Telehealth Implementation during COVID-19

2020 NASADAD National Meeting

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IOWA DEPARTMENT OF PUBLIC HEALTH
Protecting and Improving the Health of Iowans
Basic Background: Iowa SUD Service Delivery

• Iowa is a medium-sized, rural, Mid-West state of just over 3 million people.
• Iowa has 99 counties that are grouped into 19 SUD service areas.
• Discretionary grants may also be implemented via the IPN providers such as State Opioid Response, Zero Suicide, and Homelessness Grant.
• The Bureau licenses all 100 SUD treatment providers in the state.
• The Integrated Provider Network (IPN) was competitively procured in 2018 to provide Prevention and Treatment Services for SUD and Problem Gambling.
Pre-COVID-19: Telehealth limitations

• Prior to COVID-19, legal telehealth definitions allowed only secured video conferencing for medical services from approved originating sites, which limits implementation in BH providers, including the IPN

• Established trusting partnerships already existed between state and provider network; the lines of communication are open.

• Funding is fee-for-service reimbursement-based.
Quick transition to Telehealth

• March 2020: Iowa BH providers began expansion or implementation of telehealth within 7 days after the emergency declaration from the Governor.
• State SUD leadership offered weekly meetings open to SUD treatment providers for technical assistance, peer-sharing, and Q&A.
• Pandemic caused panic and fear for workforce, financial impacts, and clients health & safety.
• The declaration coincided with federal announcements which allowed flexibility in telehealth implementation to include audio-only, as well as fewer rules re: video
• State SUD licensing staff provided guidance and quick response for questions.
• Funding flexibility also allowed for adjustment to be financially feasible.
COVID Impact on Iowa SUD Services:
Total services decreased 48%

2019
• April-June total SUD services reported (all payors) = 140,490
• Overall ratios are similar for both Medicaid and Block Grant funded services

2020
• April-June total SUD services reported (all payors) = 73,929
• Overall decreases are similar for both Medicaid and Block Grant funded services
<table>
<thead>
<tr>
<th>2020</th>
<th>IDPH Outpatient</th>
<th>OP Group Sessions</th>
<th>OP Individual Sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of services</td>
<td>% Telehealth</td>
<td># of services</td>
</tr>
<tr>
<td>January</td>
<td>2,717</td>
<td>0</td>
<td>1,149</td>
</tr>
<tr>
<td>February</td>
<td>2,417</td>
<td>0</td>
<td>1,072</td>
</tr>
<tr>
<td>March</td>
<td>2,633</td>
<td>11%</td>
<td>981</td>
</tr>
<tr>
<td>April</td>
<td>1,988</td>
<td>73%</td>
<td>214</td>
</tr>
<tr>
<td>May</td>
<td>1,610</td>
<td>80%</td>
<td>183</td>
</tr>
<tr>
<td>June</td>
<td>786</td>
<td>89%</td>
<td>160</td>
</tr>
<tr>
<td>Totals:</td>
<td>12,151</td>
<td>3,759</td>
<td>8,392</td>
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Integrated Provider Network Surveys

• Original survey was sent in early April 2020.
• Follow-up survey was sent in late June 2020.
• Responses to the first survey represented 14 of 19 IPN providers.
• Second survey included 16 of 19 IPN providers.
• Respondents were asked about Telehealth implementation benefits and challenges.
Provider Telehealth Surveys Results: Offering audio-only and/or video options?

April Capacity for Telehealth
• Rapid ramp-up of telehealth service capacity: 86% offered both audio-only/telephonic and video telehealth services
• Several agencies were only able to offer telephonic services at the beginning of the pandemic.

June Capacity for Telehealth
• 100% offered both telephonic and video telehealth services.
Provider Telehealth Surveys Results:
Which type of telehealth was more common?

April: Audio-Only was more common

June: Video was more common
Provider Telehealth Surveys Results:

16 of 19 agencies responded:

What equipment, software, and/or service contracts have you had to purchase to expand your telehealth services (check all that apply)?

<table>
<thead>
<tr>
<th>Equipment/Service</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Webcams and/or headsets</td>
<td>12</td>
<td>75%</td>
</tr>
<tr>
<td>Laptops</td>
<td>14</td>
<td>87.5%</td>
</tr>
<tr>
<td>Cell phones</td>
<td>7</td>
<td>43.8%</td>
</tr>
<tr>
<td>Wifi or &quot;hotspots&quot;</td>
<td>8</td>
<td>50%</td>
</tr>
<tr>
<td>Electronic signature programs</td>
<td>8</td>
<td>50%</td>
</tr>
<tr>
<td>New or additional licenses for video co...</td>
<td>4</td>
<td>25%</td>
</tr>
<tr>
<td>ZOOM Healthcare; additionally IT time; ...</td>
<td>5</td>
<td>31.3%</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>6.3%</td>
</tr>
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</table>
Provider Telehealth Surveys Results: April: Reported Challenges

- technology glitches & limited staff experience with telehealth
- difficulty/delays in telehealth set-up
- patient preference for phone vs counselor prefers video
- shorter sessions over phone
- assessments must still be in person for paperwork
- cannot fully eliminate f2f contact
- stress of changing routines
- some clients do not have phone/equipment for telehealth
- some clients lack internet access, enough minutes/service plans for telehealth
- cannot do UAs/physical exams
- confidentiality concerns with groups via telehealth
- some patients have limited understanding/ability to use technology
- some clients don't answer phone/no show
- audio telehealth lacks cues and context of patient
Provider Telehealth Surveys Results: April: Reported Benefits

- reduced client barriers
- staff appreciate the option for health/safety
- allows outpatient safer option to continue treatment during COVID
- improved clients’ attendance
- clients more engaged
- clients reaching out if struggling
- efficiency with reduced staff travel
- helped limit COVID-related service interruptions
- patients appreciate convenience/ease of access
June Survey: What is not working?

• Groups are more difficult.

• Referrals from the criminal justice system have decreased significantly; and jail-based evaluations have also decreased.

• It is hard to onboard new employees.

• Staff and clients are feeling burnout from video conferencing.

• Providers noticed a change in commitment as the weather improved and more people were outside. No-show rates increased with this change. Individual sessions increased but group attendance decreased.

• Most have not provided phones for patients. Some would like to, but lack funding for it, and expressed concern about controlling usage.
June Survey: What is going well?

• Our group numbers have increased in some programs.
• Almost everything. Service delivery is going well. Demand for services has increased.
• Use of telehealth, in general, has worked well. We have been able to offer multiple options (face-to-face for individuals who needed this, telehealth only through video or audio, and combination groups where some individuals present in person and others join via teleconferencing.
• Flexibility for treatment services. This is particularly helpful when transportation systems were shut down or limited. It also allows us to continue treatment if a patient is not feeling well.
• Made accessibility better in rural areas.
• Support staff and therapists working together as partners though all working remotely. One of the most important components was IDPH assisting with some of the costs associated with getting this in place rapidly and being supportive through meetings. Listening to what providers needed and working with providers in a collaborative manner.
What do both providers and patients need to consider as we adapt to this new normal?
Thank you!

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COPING WITH THE “NEW NORMAL”

TRANSFORMING SYSTEMS TO FOSTER AN ENVIRONMENT OF RECOVERY

Barbara Cimaglio
Retired SSA
Independent Consultant
What Times We Are In!!!
Physical & Emotional Trauma Everywhere
Opioid Overdose Crisis Continues

3 Waves of the Rise in Opioid Overdose Deaths

REMEMBERING OUR HISTORY
Addiction – A Hidden Disease

• Early 19th Century showed a growing concern for opium and morphine addiction (these substances were not yet illegal).

• American Medical Association’s 1920 Report of the Committee on the Narcotic Drug Situation:

_The shallow pretense that drug addiction is “a disease” which the specialist must be allowed to “treat”, which pretended treatment consists of supplying its victims with the drug has caused their physical and moral debauchery….”_

Early stigma for MAT……
Not a New Struggle

• Before 1900, the typical opiate addict in America was an upper-class or middle-class white woman.

• During the Civil War, opium was used to relieve pain that resulted from battlefield injuries. The hypodermic needle made it easier to inject morphine.

• Opiates made up 15 percent of all prescriptions dispensed in Boston in 1888.

Smithsonian Magazine, 1/18
Drugs & Communities of Color

- People of color experience discrimination at every stage of the criminal justice system and are more likely to be stopped, searched, arrested, convicted, harshly sentenced and saddled with a lifelong criminal record. This is particularly the case for drug law violations.

- Nearly 80% of people in federal prison and almost 60% of people in state prison for drug offenses are black or Latino.
Early Leaders & Laws Created the Framework for Treatments

• Dr. Benjamin Rush (1746-1813)
  • Disease concept of alcoholism
  • “Father” of addiction medicine

• 1919 Harrison Act (1915)
  • Enforcement led to early approaches to opioid treatment
  • Closure of clinics led to burgeoning illegal drug trade

• U.S. Public Health Service
  • Did not assume responsibility for people addicted to narcotics
  • Treatment fell to state and local groups
Our Field Developed Because of Trauma
Recovery and Alcoholics Anonymous

• Various approaches to supporting alcoholics “culminated” with the A.A. Program (1930’s)

• Leadership that grew out of the A.A. approach to recovery led to the development of the modern approach to treatment of alcoholism.
  • Built upon the 12-step philosophy for recovery from alcoholism
  • Not focused on the narcotic or stimulant addicted person
    • More stigma for this population
New Approaches to Opioid Treatment

• Methadone Clinics have been the “norm” for most people in the addiction field

• Drug Addiction and Treatment Act (2000)
  • Permits physicians who meet certain qualifications to treat opioid addiction with Schedule III, IV, and V narcotic medications that have been specifically approved by the Food and Drug Administration for that purpose.
TRANSFORMING OUR SYSTEMS
The New Recovery Movement

- New grassroots advocacy organizations working to reclaim a more basic mission – to support recovery.

- CSAT’s funding of Recovery Community Support Program (RCSP) helped fledgling Recovery Community Organizations gain ground.

- Local and state leadership was instrumental in growing this movement.

- Congressional leadership (Ramstad & Wellstone) supported this direction.

- Oxford Houses/recovery housing grew & developed to support people in recovery.
Recovery Support Today

- Helps people gain and maintain recovery, find support services and learn to advocate for the rights of persons in recovery from addiction.
- Many states have a network of RCOs, Recovery Specialists and other structures to support recovery.
- Growing use of telehealth both in traditional treatment and with recovery support.
Federal Support for Expanded Services

- Under STR/SOR funding, SAMHSA has granted funds to states to address opioid use disorders.

- Enhanced prevention, treatment and recovery support services throughout the country helps communities to decrease stigma.

- Additional training and technical support has supported expansion of waivered physicians and nurse practitioners.
Times of Opportunity & Change
Challenges = Opportunities

challenges

• Restricted travel
• Fewer clinic hours
• Less flexible schedules
• Other challenges?

opportunities

• Use of telemedicine
• Outreach by recovery support specialists
• Develop new partnerships
• Other opportunities?
Is the Current Business Model the Best for These Times?

• Do we need to be more flexible?

• Do we need to use community resources better?

• Are there new partnerships that would be more useful for our clients; i.e., SUD treatment partnering with hospital?

• How can we make our services more accessible?
In Summary……

• Our field has always had challenges

• Alcohol & drug problems aren’t going away

• Recovery oriented approaches make best use of community supports

• Treatment has always been challenged to redefine itself – alcohol → drugs → medications → telehealth……..????
IT’S BETTER TO BE LEADING THE CHANGE THAN TO HAVE TO CATCH UP
WHAT'S NEXT?
Acknowledgements & Contact Info:

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Reference: Slaying the Dragon, William L. White
  Chestnut Health Systems Publications