Transcript:

Substance Use Disorder Treatment in Days of a Pandemic: You Need A Bigger Boat

Presenter: Sheila Weix, MSN, CARN
Recorded on March 20, 2020

PRESENTER: Hello, everyone. And welcome to our webinar "Substance Use Disorder Treatment Services in Days of a Pandemic: You Need a Bigger Boat." This webinar is brought to you by the Great Lakes ATTC, the Great Lakes PTTC, the Great Lakes MHTTC and SAMHSA. The Great Lakes ATTC, MHTTC and PTTC are funded through SAMHSA.

We have a cooperative agreement with SAMHSA. This presentation was prepared for the Great Lakes ATTC, MHTTC and PTTC with funding from SAMHSA. The opinions expressed within this webinar are the views of the speaker and do not reflect the official position of DHHS or SAMHSA. Our funding statement is we are funded through these cooperative agreements.

A few housekeeping, this is a recorded webinar. So it will be available through your computer speakers. Unfortunately, there will not be a live chat. There are no CEUs or attendance certificates. And as I said, this webinar is recorded and will be available on the Great Lakes ATTC web site and our YouTube channel as soon as possible. Please follow us on social media.

And our presenter today is Sheila Weix. Sheila is a tenured professor in the field of substance use disorder treatment. She 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 has been an opportunity to learn a great deal, experience some major challenges and participate in the innovative problem solving.

This presentation is based on that background, what we know and what we can do about the current situation. Thank you so much, Sheila, for joining us today! We appreciate it. And we will start with your slides.

SHEILA WEIX: OK, very good. I wasn't sure if there was something more in there. And just to clarify, I realize you all are from academia. So when it says tenured, you think right away, professor, I am not a tenured professor. I'm a tenured professional.

So I'm just entering in 2020. This is my fifth decade of practice. So I've been around for a long time. As noted, during that time, there has been an

opportunity for a lot of learning. So today, I'm going to talk to you about "Substance Use Disorders in the Days of a Pandemic: You Need a Bigger Boat."

For those of you that have seen the movie "Jaws," you know that was the response when it became apparent that what they were doing did not nearly meet the needs of their current situation. It was a bigger deal than they'd ever dealt with before.

I would offer that our current situation has some of the same things in common. We definitely need a bigger boat. You'll also appreciate that the reason this is recorded is because we had some technical difficulties, essentially related to a lot of overload on things.

That's the reality of our current days. And it's something you're going to encounter as you attempt to do telehealth services. So this is a very good learning experience. And as always, we'll go from here as we need to.

So the objective, as promised, we're going to look at safety precautions. That's essentially looking at what do you have to do for both your staff and for patients around COVID-19. How do to move all services to telehealth? And we'll talk about what that actually means. Reimbursement contingencies and then leadership actions underway to address this rapidly changing situation.

A few ways that we're talking about leadership, we're talking about the decisions you make in the moment, today, as well as all the way up to our federal administration, all of the departments that works with up to and including international decisions, World Health Organization, this sort of thing. This is a pandemic. We are truly in this together, folks. And what I do has an impact for you and vice versa.

So where to start? For everyone, take a deep breath and stop to think. It is very, very easy in these exceedingly rapid 24-hour news cycle with decisions being made and things being undertaken at every moment of the night and day. It's very possible just to move into a reactive mode where we're not thinking about what we're doing and why we're doing it. Those are important elements in helping determine what we're going to do and what makes sense to do.

We do have limited resources, time, energy, people, technology, broadband, whatever you want to talk about. So we really have to be thoughtful about what we're doing-- not that we don't need to react quickly. We do. But we need to do it in a thoughtful manner.

And remember that whatever you are feeling is magnified for many clients and staff. This is the sort of situation that whatever you have for anxiety will feed on it. It will make it grow. And while we need to feel the feelings, we also need

to stop and think about what we're feeling. If there was ever a time for cognitive behavioral work, this is it.

Please step back, look at what you're feeling, making sure that you're not just panicking. We don't make good decisions when we panic. It is really only good for the moment if you need to get away from a fire or something like that. It is not good as an ongoing way to manage.

So we're going to figure out where we're at. Because unless you know where you are, you can't figure out where you're going to go. So let's talk about pre-pandemic, you remember, way back in February when this was just kind of something happening in other countries far away.

We were doing services, primarily face-to-face. Some of us had a bit of telehealth. But that was really what we did in substance use disorders.

We had really strong service boundaries. 42 CFR part two encourages that. But we sometimes have much stronger boundaries around confidentiality and things than other service areas do. And while we collaborate on things, we've maintained those boundaries.

Then there were strict limits and regulations around telehealth. At that point, absolutely, I had to have all clients that we were serving had to be in one of my clinics. And we could serve them was a provider being at one of our registered sites. But that was it. That was how limited it was.

Plus there were very clear requirements for HIPAA compliance and high tech compliance in order for a particular application to be used. At that point too, there were variations in how things were being paid for-- so again, lots of regulations, lots of limits.

And then the staff skillset that we were hiring. When you think about substance use disorder work, we were really hiring people that could connect with patients, were very good at working face to face. Beyond the technology, they needed to be able to document if you had an EHR, an Electronic Health Record.

We weren't looking for a lot of technology. We were really looking for that connectedness, that ability to empathize.

And then COVID-19 showed up. So we went from where we were in February to a complete turnaround.

In our own clinics, we do a medication assisted treatment. And part of what we did was, in order to get your next dispensing of medications, you had to show up at the clinic for your appointments, for your counseling, for your medical, for your group. If you didn't, you didn't get your medication.

Imagine the shock on the part of both the providers and the patients when we said, ope, this all stops. Now they all need to stay home. And we're going to call them. And we're not going to call them in for random urines at this point. We're going to call them, make contact, see how they're doing with their recovery, and continue to dispense their medication.

Likewise, with partners-- our partners tend to be, oh, we worked with some with probation and parole and corrections and social services. But our new partners, in a big way, are now public health-- other health care providers and whoever is in that system that is going to touch the people we serve. So that's changed dramatically.

At the same time, we have to think in terms of how do our actions impact partners. That's very different.

I'm not going to order N95 masks, even if I can find them. Because that means they'd be pulled away from somebody else in health care that's on the frontline caring for people with COVID-19. That's not what we're doing. So everything affects everything else.

And then in terms of the telehealth, nearly all the limits have been removed. It has been changed to basically use any application you can find. Resume as mentioned. There is FaceTime, various Google applications, Skype, Adobe. Anything you can find that works, you can essentially use it.

We'll talk about what the challenges are with that. And we've encountered some today.

And at the same time, we've taken the staff that we have hired because of their ability to connect with people, and they didn't have to have a lot of technology. We're now seeing a need to navigate technology with limited support. Because the support's being pretty much utilized by those frontline folks.

So the world has changed in a matter of days. And much of its a 180-degree change. So this is huge.

So let's go back to the safety precautions we're going to talk about. That direction of everybody should stay home, that's pretty accurate for a lot of things.

I did have somebody mention the other day, they just didn't get what that was about. Why are we doing that?

And so just by way of explanation-- I don't have a slide reflecting it. But if you've seen slides from CDC, which has a big peak in red that goes above the line, that line is the capacity of health care versus the much longer, slower

bump that stays below line. That's what we're trying to accomplish with everybody staying home.

If we don't-- we know there's community transmission already. There were two deaths in our state that were identified today, here in Wisconsin. And we know there's community transfer going on. So coming from a particular location doesn't cut it anymore. It's already in the communities.

What we're trying to do by keeping people home is to have that long, slow rise, where, yep, people are going to get it. But it won't overwhelm health care. If we don't, there's concern it'll raise those huge levels. And you'll see what you're seeing in Italy and some other environments.

We know that we need to be prepared to change direction now if needed. What you're directed to in the morning may change by afternoon.

We may reach a point where we need to have everyone stay home. Be prepared for that. There are some orders in New York and other areas where that's exactly what it is. So you do have to determine what your service will do and be ready to change it.

For staff, you can have self-screen before coming in. Now, this temp of greater than 100.4 Fahrenheit, that had been the standard. I just saw something today. But they were talking about health care workers in acute care, they were going with a temp above 100.

The most current information I have-- and go back to the CDC for this-- is 100.4 or if you're having cough or shortness of breath. I can tell you what I said to my staff, if you're sick, don't come in.

If patients are going to be seen, prescreen them on the phone. So maybe a couple of days ago, when you gave them the reminder call you prescreened. They were OK then.

But on arrival, again, we're checking temp. We're looking for that cough or shortness of breath. Any kind of concerns, you send them home.

Now, when you send them home, we're sending them with information about what to do, contact their health care provider, how to care for themselves at home. So it isn't just close the door on them. It's also doing that.

Again, if we go to where everyone needs to stay home, we will not be doing even that level of contact. Everything will be via tele of some sort.

That brings us to partners versus strict service boundaries. So one thought would be-- and that would be consistent with our previous district boundaries-- well, why not just shut down the service and everybody stays home? As I

mentioned, our decisions now have greater impact than under normal conditions.

You know, it was always tough, particularly in rural areas, if a single agency closed. Now, if an agency closes, there's a good chance there's no place else for them to go as far as regular services.

So if we can maintain some level of services, we can help our clients and assist in not using other resources, emergency departments utilization or urgent cares. We don't want them going there unless they truly need that because of medical.

What this all falls under is ethics in public health emergencies. I mean, you're looking at ethics in relation to public health emergencies. You basically have three Rs.

Rationing, that speaks to the supplies. You've all heard about the challenges with the personal protective equipment. So you're talking about the masks, the eye protection, the gloves, all of it. It's important that those supplies get to where they're absolutely needed.

And just because you have a supply today at a given environment, you don't know what you'll have tomorrow. So it really has to be thought through. And I can tell you that people who are using those things are washing them, reusing them, things that are unheard of in non-pandemic times.

Then there's restrictions. Restrictions refers to restrictions on personal liberties. That's where quarantine comes in. Sheltering in place, those kinds of things.

We are under a number of those are ready. Schools have been closed. The bars and restaurants have been closed. You can't have more than 10 people at a gathering. So we already have restrictions in place.

But then the third R is responsibilities. And that's our duty to treat. As health care providers, we have a duty to treat to the degree that we can. So no one would expect one of us who has not done this in years to go and be frontline with COVID-19.

But I can tell you, as a RN, there may come a point where I'm asked to do something that I'm qualified to within my scope that I've not done in years. So for the vast majority of people, we're talking about substance use disorder. Our responsibility is to provide what we can within the environment for the people that we serve.

So moving to telehealth is one of the big pushes. And this is the National Consortium of Telehealth Resource Centers COVID-19 Telehealth Toolkit.

There was a webinar earlier this week. There's a tremendous amount of information in here both for medical and for mental health. There's a number of vendors. There is all kinds of linkage to what the requirements are.

It's all in there. I really encourage people to look.

OK, on this slide, we've got the connection, the URL, for the National Consortium of Telehealth Resource Center COVID-19 Telehealth Toolkit. One of the reasons I didn't pull a lot of information out of this and put it on the slide, all of this is changing so rapidly that what was put out this week, that while this is an excellent tool kit, there may be changes to legislation, reimbursement, other things by next week. So that's why, a little bit later, we'll touch on some connections that you want to maintain, because it is absolutely in a state of constant change.

So Telehealth let's assess your reality. Again, today, we've had multiple changes with the technology. That is the reality of what this looks like.

So while we no longer need a HIPAA or high-tech platform, it's pretty much wide open. You can use Skype, FaceTime, et cetera. You certainly can. But the support for it in terms of the amount of bandwidth, the capability of the system taking on this huge push. Because remember, everybody is trying to do this right now, whether you're talking business meetings or medical providers or whomever.

And the systems at this point are not ready for this huge spike, this surge. So what I would say about this is that this is one of those gaps that you're for sure going to want to identify. it would be my fond hope that in the days post-pandemic, and that will come, that really looking at what do we actually need for systems in situations like this in terms of, for instance, internet connectivity and other things, that we will keep that on the forefront and not just move on.

So with the telehealth and assessing your reality-- there are multiple vendors available. Again, that toolkit lists some. But you also can go to those things that you've always used.

Because remember, when you're thinking about that, you want something that's very user friendly from the client point of view. If they have to go through multiple hoops, that's not going to work.

They're used to FaceTime. If you have the capability of that, consider it.

But then also, remember, there's a number of environmental challenges, even beyond what I outlined. For instance, this is where we do our rural service. And if you look at that, that's north Wisconsin, northern Wisconsin, north central.

And those pictures of the roads, that's actually what they look like today. The little map over to your right where the black lines are, that's where there's four-lane. The rest of this is all two-lane. So it's not really close to any large city.

On the one between-- the line between Marshall to Minocqua, if you go just slightly east, actually, you're in Wausau. Wausau has 5G. And that's a wonderful thing. But that's not where our patients live.

So when you think about that, we have all the challenges you might expect. In that rural environment, there's low levels of connectivity. There are big sections you can't even do a phone call. You're lucky if you can text.

So for our folks, staying home often means only having access to home internet and devices. One of the families we had contact with earlier this week, there's one phone between the five family members. So they even have to schedule time for the phone.

We do find there's a high number of smartphones. Almost all of our people have them except for a few people that get what they refer to as Obama phones or phones through a program. They do not have smartphones. So you're looking at flip phones.

As I mentioned, there's fewer other devices. They don't have a lot of PCs or iPads at home. In part are tablets. In part, because there's no Wi-Fi to do it with. So that's a huge issue.

At the same time, while we had a lot of telehealth up there-- as I noted before, with the regulatory requirements-- telehealth was set up for clinic to clinic. It was not set up to reach into homes.

And finally, we're part-- our particular program is part of a large entity. For some, decisions are more involved. And going back to our partners, main resources need to go to that acute care. And that's where they're going, appropriately so in a pandemic.

So basic needs, how are we doing it? Our home needs today are being met with telephone. We've gone with 20th century. And it's working for us pretty well.

So what do our patients need? Always remember that whatever you're doing, when you're thinking this through, focus on what your patients' needs are. Do the best you can in meeting those. And you'll never go too far wrong.

If you're going to start with, what can I get paid for, you might not get too far. So start out again with what do your patients need. And look to meet that need.

So they need contact. They're feeling exceedingly isolated. We started doing this on Tuesday with the telephone instead of the in-person. So gosh, we have a full four days of this.

What I can tell you is that many of the calls aren't so much about their usual treatment. They are more about their fears, their anxiety. What about food? I mean, various things.

So our people that are making the contacts, of course, our therapists are and medical people are. But we have other team members making contacts and follow-ups.

So what are the resources in your area for people who have food insecurity? What about unemployment? That has changed too. There's not the waiting time that there was.

Work requirements-- or the need to search for work during the period of unemployment, that's been removed. There is all of these moving parts. So whatever people need, we need to determine that and try and get that to them.

Ultimate care delivery-- I can tell you they are exceedingly thankful for moving to phones. Because they had a fear of going out and being exposed.

At the same time, that fear is where we bring in the information from CDC. How do you protect yourself, hand-washing, that sort of thing. What if someone gets sick in your home? There's directions for how to care for somebody there. And then there's also information about how do you recognize it's time to go to the emergency room.

I mentioned other resources already. Oh, also keep in mind, take a look at what's in your communities. There are communities where people have gotten together. And they're doing things like shopping for people who are at too high risk to go out, or picking up medications for them, whatever is needed. Those things are available. People need to access them.

Another major thing we're doing these phone calls to support in dealing with the anxiety and fear of the situation. Some of it's about the facts. But some of it's about grounding exercises and reassurance.

One of cool things that one of our folks had mentioned the other day is knowing that he could count on that call to come through at 9:00. That made things better.

So we're having a really positive response to plain old-fashioned telephone calls. You know, it's not always complicated. It's more about making the contact.

What does our staff need? Well, surprise. If you look at this, it's the same list as what our patients need. That's a really important part.

First of all, we all know that, as a staff, we can't give what we don't have. But the thing we sometimes miss in something where there's an emergency like this, is there is an assumption, well, we'll all just keep doing this. And it's like, no, we can't.

So we have to support one another. We have to make sure that people are getting what they need.

Many of our people have partners who, for instance, are not able to work now. So what about that unemployment sign-up?

We also know that the anxiety can lead to responses that are not helpful. So really making a point to do grounding exercises, reassurance, thanking people, really upping your communication.

I can tell you, this is a time to over-communicate. Because people are not necessarily taking all of the information in.

At times, you actually have to be really direct to get people out of their panic state and back to their logical thinking state. So be sure you care for your staff, because it'll make a difference in what you can care for with your patient, your client.

So then that gets us to panic. Remember, panic spreads far more easily than calm. Panic is that fight, flight, or freeze down the amygdala. It's what keeps you alive in the face of a real, actual emergency, but not one that lasts for days.

So logical thinking and planning is blocked because it's for immediate response. It's not for maintaining.

Of course, people rapidly spread the fear to the rest of the herd. So I had a couple of times this week where somebody got a piece of information. It was not entirely accurate.

And the response was to send out an all-staff email. And then there was immediate responses back. We have put a complete stop to that.

The responses create problems. You all are aware of the toilet paper issue. There's no less toilet paper being made than there was before. It's just that people started buying it up way beyond the usual supplies. And it creates its own issue.

So calm, calm requires frequent maintenance and feedback. It's actually more difficult to maintain the calm than it is to prevent the panic, because you really have to do frequent maintenance and feedback when you haven't had an alarm to do it. Panic, you get an alarm, trust me, sometimes multiple ones.

So really, what you want to do is hardwire whatever is possible. Anything that doesn't have to change, those touch points are important. People need to be able to count on that. Allow for multiple changes.

So again, that flexibility, as in, why are we doing this now as a taped presentation? Because that's what we could do. It's OK.

But do maintain anything that you can. For example, would be we moved parking. But we moved it in a positive way because we didn't have patients coming in. So we put people up closer to the building, so we use one entrance, so we can check staff as they came in.

They liked it. And for the time being, they can count on that. So anything they can count on is important for that sense of security.

Reimbursement contingencies, this is a lot tougher. But I'm going to give you what we think is our best plan.

It's important to track the hours that are being spent coping with this, planning for this. When you're having staff meetings, track that.

Put together plans with dates. Because you might have a plan today for something that just came out. It may change by Tuesday. Update and do your next date on it.

You want to have this. And we'll talk about why. But you need to document those.

When it comes to doing that telecare, whatever it's going to be, telephone or telehealth, but particularly, if you're doing telephone, which is not usually a reimbursable, your notes need to reflect the care. And we'll talk about what the elements are.

But just because it's just telephone, don't change your documentation. Be clear how the care was delivered and that it was explained to the client but then really cover what you're doing. If there's going to be reimbursement, that's going to support you.

Also around reimbursement, do monitor updates from the government, from payers, wherever it comes from. Because there may be opportunities that we just have no idea, because it would never have happened before. It may happen now. And then do be aware of client and staff concerns.

When this many things are changing, sometimes we miss things. So if there starts to be, patients don't like whatever or we're getting feedback or a staff member says, what about this, pay attention to it. You want to address things sooner rather than later.

So around the documentation, there are no promises. But your documentation may be very helpful in post-pandemic recovery, particularly around financial needs.

Again, we don't know what will happen. But FEMA is involved. For some people, depending on how you're organized, there may be small business administration stuff. I don't know.

But if you've got your documentation, you're in a much better spot to potentially access to make a claim than if you have nothing.

And with your treatment notes, again, if it's going to be reimbursable, you need to know the methods, the disclaimer, if you're using Zoom or something. As long as you're not using those HIPAA or high-tech compliant platforms, you do have to have a disclaimer that you cannot guarantee the security of the interaction. Patient needs to be informed of that.

And then you have to cover the care that's delivered and do you usual notes as far as progress towards goals or other needs identified, whatever it is. But make sure you're doing a regular, thorough note.

Moving to the status and not doing it in the usual way does not take away our need to document. And then respond quickly to concerns and change if needed. Anything could change at any point now.

Leadership actions, this part's really important. Connect with solid resources--CDC always, of course. But your State Department of Health Services, DHS here in Wisconsin, has been amazing with what they're putting out, exceedingly helpful.

And then, of course, there's also the emergency management group. Much of that's all connected though. If you get connected with one part of it, you can access all of it.

Your local public health department. They are the folks that know what's going on right now where you are. And again, they're connected in.

I already showed you that the tool kit around the telehealth thing. There's any number of resources like that.

At the same time, utilize social media time. Social media is not your best place to be. Social media is built in many ways to induce panic, not to induce calm.

Do check the news feeds. I can tell you it's been just about every day this week at 11 o'clock, there is a-- the president has a press conference. And a lot of new stuff comes out of there. Economic recovery bill is currently in Congress. That's what came out today with bipartisan support. So there's a lot moving very, very quickly.

Do stay connected with staff. Again, even if you're just touching base with them via technology, it's important to do.

As a leader, do self-care. You're not only modeling it, but you need to be in condition to do what you need to do. So do do that self-care.

As you're going through and making plans and things, involve staff in decisions and updates wherever possible. There's a sense of agency, a sense of empowerment, if it's not just everything being done to them.

So if you can put together teams to do some of this, please do so. Prepare for rapid change. We've said that.

But also track gaps, as noted. If you're trying to use a particular application, it should work in normal conditions. But you really are not able to make it work, because there's not enough connectivity, or there's not enough internet broadband, whatever it is. We need to track that, so that after the pandemic, post-pandemic time, these things can be identified.

Because some of these have been called for for years. There just wasn't a need to do them. Now there is.

Do encourage self-care for staff. And then celebrate the wins.

I have just a brief story. But I think it indicates why this is important. We had, in one of our very rural areas, a patient that we had reached out to via phone for a group on Monday. And we aren't doing group by phone. We're just connecting with all of the group members.

A person didn't answer the phone. So we continued with attempting to reach the next day. On the third day, the person answered the phone but was disoriented sounding-- was either under the influence or something.

The therapist who spoke with the person brought it to the attention of the team, that they were concerned, and knows the individual and said, that not right.

So we made the decision for law enforcement to do a welfare check, which they did. Law enforcement knew the person. They said, oh, this is not right, and involved emergency medical services.

The person went by ambulance to the local ED, from the local ED to a tertiary level care, and later that afternoon was in neurosurgery. The person had developed a brain bleed and was having symptoms because there had been enough brain bleeding to have a midline shift in the brain.

Had we not done the phone calls and followed through with it, the person probably would not have survived to the following day at home. Because the person lived alone, isolated. And now under the pandemic, there was not anyone who was going to be going there.

So it doesn't always seem like, oh, doing a phone call is going to make a big difference. It can.

So be sure that you celebrate the wins. Be sure you thank people for what they are doing and recognizing that what you do makes a difference, even if it's a difference for one person. That's a huge difference.

So with that, if there are any questions. I will say if questions are sent in to the folks at Great Lakes ATTC, I will gladly answer anything that I am able to. Thank you.

PRESENTER: Thank you, Sheila, so very much. You are a shining example of both flexibility and compassion. And we really, really appreciate your time.

We will let people know if they have questions. We will ask for your expertise. And again, we truly, truly appreciate your time and your flexibility. Thank you.

SHEILA WEIX: Well, you are welcome. And by the way, I appreciate how challenging it is for all of you. I have seen things happening, OK.

So I appreciate your innovation and your willingness to keep going. It's all good, all right? Thank you so much.

PRESENTER: Thank you, Sheila.

SHEILA WEIX: All right, bye now.

PRESENTER: Bye.

SHEILA WEIX: Bye-bye.