Transcript:

Chicago Street Outreach and Linkage to OUD Care During a Pandemic

Presenters: Dr. Elizabeth Salisbury-Afshar, Stephan Koruba, Sarah Messmer, and Nicole Gastala
Recorded on May 18th, 2020

ANN: Hello, everyone. And welcome to our webinar today-- Chicago Street Outreach and Linkage to OUD Care During a Pandemic. Our speakers today are Dr. Elizabeth Salisbury-Afshar, Stephan Koruba, Sarah Messmer, and Nicole Gastala. Our webinar today 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 all funded through SAMHSA.

This presentation today was prepared for the Great Lakes ATTC, MHTTC, and PTTC under a cooperative agreement with SAMHSA, and the opinions expressed in this webinar today are those of the speaker and do not necessarily reflect the position of DHHS or SAMHSA. Our work is funded under these cooperative agreements.

And just a few housekeeping details today. Our webinar will be recorded and will be available on the Great Lakes ATTC website and the Great Lakes current YouTube channel. There will be no CEUs or attendance of certificates for this webinar. And please use the Q&A section for all questions. And as always, please follow us on our social media.

A little bit about our presenters today-- our first presenter is Dr. Elizabeth Salisbury-Afshar. She is the director of the Center for Addiction Research and Effective Solutions, or CARES, at the American Institute for Research, a nonprofit social and behavioral sciences research organization.

Elizabeth is board-certified in family medicine, preventive medicine, public health, and addiction medicine, and her expertise lies in the intersection of these fields. She practices at the Heartland Alliance Health, a health care for the homeless provider in Chicago, and provides primary care and addiction treatment services. We're going to turn the presentation over to Elizabeth.

ELIZABETH SALISBURY-AFSHAR: Good morning. Thanks so much, everyone, for being here. I realize these are really challenging times when people have a lot going on and a lot of stressors in their lives. So we really appreciate you all being here with us this morning.

I am doing sort of the most boring part of the presentation, which is just giving some sort of background and brief updates on some of the regulatory changes around buprenorphine prescribing during this national emergency. And then I'll be handing it over to my colleagues, who are going to talk about Street Outreach and, really, I would say, innovative models for delivering buprenorphine treatment during the national emergency. Next slide, please.

So just a few disclaimers-- nothing that we are presenting today are we meaning to serve as legal advice. We will be describing some of the regulatory updates, and I'll be including the links in the slide set that you all have access to. We would just recommend that if you're going to be making any changes with regard to telehealth, and particularly as it relates to billing, that you talk with your employer.

This has been sort of an evolving process, and there may be differences in different states. All of us are located in Illinois. But it would be important for you to look at sort of if there are any differences in your own state. And our final recommendation is just that this has been changing pretty rapidly.

A lot of the updates that I'm describing today, so far at least, are really limited to the duration of the national emergency. And it is possible that once the national emergency declaration is no longer in place, that some of these changes will be reverted back to what they were pre-COVID. So the main recommendation here is just kind of keep-- stay updated, and keep following as changes come out from the federal and state governments. Next slide, please.

So I always like to just by-- just start by taking a couple of steps back. And so I think when we think broadly about risks for people who use drugs in the setting of COVID-19, we know that the patients that we serve are often at increased risk. And there are a few reasons, and I've just listed a few. I'm sure there are many, many more.

So one is that we know that many of our patients live in sort of congregate settings. So this could be homeless shelters. It might be single-room occupancy. They're more likely to experience incarceration. They may be living in a residential treatment program-- all of these settings being places where they have a lot of exposure to other individuals. And so we know that their risk for exposure may be higher. We also know that many of our patients have many comorbidities that could put them at risk for having more severe disease if they were to be infected, so things like COPD, cirrhosis, or HIV.

And finally, there may be instances where people who would normally be using drugs with other individuals, other peers in their network, are going to be more likely to be using alone because of social distancing guidelines. And so this could put them at risk for an overdose, or an overdose death, in

particular. Because no one else would be there with them in the case that they did experience an overdose.

Additionally, if people are exposed and need to be quarantined or in isolation, it puts those individuals at additional risk. So they are at higher risk for experiencing what could be a really dangerous withdrawal. They could be more likely to reuse drug consumption supplies, because perhaps they can't get out to get to their local syringe service program.

They might be in a position where they have to obtain drugs from new sources because they can't access their normal source to be able to purchase drugs. And again, they may be more likely to use alone, again, in particularly in cases of quarantine or isolation, because they might not have the option to use with peers, which can put them at risk for overdose deaths since no one would be there to respond.

And I want to apologize. I'm sorry. I don't know why the text is so small. This wasn't the way it looked on Friday. So again, you all can get access to the PDF, and hopefully blow it up so it's easier to read.

So in terms of regulatory updates, again, I mentioned earlier, these have been changing really rapidly. So I would just encourage-- or remind people that so far, these updates are really only for the duration of the public health emergency.

So one of the first changes that came out is that buprenorphine could be initiated or maintained using telehealth. And so the initial guidance was that it had to be audio-visual. And so this is a change from sort of normal times, if you will, when an in-person exam was required for initiation of buprenorphine. During COVID, we can now initiate buprenorphine using telehealth.

Then guidance came out about a broadening of the platforms that were allowable to be able to use for telehealth. So these historically have not been viewed as HIPAA compliant. But during COVID only, there has been guidance that things like Apple, FaceTime, Facebook Messenger, video chat, Google Hangouts, Skype can be used for telehealth purposes.

Then we got subsequent guidance from SAMHSA and the DEA that as of March 31, telephone, meaning landline or cellular, would be acceptable for treatment initiation or maintenance of buprenorphine. And this is obviously really important, since we may have patients who don't have smartphones, who don't have data plans. Many of my patients usually access the internet at the library, and libraries are closed right now. So this makes it, hopefully, easier for us to be able to work with some really vulnerable patients.

And then this last bullet is specific to Illinois. But in Illinois, all health insurances are required to cover costs of telehealth. Again, sort of how that

coverage works is going to be heavily dependent on the payer and may differ by state. So again, I would recommend you all to work with your employers to figure out sort of what that looks like in your own setting. Next.

These are just the links to the exact guidance from the federal government. We wanted you to have those. Next. And this is just a reminder. This isn't actually a change, but just a reminder that when we prescribe buprenorphine, every provider has a limit. The limit could be 30, 100, or 275 patients at any given time.

And so for anyone who has a limit-- still has a limit of 30, a reminder that the Support Act of 2018 actually allowed that brand-new prescribers could go-- immediately start at 100 limit, as long as you met one of the two conditions. I'm not going to read them. Again, you have access to the slides. But if you are still at that 30 limit and you meet one of these two conditions, just a reminder that you can go and immediately apply for the 100 waiver.

Additionally, SAMHSA has reported that they're granting temporary increases to 275 patients if you are a provider in an emergency situation. And so if you think that you may need to request a temporary increase because of COVID, we would strongly encourage you to reach out to SAMHSA and ask for that emergency situation sort of allowance. Next.

So I'm going to stay at a very high level here. But I think as we think about service delivery during COVID, and I'm guessing for many of you on the phone, and it's been the same in my own clinic, the recommendations continue to evolve with regard to sort of what we should be doing, how we should be doing it. And especially, as in many of our states, we're starting to think about opening services back up a little bit. I think many of the principles still apply, though.

So our goal is really to try and reduce the spread by supporting physical distancing as much as we can. So this means we want to reduce in-person visits to a minimum. We want to minimize people having to come in for things like urine drug screens or counseling. In particular, we want to try and offer telehealth services as an alternative when it's appropriate. So that would mean using telehealth-- could be text, phone, or video to communicate with our patients.

As a reminder, this is a schedule 3 medication, so we don't want to have people come in strictly to pick up a prescription. We can call it in. Or if your state and your electronic prescribing allows it, to be able to e-prescribe. And again, that patients can be prescribed medications without a face-to-face visit.

So if you're working in a setting that typically offers in-person groups, guidance and recommendations right now are that we cancel all in-person groups and really work as much as we can to move to, again, sort of web-

based platforms. There are many options already available online-- AA, NA, Smart Recovery, et cetera.

So if patients normally find value in it-- in participating in those types of meetings, that we help them identify, or if your facility is able, to try and identify your own platform to continue meetings in a way that would allow people to really maintain that sense of community with their home meeting.

We also want to try and reduce the number of times that patients have to go to the pharmacy. So even when we're trying to provide our visits telehealth, if we're still sending people to the pharmacy multiple times a week or multiple times a month, each time they go out, those are additional exposures, so really thinking about what's the longest clinically appropriate prescription we can give. And also, trying to identify pharmacies that will do delivery to people's homes or residences when they have a home or a residence that's safe to have medications delivered to.

And even when we are extending the duration of the prescription, just a reminder that it is still really helpful for many patients to offer regular check-ins. This is a stressful time for everyone. So making sure that people have that contact with their clinical team is really important. Next.

And then if you do have patients who are being quarantined or isolated and basically not allowed to leave their setting wherever they're staying, really thinking about ensuring that they have a long enough prescription duration to last through that period. So often, at least two weeks, just to make sure they are able to stay in one place and not put others at risk, if they know that they've been exposed or have COVID.

For patients who are due for injections, obviously, this is much trickier. So it would often be appropriate to switch people to an oral medication just until they get through that quarantine or isolation period, and then bring them back in as soon as possible. Then it-- really, it would depend on the rules and guidance from your own clinic or facility as to whether or not you would want to bring someone in who had known exposure, or was known positive for COVID for an injection. Next slide, please.

So I think as many of our clinics are starting to open up, really, we want to be thinking about balancing, or at least opening up for additional services, or reopening for services, really, about balancing the risks and benefits of bringing a patient in for an inpatient visit. So one of the questions we're constantly asking ourselves is, is an in-person visit likely to change clinical management? Are we going to do something different based on seeing them in person?

For stable patients, the risk of in-person visits is likely to outweigh the benefit in many cases. So it may be appropriate to continue with just telehealth. On

the other hand, for patients who have been really unstable or maybe don't have reliable access to a phone, and so it may be challenging to actually find a-- find them at the time when they have a scheduled visit, they may benefit-- the benefit from in-person visits may outweigh risks. So really, this should be decided on a case-by-case basis, and on the ability of your clinic to sort of comply with recommendations around cleaning and screening.

So when you are offering in-person visits, it's important to make sure that you're following infection mitigation strategies. Again, I apologize that the formatting of the slides are a little bit messed up. But there is a great reference on the ASAM website, American Society of Addiction Medicine, about some sample screening protocols, as well as waiting room precautions. And we'll make sure that the PDF you get has the appropriate information for that link there. Next slide, please.

And then finally, if you are working with patients who you know are continuing to use drugs, this is a great reference from the Harm Reduction Coalition that outlined safer drug use during COVID. And so, again, I think it-- when we think about the contextual circumstances under which patients may be using drugs, really wanting to work with people to try and minimize sharing.

Because if people are all touching the same equipment, even-- that could put people at increased risk for COVID. Trying to minimize-- so really, having a more limited network of contacts or people that you're using with; encouraging people to prepare drugs themselves; plan and prepare for overdose; of course, us making sure everyone has access to naloxone; encouraging people to stock up on supply-- to stock up on drugs and prepare for possible drug shortages.

And so, I think, when we as treatment providers think about what this means for us, one of the things I would encourage everyone to do is to really think about, what are the innovative ways we can work under these new regulations to really reach patients that we might not have reached otherwise? In addition, to continuing to care for our existing patients. But also, thinking about there are a lot of people out there who may be at increased risk during COVID, and how can we develop new partnerships, new relationships, or new delivery models that will help reach really vulnerable people?

So that could be-- I think the other thing, and I think Stephan's going to talk about this a little bit, is just that there may be patients who under sort of normal circumstances may not have been as interested in accessing treatment. But right now, because of circumstances, whether it be their attempt to practice physical distancing, requirements that they aren't allowed to leave, places like homeless shelters or single-room occupancies, people may have limited access to funds. Whatever their normal means of coming up with money are, those might be limited during COVID.

So all of these reasons, people may have an increased sort of interest in engaging in treatment services right now. And so we have to think about innovative ways to find those people and make sure that they're getting the services they need to stay safe.

So you might want to consider, if you don't already, partnerships with emergency rooms who may be seeing patients who are going through withdrawal; community-based outreach organizations, like the organization Stephan represents, and he'll be speaking next; or even developing relationships with homeless shelters or single-room occupancies, so that when they identify people as possibly going through withdrawal, there is a way to really quickly offer services and make sure that people get medication like buprenorphine to be able to hold off withdrawals, keep people comfortable, and hopefully stabilize them on treatment that they could potentially continue post-COVID. So with that, I'm going to hand it over to Anne, who's going to introduce Stephan.

ANNE: Thank you very much, Elizabeth. That was some really great information. Our next speaker is Stephan Koruba, who is a full-time family nurse practitioner for the Night Ministries Street Medicine Team in Chicago. The team provides human connection, acute/bridge medical care, case management, and harm reduction services to Chicago's rough sleepers seven days a week. Go ahead, Stephan.

STEPHAN KORUBA: Hello. Can you hear me?

ANNE: Yes, we can.

STEPHAN KORUBA: Wonderful. Wonderful. Thank you all for coming and sharing part of your morning with us. My name is Stephan Koruba, and I'm the senior nurse practitioner at the Night Ministry. I focus most of my time on the Street Medicine Team. So my point piece of the talk here is to kind of try and bring a little context and a little bit of kind of what we've been seeing as a team out on the street with our homeless and addicted folks in Chicago.

So just to give you a little background on the Night Ministry, we're a 40-- we have 40-plus years of experience in Chicago reaching out to homeless and underserved communities, bringing human connection and case management to them. As we all know, that part of being homeless or part of being underserved is just losing that connection and feeling disconnected with the resources that are available. So our major focus as an organization is to get out there, learn people's stories, learn their names, and eventually, after we have a real relationship with them, working with them to better their position in life.

Half of our organization runs youth shelters. We run five youth shelters for ages 14 through 24. Some of that's helping folks get through school. Some of

it's helping them transition into independent lifestyles. And some of it's emergency drop-in shelters for LGBTQ youth.

So the other part of the organization is where I work, which is the outreach and health section. We have probably 25 years of having a big RV that goes out to the same communities. The same community gets hit twice every week. So there's six communities, and the big RV goes out with food. Once again, that connection in the outreach section, medical care, help with housing ID services.

Through that experience, we realized we weren't getting to the homeless section of that population. We were helping a lot with the underserved folks in a given community, but we weren't getting under the bridges and on the viaducts-- under the viaducts and next to the highways.

So about five years ago, we started investigating what a street medicine team would look like. We went to Pittsburgh. We learned a lot from Dr. Jim Withers, who is one of the kind of founding fathers of street medicine, as to how to kind of organize this and go about this.

So currently, we have this wonderfully customized street medicine van. The center part, where you can see where the window is, is a real nice private exam room. And when COVID isn't an issue, we have people come in there, and we have a little moment of privacy where we can do exams and talk about any topics that may come up.

Off the back of the van is where we tend to do our giveaways, as far as food, socks, hygiene, clothing type stuff. And then in the front, the case manager tends to work out of the passenger side, or even off on the street, trying to work on ID issues, trying to work on getting folks housing. And then the driver is our outreach worker who does our harm reduction issues.

They also answer the phone. We have a cell phone that we give out freely to any and all folks in Chicago who ask. They call and leave text messages on where to meet them and what they might need. That outreach worker answers that phone, plans follow-ups on both the social work and medical front, and does our harm reduction work, which has to do with condoms, pipes, straws, clean injection needle supplies.

So we're always changing and trying to meet the needs as we see. And COVID, here, offered us a real opportunity to try and do some different things as the needs changed, and that's what this slide is about.

The stay-at-home order changed the game in a day, and within 24 hours for our folks living addicted and on the streets in Chicago. If you can imagine, somebody who's living that lifestyle has a routine. They wake up. They know about how long it's going to take them to make a certain amount of money.

However, they do that, whether it's bagging, whether it's-- some of them boost or steal and pay back-- or use a fence to get their money.

They know when and where they're going to have to go to get their drugs. They know how to keep themselves safe as best as possible in those different situations, so they have a flow to their day. Anything that disrupts that can send them into, for one, detox really quickly, and also cause them to start doing some more riskier behaviors to try and send that detox off, that forced detox.

Well, when the stay-at-home order hit, the loop, downtown Chicago, turned into a ghost town overnight. It went from more or less normal foot traffic, where people could bag and do their usual hustle to make their money, to basically a scene from a zombie movie, where there was nobody in the loop except for a couple of cops. Our street med team was running around, and people were scared.

It was a scary feeling to be out there, just from the standpoint that we didn't have a lot of details about the virus we were fighting. All we knew is that it was a really weird, eerie feeling to be in the loop on a weekday with nobody out there.

So you've got folks going into detox within hours of waking up that day, having no way of making their money, having no way of fending that off. People got hungry really-- you know, within two or three days, they were hungry hungry. They were not asking for a sandwich as a way to start a conversation and build trust. They were-- they needed five, six sandwiches, because they were really, really suffering even from that most basic level. And if you superimpose springtime in the Midwest on this whole process, where you've got snow and rain and hot and cold just coming through on an hourly basis, it made for a pretty miserable experience overall.

In that time, obviously, resources retracted quite quickly. Primary care offices were no longer seeing our folks. If they needed a refill, four out of the five Chicago Street Medicine teams had to withdraw their services because they were mostly student-based and driven from the medical schools.

We expanded 12 hours a week, our team did, in order to try and meet the need, but there was no way to really make up for that loss of resources. Also, a lot of the different organizations in Chicago that do harm reduction and help with addictive-- addiction services also had to temporarily stop and then retool, and then come back out at a different sort of level than they had before.

And then the increased social isolation, which is a fundamental part of why we're out there trying to break it down, it just added to it. There was less people out. Now we're wearing masks and they can't hear us. And they're

wearing masks. And-- which isn't a terrible problem if you already have a relationship with somebody.

But when you're trying to approach somebody on the street for the first time, and you look like a cosmonaut with all your PPE on, they're really having a hard time trusting you and engaging with you. And so that caused a lot of change in how we normally operate and do what we do, and it cut down a lot of the services they were able to access in that time.

Real common in this time for people using 12 bags a day, 12 dime bags a day or thereabouts, to drop to two in a day. And you could just tell that-- I mean, whatever they were doing, they just felt terrible, trying-- you know, their brain isn't working the right-- the way it should, and they're trying to fight through and come up with a new way of dealing with this new reality.

You also saw former sheltered clients at some of our shelters in Chicago, because they had to internally socially distance themselves. Anybody who was young and very low risk got kicked out into the street. That was a new game for them to learn.

They had to learn how to protect themselves, how to get the gear. We had to try and get them tents. We had to try and find them encampments that were open to taking new people and making sure that those relationships were safe, because each of these encampments have their own social structure, their own little community. And people just can't move in without there being sometimes ramifications and repercussions.

I kind of mentioned that people changed a lot. Where the focus had been maybe bagging or panhandling for their money, to boosting or other high-risk behaviors where they were stealing. Or even there was discussion about moving into sex trade ways of making money and different things like that.

Then in this whole moving sort of whirlwind of changes in overnight differences, you had the fact that the opioid supply itself was very, very disrupted. So you've got Wuhan, China, the epicenter of the whole thing, also supplies a fair amount of fentanyl to the global market. That obviously was impacted.

Then you go down to Mexico, bringing opioids across the border was reduced because there's less traffic. Our agents are able to spend more time thoroughly inspecting more cars-- less of the opioids are getting through.

And then when you also think about going from a high habit to a low habit, whether it's the COVID response, whether it's when folks spend some time in jail, when folks go through detox without appropriate wraparound services, they're at a much higher risk for when they relapse to overdose and death because their tolerance has dropped.

And I know we had already mentioned that the social distancing aspect of that compounds it, because then they're not able to use maybe with people right next to them to administer that Narcan. And it was around weeks three and four that we really heard from folks on the street, hey, we need more Narcan. We used it all last week on these folks because of the overdosing that was going on.

It was-- just happened that we got two samples that kind of illustrate this effect, where the dope supply has been affected profoundly by COVID. On the left side, you see what we generally see in Chicago. And by the way, this is done by the Chicago Recovery Alliance. They're an amazing partner for us in many ways. They do a lot of great work with harm reduction in Chicago. They have two mass specs, and they use fentanyl test strips to kind of analyze the residual on these dime bags that we or our clients bring in, so they have an idea of what they're actually injecting into their body.

It's real common in Chicago for their heroin to be laced with fentanyl, which is what you see on the left side. The fentanyl test strip was positive. There was-- it was sold as heroin. Heroin was found, and it was cut with Benadryl and lactose. And then when you see the notes from the person, they felt that they had a good experience with it. So it kind of jives with all of the clinical information we got there.

On the right side, you see that a bag that was analyzed on 4/29, and it's got the same cutting agents, the Benadryl and the lactose, but there is no found fentanyl or heroin in this sample. Now, the library that these infrared and mass specs use is not comprehensive. There are analogs to fentanyl that maybe they won't find. But if you look at how it affected the person, the person said they felt terrible afterward, which meant it did not stop their dope sickness.

So it all kind of makes sense that the supply has been profoundly affected. And this adds to the-- not only are clients feeling ill, but there are higher rates of overdose when they do, and risky behavior because of how this all works together.

So against this backdrop of a lot of bad news, there is a silver lining-- that the telemed regulations were loosened, and our folks were more ready to change. They're like, hey, I can't do this anymore. I don't know how long this situation is going to last. What can I do in the meantime?

And they're like, you know what? Some of our folks, it was that tipping point to help them make that choice and make that decision. Of course, after the fact, when we start to go more open up and start to go back as we are now to more of our historically regular way of doing business, it's still going to be wonderful to be able to offer this if the regulations don't tighten back up. Because you never know when you're going to find somebody at that moment where they've made the decision, and you want to drop those barriers so that they

can get those resources, and hopefully reclaim control and autonomy over their life.

But it was really pretty much overnight that the docs over at UIC just put this idea in place and were able to jump on it. And in that process, obviously, any time you start anything new, you're going to have a lot of lessons learned. And as we do this each week, we fine tune it a little more and a little more, and try to make it work a little better for all of the folks involved.

One of the things we learned is when folks have their own phone-- you know, we turn it over to them. They can make their own telemed follow-ups. If they have their own insurance, they can go to any pharmacy close by, get their medication. They're basically in charge of their care, and that's the ideal.

The truth out there, though, is that there's usually combinations. Folks have a phone, but they don't have insurance. They have insurance, but they don't have a phone. And that requires more input on our end. Because if we're bringing the phone so they can make their telemed follow-ups, that means our team has to be there at a certain time-- takes more organization. And sometimes if we do it in a way that's not planned, we'll pull away from the other services we're trying to offer.

So what happens with us is that folks who aren't insured can still get their medication through a UIC program, but it has to be dispensed from their pharmacy. So the docs have been great about trying to organize and plan their MAT follow-ups on Monday days, Thursday nights, so that we know that those runs are set aside for follow-ups primarily.

We may do other work. But that is the primary focus of our team out on the street at that time. It will allow us to focus either having myself on those runs, or our substance use advocate on those runs with us.

It also became clear real quick that we needed a weekly follow-- a weekly Zoom meeting, where we could all run the list-- the docs from UIC, and me and Andrew, our substance use advocate, where we could sit there and go through each person. When did we see them? What do they need? Did they fall off the radar? How do we keep the balls in the air?

And then we need different gear than we have. We have a very old iPhone that we use to tele-- to do our telemedicine visits. And out in the rain and the wind, the sound's not great. We're hoping to upgrade to a larger tablet that has a nice cover. It's protected. It's made to be out in the elements, and it has some-- it's better fitted for what we're trying to do.

And also, in that give and take on that phone call with the providers, they've been able to say, hey, I'm not so comfortable about so-and-so. I'm worried

about maybe diversion. Can you do a witnessed or an observed dosing with them? And of course, then we work that into the schedule.

And also, they've been able to say, you know, clinically, we can give them a two-week supply right now. And we can say, OK, great. Do that. We'll still be there for that follow-up, for that phone use in a week. But they'll have two weeks of the medication, and we can go through it with them. And it saves us running back and forth as much in the van.

So I hope that gave you all a little bit of an idea of what we're seeing out on the street. And I will turn my time over to the rest of them.

ANNE: Thank you very much. That was fascinating. You're doing some really amazing work. Our next two speakers are Nicole Gastala-- Dr. Nicole Gastala. She's a graduate of Loyola University Stritch School of Medicine in Chicago, and completed her residency at the University of Iowa in family medicine.

She's board-certified in family medicine and addiction medicine, and she's currently the Director of Behavioral Health and Addiction Services at the University of Illinois hospitals and the health science system, Mile Square Health Center in Chicago. Interests include treating whole families, with a special focus on prevention, health care, group visits, and medications for opioid use disorders.

And Sarah Messmer, M.D., is an assistant professor of clinical medicine and pediatrics at the University of Illinois at Chicago. She is board-certified in internal medicine and pediatrics, and works in both inpatient and primary care settings at the University of Illinois. She provides primary care and addiction services at a clinic co-located with a syringe exchange run by the Community Outreach and Intervention Project on the west side of Chicago. Welcome to both of you.

SARAH MESSMER: Thank you so much. Thank you to everyone for spending some time with us this morning. I'm looking forward to sharing with you the work that we've been doing. From our perspective, it's been a really positive partnership with the Night Ministry. And we're really grateful to be able to do this work.

So I will start the presentation, then Dr. Gastala will take over in a little bit. Let me see if I can-- all right. So essentially, what we're going to walk through is a little bit of background about Mile Square and the overview of our program. We'll go through a patient case, our workflow, some registration details, the handouts we use, and then some lessons that we've learned as well.

So Mile Square Health Center was founded in 1967. It's an FQHC system within the University of Illinois at Chicago with locations listed here, as well as some school-based clinics. Through the partnership that we've started with

the Night Ministry-- this slide actually is a little older. We now have 18 patients that we've seen so far, which has been really great.

We've seen a number of uninsured patients. Of the 14 listed here, 9 were uninsured, 1 was unknown insurance status, and 4 who were insured. And all were experiencing homelessness or insecure housing situations. Since this time, actually, we've had more people follow up. Some follow-ups are still pending. And we're working, as Stephanie mentioned, in partnership with the Night Ministry, to make sure we're keeping track of folks.

So this is just an example of a patient who's been seen through this partnership. The patient's a 38-year-old woman with a 19 year history of opioid use currently experiencing homelessness. She's had multiple sequela due to her opioid use disorder, including untreated hepatitis C, infective endocarditis, DVT, requiring lifelong anticoagulation, and multiple admissions for injection site infections and osteomyelitis. Previously, she achieved five years of not using while taking methadone-- had never been on buprenorphine before.

Back in the beginning of April, the Night Ministry clinician encountered the patient, and she was interested in starting this telehealth Suboxone. So she, the following day, was able to start with an induction onto buprenorphine. And since that time, actually, now, she's had more follow-up visits and has completely stopped using.

She's been working also on housing through social service organization, working with Mile Square on getting her access to anticoagulation, and continued to form this therapeutic alliance with the providers and Mile Square through the help of the Night Ministry, including future goals for treating her hepatitis C, and making sure that she's continuing to have adequate follow-up for Suboxone.

This is just kind of looking back at this patient who'd been engaged in the UI health system prior to this partnership. You can see over the last couple of years she'd had many different emergency room visits, including multiple hospitalizations, with attempts to connect her to care afterwards, which was not very successful due to a variety of factors. But the traditional medical system was obviously not working for this patient in terms of follow-up.

However, since the partnership with the Night Ministry, we've been able to actually really have fantastic follow-up with this patient with over six visits now for Suboxone, as well as multiple phone calls to coordinate her care. So you can really see that although this partnership started during COVID-19, it's actually had a very positive impact on this patient's ability to really engage in the health care system and address not just opioid use disorder, but multiple other issues as well.

So this is the workflow that we put together, which is, as Stephan mentioned, an evolving process. The nice thing about Mile Square was there was already a telehealth system in place and schedule in place, so we were able to really pretty easily during business hours plug into that.

So essentially, the Night Ministry clinician encounters the patient who's interested in starting Suboxone. They are given the handouts that Dr. Gastala will go over shortly, going over the options for medications for opioid use disorder, as well as on the home induction handouts. They then call the certified addiction RN, Phil Mays, who registers the patient, does an intake with the patients, and then puts them on the virtual schedule with a clinician doing telehealth.

Then the clinician is given a brief report, who then FaceTimes or Doximity-- one of the different modalities. I think most often Doximity, through the Night Ministry phone or the client's phone, they then do the telehealth visit. The prescription's then called in either to the pharmacy of choice for the patient if they have insurance, or to the Mile Square pharmacy if they're uninsured, because we're able to provide medications for those without insurance that way.

Follow-up is then scheduled with or without the help of the Night Ministry clinician, depending on if the patient, as mentioned, has access to a phone. The prescriptions, then, kind of align with the schedule for the Night Ministry, if they're the ones who are going to be picking up and helping with the medications. And then the patient is given the direct phone number for our-- for Phil Mays, the addiction nurse, to call if they have any questions or issues that come up.

Nights and weekends are a little bit different and are more of an evolving process, I would say. It's pretty similar that the Night Ministry clinician will find-- encounter the patient who's interested in starting treatments, and they're given the handouts as well. And then we have certain on-call physicians that then the Night Ministry will get in touch with and to set up the visit.

We make sure we get all of the registration details. We do have the ability to register folks remotely, which is helpful. And then essentially, the on-call clinician will then do the visit with the patient. Then we set up follow-up, and the rest is sort of similar after that point.

This is just a list of the standard questions that we have for our registration process. Every hospital system is different, so I think making sure you understand what information is needed to register a patient, so that if for some reason you can't connect to register the person in the moment, you can do it after the fact. For us, this is the information that's required. All right. So I'll turn over now to Dr. Gastala to talk through our handouts that we give.

NICOLE GASTALA: So we feel like it's really important to make sure and educate patients about all of their options. So we discuss all three FDA approved medications for opioid use disorder, and we use this handout that was created from Arnold Ventures Foundation grant that compares each of the three FDA approved medications in sort of a very patient-friendly and visually appealing, I guess, sort of way.

And if the patient is interested in methadone, we do have a handout that gives them an idea of the different centers across the city, as well as specifically family guidance, because they do take patients without insurance or IDs. And they are taking patients right now. So that's also really important to make sure that if we do connect them to methadone services, that it is a facility that is still doing intakes, because not all of them are at the moment for new patients.

And then we also talk to them about buprenorphine and naltrexone. Buprenorphine, of course, is the one that we are able to prescribe. We can also do naltrexone. But as many of you know, naltrexone, you need 7 to 10 days without opioids, which is not most of our patients in that case. So we sort of kind of go through that handout with them, make sure that this is the one that they feel that's right for them, and then sort of go from there.

If they do decide that Suboxone is the right medication for them, then we do sort of our intake, our HPI, get their history, confirm that they have opioid use disorder, and go through this take-home guide. So this is also sort of a patient-friendly way of going through their withdrawal symptoms.

So for example, we say make sure you have at least three of these symptoms-- runny nose, yawning, restlessness, and large pupils, stomach cramps, nausea, vomiting, or diarrhea. And then it explains how to take the medication so that they make sure they absorb it properly.

A lot of times, many patients have had taken Suboxone before, whether they've borrowed from a friend, or if they were prescribed it in the past. And so you can just make sure that they wait-- it's really important that they wait long enough before taking the medication, and they titrate to the appropriate dose sort of following these instructions.

One of the questions that I think is important to kind of go over, because when we do these sort of projects and work with community partners, it's so important not just to think about, OK, what can we do in the moment, but how could we potentially make this a sustainable process and program for patients?

So if you are able to bill, which luckily, with a-- like, Elizabeth had gone through, a lot of the changes currently in this pandemic have allowed us to bill when we wouldn't have been able to before. And we, as an FQHC, see patients regardless of their ability to pay, so it doesn't really make a difference

for us. We will still see them even if they can't pay, even if we can't bill. It doesn't it matter. But if we can bill, of course, it helps the sustainability of our system.

So for telephone-based care, we're now paid at equal rates for Medicare, Medicaid, and most private insurances. And that's usually a 992-- and then, of course, whatever the normal billing is after that. The telehealth-based care, so that's when you do audio and video, it also continues to be paid at equal rates for Medicare, Medicaid, and most private insurance. And there is a tech facility fee that you can do.

Not all FQH-- I don't know if FQHC specifically can do this, but I know private clinics can sometimes do it. And that's where you can get a CMS value around $25 per visit. And so you do your 992 appropriate CPT code. And then you add a 95 modifier on it, which allows you to bill the tech fees, if possible.

And providers can either bill based on time or based on complexity of care. And time can include time spent on the date of services reviewing notes, labs, imaging, and include the time spent counseling the patient or coordinating care, which is really a big part of what we do, coordinating that follow-up, coordinating with Stephan, coordinating how to get their medication to them. So those sort of things you can also add as well.

Another important aspect-- so when you're doing your documentation, so here's billing guidelines when there's really minimal physical exam documentation. So it has the CPT codes on there, the qualifying codes-- 99202, 03, 04, 12, 13, and 14, as well as the time base, the history, the number and complexity of problems addressed, the data to review and analyze, and then the risk of complications and/or morbidity and mortality that you can sort of include as part of that. And so I found this to be really helpful for our sort of billing team to kind of have an idea of what we can do.

So Stephan kind of went through a lot of these, but the most important thing is really sort of that frequent follow-up and frequent meetings with your community organization to make sure you're meeting their needs and really discuss any barriers and facilitators. One of the biggest things from our end that we need to really work on is helping patients sign up for insurance and IDs if we want to continue sort of this afterwards.

Like, what happens if they roll back the measures and we can't do telehealth anymore, but we want to make sure that the patients are all lined up so that they can either transfer to a clinic that's closer to where they live, or if they follow up with us, that we can sort of help them through that process, or if they need higher level of care.

Eventually, we want to get them enrolled in sort of full spectrum care-- screen for hepatitis C, HIV, primary care, cancer screening. All of that stuff is really

important to help improve their health outcomes as well. So just by initiating this sort of addiction care, we're sort of embracing them within the health care system and making them feel comfortable.

And then we want to really pave the path for them to make sure that they have access to all the health care that they need and that they deserve as part of their sort of full spectrum care. So that's one thing that I really want to work on over the next couple of weeks to couple of months as we continue this program.

ELIZABETH SALISBURY-AFSHAR: Great. Thanks so much to all three of our panelists. We're going to move now into questions. And again, if people have questions, we'd ask that you put them in the question and answer section. And so I'm just going to start at the top, and we'll sort of move down. And we have about 10 minutes.

So the first question was about, can buprenorphine be prescribed by telephone in Illinois? And so I want to answer more broadly, the guidance that I referenced is federal guidance. And although I haven't heard of a lot of state differences, it is possible.

So I would just confirm. We can tell you, because we work in Illinois, that the answer is that yes, per DEA and SAMHSA guidance, it can be prescribed by telephone. And that would be regardless of insurers. So there, again, may be differences in billing and payment, but Nicki reviewed those.

And so, again, I think legally, yes, buprenorphine can be prescribed by telephone at the federal level. Legally, yes, in Illinois it can be both initiated and maintained by telephone or telehealth. So this-- and I will just ask, anybody have anything to add in addition to that, any of our other panelists? OK.

So the second question was whether a patient would need a doctor's visit to get an increase. And so I think maybe-- I don't know, Dr. Gastala, if you want to respond to how you guys are managing sort of dose changes.

NICOLE GASTALA: Sure. So they can call our certified addiction RN, Phil, and just say, I'm having some-- I'm having worsening withdrawal, or I'm having cravings, or I don't think this is the right dose. I was on 24 before. We started out at 16. They can call Phil, and then he can run it by us. And then we can do some dose adjustments that way. Or we can have a telephone visit with him-- with the patient.

So it really just depends on where the patient's at in their treatment, and sort of like case-by-case variables. But you don't necessarily have to have an in-person or telephone visit. Sometimes they can work through your nurse, just

like your diabetic patient would work through your nurse. It just depends on your workflow.

ELIZABETH SALISBURY-AFSHAR: Dr. Messmer, anything to add or anything different there?

SARAH MESSMER: No, I think that sums it up. Yeah.

ELIZABETH SALISBURY-AFSHAR: Yeah. And I would just say, if others are in clinics where you don't have the luxury of having a nurse Phil, this is something that we deal with as well, and often, just through a quick telephone check-in, especially in those-- when someone is new for initiating treatment, we often do more frequent check-ins, like every couple of days when we can, just to make sure that we are adjusting doses properly. And really, just adjusting dose based on patient symptoms, patient-reported symptoms. And so I think that is really standard sort of across the board. And you obviously will work with the teams that you have to make sure that patients get what they need.

The next question is for Stephan, and it's about your largest barrier with engaging folks on your street medicine team.

STEPHAN KORUBA: Yeah. Before-- it's definitely a lot different now with COVID, with everybody using-- having to use masks, and if you get close enough to do exams on people, face shields and gloves and all these different things. We used to jump out of the van and hail someone from a few feet away. And if they were open to it, we'd just go visit with them. We consider a hug or a handshake a sign that we were doing our job, that we were trusted, and that it was safe for them to get close to us.

Nowadays, we have to ask people to please back up, which seems really hard for us to do, because that's not how we would operate. And it feels wrong to say, trust me, but leave me alone. Or trust me, but now put this mask on. It's a lot harder now to do that.

And if you add the environment you're working in-- when we do train outreach, a lot of the folks have moved out onto the trains and are sleeping there overnight, and we've done train outreach. If you're on a train car with a bunch of people crashed out, and you're trying to wake them and you're look like a cosmonaut in full Tyvek suit, and the train's rattling and they can't hear you, and you're trying to earn their trust-- that is not a recipe for success.

So I think right now it's that needed social distancing that is really making it hard to engage new folks. Our old folks who know us and trust us, they're just rolling with it. But when we come across new folks out there, which we do every day, I think that's the biggest barrier at this point.

ELIZABETH SALISBURY-AFSHAR: Great. Thank you, Stephan. And there was a request in the Q&A for your van cell phone number, which you very kindly shared. And I did put the phone number for anybody who's Chicago-based and possibly wanting to talk to Stephan and his team. I did put the van cell phone outreach phone number in the Q&A. So yeah. So it's there. So you people can jot it down if you need it.

This next question, I think, is really for all of our panelists. And the question is, have you seen a reduction in people starting to use, people quitting, or relapses because of the pandemic?

STEPHAN KORUBA: I could--

ELIZABETH SALISBURY-AFSHAR: We can go-- whoever wants to go first. Yeah, please.

STEFAN KORUBA: Yeah. My first thought is definitely, our program here, our partnership we're talking about right now, has shown that some people were definitely willing to make a big change on the positive front. They were already detoxing. The future was uncertain. They didn't know how or where they were going to go.

Obviously, they were at that contemplative stage already in their process, in their life. They were sick of chasing the drug every day and the lifestyle, and they wanted to get back to friends and family and reclaim their life. And this was that excuse, or that push, or that final thing that said, yes, I'm going to do it. I'm moving on.

There are other folks who, I assume, are just-- are in that transition. They're still trying to figure out the new hustle. They're still trying to really not wanting to change, but maybe they're forced to a little bit.

I haven't seen a lot of folks who have relapsed because of it. I haven't seen people come when I'm visiting with folks and them saying, yeah, yeah, it was just too much. I couldn't stand-- for me, it's homeschooling-- I couldn't stand homeschooling anymore. I had to go back and I relapsed. It was too much. But I haven't seen that end of it, so--

SARAH MESSMER: I would say my--

ELIZABETH SALISBURY-AFSHAR: Dr. Messmer.

SARAH MESSMER: Yeah. I was going to say my experience has been kind of similar. I'm still going out to the west side where our syringe exchange is located and still seeing patients there. So I've had a number of people that we've started on treatment also, and who are saying-- oh, maybe they've been put up in a hotel when they previously weren't stably housed, and it's

been just a whole change of scenery for them. And they're like, you know, this is the time that I-- things are so crazy right now, now is the time I'm going to try to get on Suboxone.

And so I think that's been a positive thing for some people in this situation. I know that there's also increased overdose rates, though, in other-- in many parts of the state. So I think that we're seeing kind of both sides of that issue, I think.

ELIZABETH SALISBURY-AFSHAR: And I'm so sorry, because I'm looking at the time, and I want to be respectful of everyone's time. And we just have a couple of minutes left. So I do just want to quickly acknowledge there was one question that asked about whether the regulations are the same for buprenorphine and methadone. And the answer in all caps is NO.

There is still a requirement for an in-person visit, and that's some of what Dr. Gastala was mentioning. And there are more-- there are sort of stronger requirements about the number of in-person visits and when those can happen, based on the longevity of someone's treatment.

And so if you need those resources, we can work to get you the links that have the SAMHSA guidance around the changes and regulation during COVID. But it is important to note that, yes, they are different.

And for the sake of time only-- these are great questions, so it sort of breaks my heart we can't get through them all. But I, again, want to thank everyone for being here. I'm going to pass it back over to Anne for our sort of housekeeping and closing.

ANN: Fantastic. Thank you very much to Elizabeth and all of our panelists today. Just a quick note, if we were not able to get to your question, we will send all of these questions to the panelists so that they can answer them. And then those questions will be on our ATTC website, along with the recording of the webinar and other resources that were discussed today.

Again, a huge thank you to all of you for this amazing information. I just also wanted to let everyone know I misspoke at the beginning of our webinar. You will be getting certificates of attendance. So as long as you were signed up and we have your information, you will get a certificate. And again, thank you all for your time, and we hope that you enjoyed this webinar. Thank you.