Transcript:

Telehealth Services in the Days of a Pandemic (Part 3): Gifts of the Pandemic

Presenter: Sheila Weix
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ANN: Hello, everyone and welcome. Today, our webinar is Telehealth Part 3: Gifts of the Pandemic. And our speaker today is Sheila Weix. This webinar today is brought to you by the Great Lakes ATTC, Great Lakes MHTTC, the Great Lakes PTTC, and SAMSHA. The Great Lakes ATTC, MHTTC, and PTTC are funded by the following cooperative agreements with SAMSHA. The opinions expressed in this webinar today are the views of the speaker, and do not necessarily reflect the official position of DHHS or SAMSHA. The Great Lakes ATTC, MHTTC, and PTTC all believe that language matters, and words have power. And we use affirming language that inspires hope and advances recovery. I just have a couple of housekeeping details today. If you are having technical issues, please individually message either Kristina Spannbauer or Stephanie Behlman in the chat section at the bottom of your screen, and they'll be happy to help you. If you have questions for Sheila today, please put them in the Q&A section. And we will address them during the webinar. A recording and a PDF of the slides will be available on our websites in about a week. You will be sent a link following the presentation to a very short survey. We would really appreciate it if you could fill it out. It's how we report back to SAMSHA. And it really just takes about three minutes. Certificates of attendance will also be sent out to all those who attend the full session. And they will be sent via email. Also takes about a week. If you would like to see what else we're doing, you can follow us on social media. And again, I'm happy to say that our speaker today is Sheila Weix. Sheila is a tenured professor in the field of substance use disorder. And has just entered her fifth decade of practice with experience in private and public services across the entire continuum of care.
During that practice, there have been the opportunity to learn a great deal, experience some major challenges, and participate in innovative problem solving. This presentation is based on that background and what we know and can do about our current situation. Welcome, Sheila. And I'll turn it over to you.
SHEILA WEIX: Thank you, Ann. Are people able to see my slides? Yes?
ANN: Looks great. Yes.
SHEILA WEIX: OK. Very good. As an indicated, this is Gifts of the Pandemic Opportunity in Chaos. And there will be a few references to things around policy. I just wanted to let you know I am located in Wisconsin. So when things come down to policy, I would encourage you to connect with your own states because some things vary by state as you're aware.

So I just wanted to give you that disclaimer. But beyond that, we're all sitting in a great deal of cold today. It was 40 below chill factor at my house this morning. So when we talk about gifts of the pandemic, doing virtual has great appeal under circumstances like that. So we're going to talk about it.
And one second here. There we go. So the objectives for this presentation. Being able to recognize some of the opportunities that have resulted from the impact of the pandemic. It's very easy to focus on all of the negative impact, if you would, or the challenges. But there are also opportunities. And then being able to explore the role of resilience in provider responses to service needs. During the pandemic as a path to opportunities, we often talk to the people we serve about resilience. But situations like this challenge us to exhibit our own resilience. And resilience as agencies.
So my background, Ann had touched on it a bit. But I'm a registered nurse by education and practice. Substance use disorder work since the mid '80s. So yes, many decades. And I'm sure for some people that would be before they were born. So, yes, I am that tenured. But I'm not a tenured professor. That part ends up in there. Nope. Just tenured professional.
I have worked acute care in hospitals. Full continuum of substance use disorders services, outpatient residential IOP day treatment, et cetera. I've also functioned in both the private and public, including the county and state systems. So I had the opportunity to learn a lot of things. Currently, I'm Director of Substance Use Disorders Services for a federally qualified health center. So there's the opportunity to do quite a few things through that route.
So we will go to February of 2020. Take you back there. It was business as usual. BAU as we like to talk about. Primarily, we were doing in-person services. My current practice is an outpatient practice with medication assisted treatment. We had crowds. We had groups. Group was occurring several days a week. Various settings.
The only telehealth that was occurring at that time was between clinics. So a patient might come in to one site in order to be able to see the psychiatrist who was located somewhere else. So there was some telehealth. But again, it was within that very focused clinic setting.
We had multiple people, as I'm sure you all did, dropping in for various things. Paperwork, doing urines, picking things up. There was just a steady flow of people in and out. Likewise, staff offices were busy. Multiple contact. Staff saw one another. They talked. The fun things that go on at offices. You could do a potluck. Again, the days that were pre-COVID. Business as usual.
And then the pandemic arrived. And for all of you folks who worry about copyright, this is a public domain. No copyright. Free to use. When the pandemic arrived-- and please note that my dinosaur was holding a cup of coffee. And then there's the Uh, oh. And that is truly, truly what it felt like when the pandemic hit.
In March of 2020, we had been hearing about a new respiratory illness since January. Some of us kind of key into those things. We had had some experience with SARS and some other things because we were acute care hospital. Myself and some of our team. So we had been following this. Plus we had from some other parts are federally qualified health center. We had a colleague whose family lived near Wuhan in China. So we were following that

closely, and really feeling for her and her family. So it was not a complete surprise.

However, as its second point identifies, initially it was far away across the world. And that was more the thought. We have one of our physicians who is on a special contract. And half of the year he's by us. And the other half of the year he travels to his homeland in Asia. So we were concerned about that-- that kind of thing. That changed completely because suddenly it was covering the world. And it was here in the US with rapidly escalating infection rates, hospitalizations, and deaths.

That was probably one of the most rapid times of change that many of us can recall. Suddenly, the order safer at home order came out here in Wisconsin, which I believe was March 12th. And at that point, business as usual screeched to a halt in so many ways. Not just within the services we provide, but schools, churches work. Who's an essential worker? And who was not? How did the illness spread? Should we mask? Should we not mask?

So much information that was at odds with one another. It all became just exceedingly challenging. So when I show you the dinosaur and the uh oh, It really did have a lot of that feel. And more than we could even anticipate.

So the immediate challenges. For our service, we needed to pivot to full telehealth delivery. It was either that or close under the safer at home. Now because we're a federally qualified health center, we're pretty nimble. We don't have a lot of layers. We're part of a very large organization. But the FQHC is not.

So in our agency, that essentially came down to myself and a couple of my key team members. And by the end of that first day, we had all of the patients switch to telephone appointments. Because the other thing to know about-- excuse me-- where we deliver services is in rural Wisconsin. Particularly rural Northwoods.

So when you look at that, the concept of telehealth-- because that also would have been acceptable under regulatory. Bottom line. There wasn't enough internet broadband to support the kids to do their schoolwork from home. Much less to support video and audio visits with us. So our answer was telephone. That was what we could do. So that was what we did. And we were prepared just to do it if we had to for a period of time without payment. But there were multiple regulatory requirements placed on emergency hold. And so shortly after we had everybody switch to phones, we got the good news we could be billing for it. So that was a very positive thing. Payment was going to be allowed for services that were not covered before. Prior to the onset of the pandemic, you could not bill for a telephone call. Now you not only could, you could bill as if it was a face to face visit. That's huge.

Staff and patients had to adjust to multiple changes and challenges. When we think about that-- and I would ask you just to think about your own practice. I know in our practice, screening. Screening before you left home that you had to fill out before you left. When you arrived in the building, if you came to the building, screening that you did at the door.

Multiple staff under the safer at home, if I could have them work from home, we moved them home. So people set up their offices at home, and began providing services from there. For folks other than ones that are going to give an injection, or do something else hands on, we found very quickly that things

we had always assumed needed to be done face to face really did not. Many, many things could be done in a virtual environment or done with a team. So there were multiple changes and challenges there.

At the flip side, the people that we served were terrified and understandably so. Again, we're a federally qualified health center. So many of the people we serve are in the safety net I guess is what I would call it.

Socioeconomic issues are our major challenges. Social determinants of health come to bear. A number of them were in multi-generational homes. So there was great concern about the older family members when it became clear that the COVID virus was taking a huge toll on people who were older or who had co-occurring health issues. So there was a great deal of fear.

There was also, well, how do you get tested? Where do you get tested? How can I quickly get in? All of that came to bear. So we had some days-- that we did from our substance use disorder treatment because that's what we are. We had some days we did as much just helping people connect with COVID resources, and making sure that they were doing OK otherwise, as we did with actual substance use disorders specific counseling. Because when you look at supporting people, and when you look at what were they experiencing, what did this bring up, et cetera-- the usual things you Look at with substance use disorder-- their current need at that moment was what could they do to connect with resources. So that's what we spent a lot of time doing.

Now here we are February of 2021. And everybody that thought it would be over in a few months, gone by Easter, gone by summer, gone by the election, not so much. Here we are. The pandemic is still active with variants developing. And just to be clear on the variants. Part of the reason that there's this big emphasis on getting people vaccinated is the mutations only occur when the virus is within a host.

So if it's sitting on the counter, there's not a mutation. It's only when somebody is actively infected. So the sooner you get everybody vaccinated, the less variants that will evolve. But developing variants is what viruses do. That's what they're cut out to do. So we're not sure how far that's going to go. Likewise, vaccines are available now. But not to everyone. Not yet. So getting those vaccines out is a huge piece of it.

None of the patients we have, except a few of the elders, have received vaccines. My staff have. So that's a positive. But we're not in a spot to bring people together for group until we can assure that they won't get infected coming into the group. So the PPE and all of that is being used. And masks are there. But there's still many, many effects just trying to cope with today.

In addition, there were many, many deaths in the communities where we serve and live. There was almost no one who did not know or be related to somebody who at minimum had had the disease very severely. In some cases had died. Or there's some of those long haulers where it's not clear what the outcome is going to be. Are the cardiac issues going to resolve? Are the neurological issues going to resolve? There's so much that's not known. So this is very, very much present a year later.

The other thing that we saw in many ways, and we heard it from the people we serve as well as from our staff, a huge amount of disruption in the organic supports that people don't even realize they have or that they depend on until they can't. Jobs. What you do with your day, and the structure of a job, does a

great deal for people in recovery. As well as it does for staff. So for those people who lost their jobs, and a number of people did particularly those working in hospitality and some other things, they lost that support as well as the financial implications of it.

Likewise, with the schools, that was huge that the kids could not go to school. Understandable. But in some cases, you now had children home with parents trying to help them. And the parents had struggled in school. And oh, by the way, they didn't have decent internet. So they had to sit in the McDonald's parking lot to try and get on the internet because you couldn't go to the library. You couldn't do other things. So huge disruption in schools.

Likewise, for some of the families that we serve, the schools have been a major part of working with food insecurity and things. There were struggles with that. And then family contact. There are many people who have purposely in an attempt to stay safe and keep their loved ones safe, done a lot of isolation from families. So all of the things that people routinely count on as part of their supports were not there.

And then a huge, huge piece is recovery meetings. AA and NA developed face to face, side by side. And with that feeling of community and that support that was such a huge piece of it. Yes, there are online meetings. But particularly for newcomers, that may or may not be adequate.

So again, many of the basic organic supports that are just there for people were not there. I did not even go into churches and other things. Club get togethers. Social get togethers. So much of that was either lost or really curtailed. Or the people who did opt to do it, sometimes they became super spreader events unintentionally.

I had a colleague, who at the request of an elderly relative, got a small group of people together for that elderly relative's 90 plus birthday and was almost 100 because the relative said I'm afraid I'm going to die without seeing you all. They got together, and it turned into a super spreader event. And ultimately, the elderly relative did die less than 60 days after the birthday party. And several relatives were hospitalized. Others were very ill at home.

So again, there was so much that was at stake, and things have changed so dramatically. The other thing, this is out of the data, substance use is up. In the drugabuse.gov, and you've got under the references, there is a report in Nora's blog. One of the companies had 500,000 UDTs across the country. And they were done during the pandemic. And the increases that came across-- so this would have been before the pandemic and then during the pandemic. Cocaine being up 10%, methamphetamine 20%, heroin 13%, and fentanyl 32%.

So this is not depending on reports by the individuals. This is the actual finding. And 500,000-- half a million UDTs. This is what they found in. So we had heard about use being up. We had reason to suspect it would be up. You have data that shows it's up. Then there were the alcohol increases.

March of 2020, which would have been right when the lockdowns and things occurred, there was a 54% increase in alcohol sales. And when you went to online because remember people were afraid to go to the grocery store, and you can get anything delivered to your house, 262% increase in the purchase online of alcohol.

They did do a really nice study-- this is jamanetwork Pollard had done it. And this is self report. But again, that's a standard approach. They did surveys of a group of people. And then they did it a year later into the pandemic so that they could see what the difference had been.

So I believe the end of it was June of 2020. They showed a consumption where three or four adults in the survey had added one additional day per month of alcohol use. Now that doesn't sound like a lot. But if you think what it would take to get there, a lot of people increased alcohol use.

In addition, for women in particularly, there was a 41% over baseline increase for heavy drinking. I don't know how many of you paid attention at the end of December beginning of January when people were talking about doing dry January. Some of them were doing it because they had become aware of what was happening when they drank. And they were drinking too much. They were definitely in risky use. And in some cases, it was starting to have implications for them.

So being at home, being isolated, being locked up with your family for long periods of time not knowing what's going to happen next, it is not surprising that people turned to substances including alcohol to cope. Something to take the edge off. Something to make those long days go more quickly. Something to help deal with the anxiety and worry that was forever present.

Then we saw that there were treatment impacts from all of this happening. Telehealth is reasonable for outpatient. You can readily do that. But when you think about higher levels of care-- example, residential. And when somebody needs residential, they really need residential. There's huge, huge challenges. A number of residential programs have closed during this pandemic.

And I had the opportunity for a discussion with a colleague who's been with us a long time, and knows how to do residential treatment. And she was talking about the stressors. I asked. I said, well, where is your break even? Comes down to her break even in her agency is 75% to 80% occupancy.

But since the lockdown starting in March, the maximum she can have is 50% occupancy. You've got a 25% to 30% gap that's being lost every day they're open because they can't get to break even status. Now that's going to cost more residential treatments unless there's something done to help subsidize that. To help make that better. Again, that may vary by state. But again, this is somebody who's done this for a long time. She knows how to do residential treatment. She's been successful with her agency. And I think these gaps are huge.

Another issue-- and I identified this a little earlier. Internet access is extremely limited. Telephone services may be the only access. That's an important element. It does make a difference when you can't see the person. Depending on how the interaction is going, it is easier to do a short phone call than having the telehealth where you can see one another and you perhaps can keep the person more engaged.

The other thing is because telephones are so portable it's really easy to say I'm shopping at Walmart. But it's OK. I'll talk to you. We have to tell people that that's going to count as a no show if when you have your appointment you're shopping at Walmart, or you're in a car with your kids when you know this call is coming. You scheduled it. We need to have you been a spot where you can take advantage of that time.

But we have some areas in the rural Northwoods where you can't even get the phone call. They have to plan to be where there's better connectivity for their phone because all they can do is text. So when you look at social determinants of health, the telehealth world has the potential until there is greater internet broadband availability-- you have the potential to just carry on with the continued social determinants of health leaving large groups of people out. So that's an issue.

Staff. It's been a year. I don't know how you're feeling. But staff are tired. They're isolated. And they're experiencing all of the emotions present in the rest of the population. Because the other thing to remember is 2020 was exhausting. There was so much more than the pandemic. There was the election. There was all of the communication that was at odds with one another. There was so much. And the pandemic. It was an exhausting year. And staff were exhausted as well.

So that has an impact on treatment. And it's important that staff are able to find that spot of calmness. Or otherwise, they're not necessarily being of assistance to the people we serve. It's always important to the people we serve are not having to comfort the care provider. That's a little concerning when we get there. So again, 2020 was much more than the pandemic.

So about those gifts. Promised them up front, and we haven't gotten to that yet. Well, the gift is disruption. And while people don't generally look at that as being a gift, it absolutely is. There was a rapid change to delivery systems. I'm going to give you a little history here on telehealth.

When I went and started looking at this, I expected that it went back quite a ways. I didn't even include one of the elements I found. I did find one article-- and I didn't look into it more deeply, I'm sure there are others-- that talked about back in 1906 the first electrocardiogram sound was sent by a telephone. That would put us 115 years ago folks that there was first initiations into telemedicine, telehealth.

But some really solid stuff. Those University of Nebraska folks have been doing some great work. Back in 1959, they were sending medical reports across the campus to their medical students so they could get test results and things. It was a two way interactive television type thing of some sort. By 1964, the folks at the University of Nebraska were doing video consultations to the state hospital, and providing services like occupational therapy and other things. So think about that.

Again, over half a century ago this was happening. In 1996, there was a study showing equivalent outcomes with E group and in person. And-- this is the big and-- greater patient satisfaction with the convenience and confidentiality of e-services. King et al. has that study. Again, this is 1996. So it's 25 years ago there was evidence that E groups-- and what this was a methadone program where people were having difficulty with compliance. So they separated people into-- the people had to have a greater intensity of services.

So they separated them into people who needed to come in person for group or people that could do the group online. The results for the increased compliance and having appropriate urines was the same. I think it was 70% versus 71% for the two groups. Plus you had the piece about patient satisfaction. Because with the convenience it had to do around work. And the

confidentiality. No one saw them having to go to that group. So they had the confidentiality working from home. Again, 25 years ago.
So for over 50 plus years, this is hanging out of here and nothing's really going on, there's some little inroads into it. But telehealth is not necessarily a big deal. Particularly in substance use disorder. Maybe the psychiatrist does a consult or something. But the rest of it's pretty much in person. And then we have the pandemic. And in one month, boom. Literally, boom in one month. So when you want to look at gifts, disruption can be that. This is actual CMS data. And it's weekly for fee for service telemedicine users. And it is just for 2020 first quarter thereabouts heading into April too. So it's just above-- well, let's see. It's under 200,000 all the way through March 14th. And keep in mind, these are weekly reporting. And then you get this lovely write straight up.
There's an even more evident one that they may had, but it looked like it was copyrighted so I didn't pull it for you. This one's out of regular CMS data. Verma does a report on it. That one where it is by month is literally right straight up. That is the kind of impact that disruption has. All kinds of things needed to align right now, and they did. So telemedicine came into its own during this time.
So why the delay? If it's been out there for 50 plus years. Why weren't we doing this? Well, go back to the dinosaurs. We do what we do until we can't. And dinosaurs have certainly been applied as a label to certain aspects of the treatment we do. Because some of the things we've been doing, we've been doing for a very long time.
But there were other things. This isn't just on the providers, or just on the agencies. Payment wasn't there. There was plenty of proof of concept. But until there's proof of payment, you really can't afford to do stuff unless you've got a grant or a study to support proof of concept. You can do that. But that's a limited sort of thing. You have to have payment to build services and have it work.
Likewise, there were regulatory barriers. It was just the previous year that here in Wisconsin I didn't have to get a telehealth separate certification for my state certified substance use disorder agencies. Otherwise, there was a whole separate certification that we had to do. They did drop that before this came. But I can tell you we're still at a point that if we're going to use telehealth they want that noted on the treatment plan. They don't want to just note that we're going to be doing early recovery skills with a individual new to our services. They want to know that we're going to do it in person or are we doing-- well, actually we don't have to put if it's in person. We have to put if it's going to be done by a telehealth.
I have argued that point a little bit because it's sort of like if you're going to do a protocol to treat a particular substance, and some manualized disorder, and some manualized treatment, you don't necessarily say I'm going to see this person and we're going to talk face to face. You say we're going to go through this manualized treatment. And here's the goals the patient has identified, et cetera.
So I'm trying to work to have it just be however we deliver the services is just the route of delivery. Yes, there are concerns for telehealth. No difficulty with that. But really recognizing this is becoming a norm. How we do it. It's more

important that the patient receives it, and the patient is getting what they need. So lots of regulatory barriers.

And then organizational barriers. Whether you're part of a large entity or a small entity, it is no small undertaking to change major pieces of what you do. People had to immediately find a platform to do this telehealth on. And because the regulatory barriers were dropped for a little while, it was sort of OK to use whatever you could get. Well, that's a very time limited sort of thing. You still have to do risk mitigation and some other things to have the best platform that you can access to do it that's going to maintain confidentiality and things.

Plus, if it's a whole new way of doing things, there are policies, procedures, forms. I mean, anyone who's done this work has a feeling for how difficult it can be to make changes. So it's not on any individual. It's a matter of we needed the disruption to the systems to make this happen rapidly. But it was pretty impressive how quickly It did happen. Any questions with this at this point?

ANN: We do have one question. Renee wants to know how you managed urine screening for MAT with more telehealth services.

SHEILA WEIX: What we did is, for a little while immediately after the lockdown, we did stop doing them for a brief time. Not for very long though. Then we started doing some real critical thinking about who needed them and who did not. If we had people that were doing well otherwise, and perhaps they had a history of a number of appropriate ones, we held off on them. People who were new into treatment though, we got them back in.

But we were careful to schedule them in such a way that we never had a crowd in the waiting room or anything like that. We really gave them an appointment. And sometimes that was the only patient physically in the agency at the time they were doing that urine.

Because of the other barriers though, what we've moved to is when we call, we offer like three days. They can pick one of those days and a time. They're committed to that. But recognizing the challenges with transportation, child care, et cetera, we do give more leniency about when they're going to come in.

We never did do that you have to be here within the hour kind of thing. So we opened that window further. And if someone does not show up for one that they've scheduled unless there's a snowstorm or something like that, we expect them to be there or does count as a positive urine. So that's how we've handled that.

ANN: Great. Thank you. One more. How do you track client service utilization and engagement remotely?

SHEILA WEIX: It has to do with some of this is really basic. We've talked with staff about showing up. Answering your phone for that phone call is no different than presenting at the desk to check in when you were doing it in person. And we're really clear with people about that. Plus, we've done things like the appointments that are in high demand like near the end of the day for folks that are working, you have to take your phone call and show for those appointments. Otherwise, we do no show for phone appointments just like we would for in person.

We have shortened the appointments. In general, our phone appointments are half hour rather than the hour that in-person used to be. Part of that has to do with access because we used to run a lot of groups. We are not currently doing groups because we're so limited with the telephones. I do have colleagues in other parts of the state that have better internet access that are doing group via telehealth. And they've had positive experiences with it. Generally speaking, initially, I had some of the providers who struggled to keep people engaged very long. But I've had some others do just amazing work. And that half hour is up, and they have to really work to shut things down. At the same time, we've had some patients that almost seem like they're more forthcoming on the phone than they perhaps would have been in person.

So people have shared things that have been difficult for them to share. Including return to use, and what's gone on, and fears and things. So it depends on the person. And it depends on the provider's ability to do that engagement. But I found ones that really engage their clients before are able to do so as well on the phone. Or in telehealth for those few that we can. OK.

ANN: Thank you those are all the questions we have right now. But just a reminder to everyone, please put them in the Q&A section.

SHEILA WEIX: Thank you. OK. Current status. So we've taken a look at what's going on. What do we think is happening. As it just kind of touched on, we've got a mixed bag. Some individuals absolutely love telehealth-- particularly telephone. Because they will schedule their appointment and take their appointment during their lunch break or if they work in working environment where they have a regularly scheduled break earlier in the day. I had one person that was working at one of the hotels. Her employer knew. And would allow her to put her two 15 minute breaks together for her half hour appointment at a set time. And that was working very well.

So if you think about the weather we're having today, and picture having small children because child care up where we're delivering services is very limited and there's no drop in care. So people gather up their kids and bring them with. If you don't have to gather up the baby and come out because we can give you a phone call and accomplish that, we've probably given you back several hours of your time.

And a lot of extras trying to gather up the children and bring them. And the car is not starting in weather like this. This is a sort of day that when we were in person we probably would have had almost all no shows because of the cold and the travel distances they travel.

Today, I've got a few. But very few. So people really, really like that part of it. But others have said they cannot wait to be back in person, and be in the groups. The need to connect is so strong. And particularly, we don't have the video to go with where it's just on the phone.

For some of those folks it's much harder. I think also for folks that are just starting into treatment, initiation is one of those times when you really need to connect. You really need to develop that engagement that the previous questioner had asked about. I think it can be much harder. And I think we perhaps have lost some people that we would have retained had we had more direct in-person contact with them.

Groups, as I mentioned in our practice, we don't have enough technology support to really allow that to happen. So where do I think we're going to go? I think we're going to end up, if the regulatory environment will allow it, we're going to end up with a hybrid model where there will be some services we will consider or we will continue in tele without any interruption.

For people as they move into their recovery and they become employed and things, that may be a real plus for them. But they will be folks too that have had that opportunity for in-person and to develop that engagement and to begin their self-directed recovery elements. So again, I believe it'll be a hybrid model. But at least we have that capability now whereas before, well, if you didn't come in person there wasn't a lot else we could offer.

Current status with staff. Again, I've got a mixed bag. Some providers are absolutely doing amazing work connecting biotechnology. One of our NPs had worked closely with a patient who has co-occurring disorder. And the person had started to miss some of their meds for their mental health diagnosis, and was decompensating.

She was able to determine in her video-- this particular one happened to be a video because we did have him come into one clinic for her to see him from another clinic. But she was able to determine that he was struggling and was having other stimuli he was responding to. And in fact was becoming suicidal. And we were able to get him into crisis services directly out of that visit.

Since then, there have been a time or two because, again, this is a long term patient. And over the past year, there's been a time or two were on the phone he has begun to share when he is struggling. And so he's been able to get into services before it reached the point of having to have crisis. So that's been positive. Other folks, again, not quite as able to do this through the technology.

On the other hand, the removal of barriers including travel, bad roads, work hours, and physical limitations has been very positive. One of our providers was comfortable with me sharing this. It is someone who's a more tenured provider. And the person had an orthopedic procedure for which the usual recovery would be being at home for 8 to 12 weeks because the person also has to commute about an hour to her office.

And because we could do telehealth-- and remember that at one period of time everyone was at home for my agency except the MA and the NPs. This person had been working from home when she had surgery. And she was able to return to work via tele on a part time basis I think it was 10 days after her surgery. Had the OK to do it because again she was working from home. She could work with the elevation or whatever she needed. It could be just a couple of hours whatever it was. There's no way that she would have been back at work if she physically had to go to work.

Likewise, when we have an ice storm or something, we have not had a day that we are closed since we went to tele because I always have a few people that are able to go in. We have everyone who does go in routinely take their computers home the day before the anticipated storm. And we just continue on with services.

With all of that happening, and the current shortage in substance use disorder workforce, we anticipate for those folks that do a number of the services, whether it's the psychiatrist, one of the therapists, the counselors, that for

some of the more tenured staff as they approach what would normally be their retirement, I believe that there will be some of those folks that will be open to doing some level of part time work via tele because they don't have to do the travel things.

And I've had a couple of them actually identify that. So we think that that will extend some careers, and maintain some access that we might otherwise have lost on the basic how we've done it for years. You come to your office, and patients come see you.

The other thing for some staff that had underlying medical concerns, this was far less frightening, if you would, to deliver services because they did not have to worry about infection control when they're working from their home. And they're talking to the patient on the phone. So it was less frightening for patients. It was less frightening for providers. So under a pandemic, which we hope we do not routinely have. But again, it was another one of those gifts, if you would, that they did not have to be frightened of that.

The other thing when I say mixed bag, this was part of the other part, we have some providers it really need the in-person contacts. And readily identify that they do not believe they get the level of engagement without being in person. And we understand that. There's different styles and different matches of patients and people that we provide services to. So we get that.

The other concern is the time boundary concerns. Systems being systems, as soon as you don't have travel and stuff, sometimes there tends to take advantage of individuals. So I found for myself the other day starting at 7:00 AM, I had nine straight hours of meetings scheduled because they were all virtual. And so they could be. It gets to be a really long day. So there has to be within the agency awareness of what's reasonable here. And then within the individual the capability of setting some boundaries.

Otherwise, given the amount of patient need-- I talked with somebody, a colleague in another part of the state earlier this week, that individuals on an early meeting with a group of us. And then she was going to be providing teleservices until 8 o'clock that night. Again, the self care. The permission to do self care, the support for self care, has to be there because this can invade your home. I mean, at least when you were working at the office, when you left the office, you left the office. Now it just goes with you. So there is that time and boundary issue that has to be just watched.

Agency's current status. Well, those emergency rules that came into effect a year ago are time limited. Don't know quite when they're going to end. But some things may go away. There's a major revision of regulations and requirements underway. Certainly within Wisconsin that's all being looked at and will be rolled out. But there's also some things that are federal. And then commercial insurance varys quite a bit.

I would encourage everyone to follow your state updates very closely, and advocate where you can because again I think that the potential future best model will be a hybrid. But as I identified previously, no agency can provide something for very long that is not reimbursed for. So it's important that the regulatory changes support what patients need in the best possible way. So be aware of that.

Another piece was staff education and CEUs. I have attended a number of virtual, like this, but virtual full conferences. And when I've done the feedback

on them, including a couple of state level conferences, I had to tell them for me personally while I miss the networking, it was the best conference ever. Because every single conference, I've got a seat where I can see the entire PowerPoint. I can hear everything because I'm not sitting next to a table of people who are visiting instead of attending to the conference.

Likewise, I'm kind of short. And sometimes a screen that's way up at the front of a large conference room I have difficulty reading. Either I'm behind a tall person, or again it's a vision issue. Well, from my home, I can take care of my personal needs, including that cup of coffee without bothering anyone. And I always have the best seat in the house. So I have to tell you, I love the virtual conferences. The only part that's missing is the networking.

On the flip side of that, for my staff, my cost for staff education and CEUs this past year has been amazingly low. No travel. No hotels. And then most of the conferences in order to help ensure good attendance had really reasonable rates this year. So people are able to get their CEUs very readily. And that's been a positive. So it would be my hope that going forward there's a major awareness and emphasis on at least some element of virtual conference availability. Even if what that means again is some sort of hybrid model that perhaps there's only elements of a big conference that are available virtually. But that would be a real plus.

Wisconsin, as a state for those that are familiar with it, if you live up in the north and a lot of the educational pieces are done south of Highway 10, it can be quite an undertaking. And loss of several o these available services when you travel for a conference. So that's been huge.

Another piece that's happened for agencies is a lot of staff churning. It's been kind of interesting as I probably have been able to hire more people in this past year. I've had more applicants than we've had for several years. Plus I know at the state level many people have made changes in their careers. Coming to the state. Leaving the state. Those kinds of things. And I think what that may be about is just as people have looked at many elements of their life under the pandemic-- pandemics are one of those things that do that to you-- I know people have rediscovered meals with the family.

Prior to the pandemic, there were people that were so scheduled they were lucky, if a family of four, if there were two of them at the table at any given time. Well, under lockdown for many months that really changed. So I don't know if that's what it is or not. But I can tell you large amounts of staff churning. I do believe with people finding what they're looking for that does bring them joy. Whatever that may be. But it does have an impact for agencies.

So the opportunity. First of all, take a deep breath. You are indeed going through a once in a lifetime or more experience. Remember the last big pandemic in this country was back right after World War I with what was referred to as the Spanish flu at that time. Yes, polio came through and that had impact. But that tended to be more pockets at any given time. It was the Spanish flu that went through and killed people across the world.

So again, over a century ago, this is once in more than a lifetime. But then remember you are here. You have made it through this to this point. So you have survival skills. And whether it was just luck that you weren't exposed or whatever it was, you are here.

So it's important to look up from the day to day and actually do a critical assessment of what and how things are working. Part of the issue is we cannot recognize opportunity unless we're open to it. So you can't just keep doing what you're doing every day. You have to take that time out to look at what you're doing. And what's the impact of your doing.

When we just keep our heads down, we miss so much. I don't know if anybody's seen the ad for some new sort of stimulant medication that's to help with the daytime sleepiness for people that have issues with nighttime obstructive apnea. And they show the flying pig, and the guy never sees it. Well, this is sort of like that. You're never going to see the flying pig if you don't look up.

When we talk about opportunities, it's how we look at things as well. My favorite example is dandelions. There are people who view them as absolute noxious weeds. And there's others, and I put myself in that second group, dandelions can be lunch if you know how to pick the young greens. Absolute joy if you just love looking at the yellows.

Or if you've ever had a small grandchild, there's nothing more fun than dandelions. And then huge pollinators support because they're among the first blooming to support pollinators. So what is it? Noxious weed or all these other things? Well, a lot of it's your point of view, and how you choose to look at things. So that's the opportunity piece.

Moving forward, how would you do that if you decided to raise your head? Well, you want to get feedback from patients and staff. And when you're doing that, you don't want to say, well, what do you think about this? Ain't it terrible? You want to think about what your questions are. You want to look at what is working and what would be even better if. That's how you get to the things are not working as well. As you remember, attitude determines a lot about how we look at things.

Then determine what can continue regardless of regulatory changes. I would love if CMS would not require service to Medicare patients to be incidental to an MD or DO with the patient so I wouldn't have to have that sign off. Well, I can continue to advocate for that. But that is not my control.

Things I can actually control? I can control how we do our intake process. I can control as an agency how often do we have people come in for UDTs. What's the driver for that? I can control lots of things. So really looking at what can you control. And then be prepared to respond to reimbursement and other changes that can support your service.

If you are prepared to do that, you're in a spot where you can actually make a difference with it. You have to be paid in order to continue something. So stay on top of those things as an agency, or have people that are dedicated to it. Or be involved with the support agencies in your state. That's how you know about these things.

Make conscious decisions. So much of the past year has been reactions to rapidly changing situations beyond our control. Much of it has been. But not all of it. Do look at your data. It's important that you do have data for this time as far as what's happening. What's your level of engagement? How many people are you keeping past post initiation? When are you losing people? Know those things.

Plan for your practice post-COVID. This too will end. Along with the emergency regulatory and some other things. So what do you want it to look like? Be prepared for something that looks very different than the past decades. What about all those forms? I know of an agency that has a 10 page written intake form that the client has to do before they can start services. I'd really suggest looking at that.

Then practice the skills of resilience. I think you're all familiar with this. But this was just kind of a nice collection of them. King has this in a blog. "Seven Skills Resilience: Psychology Today." It's from March 2020. The timing was good. You've got the full reference. But basically, cultivating a belief in your ability to cope. Staying connected with sources of support. Whatever that may be. Talk about what you're going through. Be helpful to others. Activate positive emotion. Cultivate an attitude of survivorship. And then seek meaning.

Again, this is what we talk to our patients about. This is what we help them develop skills with. It's important that we do it as well. So in closing, while chaos is challenging, opportunity does bring loss and giving up the familiar. Again, opportunity is never easy. If it was, everybody would do it.

Growth opportunities can sometimes be the most difficult times in our lives. But we do have the opportunity to go forward with changes that can make a positive difference for the people we serve. And how we provide that service. The question is, will we? Or are you going to want to just go back to what you were doing pre-COVID?

Do remember life continued after the dinosaurs. It's really bad for the dinosaurs. But life did continue after. So life goes on. And with that, that's my contact information. Are there any questions?

ANN: There are. Thank you. This was, again, an incredible presentation. We always look to you for great information and inspiration. So the first question is, can you talk about the finances of disruption? Do you think this will bring us closer in the long term to patient centered care where a location of service is considered? Or will we go back to being guided by finances?

SHEILA WEIX: I think it's important that we really advocate for it going to where the patient is located, and not just driven by finances. I know I had been asked to put together with another colleague a bit of information about that that was going forward to a policymaker.

I think take every opportunity you can to identify how this makes a difference. Whether it's your data for your feedback, or it's out of studies. There's a number of studies out there you can pull information from. But make sure that the policymakers who could make those decisions, both within your agency and at the state level, have the information they need to support this.

One of the things that I've identified as a goal, if we could make treatment as available as drug dealers make drugs, including via the internet, I think we'd do better. And so if we revert back to putting all these restrictions on people getting to treatment, it's never going to look a lot better than it does. So to your question, we really need to focus on having it be patient centered. And make sure that every policymaker that possibly can nobody knows that information.

ANN: Thank you. Someone asked if you could discuss the preparation of staff for telehealth. We know many providers move to telehealth without any

training and experience. And could you talk about how you were able to train your staff, and have them build rapport with their patients.
SHEILA WEIX: Yes, I can briefly. I have to tell you we did it in one day. So what it was is everybody kind of got thrown in. But it was kind of handiest because it's just on the phone, everybody has used the phone. So after that, what we did is we supported the staff in doing so. Let them know that you can do this. But we're going to provide training as needed.
So then we sought out some seminars. There were some really good things-- and webinars. There were some really good things for instance in our Wisconsin State Conference this year that really talked about empathy and using telehealth. If you go out and search on the internet, a number of the various organizations have telemedicine and telehealth how to do it. And I'm going to ask, does ATTC have anything like that that would be available to folks?
ANN: We do. And I actually put it in the chat. So I'll be sure to share that again when we send the follow up resources. I'm sorry, when we post the follow up resources.
SHEILA WEIX: Excellent. Because using those sorts of resources, that's been very good. Or the other thing that we did is we had somebody that just was really good at it. And we had that person serve as a mentor to some folks that were struggling. So again, combination of online resources, local mentoring, and then training wherever we could get it. And we used pretty much free training because that fit with my budget. But we were able to find resources like that.
ANN: Great. Another question is, some agencies are not requesting CADC in outpatient treatment. Did you change the curriculum? Or did they change the curriculum?
SHEILA WEIX: CADC. Got to tell me what you're talking about.
ANN: I will be completely honest. I do not know.
SHEILA WEIX: Yeah.
[INTERPOSING VOICES]
SHEILA WEIX: If that one could be clarified in writing, I can loop back. Yep.
ANN: Someone asked if you could give your thoughts on managing clinical supervision, telehealth, or telephonic.
SHEILA WEIX: Well, we have done both. In fact, right now, we have an internship that is for an LPC and training. Licensed professional counselor in training. That is being done all by tele. Either telehealth or telephone. We prefer the telehealth for that wherever possible. And because the clinic to clinic telehealth is very easy with excellent connections, we do as much of our clinical supervision telehealth as we can if we cannot do in-person. Those interactions and truly being able to see one another we just find to be very important.
And then, wherever possible, we do with letting the patient know, we do the conference calls for the clinical supervision of delivery of care for people that are at that level to do the counseling via phone and things. So we have several different ways that we do it. But I still prefer when we get around to it that there will be some sort of frequency of in-person as well. Again, I believe it's very important.

ANN: Great. I just want to be respectful of everyone's time. It is 1:01. We do have a couple of questions. And CADC is certified alcohol and drug counselor in the state of Michigan.
SHEILA WEIX: That's what I was wondering-- if it was a credential. And so what was the question again?
ANN: Is that some agencies are not requesting that credentialing in outpatient treatment. Did they currently change the curriculum?
SHEILA WEIX: I would not know from Michigan. I can tell you in Wisconsin what I have stayed with is whatever the credential would be to deliver the service in person is the same credential we use to do it via tele.
ANN: Great. Thank you. And then the last question. Bri had a question about different platforms for technology. And I think we're going to provide a lot of that information in the information that we post.
SHEILA WEIX: Please do. Yes.
ANN: Yes. So again, thank you so much for your time, and your expertise, and your incredibly good information. I would like to thank also everyone who logged on. And again, this will be posted on our websites. It'll take us about a week. We'll send you a brief questionnaire this afternoon. And otherwise, thank you all. And stay warm.
SHEILA WEIX: Indeed. Thank you. Bye.
ANN: Thank you. Bye. Bye.