additional funding is available to expand this program. However, your OTP may choose to use your own funding or resources to set up this model. All right. I will pass it back to Adelaide.

Adelaide Murray:

Thanks, Molly, and thanks, Melissa. Thanks, everyone for your attention. We can head to the next slide and we now have some time for Q&A. Question and answers. So I will go ahead and mute and feel free to raise your hand. Come off mute, use the chat like Melissa just wrote in. We definitely want to hear your questions and hear what you're thinking about before we head into our breakout discussions.

Melissa Schoemmell:

Quiet group today.

Adelaide Murray:

Okay, keep thinking, we'll give you some time. And I hope that, you know, this is this is a fully safe space. No bad questions. All good things. We want to know what you're thinking about.

What do you think, Melissa? And so do you think folks just want to get into their breakout rooms?

Melissa Schoemmell:

Maybe. But I'm wondering if anyone wanted to share if they do this and want to share your initial experience with doing this, either in any of the modalities that we just went through? But I think if if not, I think we have more time to talk, as peers, and really dive in to each role.

Adelaide Murray:

Yeah. So we will have time, for questions and breakouts and, and our report out. But if I am going to transition us to our breakout rooms now, I am going to respectfully ask, our colleagues at DPH to please head out now. We so appreciate you being here today and and respect your your participation here. Thank you. So now, as I do transition us to breakouts, what we're going to do, which some of you may be familiar with before with, the OTP TTA center is we're going to have you all self-select a breakout room, based on the role that you hold at your organization. So you'll see the options that will pop up in just a minute. If you want to head to the next slide, Shaivi, you're going to have both a facilitator and a note taker in your breakout room from the JSI side to kind of help you walk through these, questions and make sure that you feel super supported in that discussion. They are going to share these questions that you see on screen. So no need to try to commit them to memory now. But we're hoping that folks have a chance to talk about, to what extent, you know, you and your staff are understanding infectious disease testing, how you incorporate infectious disease testing into OTP assessments and treatment planning. If the OTP receives a positive result for a patient, what do you typically do? What processes in place? If a patient comes into the OTP and wants to start treatment for an infectious disease diagnosis, they've already received? And what are your top two barriers in implementing or expanding infectious disease testing and linkage to care at the OTP? So this is what we are going to be talking about in our breakouts. Does anybody have any questions before we go ahead and open up the rooms? All right. We'll go ahead and get them open. You'll see that if you are a a admin or manager or a medical provider, there are two rooms that you can join. They will be the same, just based on the number of people wanting to make sure that folks have, you know, a small group for discussion. So I will give you all a few minutes, to go ahead and select your breakout room based on your role.

Hi, everybody. Welcome back. We're now going to share a little bit, about what you all talked about. I think Shaivi we can go ahead and end the screen share for right now. Well, we will bring it up. Yeah, I'll share some resources. But first I want to hear what you all talked about. Had some great conversation in my room. So let's see. I think that

room one two was admins and managers. Is somebody ready to report out from that room?

Tasha:

Well, hello, I'm Tasha and I will I will try my best at this.

Adelaide Murray:

You're going to do such a good job. I'm sure. Thank you so much for doing it.

Tasha:

Of course. So in our group, we discussed different, the different questions that were on there. One of the ones that we had was about the barriers. And for us to be able to do the linkage of care for patients and our, our site one barrier, that my manager brought up was we don't do the blood work testing here on site. We have, a company that comes in twice a month to do that. So it kind of separates the patient's admission and makes it a little bit harder on the patient. And that could be one of our barriers here. But also I think it's just some patients are just reluctant, and nervous about the testing because it's not a requirement for our site.

Adelaide Murray:

Can you tell me a little more about what they're nervous about? Like, is it around getting their blood drawn or finding out the results or, or other things?

Tasha:

From what has been shared to me by patients, and I'm the medical assistant for my site. So I do some of the admission portion, and it's, you know, I, I hear, you know, I don't like needles. You're not going to be able to find a vein. I'm too nervous to to do that. I, I'm not into doing that I actually was told, my last admission I did, and I had asked if it was more being nervous about what the results could be, and it was just you know, no, I don't want to do that. I also do feel as though at admission, there is a lot of information

that’s handed to patients. So when you're adding in, that it might just be a little overwhelming for them. I do circle back because like I said, we have lab days twice a month here, and I do circle back to the patients that have opted out of it or haven't done the blood work to try to get them to do it again.

Adelaide Murray:

Okay. Thank you so much for sharing. I was there anything else in your group that you wanted to share with us?

Tasha:

Oh, geez. See, you put me on the spot there.

Adelaide Murray:

Oh. I'm sorry, I don't want to.

Tasha:

Oh. You're okay. Don't worry about it. We, We do make sure that we have conversations with our patients and letting them know. Krista was saying how at her site she's having, some issues with, like, consent and stuff with being able to do the HIV testing. So that's one portion that they're not doing at their site.

Adelaide Murray:

Okay. Interesting. Thank you for sharing that.

Tasha:

Yeah.

Adelaide Murray:

Kelsey, I saw you come off mute.

Kelsey Berdeguez:

I did. So, for breakout room number one, we did not discuss who would report out, but I wanted to open the floor to any of our participants from that room, if you would like to share. And if not, I'm happy to give a recap. Okay. I don't see any of our participants coming off mute, which is totally fine. I'm happy to share.

Adelaide Murray:

Thank you Kelsey.

Kelsey Berdeguez:

We talked. We talked about, very similar things as, as was just described, our, our participants, mostly would partner, with either a local hospital or maybe not a formal partnership, but that's where they would, refer patients to, for testing. But it seems like very PCP heavy, and that a lot of clients had access to their PCPs for testing, which was, positive to hear. We also had one of our providers who said that they are partnering with a mobile man, provided by a tapestry that comes, every third Wednesday for testing and treatment. And then they also come every two weeks to provide harm reduction services. So, amazing partnership there that seems to be, working really well. We also talked a little bit about combating stigma and shame. And also, having the barrier of conducting blood draws as well, so very common. So really leaning on education. We had one of our participants who said that it typically takes around a month for for patients who are kind of working through that shame, through that stigma to kind of come around with, speaking, working with their clinician, understanding that there is treatment that, you know, that there is no finality in a diagnosis, that it is just, you know, about getting treatment, education and getting those resources to help with, patients who have to tell family members or loved ones or partners. And those were kind of the big takeaways from our group.

Adelaide Murray:

Awesome, thank you, Kelsey. I am excited for Heather to share next from our clinician, from our medical provider group. Because I think that we're going to hear some similarities and also some differences, as Heather does have her testing on site. So, Heather, are you ready to report out?

Heather Birt:

Yeah. So sorry. Hold on. I don't have my video thing going. I don't know where that. Oh, okay. Okay. Yeah. So, yeah. So we have testing on site, which actually makes things a lot easier for, for us here. It's literally the lab is down the hall. We're attached to a hospital. So some of the barriers, mostly are getting people connected to the actual treatments. A lot of our patients don't have primary care providers set up or, if they do, they don't even they think they have somebody that was assigned to them and they've never talked to them. So, that's been kind of a little bit of a problem for us. So and what else did we what else did we talk about? I can't remember.

Adelaide Murray:

Could you share a little bit, Heather, about your, your new navigator position?

Heather Birt:

Oh, yeah. So we I think most OTPs probably have navigators, but we we were just able to hire, three new people, and they're really able to kind of communicate with the patient easier than we can. They have cell phones that they can text the patient, they can help with case management, really helping them set up doctor's appointments, even driving them to their doctor's appointments. So that's helpful for us. We live in a kind of rural area. There's not a lot of transit, public transportation. So, that's always kind of a barrier for us as transportation.

Adelaide Murray:

Thank you. Heather.

Heather Birt:

Welcome.

Adelaide Murray:

And we talked about a little bit about like that time right between the connection to the clinic and then the first appointment, is definitely the spot, where we got to help people make that connect. So definitely, lots of really good things happening there. Heather, thank you so much for sharing those. And then I think, Jasmine, where are you going to report out for your discussion.

Jasmine Quinones:

Hi. So. I'm echoing let me go into this other office.

Adelaide Murray:

Oh no worries. Those tech issues are just they get us all, they come for us. You know.

Gary Frankowski:

There you go.

Jasmine Quinones:

Hi, it's Jasmine. Hi. Hi, hi. I was echoing, so I came over here. So we talked about it was mentioned earlier how we are partnering with tapestry, to help us with STI testing and treatment. And I think at baseline we all kind of have the same knowledge of, like, the testing. What I discussed in my room was the barrier for most of the clients seems to be not having a provider or not knowing who their provider is when it comes to linking them to care.

Adelaide Murray:

And that's the PCP specifically.

Jasmine Quinones:

Yeah.

Margo Moyer:

And and so we talked a little bit more about, you know, with this barrier, with being able to find a PCP and also like knowing what type of insurance they will accept, I think we were also curious maybe hear from other folks if there is specific case management they have to help support this fear, with their patients. So I don't know if this is the time when we get to open it up to other folks so I can save that to for the end, but that's what we were wondering.

Adelaide Murray:

So the question, Margo, is, do other people's case management staff have good information about what insurance is going to cover, what to help kind of talk folks through that?

Margo Moyer:

To talk folks through that and also in supporting with finding a PCP who is external. Yeah. So just putting that out there.

Melissa Schoemmell:

And to supporting people who may be at like a residential treatment and have like a little bit of a blip in where they are. So their providers may be at home. And so it's like a little bit of a transitionary time for them. And so finding a provider team in that transition time.

Adelaide Murray:

I would guess that that's a shared a shared challenge, Heather shared, if I can speak for you for a moment, Heather, about like having a patient come out of a detox program that had gotten started on their hep hepatitis C treatment in detox, but then didn't really have any kind of aftercare plan. Wasn't the medication wasn't continued for a refill, you know, a linkage wasn't made. And so Heather was kind of like, what do I do? You already started, and I don't know where to go now. So definitely that sounds like a really challenging situation to be in at the OTPs.

Heather Birt:

Yeah, I actually called his PCP and they wouldn't see him, so. So yeah. So.

Adelaide Murray:

Oh, Heather, we're all like, that's terrible. But we're glad that that that that that client has you, you know, you're trying you're trying to get the connections, even if some other providers aren't as supportive. Were there any other things that folks wanted to share before I share a couple of resources with you to, to bring us towards our end?

Okay, definitely. If any questions come up for you, feel free to reach out to the TA center, to put them in the zoom chat before you leave. We definitely want to continue to be here, you know, and help problem solve or think through things or provide some, some resources. And to that end, Shaivi, if you could, if you could throw the resources, slide up, some easy links that we wanted to make sure we're accessible to you are around the data security and confidentiality guidelines for the conditions we've been talking about today. A guide that is specific to supporting individuals with HIV and hep C in a substance use service setting. The Mass DPH Hep C website, some Massachusetts HIV specific criminal laws. We didn't talk too much today about the way that HIV is criminalized in 2024, in some places. So we did include this link that will give you some information about specifically in Massachusetts, what those laws are because that can be important to help folks navigate, if they do end up with a diagnosis of HIV. We have the memo and the Dear Colleague letter, which we did share in chat already. And then we have another guide, specifically for integrating infectious disease testing and treatment services into OTPs. So with that, I will pass it over back to Melissa to close us out. And thank you all from the infectious disease team. Thank you so much for, your engagement and coming and sharing and learning today. We really appreciate it.

Melissa Schoemmell:

Yes. Thank you. We were all taking notes in those breakout rooms, and our teams are going to be debriefing and figuring out how we can best move on from this and what, like action steps are next steps we can do to support this, happening for everyone at the OTPs in Massachusetts.

So on our slide right now and in your, chat, there is a link you could link if you can get in there now, and let us know how we're doing. Kelsey, our evaluation lead will forever be your best friend. But no, we really want to hear from you. And we want to know how we can help you and what is what is helpful, what resources are helpful, what topics, times all of the above. We are a resource for you, OTPs specifically. And and we're trying to listen to you and, and listen to what BSAS is hearing. But your feedback is gold. So let us know.

And then on our next slide. We just want to thank you again. And if you aren't on our contact list yet, please do get in touch with us. We have regular updates, information, any of our events, or things that BSAS is really trying to promote. We will make sure that that is pushed through that channel. It's just kind of go to spot to get all of your news for OTPs in Massachusetts. So, and I didn't know if you skip that on purpose, but we have an event coming up, our next event.

So we're going to skip over December. We don't have an event in December. And, our next event is going to be in January, January 14th, 12 to 130. And we're going to talk about telehealth, and some best practices around telehealth in the OTP setting. So stay tuned for more information and registration on that. And please be in touch on that email and in your survey. We look forward to, to connecting with you all. And I do believe we can close out a little bit early, unless anyone has anything else they would like to say.

Adelaide Murray:

Thank you again everyone.

Melissa Schoemmell:

Yeah. So thank you to our colleagues from the infectious disease team. It's been a great partnership.

Adelaide Murray:

Thank Melissa. Have a great day everybody.