Telehealth Best Practices for SUD Considerations for Engagement in Counseling Webinar Transcript

Lili Njeim:

And please complete our evaluation. Our team will share a link in the last few minutes of the session. Your feedback is really important to us as we continue to develop this TTA center. And Melissa just dropped our contact list in this chat. I'm sure many of you are a part of our, contact list already to have received this information, but if you're not, please join.

And for those of you who are unaware with our about our teaching center, the purpose for the OTP TTA center is to increase access to MOUD and improve patient care, provide tools and trainings and resources, promote best practices, and address challenges. We aim to support OTPs by providing free, responsive educational opportunities to enhance the delivery of MOUD. And our mission is to improve service delivery and outcomes for individuals with OUD, with a focus on aligning the updated federal and state specific regulations for OTPs. And we are funded by the Massachusetts Bureau of Substance Addiction Services.

This is our lovely team. My name is Lili. I'm the training and technical assistance coordinator. And today on the call, we have Gretchen, our project coordinator, Melissa, who is our training and technical assistance lead, and Audrey, our health communications lead, and Jo, our needs assessment and Advisory Council lead.

So a look at our services. We provide tailored technical assistance to support you on a wide array of topics. Expert support and peer learning opportunities, and some resource development.

So, just a few housekeeping rules. Our lines, your lines will be muted and use the raise hand feature if you'd like to come off mute, which we have a little graphic here to show you where that's at.

And please use the chat to submit questions for speakers and panelists and our team. And we will be recording today's session. But we will cut out the Q&A session. So feel free, you know, to be comfortable asking questions. We'll just record the session for, our TA inventory just so we can provide the webinar to those who couldn’t to make it.

So a quick look at the agenda today. We're going to go into the history and future of telehealth with a Q&A with our speaker, Linda Hurley, the president, CEO of Codac. And

then we're going to have an op spotlight with a Q&A with Laura Frangipane and Jessica Fortier-Goss from CTC Group, Acadia Healthcare. And then we'll have our wrap up and evaluation. So there will be two opportunities to engage today in the Q&A's.

At the conclusion of this webinar, well, we hope that you'll be able to identify barriers to telehealth, identified methods to successfully create a systems change inclusive of telehealth, identify the needed culture change for this shift in service provision, and identify where telehealth has shown efficacy and efficiency.

And just a quick, fun question or poll, what do you all guess that the first documented use of two way video communication for telehealth occurred? And what year? What is your guess on that? You can put it in the chat if you'd like.

All right. Answers. So coming in and we have Linda Hurley with the correct answer. Everyone. When we did this we did this as a team. Melissa put this together and I think we were all we were all incorrect. So it was actually 1959 for the, year was the first documented use of two-way telehealth?

Linda Hurley:

I was the only born then, so.

Lili Njeim:

That was that was really shocking to me. But yeah, I had said in the meeting with our team, I was like, we're we're can video communications even a thing then? Like, when did TVs come out? And everyone's like, no Lili, they've been out for long before.

Linda Hurley:

Yeah. And actually the history of telehealth, we'll talk about it. But it's, it's been actually evidence based even for decades.

Lili Njeim:

Yeah. Oh all right. Well here is Linda. She has spoken. Welcome Linda! So Linda Hurley has 40, over 40 years of experience in SUD treatment and behavioral health care. She is, the president of Codac. She's been with Codac since 1991 and became the president CEO in 2016. Under her leadership, Codac became the first OTP in the nation to receive health home certification and the first in Rhode Island designated as a Center of Excellence. She also pioneered several programs, including medication for addiction, treatment for corrections, a tobacco cessation program, and a hepatitis C treatment program embedded in an OTP. Miss Hurley is a key advocate for policy change in Rhode Island and has consulted for state and federal agencies, including SAMHSA and the US Senate. Welcome, Linda.

Linda Hurley:

Thank you.

Lili Njeim:

All right. So I will let you introduce the presentation and then give a quick, overview of the Opioid Response Network.

Linda Hurley:

And that's me?

Melissa Schoemmell:

I will I'll take sorry I'll take care of that okay. Okay. On behalf of the ORN pleased, to share about this wonderful, opportunity that is open to, everyone, all organizations or communities. And the Opioid Response Network provides resources and technical assistance to states, organizations, individuals to address, the opioid crisis and stimulant use. Each, state and territory has its own team, and those are led by the regional technology transfer specialists. And there, is a website you can visit to request just like we did to bring in Linda today. And, thank you to Jenna from ORN, who is joining us to, help coordinate all of this. But, just noting this wonderful resource. And thank you, for for your help in bringing Linda here today. To bring some great, expertise into the room.

Linda Hurley:

And now it's my turn. Right? Okay. Thank you. Well, I'm grateful. I think we have, 20 plus individuals on the call. So thank you so much for caring about this and caring about the people that come to us for care. And when we look at the evolution of telehealth for behavioral health care, just as, I had absolutely nothing to do with that, that quiz at the beginning. But it was a wonderful idea because it brings it all just as you'll see as we go forward that, telehealth has been, practiced for decades. And decades. And it has been evidence based, as SAMHSA defines, evidence based, which which is, very well vetted research, for at least three decades. Okay. Obviously it's increased since COVID, but so we'll look at the evolution, just a little bit of the history, some of the research, and then what has happened, post-COVID.

So, you know, all of us in the opioid treatment field, all of you, anyone that's had anything to do with it, we've had a remarkable, remarkable, remarkable, successful, creative and courageous response to, the COVID-19 epidemic and the fear that we all had the deep seated unknown, the fear of the unknown around COVID. We did a wonderful job. And our response to keep our patients safe we call the people, patients in Rhode Island to talk to, you know, everybody's different. But, the folks, the peer recovery group, prefers to be recognized as patients here. So that's what we continue to do. So that that, you know, the risk mitigation activities that we all did, I think were were actually brilliant. And we'll talk a little bit more. Well, I'll talk about them. Now, I know that, many of us, within who is February 2020, right. The first week of March 2020, that is when, the sky fell and all of us, all of the OTPs immediately looked at how we could keep our patients safe, our clients safe, and we did, across the board nationally, even, curbside dosing, various delivery systems, to keep people isolated, to keep people, in terms of risk mitigation. We did, a huge, huge we created a huge influx of medicine into the community because we, I think it was 500%, that was the increase in take homes, which really, set this because we did it so well.

You did it so well, it it's at this stage now for SAMHSA and Doctor Olsen to be able to say, okay, DEA, you know, CSat, we're opening we're opening the take home medications so that the entire piece there. So everybody did a great job and telehealth became immediate. It had to be right. And then, you know, the problem was that we we did it because we had to do it. We did it in two weeks. You know, everybody look back. Remember, that's what we did. We started moving within two weeks. Ten business. Well, 14 everybody was working weekends then. And so it it was telehealth was adopted wholesale because we had to, to keep people safe. And we didn't have a plan.

There was no strategic plan, you know, there was no systems change 101, you know, or a science to service initiative from the ATTC. None of that. We just jumped in. Now, some of these things that I'm talking about on this slide, are now contribute to what some of the barriers have been around a continued adoption or retention of the utilization of this modality. And, you know, when we jumped in, you know, our, regulatory entities and us, our culture was saying, “oh, this is going to be scary. Oh this isn't going to be safe.” Despite the decades, literally decades of evidence based, of evidence that telehealth was safe and telehealth was effective. And we actually are proving that now, with continued research. And, am I moving these or are you?

Gretchen Shoemaker:

I'm moving them. So you can just let me know when you're ready to move on.

Linda Hurley:

Oh, okay. Gretchen, thank you. Let me get rid of this, then. Okay. Please. Next slide. Please, no, that's good. Thank you. So this just gives you a little bit of background. Okay. 13.5% moved to 17.5% of all services increased across the country, mostly in rural areas, from 2016 to 2019. And then we look at the Medicare mental health visits and Medicare mental health visits means generally aging population and those that have some pretty significant diagnoses. Correct. And between 2010 and 2017, telehealth was already picking up steam, 425% increase. Right. Now, those two demographics, those two populations, the primary barriers to access was geographic limitations. So, this probably we didn't feel this much on the East Coast because we don't have that same not like mid-country, the same limitations. And then we look March 11th through April 22nd, you know, of 2020, how long is that? Five weeks. That jumped 556%. And again, I think we all need to be proud of that. And it's continued it it continued to rise during COVID. Next slide please.

So again ,just keep in the back of your mind what we're looking at here. What are the barriers you're facing now to having staff be excited about this wonderful gift that we can give patients and our providers to be able to connect in a more effective and efficient way. So I don't know if you guys, you know, Deming, I just use Deming because he was the very first person to talk about systems change.

He was over in Japan and he was working with some kind of Japanese technology. So you make you find something that needs to be done or fixed. you plan. You do the plan.

You check the plan and you check your matrix. You do all the things you need to do, and then you act, and then you check and act and check and act. You know, we had five weeks to do this and we were not doing a Deming project. We were not doing systems Change 101 and again, we're paying for that now because even we you know well we'll talk about a little later. So next slide please.

Okay. So what we know this is what we did. You know. And we did it haphazard because we had to do it haphazard. We were literally I believe we saved people's lives by really making sure that we mitigated the risk of transmission. So this is exciting because we improve population health, right? Improved the quality of life, mental health, depression, management and satisfaction, compared to in-person treatment. And there are so many research articles on this, by the way. I, we gave you some there's some in the at the end of this, presentation, but, you know, my suggestion would be just to go into SAMHSA and look for them because there's so many and we can really use these to kind of sell this to, patient or to staff that we're onboarding, to sell this to staff that's been around for several years and have the cultural barriers, and the improved population health is also clearly, clearly recorded. For substance use disorder reduces alcohol use, boosts tobacco cessation, and improves opioid treatment engagement and retention. Next slide please.

Okay. Provider. This is this is a good one when we're talking to staff okay. When it's been researched and it's been researched nationally, let me see. But I kind of want to lose track of myself. Provider experience has been they love the increase in flexibility in scheduling. It improves coordination of care. You get, you know, you can, do a conference call and have an introduction and you can be there to keep, you know, individuals safe, feeling safe. For us, we have spent a lot of dollars and utilized a lot of resources in creating liaison positions where if, one of the individuals that come to us for care are getting primary care for the first time are going to, treatment for a more severe mental health issue, whenever, whatever it happens to be. We actually paid liaisons to go and meet the patient at the doctor's office because our patients history has been such that they are they are, they were and remain stigmatized because, you know, this country stigmatizes poverty. I mean, it's it's across the board. We stigmatize poverty. We have when we serve 93% of the folks that many of us or that we serve are Medicaid patients. So, you know, in addition to all of the other, institutional, stigmatization, they, poverty in general is one. And so so we would spend money to do that. Now, you can just do it. You can do a conference call. You can make sure that individuals are following through and the three of the provider, the referral source, the referral and the client or patient can all come together and not have to spend the time driving, taking a bus or walking, and these are what has come out of, these various, various, I'm sorry, I just had

a blank there. These very intense research projects, helps to reduce stress from workforce shortages because the time is so much better used. It reduces provider burnout. And again, these are, like 20 years old. This isn't, like, new stuff. And individuals, individual providers and providers, by the way, here in this presentation are anybody that provides service. So it's not just a doctor or a prescriber, it's a therapist, a counselor, clinician. So this is provider experience. Increased ability to assess psychologically and environmentally, having a sense of where someone is, their their living their living condition, their living arrangement. And that's one of the biggest barriers when we hear people say that they don't like or they don't want to do, telehealth is because, you know, “oh, I need to, you know, it's so important for me to be able to assess them person to person”. And, hundreds and hundreds, probably thousands of therapists, counselors, clinicians, doctors that have been interviewed have said that, it increased the ability to, to access, because the access issues were heard and of course, reduced wait time connecting to crisis services. If any of these didn't make sense to you, asking to chat or give us, let us know.

So next. Yeah. And the financial benefits have been this. This is amazing. Increased utilization is really important because we can bill for it. So, and we saw a and I'll show you have a graph for you here later. The increased utilization of counseling sessions of medical contacts, the increase was tremendous. And we saw the increased revenue. Now that's just still this increased, revenue is results in pushback from our third party payers that, some like in some states, some counties, depending on your state, individual third party payers are not, you know, “oh, you know, it has it can't be audio only”. Well, how many of our patients don't have full access in their contracts with their iPhones? Right. They know they don't have FaceTime. So we have to be able to use audio. That's one of the biggest. That was one of the biggest fights in Rhode Island. And it's really not still resolved. But across across the country, you know, a lot of the third party payers, have have really put up barriers to decrease the amount of money they're going to have to spend to pay us back for the services we're doing and, reduce staffing costs. So of course that works well. All right. Next, please.

So you just saw, providers have loved this, and organizationally, providers have loved this. So why hasn't this transition been simple? And a lot of it has to do with, you know, and I said it in the title and I'm going to keep I'm going to be redundant about using the word, culture. The culture of OUD treatment has been driven by punitive and paralegal, regulation. The DEA is the Drug Enforcement agency in the 50s, it was a paralegal, just like a police department, a paralegal, I mean, paramilitary, paramilitary, structure. And the regulation was as such. So when, when individuals have been in the field for three decades, two decades, even into one decade, this this culture exists because it moves

by, you know, those that have been senior, teaching those that are coming in for the first time to provide services. And there's so many aspects to this one. In addition, we didn't have a well defined or vetted strategic plan. We didn't. So we were doing it and then creating that plan. We're getting better. But policies and procedures were created and then changed and revised during implementation. And, and so when you have policy and procedure, generally, we love to use that because we love to use policy and procedure because some we, you know, even during orientation, if this happens, here's the policy and procedure. You go to that first. If this doesn't work you go to your supervisor. Policy and procedure creates practice and practice guidelines that we want our staff to use. And so when these policy and procedures are mixed up, they're not clear. Then our staff aren't clear. And, you know, lack of clarity results in anxiety. And then also, you know, we also, we had a lack of alignment and clarity among formal regulatory language across the board. CSat, various accreditation agencies, DEA, your state regulatory agency BSAS in Massachusetts. And so none of that, none of that what was written was anachronistic, what was amended was quickly done and contradictory. And then there was so much that was verbally approved and didn't even get written anywhere that that also caused anxiety. Correct. So there's all of this bubbling in the background of “this is what happened in 2020”. And of course the resistance of third party payers. Next slide please.

Okay. The internal environmental variables. Okay. Again, opioid treatment, and I’m being redundant about this because we really need to address it with folks, internal the internal environmental variables are, you know, the stigma and stigma has been overregulation, under compensation for 100 years. It continues to be. But it is much better now and again. I'm I'm so grateful to the last year and what CSat has done. They have done a remarkable job in assisting us with these guidelines. And under recognition of treatment success. Everybody's so afraid of the disease that they don't recognize, it's not publicly recognized that treatment is successful. It's not recognized now. Now it's it's it's a new sort of conflict that is emerging or has emerged that, you know, you know, treatment is wrong, you know, in mass, Markey is saying that we're, what is it? Cartel? We're a cartel, and we're only in it for the money and all of that nonsense, but that it was easy for him to sell that because history allowed it. And, so that's where we are right this moment. And that's also an important internal variable. We created truly a fear-based system of care for the patients and for the staff.

And if you would like to change. The move, the. Thank you. So this is all the history, you know, we know it works. We know we have stigmatized regulation and we know that it's now 2020 and we've just turned the snow globe upside down and we don't know where anything's going to land. Okay. Next slide please.

So Codac and others. But we knew out the gate that we were going to have problems with our third party payers. So and that's really why we did this. We created a telehealth survey with Brown University. 106 patients responded. These areas are important: satisfaction, convenience, therapeutic relationship, substance use, recovery, and general feedback. And, we examined both patient and counselor experiences, with these with these same five. What's interesting here. And I'm just going to talk to you a little bit about it and then I'll skip this next slide, is that we measured what they call valences. But you know, satisfaction, you know, are patients happy with it? Is it positive or are patients negative with it? And we measured it through these five pieces. But what happened with the folks that were the primary researchers in our in our research project, were that on the positive side, you had to be positive in all five areas. If someone answered and said, the therapeutic relationship, convenience, satisfaction, all that was great. I happened to relapse because I was scared, then that went to the negative side. So can you hear how that balance would happen?

It had to be all five in order to be positive. And you'll see that even as with all five being positive, it was still please. Next slide. It was still 78% positive. So these are all the pieces, the qualitative overview of what was measured. I don't need to get into this. You can look at it if you would like to, but everything is positive. On the therapeutic relationship factor. A few people had mentioned impersonal experience. And then on the personal factors, all of them were positive. And some people were indifferent. So I think I think you can feel from here and I'm hoping that you can, that this was current and this was real. And it is a good example of how positive, how effective and how efficient telehealth is. And we used it not just with counseling, but, you know, with case management, with medical case management, with doctor's appointments. You know, I'm sure that Laura and, Jess will talk about their mobile units. We use it, we use telehealth, to connect to docs when we're out with, doing mobile health. So this was good. This was strong. Next slide please.

Okay. And these I'm just really giving you, some of the, the direct responses, and, so we don't you don't need to read through those. You can read through them at your leisure. We can go to the next slide. But, individuals really liked the, the relationship, the communication. They really liked the convenience. No lines. Don't have to bring my kids out. And, you know, and it assisted them and and this is important, the one it says “keeps me from getting COVID-19”. That sounds like a very simple phrase, but it has a lot of therapeutic value, because what we heard from people is “you heard our fears and you are responding to them. You really heard me. I was afraid, and you didn't make me come in and you gave me better service”. That's critical. Next, please.

Thank you. And then these are the negative, valences or negative aspects. And for me, the top two, feels like they were far more individual than about the process. Not sure. And the bottom one actually ended up being positive. Anyway, so there you have it. Next.

Okay. Yeah. This is the one. I really I enjoyed that, I enjoyed hearing that. I thought it was important. And you got to figure this as well over, 78% of 160 people. So it's a pretty consistent response. Next, please.

So. We are missing 1, huh, okay. Look at what happened here. This 2024 was the first quarter, the a year ago I had asked I wanted to know where we were with telehealth because I wasn't getting as many requests. There weren't many laptops being utilized. I wish there was something because I'm the CEO. I'm, you know, I'm so far removed. You know, I really don't have good knowledge. And, I asked our IT department, our QA folks, to, show me this and look what we saw. So that to me, this really shows me that, you know, again, we know what we have to do. We taught we we but the technology we taught, the technology we created, policy and procedure. We did all of the things that we were supposed to do that would have a strong outcome of sustained performance and providing telehealth. Right. But when to to sustain it, you have to review and review and review. And please, please know that this is a cultural change for individuals. They're afraid of confidentiality issues. Because second, to the DEA, we are afraid of 42 CFR. And again, it's very fear-based for many of us. We used to get a lot of litigation around 42 CFR. So confidentiality is huge. You know. And then most importantly, you know, I've had many experiences where people have lost jobs because someone found out they were on methadone. People have lost their health insurance, because they were on methadone. So 42 CFR really provided, wonderful protection. And what we're happy about now is that that has, you know, we've figured out a way to have those protections and still can have strong, good communication to provide coordination of care. So what did we do, okay? What did we do about this?

We went back in and showed the evidence through supervision, through trainings. And we made sure that our clients, our patients, and our staff knew how to use the technology. And then, we made it very clear through surveys with our patients, through asking people to ask their clients to, from the people we serve that they were motivated to participate in telehealth. You know, it was almost like at this point, you know, when people started coming back into the offices in 21 and 22, it's like, “well, I came back. So, the patients come back and we'll get everything back to normal”, and that is not what we wanted to have happen. And here I am like, I'm out there talking about telehealth and fight with insurance companies on a national level and doing all this stuff. And my own

backyard just started to go down and down and down. So it was, we have to we in order to retain any new service, any new modality, we need to review it over and over and over in training and supervision. And, you know, as much as they sometimes get tired and you might get tired, you know, why does CAR for JCO or not the joint, the joint commission, you know, why do we have to do this every year? And but it's good to do it every year. So many things need to be reviewed and so many things get updated. So, but the client stakeholders, we went back to, we did go back to the beginning. Remind the the remind the staff that patients are motivated, they want telehealth. And when we give it to them, they feel heard and the relationship becomes more solidified. Next.

Okay. Again, organizational stakeholders. We need to have staff and clients with telehealth technology. They need laptops. We got laptops. We just got funding to get we have a fair amount of those that are unhoused. So we, got iPhones and we're, you know, we have to continually find dollars for iPhones and, and then we continually have to get help for people for us, to provide, the minimal service for allowing people to have connections and linkages in the community for safety and for their care. And to ensure that this is big, ensure ongoing IT support. And then training over and over and over. And to maintain confidence, there has to be regular clinical supervision that focuses on telehealth issues. You know, the kind of conversations that people are afraid of that, you know, I don't know, “how do I address when people walk through the door into the room where my client is, is, is having the exchange with me, with their with their, IT equipment”, you know, “how do I address, you know”, I mean, a lot of times, you know, it's we ask people to, perhaps not just climb out of the shower in a towel to speak to me, but, like, you know, get yourself ready, get dressed like you're going to go, out to see us and have that kind of, you know, and I, I mean, I could talk on all of these things for the next six hours, but it's those kind of role plays as part of clinical supervision tom it is necessary for people to get comfortable believing that they are, that, that they are participating in a modality that is effective. So get comfortable with how you make it effective. And of course, if you can or if your, your entity, your organizational entity can advocate for policies that support us, because reimbursement. Again, I did that, I gave you that little piece about the struggle of having iPhones and then the communication program that they can at least have audio communication with us through various, I don't know, with Verizon/Cox, whatever it might happen to be. Next, please.

Okay. Again, provider stakeholders, what we need to do for them is continuously review evidence. This is good. If you're if you are not feeling that it is not good, then let's work on it. Because for most people it is good. And nothing is good for everybody. Right. It's really important. I should have, when I was talking about who providers were, I should have clarified it in the beginning. Telehealth is not good for every single person. It isn't.

Okay, that makes good sense. There needs to be, you know, your initial assessment, now that we're no longer in crisis, an initial assessment. And, and then you have training for the counselor and training for the patient or the client about the utilization basic, you know, actually it's checklists. And there are a number of them out there, APA, SAMHSA and I am happy to give you some of them. If you want them, you can email me or email, Gretchen or Melissa, right. And this is, this is just I can't say it enough, acknowledge the biases from embedded cultural beliefs. You know, we, I hear and I have heard from the clinical director here, you know, “how can I be present? How can I be, you know, and present, meaning, you know, allow myself to be open and allow the patient or client to know that I am open.” People feel like in order to be present, they need to be within three feet of someone. And, I mean, we, you know, we can all do this. We we on zoom. If any of you have taught on zoom, you can tell when somebody is present to what you are trying to provide and when someone else is not, you know. You can feel it. You see it, you know. So again, it's practice, but the idea that presence, presence is very much possible in telehealth. Absolutely. And, you know, and I would, I would often suggest, you know, ask somebody to think about when you were with somebody in person and they weren't present, you know. Yes. No. Okay. Well, you know, you know, when somebody is present or not in a relationship, and I'm going on and on about this because I have heard that it is a critical piece in the lack of understanding of the possibility of efficiency. And I think I'm running out of my 40 minutes. So, next one, please.

Okay. Because this is big. This is the next big one. Another, barrier is adherence to confidentiality. So again, I had said this before, right? That, you know, it's to prevent stigma and discrimination, legal, regulatory consequences, all that is great. It protects our patients. All right, our clients. However, confidentiality is not a reason to, say, “oh, well, you know, we don't know who's in the house, so we can't maintain their confidentiality.” That's part of the checklist. That's part of the assessment. That's part of the training. “Look, if you don't want to come in, you know, and you don't have to, then we can do it this way. So how are you?” You know, give the give the client, okay, the responsibility to maintain their own confidentiality. That's that's further valuing. So, you know, so it's just ongoing supervision practice reviews, etc.. it's but if you're going to get three, three, sort of take three things from this and I don't have a slide on it, I will next time. Confidentiality presence and observation. Those are what people say are barriers to doing good care through telehealth. And they are inaccurate for most people. But you will hear it a lot. Next, please.

Okay. Again, this is just the systems change. Policy and procedure. Please have informed consent and policy development, because that's part of the training for your

staff and their client to be able to, to, to be able to move forward into telehealth. And we have some but again, also the APA, there's a couple of, I think I wrote it down for you because I always forget the acronyms, but I if you chat a question, I'll be able to give you a couple areas that you can find really good templates. All right. Next please.

So. Oh, this is so nice. You did this for me. Thank you. It's a proven modality. Evidence-based. Satisfied. Technology does enhance client centered care. The concepts of being present, the concepts of confidentiality and the concepts of needed observation are very often, misunderstood and end up being a barrier for this care. And systems of change, improving technology literacy and challenging outdated treatment beliefs. Thank you. And person centered care. And this, next to the last bullet. Please hear this. Can you go back? Just it there it is. Opioid treatment programing, it's showing that opioid treatment programing is responsive to current community needs because our community has said that this is what they need, and that is the bottom line okay. Thank you. Next.

Are we done? Yay. There's all these references but there are tons and tons more!

Melissa Schoemmell:

There is so, so much. Thank you. Linda, I'm, these slides will be sent out so you can check out those resources. But we do have time to open this up for questions. I did put a prompt in the chat to, see if there were any questions that folks had. But I will stop talking to see if anyone would like to, raise their virtual hand. If not. Our team has some questions that we would like to ask Linda.

That was a really that, We didn't even mean to have that, mind meld in the beginning with the quiz, so that was fun. That was lovely. I'm glad you got it right. So so our team had some questions. I don't know if anyone else feel free to to soak it in. While we have Linda here. And raise your hand if you do have questions. But, Linda, what? What would you or how would you ensure equity? When trying to increase access and distributing technology to patients, knowing that access to technology, can be a barrier?

Linda Hurley:

Well, I know that, I mean, I'm not going to get into policy and procedure relative to equity, etc. But the bottom line is everybody that comes to us for care needs to have the opportunity for telehealth, if it's going to be effective for them. Right. So that's the assessment process. And at that point, we assure that every person has at a minimum, every person has at a minimum a, iPhone, and that iPhone has the capacity for audio. And occasionally, you know, somebody, a carrier will be kind and say, “oh, we'll give you

six months of face, you know, FaceTime too", but it at a minimum that way we know that they are linked to safety if they need it. And at the same time, they're they have a link to us and we have a link to them. And I know that's a simplistic answer, but it's everybody that comes to us for care has that.

Melissa Schoemmell:

And it is simple, but it, it that is how we live our lives now. I mean, you can't successfully live without your phone these days and have that connection.

Linda Hurley:

You really can't. And it's complicated because, you know, many of the folks that come to us for care, and I'm sure the rest of you, you know, that are on that work in OTPs, many of them are unhoused and their life is in upheaval and stuff gets stolen, stuff gets lost. Somebody might have three phones throughout the course of the year. You know what? If I have them, you have them. I mean, that's just what has to happen, you know? So.

Melissa Schoemmell:

You talked about presence and the importance of presence. I totally understand like I understand what you mean with that. But do you have any or I guess I'll ask you first, but I would also open it up to others, examples of what you've done to, like, what you can do to to create that presence or to establish that feeling of presence.

Linda Hurley:

I don't think that there is a physical piece to that. I mean, when, when we look at, okay, how do you establish this, you know, you have your consent, and you have your training for both. And now, you know, you move forward and you work for a while around making sure that there is a, a place relatively quiet and private for the client to be able to speak with you through telehealth and receive the modality. And then it's the relationship. I mean, it's it's all about the relationship. I mean, we could, you know, we could do another training on supervision around this if you want. I think it's fascinating. But, you know, it's it's first it's the groundwork because nobody can be present if they have two kids under the age of two and a dog and a television on at the same time. We can make

sure they're safe and have that conversation about being safe. But we, you know, it's not going to be that kind of a conversation, that counselors we often refer to as being present. You know, if I, if I'm making sure you're safe, I'm present and that, you know, and you are too. But it's it's really defining presence. And and understanding what that is and then understanding probably through experience I would say that that, telehealth is a modality that will support presence.

Melissa Schoemmell:

And in said that, like with supervision. That could be something that is supported and modeled, I guess.

Linda Hurley:

Yeah. Role playing is so good. That's really important to do with this. And it doesn't take much. You know, once people get comfortable with it, it doesn't because it's good. So it doesn't take much. When somebody has an understanding and when we don't have an understanding, we get scared. Some people are afraid. It's okay. Nobody else has any questions?

Melissa Schoemmell:

Don’t worry, Linda, they are historically a very quiet group.

Linda Hurley:

Okay. So.

Melissa Schoemmell:

But we are at time, so I think if we do have time at the end for more questions. And, Linda is planning on staying through the end. So, if something comes to mind, please chat that in, or raise your hand following our our next, presentation. So, Lili, I will hand it back to you and we'll get our slides back up. Thank you. Thank you, Linda, so much.

Lili Njeim:

Yeah. Thank you. Linda, that was honestly such a great presentation. Was very engaged. So thanks.

Linda Hurley:

Thank you. Really thank you.

Lili Njeim:

And I'm very excited now to turn it to our other presenters. We have Jessica Fortier-Goss in the room and Laura Frangipane from CTC Acadia HealthCare. And Jessica is a graduate of Fitchburg State University and Kaplan University, holding a bachelor's in psychology and a master's degree in psychology with a concentration in addictions. She started her career in Worcester, operating a clinical support services unit and also treating patients with co-occurring disorders and enhanced acute treatment services. She then went on to subcontract for the Department of Labor, working with adolescents struggling with addiction. Jessica has been with Acadia for ten years, working in medication for addiction treatment, during which time she opened a corrections-based OTP and now oversees eight OTPs in one mobile unit. She still oversees corrections care in the OTP setting, and has partnered with jail, skilled nursing facilities and various other community stakeholders to help decrease barriers in accessing care and diversifying treatment methods. And, we had updated the slides, but I don't think they're showing up. So Jessica works in Taunton, Fall River, Wareham, MASAC, Yarmouth, Wellfleet Mobile Unit, Providence and Woonsocket in Massachusetts.

And Laura Frangipane is a graduate of the University of New Hampshire and Cambridge College, holding a Bachelor of Science in occupational therapy and a master of Education in Counseling and Psychology. She began her career in behavioral health in 2003, working with adults with intellectual disabilities, brain disorders, and mental illness. In 2010, she founded a community based organization providing services allowing people to remain living independently. During that time, the need arose to create community services for people who had experienced traumatic brain injuries as a result from using illicit substances. Upon the sale and transition of her company in 2016, she began work opening ATS and CSS programs in the Commonwealth. From there, she took employment in 2017 with Acadia Health Care, overseeing 7 OTPs across the state. Since 2017, she has expanded access to care, and formed partnerships with

corrections facilities, skilled nursing facilities, health centers, and various other community partners. So with that, I welcome Jessica and Laura.

Jessica Fortier-Goss:

Thank you Lili.

Laura Frangipane:

I should probably come off mute, huh. Thank you, Lili. We want to go to the next slide.

So Jess and I, I think, you know, we we came to talk a little bit more about our experiential learning that we've had over the past few years with telehealth. I think we're going to look at this, in a little bit of a different way, at least to start and not just, talking about telehealth in the most obvious way, which is, of course, clinician to patient and physician to patient. And really talk about our journey that started in 2018. If we want to switch slides.

Of course, we'll talk, about increased utilization of telehealth, and our approach at the CTCs. And we'll end with some questions. Next slide.

So as I mentioned we're sort of going to talk a little bit about telehealth dating back actually all the way to 2018. Which sounds a little strange because we know that we, you know, as, as SUD providers didn't really start getting into the game until COVID hit. However, I want to talk a little bit about the Merrimack Valley gas explosions that took place on September 13th in 2018. For those of you who are unfamiliar with that event, the city of Lawrence experienced a major emergency when the underground gas pipes experienced dangerous pressure, thereby causing underground explosions and many fires, effectively really shutting down the whole city, and outside into the Andover areas as well. So when this happened, we were unable to access our Lawrence clinic, and we had over 700 patients who needed to receive their medication and their treatment. So this was sort of the first time we really dipped our toe in the technological waters of how we could really provide our care, not in our building, you know. Of course, we have to medicate face to face, but how are we going to do that without a building? Well, the way we were able to accomplish that was to utilize our cloud based, EMR system to essentially create our Lawrence Clinic in our Lowell Clinic, nine miles, up the road. And our patients were able to be shuttled those nine miles. They arrived at a window in Lowell, and they were able to speak and function as if they were in the Lawrence clinic,

which is a little unorthodox in terms of telehealth. But I think really an important highlight here, when we're talking about what our capabilities can be, transferring care to different locations and really providing seamless access to folks who need it. Of course, then sort of simultaneous and, and right after that COVID-19 happened, which was also a time when we started integrating our services and our treatment modality into the corrections settings. So that was real fun trying to learn an entire new environment and not really being able to provide care the way that we were used to. But as it turns out, telehealth was really to the rescue there. You know, especially when we had folks who were coming in, they needed to be quarantined, but they also needed our care. So, you know, how are we going to do that? Telehealth was a major integral part in our success in being able to implement and continue services and care in the corrections setting. We were able to co-credential staff, in the corrections environment so that they were able to access our EMR legally and effectively, so that we were up to regulatory standards.

It really paved the way for us to continue to offer additional care, and really utilize different workforces, simultaneous to that as well. And then as time has gone on, we've used a lot of those lessons learned to expand into skilled nursing facilities. You know, folks who are at different levels of care, who continue to need our medication and our service. Telehealth has been invaluable to enrolling them so that they don't have any gaps in their medication or their treatment. They're able to sit comfortably, in their, in their new environment where they need to be medically cared for, but also participate in clinical care. And of course, the the intake process has become a lot easier as well. And most recently, what we've been able to do is start expanding our care to day treatment services. Really we sort of have a hub in Lawrence, but using telehealth, we've been able to offer our day treatment services across the state. We're sort of calling it hybrid. So since all of our sites are licensed as day treatment centers, anybody can walk into any one of our facilities and receive either in-person or hybrid treatment services.

So, for example, the greatest case study we currently have is a woman who is located in fall River who is unfortunately unhoused. She arrives at the fall River clinic, and she is able to access their technology and tap in to the day treatment services that are taking place in Lawrence, Massachusetts. So it's really a fun, new way that we're utilizing telehealth. And we're finding it to be exceedingly effective. And lastly, and again, a little bit less, traditional, we have been able to not only, you know, the whole statement of “meet patients where they are”, you know, not just mentally and emotionally, but physically, patients have a hard time getting to us. Patients, especially who are unhoused, have a hard time making it from point A to point B. They're they're at a level of crisis that prevents us, prevents them from moving very far in the day, unfortunately. And what we've been able to do is take our technology, take our iPads, take our laptops,

and do admissions on the street, do admissions in health centers, find them where they are and really, truly mobilize. And then one person, with that one piece of technology can access clinicians, physicians, anybody who can complete an intake. And then, quite frankly, we're able to achieve even same day dosing because after that intake has taken place, we're able to put them in an Uber health or some transportation that we have access to and get them immediately to their dose of medication. It's been wildly successful specifically in Lawrence, they have a partnership with their health center. They have had grant funds to make this happen, and we have seen the participation in Lawrence increase tremendously. Next slide.

Jessica Fortier-Goss:

Awesome. And again, to highlight some varied uses of telehealth that aren't the traditional audio, video model. There are now a lot of an app because now there's an app for everything, but there's also apps to assist OTPs in delivering and diversifying their services. On the Acadia's side, we have some clinics that are partnering with Sonora. Sonora is a virtual dosing window that a patient can download on their iPhone. So if we if we're trying to move a patient towards having homes and being more autonomous, but we still want, you know, a symptom screener or be able to make sure that they're taking their medication the right way, Sonora allows us to take forms with QR codes. The patient then scans the QR codes when they go to take their dose and the video pops up. Nursing can access these videos and review them to make sure that the patient is dosing the way they should be, that they're not experiencing any adverse side effects.

And this, this is a real game changer when you talk about rural health inequities, you know, not everybody can make it to that window every day, especially when we think about parts of our state, you know, northern central Massachusetts, it can be difficult and there can be a lack of public transportation. And through app-based technologies, we've been able to expand access to take homes through the Sonora app. Another app that we utilize is the Marigold Health app. We've partnered with Marigold Health. They are a Recovery Coaching and Navigator service. This is an anonymous network for anyone interested in recovery. We also offer it to every intake that comes through our door, every person. They can download the app and receive one on one recovery coaching. They also have 24/7 access to moderated anonymous chat rooms, where they can ask questions. You know, if someone is experiencing a trigger in the middle of the night or an overwhelming urge, they can access on-demand support in extension of the OTP hours.

We've also partnered with Dynamicare in Rhode Island and we've been expanding it to the payers that accept it in Massachusetts. Dynamic Care offers individual contingency management services. Some payers are reimbursing it. Blue Cross is. I know they're working on, credentialing themselves with MassHealth to broaden their reach. I'll use Rhode Island as an example. So the patients have a $600 benefits that they can access as part of their health plan. And you can set the contingency parameters to whatever your your individualized rules are for the patients. So if it's someone who struggles with engaging with their counselor dosing daily, you can set contingency management goals for someone who doses every day for a week, they'll get a buck in their account. The payoffs increase as the patient's journey through and complete more goals. And at the end of it, there's a $600 bank that they can cash out, in a bunch of different gift cards. And they can also earn small tokens for accessing a skills library. It's CBT-based and it's on-demand, and it's nice to see the progress. And as the patient's journey through, on Dynamicare Health, they work towards broadening social determinants of health goals towards the end, which have, you know, bigger numbers attached to them. And that might be something like working on getting their GED or obtaining their GED. So we did want to highlight some of the different ways that we look at telehealth that are nontraditional as technology evolves. Next slide please.

Okay. I just wanted to highlight a little bit about the effectiveness of MAT. We do know that in the OTP, we have an 80% reduction in illicit opiates after six months. Improved retention rates, increases in employment and other social determinants of health. And we really do credit telehealth with being able to reach more folks and drive the positive outcomes. Next slide please.

On this slide, we really wanted to highlight two things. 150,000 group counseling units provided each month and 250,000 individual units provided a month. So this is nationwide, across our agency. This data is as of 12/1/23. We reviewed data a few days ago of the 150,000 and 250,000 counseling units that you see being delivered across the country, 60% of those are currently being delivered via telehealth. And it really is a driving factor in our patient satisfaction score. Next slide please.

We again just wanted to, you know, highlight that telehealth is still a comprehensive healing approach. It does still address the underlying causes. The services can be delivered with evidence based curriculum. We utilize Hazelton. It is sustainable, it is a sustainable form of access to support. And we do believe it enhances the quality of relationships so that our patients can focus on rebuilding and strengthening versus physically getting to us every day or for every appointment. Next slide please.

And we wanted to highlight that every patient on their personalized care journey can still access, and you know, check off and, you know, make make their journey through to sustainable recovery regardless of the method that the treatment is being offered in. So whether it's you know, telehealth or in-person or hybrid, the care journey is personalized and still looks the same. Next slide please.

All right. And then it's all about access. It's all about reaching more folks, whether it's addressing rural health inequities or bringing treatment to encampments. You know, the the work can be accomplished in a variety of ways. We talked a little bit about traditional OTPs. I know we talked a lot about mobile units. I know Laura did have to jump on the call. Laura did just open a med unit in Boston that’s open to Boston HealthCare for the Homeless. We’re really excited about that. I don't have all of the data, and she did unfortunately have to leave, so I, I am of picking up on this one, but we are seeing a great retention rate within that med unit, and we're seeing that it's garnering a lot of interest to bring treatment to our patients. And we also wanted to highlight OBOT treatment as well. All the services can be delivered through OBOT, just like they are for the OTP via telehealth. And in our Taunton program, we are seeing rapid increases in utilization of telehealth for OBOT. The program has been open for less than a year, and they have a current average daily census of over 60. And telehealth has really helped us to reach more folks in that area. Next slide please.

Any questions?

Melissa Schoemmell:

Thank you so much, Jessica. Did I miss it that Laura had to leave?

Jessica Fortier-Goss:

Yes she did. She, she texted me. So.

Melissa Schoemmell:

Oh. I hope everything's okay. So there were no questions in the chat. Surprise. Did anyone have questions for anyone related to telehealth?

Did anything come up for you as far as what you may consider in your own practice, as far as looking at data or, checking your policy or procedure? I know, updating telehealth

policies is part of the new regulation. So I know they should have been updated by October, so just anyone want to weigh in?

They're going to drop like flies. So I'm going to throw up the evaluation link for both ORN, Opioid Response Network, for Linda Hurley and her expertise and that coordination. And our TTA center. Please fill out the evaluation and let us know how we can, improve these, these events going forward and make them more engaging and, have, have it be, a valuable use of everyone's time.

We have an event that we will be sending out a formal invitation for on February 12th. And the focus of that event will be person centered care. And we are super excited about, our, our spotlight and the, the approach, that we will be taking for this event. So the registration is open and, please fill that out.