

Empowering Patient Choice (OTP Session 8)

Sasha Bianchi:

Into our empowering patient choice, which is our opening session for today. Here at the OTP center, we really feel it's important to ground all of our technical assistance in improving patient experience. And definitely want to hear from the patients themselves about how their experience at OTPs has been. So today we are really thrilled to have Jelena Dansby joining us.

Jelena was born and raised in Brockton, Massachusetts. She's a mother of three beautiful girls. She has over ten years of experience, both personal and professional, in substance use. And she believes strongly in the benefits of harm reduction and maintenance medication. She's a patient at an OTP, and she's also a member of our patient advisory committee. For the OTP TTA center. She's been really generous in sharing her story with us. And I know you'll find what she has to say really powerful. After Jelena, Jelena offers her story, we will be doing some reflections, and then I'll share a bit of information and data from our needs assessment, that we conducted for the OTP TTA center.

And, our learning outcomes for this session are that we hope you'll walk away with at least one OTP policy or procedure that can be changed or adjusted to improve patient experiences, and outcomes or quality of life. And then that you'll be able to name at least two benefits, to patients of engaging in shared decision making and individualized treatment planning. So with that, I am going to turn it over to Jelena.

Jelena Dansby:

Hi everyone. My name is Jelena. I was born and raised in Brockton, Massachusetts. And thank you, Sasha, for the warm introduction. I greatly appreciate it. I'm just here today to tell you guys, a little bit about myself, about my experience, on maintenance medication and particularly in the methadone clinic.

Just to kind of start off, I think I should just give a little bit of background of how I got to the methadone clinic. So this was about eight years ago. Substance use has always been in my family. It's, it's a strong part of my family. Everyone from my mom to my father, has struggled with substance use.

And for a long time, I thought I was the fortunate one who, you know, didn't have to worry about that because I had a healthy understanding of what addiction looked like. But unfortunately, after experiencing some, medical difficulties and being prescribed opiates, and being taken off of them very quickly, I went to find them on the streets and, you know, they released and one thing led to another and I began my battle with substance use.

About six years ago is when I finally hit rock bottom. At this time, I tried basically everything, multiple detoxes, inpatient clinics, halfway houses, anything that you can think of, I tried, the one thing I didn't try was maintenance medication. And as a last resort, that's what I went to. I always heard horror stories about getting on the clinic. You know, my teeth are going to fall out. I'm going to gain a bunch of weight. So I was really, really scared, when it came time to, you know, go to the clinic and get on methadone. I remember my first time going into the clinic to to begin my intake. I felt like it was like, you know, my, my first day of school, I don't know, I just have, like, all these nerves. I didn't know if this is going to work for me. But I was willing to take a chance on it.

I wish when I first came out, I had more of a welcoming feeling. You know, when I. When I came in, I kind of just was asked, you know, general questions. When's the last time you used, you know, how long have you been using for. What's your drug of choice? Just basic, general questions that I'm sure you know, they ask everyone during intake. And I was in and I was out there really wasn't much to it. During that intake process, I thought that I was going to get more of an in depth questioning, you know, really getting that like, individualized care. But, you know, at least on that first day, that didn't happen. So I left with a lot, a lot more questions than answers I should say. And that's just kind of how it was. I just, you know, was going in dosing and and leaving. I tried my best to stick with the rules, you know, make sure you go to your groups, you know, make sure you're staying sober. And it worked for me. But I didn't, like I said, I didn't really have any interaction and during that time I was at a halfway house, so that was my first clinic that I went to.

After leaving the halfway house, I transitioned to my the clinic I'm on now and I was hoping for a new start. I was really looking forward to being back home. And looking forward to seeing how things are going to be different. At this time, I had a few months of sobriety under my belt. You know, it was still very new to me. There was a lot of temptation around me with being back home, in my hometown, because I knew how to get it and where to get it. And I remember my first appointment, you know, meeting my clinician for the first time. And it actually was a positive experience. I finally felt like, you

know, she understands me. And it was amazing to have someone to actually care about, my sobriety. And, I wish that lasted.

Unfortunately, there was a lot of, you know, heavy turnout. They, you know, I would have a clinician for a couple of months and then, you know, I'd lose them. So I was constantly trying to build a rapport with new clinicians. I was never really given proper notice. I would, you know, meet someone. I would think that, you know, it's going good. And after a while, it's kind of like, I'm not even going to open up to you anymore. I don't know how long you're going to be here. So. And that honestly did affect my, my recovery. I went from having someone that I can talk to about anything, to sharing my story a bunch of times and getting different responses from each clinician that I was with, not even knowing who my clinician was. And during this time, you know, a lot of changes are happening in my life. You know, I, I was transitioning to the real world now from a halfway house. I was, you know, having my kids back in my life, going back to work full time really tried to turn my life around. And it was a time that I needed support the most. Like, I felt like I was just coming to the clinic to to dose, and that's really all that mattered. And there was really no, you know, one on one time, during this time, you know, I did manage to stay sober, and it took a lot of work on my own. And I definitely could have used the added support. But like I said at the time, I went through foreclosures, and I just didn't really feel like I had anyone.

I ended up getting pregnant and it was probably the best thing, you know, I did it. Well, let me back up a little bit. I didn't know I was pregnant until I was about 20 weeks along, so I found out pretty late in my pregnancy, and, I really didn't know who to turn to. When I first came into the clinic, I had made it very clear, that I could not have a male clinician, just from past traumas. And, I was put with a male clinician, so, I at the time that I was more sensitive. I'm pregnant. I'm just finding out that I'm pregnant. I have a male clinician, which I'm already uncomfortable with, and I've already disclosed that, like, I can't I can't have this. I just feel like I didn't have, I didn't have anyone.

I tried, you know, when you're pregnant, a lot of things happen around you. So there were times where I was late to work. I'm sorry. Late to the clinic. There was times that I, you know, probably missed my dose or missed group, and, these things were being held against me. You know, even though that I was maintaining a full time job, even though, you know, I'm doing my best to check in with my clinican, these groups, you know, that I couldn't get to because some days I just couldn't get out of my bed. So those were being held against me. Yeah. I'm sorry if you guys hear any background noise alarm going off, I apologize. And I just, I felt stuck. I felt. Like, you know, it was them against me. They didn't feel like these were people that I could go to.

I just felt like, you know, this is, you know, you're going to be reprimanded. I remember, you know, it was towards the end of my pregnancy, you know, being put on a discharge plan, pregnant. And if I don't, you don't even supposed to be put on a discharge because you can't discharge someone pregnant. And this all had to be strictly off of groups. But like I said, I was holding a full time job. Like, I was doing, everything that I could. What got me to, you know, which was a lot of things had happened in that amount of time between, you know, having the male clinician, being put on discharge plans, pregnant. I felt no choice but to advocate for myself. And it took a lot of, a lot of that because I felt like, you know, if I don't take control of my care that no, no one else is going, no one else is going to help me. So I did advocate for myself. And, I was finally put with a female coalition, and sh, she really helped me understand my pregnancy and what being pregnant on methadone looked like.

During this time, I really didn't have access to a doctor. My doctor only see my doctor at a clinic. At this clinic. So he'll see we about two times my entire pregnancy, and I was going up on a dose. You know, you say they say when you're pregnant, you're going to go up because you're not just you are taking the methadone, but the baby's taking the methadone as well. So I'm going up. I'm getting up to almost 240mg on methadone, only to check in with my doctor once or twice out of my entire pregnancy. And, you know, and I'm scared, you know, I don't know what's going to happen to my baby. I don't know, you know, another thing? That they scare you with is like, oh, DCF is going to be involved now. And no. Was there to tell me like, this is what's going to happen. This is, you know, this is a plan that we're going to take. Instead, I was starting treatment plans that I didn't I never reviewed, you know, and I just felt like I was being signed off. And, and like I said, up until I met my last month, the clinician that I'm working with now, after advocating for myself, actually helped me get an understanding.

And, she had, access to resources that I never even knew about. And at this time, I, I am about 5 or 6 years deep into the clinic now, and it took all that time to just meet one person to provide me with those resources that I probably could have used years ago. It could have shaped my entire experience on the clinic years ago. I feel like my quality, the, the quality of care would have definitely improved if I had access, to these resources, and I didn't. It it's unfortunate that it took all that time, I do want to say that, you know, change is only going to be made if we talk about these things. For a very long time, I sat quiet.

I kind of just let things happen, and I let someone else interpret what my care was going to look like. My care probably looked like everyone else's care. I never had that individualized one on one care. It was kind of like, you know, you're one of many. And that's how I truly felt. I didn't see a doctor. I wasn't seeing a doctor, you know, I was, you

know, staying, I was staying clean. But I had to do mouth sobs during my pregnancy and they weren't even being put towards, you know, take homes because I couldn't pee in a cup. And these are all things we worked so, so hard on, not just for your sobriety, but for your you try to, you know, maintain sobriety while pregnant. And these are the little milestones that you're like, completing. And it's not you you don't feel like it's being worked towards completing the bigger picture. So it didn't it didn't matter if those mouth swabs were coming out negative and I was passing those drug tests because I, you know, I wasn't you know doing a urine sample in a cup, that was being held against me if I didn't go to these groups.

But I was at my full time job, that was being held against me. I just feel like everyone's recovery and everyone's treatment is going to look a little bit different. And that's why it's so important to really get to know your patient on a more personal level, to see what's going to work with them, what's not going to work with them. If when I reported that, you know, I really can't have a real connection, if someone was to listen to me, then I probably would have opened up a long time ago and maybe had the resources that I have available now. And it just takes it it doesn't take long, you know, we have we have surveys here where, you know, they they invite us serve with some donuts and some coffee and, you know, here's a survey for you to do and tell us how we can improve.

We don't see any changes. So, you know, we, we just feel like it's a waste of our time and our voice, you know, doesn't matter. And I don't want to ever feel like that in a place that is helping is such a big part of my my health, my care. My sobriety. I just feel like we we definitely need, you know, better access to, one on one care if we're going to see any changes here. We definitely have to get to a point where we we have an understanding that it's not going to be the same for everyone. What works for me, might not work for the next person, but we're going to take the time to listen to you and understand you. You know, I, I've maintain my sobriety. I'm doing well, and I'm a big, big, big advocate for maintenance medication.

Methadone truly did save my life. And I, you know, I, I, I, I really I don't believe that I would be here today, if it wasn't for it, but, I, I would like to see some positive changes that I know that we can definitely get there, but it's a group effort. But I appreciate you guys for letting me share today. Thank you.

Sasha Bianchi:

Thank you so much, Jelena. I, I just so appreciate you sharing your story. Being so candid, and advocating for change for yourself and for others. So now we're just going to take a minute because, we've heard something, I think, really powerful. And I think at

these types of conferences, sometimes we cram a lot in, information, and we don't always take the time to reflect on what it means to us, what we're going to do about it. And as Jelena said, really, she's giving us a call to action. So we're going to just take I'm just going to take a minute, now and just give you some time to think about, What Jelena, Jelena just said and, what it means to you.

Okay, so I'm going to move into some more time. Structured reflections. So the first question, that's related to the learning outcomes we had for this session is how does individualized care and shared decision making benefit OTP patients? So here what we're looking for you to do is just take some time to really reflect on this. Maybe write it down. Write down your answer to this. Just take some personal time to think about it, and then we'll come back together and see if a couple people want to share. So I'll give you about 30 seconds for this. Okay. Anyone want to come off? Raise your hand, come off mute or put anything into the chat? Related to this? Yup, I see you, Heidi. You can mute yourself.

Heidi Ginter:

Thank you. Jelena, thank you so much. The the the courage that it takes to really tell that story to a bunch of strangers is phenomenal. And I'm grateful for it. As a doctor who's been working in OTPs for about 20 years, I think one of the things that is so striking to me is that in the field of addiction, the person who's the expert in their experience with the disease of addiction is the person with the disease of addiction, and the person who is has the magic letters MDDO and RN whatever after their name is somebody who has been given the power to work with the person with lived experience to help them get the outcome that they're looking for, and to provide evidence based but patient directed care that is useful to that individual.

And I think you said it so beautifully, like if there's partnership, if there's listening, if there's respect and acknowledgment of what your experience is as the person who's the expert, then you can use the tools of the system, as long as they're willing to acknowledge your expertise and you and and that was just so beautifully put.

And that's for me, the most powerful thing is, like, the person who's in front of you is the expert. And what can you do to assist them on their path that they're telling you that they want to follow, so thank you for that. Thank you. Wesley. I see you.

Wesley Marshall:

Okay. I just unmuted myself. Can you hear? Can you hear me? I can. Okay, great. Well, I just wanted to also comment a little bit on, you know, the, story that we just heard, I'm sorry, is it Helena or, is that how you pronounce it? Jelena. Okay. Sorry. I, that's what I thought, but for some reason, I was questioning myself.

Anyway, as a, I've worked as a, counselor at a methadone clinic for, And not just methadone, but primarily methadone for, five years or so. And so, I wanted to just come and it's like my, my first reaction is, I want to defend myself and, but the truth is a lot, you know, you pointed out, a lot of, things that sometimes don't go right. And, and it's good to hear that the, the last week there was, more, you know, the perspective was more of like, oh, things, all these things are great, but we need to hear, you know, both sides. And, there's a lot of improvement that in methadone or MAT that we still need to see. I think that some of the changes that have, been made in the past year or so to make, MAT more and methadone, like fewer barriers are I hope that that's going to improve some of the things that that you had to, to deal with. And but I think it's also going to take time.

And, but yeah, really, it points out, it points out some weaknesses that definitely, I'm sure exist across the board. And, and it's, you know, some of those things like the, that I've seen, that where I work too, with, you know, like, oh, why can't we get a blood test or a urine test with my doctor instead of at my clinic here? And to, the these are some barriers that still probably exist. And, so, I know I'm kind of rambling, but I just wanted to say thank you for for sharing your story in and the you have definitely pointed out things that, that, that are, that still need to be improved and, and, yeah, that's all I got.

Sasha Bianchi:

Thank you. Thank you. Leslie. So we have a couple more reflections. I'm going to combine them together because they kind of go together. So the first one is, getting to that action. What policies, practices or procedures would you change in your OTP? To improve patient experience, similar to in response to some of what you heard from Jelena, are there some things that she said that you could identify as being, something that could be worked on in your OTP?

So take some time to think about that and also, go to the next step of what would be the first step that you, or your colleagues could take to change that policy, practice or procedure. So I'm going to give another minute for some silent reflection on that question. And then we'll come back together.

Okay, does anyone want to share their insights on this. You can either put it in the chat or you can raise your hand. And I could take you off of mute. Okay. It's alright if nobody wants to share, hopefully you're thinking on about it on your own. I see Michelle says make sure the team stays on top of showing empathy. And that the team is approachable. I think that's definitely, very important and foundational from what Jelena shared. Phoebe, I see your hand.

Phoebe Cushman:

So, I mean, I think that there was really kind of a pretty sad, missed opportunity from what Jelena was saying. In that she said they were gathering feedback and like that, that the, the clients at the OTP were asked to fill out, the, the feedback forms and that nothing really changed. So I think that's really important. It seems like there could also be I'm not sure exactly how this would work. I know at our clinic we have sort of, some groups that are geared towards pregnant women. And I don't know if there could be, information gathered in that group, to give feedback to the system. I don't know, like, I think that when as a physician who also takes care of a lot of pregnant women at the at my OTP, I it it definitely saddens me because it's really it's really required.

It was my understanding, even this is like something where I feel like, the patient's wishes and my values and also the federal guidelines, actually, align, which is not always the case. And that is that, you know, we should be seeing pregnant patients, at least monthly during their visit. Having said that, we don't, at least in my clinic, we don't we don't make it. We don't force people to stay and meet with the doctor. But, you know, we recommend it. So that that feels that seems like that would be, you know, that kind of, oversight could even be, you know, sent in to BSAS. But again, if Jelena didn't know that, then she wouldn't be. You know, then it's hard to sort of put it on her to, to ask for the clinic to be, following the regulations.

Sasha Bianchi:

Yeah. Thank you. Phoebe, I see a couple thoughts in the chat about bridge session sessions for changing clinicians and listening to patients again. Thank you all for those reflections. We are going to, I'm going to move to the next phase. Jelena is going to stay here. We're going to hopefully have some time for more, question and answer, at the end. But right now I'm going to move to, the next part of this session, which is, you've heard from Jelena, she is one person with her own story. And we also wanted to share some data, from our needs assessment for the OTP TTA center, just to show some alignment between one story of one person and the stories of many people.

So for our needs assessment, we looked at three different sources of data, to reflect patient experience. We also, did some, some focus groups with OTP staff. I'm not going to talk as much about that today because we're really focusing on what the patient's experiences are. But so we looked at three different data sources. One was a survey that was conducted, in 2021 and 2022, in Massachusetts of, OTPs. And this was a survey that was commissioned by BSAS and conducted by JSI. And there were 4500 around 4500 responses to the survey. It measured across 53 different, community based OTPs, measured multiple dimensions of patient satisfaction. So we looked very closely at that. We also looked at the OTP patient complaint data that comes in to BSAS from 2020 to 2023. Looked at those three years of data, we also did a literature review focusing on patient experience and OTPs and looking at qualitative data. So that's data that's more like from interviews or focus groups or open ended survey questions. And we know that this data is all kind of, has happened before these new regulations came into place. But at least for the Massachusetts data sources, it was during the time period of the Covid 19 flexibilities, which kind of became the precursor to the current regulation. So it reflects some of that. Also, we know from our patient advisory committee that, a lot of the themes that came up in this needs assessment are still really relevant to patients, today. And, we're encouraged that these new regulations will hopefully facilitate a lot of the recommendations that came from this needs assessment. So let's go to the next slide okay. So these are the findings. Very high level overview. So the first thing that you all heard and I saw in the reflections is that, you know, not surprisingly OTP patients want a to walk into a welcoming environment with staff that are non-judgmental, and trauma informed, and they want to be seen as full humans, who are more than just their addiction.

From the literature review, we definitely saw a very strong and consistent theme that stigma is a barrier to people entering treatment. Jelena mentioned, how she had heard horror stories about treatment that may have stopped her for a while. And also, not just stigma about opioid use disorder, but also stigma about the medications themselves. And that keeps people from entering and staying into in treatment. When we looked at the, OTP, the complaint data, grievances related to patient rights, were the second most, frequent, type of complaint. And those relate to experiences of, feeling dignity or, respect was not there for the patient or that they weren't getting equitable treatment.

Going to the next slide. But it's really going slow. So of course you know, the, the alternative or the, the, the the solution to having care that standardized is having more individualized care plans and shared decision making. Jelenamentioned how she, was signing off on treatment plans, she had no part in developing and that that does need to change.

And this is pretty, consistent across the literature review. People want this type of individualized care, that's considering their specific needs and preferences. And that this will, under this will help them with their motivation to continue in recovery and engage in treatment. Okay. Little like, oh. Gretchen, I think I'm seeing the wrong slide here on the wrong screen. Not seeing my slides anymore.

Gretchen Shoemaker:

Stand by. Just one minute. Okay. Something went a little awry. Here we go. Resharing, Thanks, everyone, for your patience.

Sasha Bianchi:

I can also share my screen as well, Gretchen, I have the slides up.

Gretchen Shoemaker:

I've got it. I think it just shorted out. There was a lot of people on there. Here we go. And let me reshare. There you are. You seeing the slides?

Sasha Bianchi:

Yes, now I am. Thank you. All right. So another piece of this is coordinated and comprehensive care. So you remember from Jelena's story that she said, you know, it took her six years before someone connected her with certain resources. Definitely in the literature review, there was a lot of, themes related to have people needing to have their social needs met in order to continue with their medication, in particular. Not surprising to many of you, I'm sure. Transportation, housing needs, and also needs related to insurance coverage, were some of the biggest ones that were mentioned, in the, grievance from the complaint data. One of the top five complaints, that BSAS received was related to, being referred to resources. And in the patient satisfaction survey, about 20% of patients said that they were not satisfied with the resources that they were offered.

Treatment, admission and retention is another big theme, across all of the data sources, wait times were mentioned as a barrier to entering treatment. In the literature review, we saw, some mentions of restrictive admission criteria, people having to meet certain criteria in order to enter treatment. Some of this may have gone away with the

new regulations. Also, ease of negotiating admission was the, domain of dissatisfaction survey that had the lowest overall satisfaction. People really struggling with that. Another aspect of this is, medication dosing and getting up to the right dose quickly. Definitely came up in the, in the satisfaction survey. People said that when asked the question of what would make this program better for you, being able to get to the right dose more quickly was, one of the most frequently cited responses.

Also, the complaint data from for BSAS, medication related response, medication related complaints were the top complaint. And that does include dosing adjustment grievances. Another thing that came up in this category was flexible scheduling. People really wanting to have more options, for when they can come in for their appointments. And in the patient satisfaction survey one of the people that said, one of the the questions was, what's the least, helpful service other in your OTP and, the, the, the hours of operation was one of the most frequently cited responses to that.

So of course, home medications is a huge one as well. If for those of you who were part of the opening panel, Kaitlin Small shared her story of coming into the clinic every day for to get her medication for four years and how that really did limit some of her ability to pursue her other, recovery goals. And that is a huge theme across the data sources that we looked at as well. People, in the for the literature review saying, you know, that take homes were very difficult to obtain and easy to lose, and they wanted that to change. We know the new regulations are hopefully helping people get to that place. When we looked at the, survey data, there, one of the things that that they said would make the program better, the top thing that they said would make this program better was easier access to take homes. There was also a part of the survey where they looked at those who received take homes as compared to those who did not receive them. And the patients that had received take homes had higher satisfaction scores for every single domain, that they measured as compared to those who did not. So it really is a key driver of patient satisfaction.

And the last thing I want to mention from the survey was that the receipt of take homes did not appear to be equitable. People who identified as white were more likely to have received take homes than those who were in other racial categories. Telehealth, is another huge, opportunity, for reducing barriers to access and something that became much easier during Covid. We will have a session specifically dedicated to this, from 3 to 4 today. But in terms of our literature review, definitely heard about how telehealth had mitigated barriers, for people, to access their treatment, especially people who have transportation issues, and people in rural areas. Some did also say that not having to go in person itself kind of reduce the stigma of, being a part of an OTP.

So that was interesting to hear. In the patient satisfaction survey, again, they looked at people who who had been offered telehealth versus those who had not been offered telehealth and similar to take homes, anyone who was offered telehealth had higher satisfaction scores across the board than people who did not have access to telehealth. And of course, there are people who do not like telehealth, do not want to participate in telehealth. And that's that should be an option for them, but not a requirement. And the literature review, there were some concerns from patients around, the quality of the services that they received via telehealth as well as, privacy concerns that they had if they're participating in treatment, at home, if they don't have the right place, to go.

And on the, satisfaction survey, about 20% of patients said that they would continue to participate in in-person only services. And then the last thing I want to say about telehealth, is on the survey again, the receipt of telehealth being offered, telehealth did not appear to be equitable, with people who identified as white or non-Hispanic, being more likely to be offered telehealth.

Counseling came up, in Jelena's story, where she was being required to go to group counseling sessions and being penalized for not going to those sessions. Of course, we know that that has changed with the new regulations. And that is a welcome change from patients based on what we saw in our, needs assessment. People really do want to have a choice about counseling. They want to be that is similar to what we said about individualized treatment, Have an array of options available for them, about how they would manage their, mental health needs and other needs. In the patient satisfaction survey, it was interesting to see that there was quite a diversity of responses about counseling, with some people saying that that was the most helpful service that was offered by their OTP, and others saying it was the least helpful service.

In particular, group counseling had very divergent opinions about it. Some people chose to write in their open ended responses, that they did not feel comfortable being in a group with others sharing their stories. And that this as a mandate was very difficult for them.

And then I'll just end by talking about pregnant and parenting populations. This is a big part of what Jelena spoke about today. And we definitely heard, from our staff focus groups, about the challenges that their patients, encountered. Even patients who had been stable on medication for opioid use disorder for years. That challenge of being having a, a report, to Department of Children and Families, for them, just because their, their child or their newborn had been exposed to opioids, we know that this law has changed, and that that's being operationalized now, and that's a huge opportunity.

This did not come up as much in, from our patient data sources for our needs assessment, but still felt like it was important to mention it. And it has certainly come up in our, patient advisory committee meetings.

Okay, I know that I just said a lot, in a very short period of time, but that is, sort of just an overview of what we found in our needs assessment. I'm going to just take one minute for you to sort of digest what I've just said and how it relates to what Jelena spoke about. And kind of looking back on what you were thinking about for policy or procedure changes, that might be needed in your OTP. Wondering what you might add. Based on what I just said about the needs assessment. I see your hand. Phoebe.

Phoebe Cushman:

Oh, I just had a question, so. But I can wait while we reflect. It was sort of a follow up question to one of the things you just said.

Sasha Bianchi:

I think you've got the floor. Go.

Phoebe Cushman:

Okay, okay. So so my question is this, early on, you said something about that patients were not happy with their referrals for resources and they weren't happy with the resources. That kind of, I, I wasn't like, I was interested in that comment, but I didn't really understand what the question that maybe people were referring to when, you know, when the survey was taken, is, is is, I wasn't sure how to interpret it. Are they saying that they want more services on site? They don't want to be referred out? I just was sort of like, interested in knowing more about that.

Sasha Bianchi:

So, So the the domain that they were responding to on the patient satisfaction survey was they were to rate their level of satisfaction with the resources that were made available by their counselor. And so four out of five people said they were satisfied with the resources offered by their counselor. But one out of five said they weren't. So, that's what they were responding to. It was a, close ended question. So there's not a lot of other detail I have with respect to the patient complaint data. It was categorized as lack

of referrals. The complaints were under that category of lack of referrals. That was a top, one of the top five complaints. And I know it certainly came up for Jelena too, I don't know, Jelena, if you want to share some of the, the referrals that you were offered, when you, when you were offered those, referrals, your resources, what those were. And, because you said you hadn't been offered them before.

Jelena Dansby:

Yeah. So when I had first come on the clinic, I was going through financial insecurities, housing insecurities because I was coming from the halfway house. And this was things that, you know, I made my clinician aware of. But at the time that I made her aware of it, she was transitioning out, that I was not made aware of that. So she wasn't able to provide me with those resources. And this all should have been added to my my chart so that the next clinician who came in, would be able to take that over.

But I ended up having to get those resources myself. Those weren't provided to me. As far as, like pregnancy resources as far, like Moms Do Care, all all of that, I had to repeat multiple times that I can't do the Moms do Care program that was referred to me about 5 or 6 times, or because I worked for the Moms Who Care program, so that we were referring me to things that didn't make sense for my care, and things that I was it was already generally reported to until I met my clinician now who actually sat down with like, you know, and we discussed, what was going to work for me, like early intervention she thought would be appropriate. You know, advocates, if DCF does get involved, advocates for that, like how to get more support with that. And my daughter, her father is not alive. She provided me with grief counseling because I was going to be, you know, my my daughter's father passed away before I found out that I was pregnant. So she provided those resources because it was a big hit, for me, when my daughter came here. But before I, before I had her, I didn't have access to other resources because no one really took the time to figure out what was working for me.

And they were or they were referring to things that really didn't make sense to what I was asking for.

Sasha Bianchi:

Thank you for that, Jelena. So we are getting close to the end of our time. We're not going to have as much time for questions as I had hoped, but I do see some in the chat, a comment about how now that that individualized and group counseling is not required, that the counselors may have more time to do, other types of work with patients to

individualize their treatment plan. So that's good news. One question about the report, our needs assessment report being available, that's something we can work with BSAS on, to get, see if we can get permission to share that out to folks. So I'm going to move on.

Sasha Bianchi:

Now it's my pleasure to introduce our opening speakers. Doctor Robbie Goldstein and Deirdre Calvert. Doctor Goldstein, MD, PhD, was appointed commissioner to the

Doctor Goldstein:

Great. Thank you for that. And good afternoon, everyone. It's great to be here with you. I'm going to start with a question. What if the future of substance use treatment was not