ARIA JAVIDAN: We are a few minutes out from the webinar, so we're going to get started. We see two other Doctor Wiseman's out, the other two you are not speaking correct? DR ERRIN WEISMAN: One of them looks like Kayla and the other is my MP. ARIA JAVIDAN: The other two if you don't mind turning off your camera for the duration of the webinar that would be great. Thank you so much. Before we get started, just a heads up one side will open up the webinar all the attendees will start Strickland and they will be able to see and hear a thing you are doing. Also as I am located in the state of California I am required by law to let you know this webinar is being recorded today. Any questions before we get started? OK, awesome, opening up the webinar now. Hello, this webinar will begin in about 30 seconds. ARIA JAVIDAN: Hello, my name is Aria Javidan, project manager for the national Consortium of Telehealth Resource Center's welcome to the latest presentation in the series, today's session is on Virtual Support System's the impact of telehealth on SUD/OUD prevention treatment and recovery. This is presented by the Telehealth Resource Center, these webinars are designed to provide timely information demonstrations to support and guide the develop and of your telehealth programs. Just to provide little background on the consortium located throughout the country there are 12 regional telehealth resource centers, and to national focused on telehealth policy and the other on telehealth technology assessment. Each serve as focal points for advancing the effective use of telehealth in supporting access to telehealth services in rural and underserved communities. A few tips before we get started today, your audio has been muted. Please use the Q&A function of the Zoom platform to ask questions, questions will be answered at the end of the presentation, please only use the chat for communicating issues with technology or communication access issues. Please refrain using chat to ask questions or make comments. These also note the close captioning is available and that is located at the bottom of your screen. Today's webinar is also being recorded and you will able to access today's and past webinars on the ntcrcwebsite@divisionofmentalhealth.org, without a will pass it over to Luke Wortley Program Director at the Upper Midwest Telehealth Resource Center. LUKE WORTLEY: Thank you so much, Aria, we are pleased to have a stellar set of guests here presenting with us today for a topic of Virtual Support System's, the impact of telehealth on substance use disorder and opioid use disorder prevention treatment and recovery. I will first begin by introducing my colleague here the Indiana Rural Health Association Doctor Amnah Anwar, Senior Director and epidemiologist here on staff that worked extensively not only with the Upper Midwest Telehealth Resource Center but in prevention treatment and recovery efforts through a variety of funding mechanisms to the state of Indiana and has served on so many resourceful committees and we are so lucky to have her as a Senior Director here. Next we have Doctor

Ryan Sarver. Doctor Ryan Sarver is somebody who I've had the pleasure of knowing over the past about half decade or so, he graduated with his medical degree from American University of the Caribbean and has worked in the substance use disorder space for some time now has extensive experience in serving rural and medically underserved communities, not only as a family physician and addictionist but also staunch advocate for mental health and medication for opioid use disorder treatment. And then finally we also have Doctor Errin Weisman, Doctor of osteopathic medicine, she received from Kansas City University. I also know from seeing other programming from Doctor Weisman she's a staunch advocate for preventing clinician burnout as well as being a tremendous advocate for patient rights and all sorts of amazing work that she's doing throughout the region. So I will go ahead and handed off to this wonderful panel. DR AMNAH ANWAR: Thank you so much Luke for those wonderful introductions and thank you so much for our panelists who are willing to participate in today's presentation. We have to start off with the this claim are we given the beginning of all of our presentations, this presentation is made possible under the fundings through the Health Resources and Services Administration and prevented the number represented. This program is funded to provide technical assistance to the telehealth community within four states, Indiana, Ohio, Michigan and Illinois. Next slide. As Luke already provided the introduction to all of us, I'm not going to waste any more time doing that. I think that our present is today have tremendous experience in providing substance use disorder, opioid use disorder treatment in the underserved and rural communities in Indiana and other states as well. Next slide. So the objectives of today's panel presentation is busily to evaluate how telehealth has expanded access to substance use disorder, special focus has been on the opioid use disorder services, particularly in the remote and underserved areas. We will discuss the recent policy and regulatory changes affecting telehealth delivery to substance use disorder and their implications. We will also analyze the management of complex SUD/OUD cases in telehealth including challenges and effective strategies, and in the end we will also discuss the recent technological innovations in telehealth that enhance the prevention treatment and recovery when it comes to substance use disorder in rural areas specifically. Next slide. So I will hand it off to Doctor Sarver, I had the privilege of working with him in a program when he was still in Indiana, in southern Indiana, that was the Rural Community's Opioid Response Program, at that time it wasn't really a long time ago but he was the only MOUD champion we had within our consortium that we had and staunch advocate for the medications of opioid use disorder and modalities to provide that treatment to the people in rural Indiana. So Doctor Sarver, take it away. DR RYAN SARVER: Alright, thanks so much for having me. I have no relevant financial disclosures, you can go to the

next slide. Alright, so we've been tasked today with a couple of items here full stop the first one is to evaluate how telehealth has expanded access to both substance use disorder and opiate use disorder services particularly for remote and underserved areas. Next slide. Oh no, next slide. Thank you. So really what we are looking to do with telehealth in the primary goal is to overcome barriers to care. Really to establish what's considered a low threshold MOUD clinic. This is a concept that analyzes barriers whether they are social economic barriers, different social determinants of health barriers, access, transportation, all these things that get in the way of a patient really being able to get into treatment telehealth can tackle many of those. Next slide please. So talking of Social Determinants of Health I'm sure many people in the audience are aware of what the term is but I'm going to go through an overview. Essentially taking into account the patient's background. So, their education background, what is their level of education, what is their reading comprehension, they have access to quality health information, do they have access to quality healthcare. In many rural areas, the only access to healthcare is going to be many many miles away, and they may not have reliable transportation. Many patients who are affected by opiate use disorder and substance use disorders also have poor social resources. Many people in the throes of active chaotic addiction will burn through relationships in seeking out their drug of choice. Many of them don't have the same social networks that somebody who is not in active chaotic addiction would have. They don't have access to reliable transportation they may not have funds to purchase a car full stop they may not have funds to, you know, hire an Uber, when you live in a rural area you don't necessarily have Ubers, they just don't exist. So what we really need to do is figure out how to get access to these patients. Most patients have access to a smart phone, so they can get on two different telehealth modalities. For many practitioners there are - and those in rural health clinics - there are actually free telehealth resources such as Docsimity, which cost nothing to sign up for which sent a link to the patients and they can have access to the clinician so the clinician can then prescribe lifesaving medications without having to worry about having a robust case management team that is going to get transportation, going to get a medi-cab, bus tokens or whatever other modality to get them into the clinic to stop it's really where telehealth is going to come into help out overcoming those barriers to care. Next slide. What I recommend for anyone who is looking into figuring out how to implement telehealth or how to overcome these barriers, figuring out what your case management resources are. So if you don't already have case management, you should talk to your healthcare administration and have somebody who can coordinate with these patients. Oftentimes that starts with a peer recovery specialist. A peer recovery specialist can reach out to these patients via phone, peer recovery specialist first of

all if you are not free with the term it is someone with lived experience. They are some buddy who is in sustained recovery from addiction, sustained recovery is longer than a year, who then goes through a rigorous training program to become someone who has case management abilities and skills who can then connect patients to community resources, whether that is triaging them to the appropriate level of outpatient care, whether an intensive outpatient treatment program, an opioid treatment program colloquially known as a methadone clinic or detox or rehab center. That peer recovery support specialist can contact the patient via phone number they don't have access – ready access in person, or also through a telehealth visit. So they can open up video chat and check on the patients, see if they have access to medication, have access to harm reduction resources such as naloxone and have access to transportation, if not can arrange for transportation. Sometimes that is not feasible in rural areas either, having resources for dear recovery specialist, in which case just being able to pick up the phone and get into an app like Docsimity to get someone on video can become a lifesaving banality to prescribe medication to a pharmacy and they can pick it up and they will no longer be looking for their medication of choice or drug of choice on the street. A couple of other resources of patients don't have a smart phone which most do, perhaps they are actively homeless, or they are lost or have their phone stolen, many public libraries also have private computers that can be used in a private room where you can have a telehealth visit. So that's another resource you consider. I would also consider putting together a community resource list if one isn't already available through your case management team that you can hand out to patients or if you have a Peer Recovery Support Services list are looking to develop that team they can put together that resource list to help patients find how to overcome those barriers to care. Next slide, please. So now I want to talk a little bit about policy changes that have happened since 2008 and the Ryan Hayne act, occurring during the COVID 2020 pandemic which reduce some of the barriers to telehealth in providing MOUD medications. Next slide please. In the CARES act which is the coronavirus aid relief and economic securities act, you had to have a visit scheduled first, for two through five vacation some of those were relaxed were you could actually Institute medications for opiate use disorder over video. In fact, if you work in opioid treatment programs and no TP or methadone clinic you can actually prescribe (unknown term), those relaxed during the coronavirus pandemic and was set to expire last year, that was renewed for another year, that goes through December 31 of this year, so we are waiting with baited breath to see if they are going to continue those rules and allow us to continue to provide these lifesaving medications through telehealth, fingers crossed they will because we have the data, it is in and access to telehealth for prescribing (unknown term) saves lives. Next

slide. So there are many articles out there I put this one out there from the American Medical Association that really shows having access to – (unknown term) produces patient seeking it out on the street, everything out there, hair when or pills on the street, press pills out there are either fentanyl or a mixture of fentanyl and xyloxene, it's really up to us to advocate for patients to get these mitigations into their hands. When patients go to the street they don't have access to harm reduction strategies such as ready Narcan and don't have access to bupenorphine, they don't have access without us, to help them that's were expanded access telehealth is going to help out. And really going to save lives, next slide. I want to talk a bit about what the White House is doing for their – expanding several points for access to these services, I did put out link you can review this policy statement that the White House has put out - they just put out a bulletin they arefor yourself and expansion of MO UD services. They are hoping to make the COVID-19 era flex abilities for telehealth permanent for many given aspects. One of them is if you work in OT peak, patients can receive take-home doses of methadone, longer take-home doses, if you're familiar with this oftentimes patients will have to go get their methadone every day and that's just not feasible for many patients. Eventually they get take homes for a week at a time, two weeks at a time, up to a month at a time so those rules and COVID-19 relaxed and hoping to make that permanent. For telehealth, but I was speaking of before methadone can actually be prescribed by video and audio andbupenorphine only over the phone if you are in. ODP if you are not OTPF, you are a DE licensed petitioner, nurse practitioner physician associate you can prescribe bupenorphine over telehealth so you don't need to have that information especially if you are going to continue something already prescribed. For some of the barriers and to entry in a treatment program, this is for him to either detox programs or oh TP, you don't have to have a long history of addiction before they are eligible to go into these programs or if you have a patient who is an active chaotic addiction and triage them and you find they are not safe for outpatient treatment especially in a rural pinnacle or maybe you don't have the same number – amount of resources, maybe the rules for getting them into a detox our little lax their. And then expanding access to medication treatment wall, the goal is reduction in barriers to care, next slide, please. Some of you may be aware several years ago the requirement for X waiver to prescribe bupenorphine was limited. For those don't know what it is, prior to a license, anyone was required to get eight hours if you are a physician, you are required to have an eight hour training program in order to prescribe bupenorphine. If you were nurse practitioner or associate you had to do 24 hours of training in order to prescribe bupenorphine. That requirement for the X-waiver was lifted now if you hold a gay license you can prescribe it out of your clinic and if you are in primary care you should be prescribing

bupenorphine for your patient. Addiction is a chronic relapsing disease in the brain no different than diabetes or heart disease and we should be treating this, now if you are treating out of a rural clinic and you are in primary care, you more likely have DEA license you can start prescribing bupenorphine. The Biden administration in 2021 lifted the X-waiver. Now in order to renew your DEA you need to do 40 hours of training now they made everyone who is going to get the license renewal get the training you need for X waivers now if one can prescribe including over telehealth. Next slide. Then the last thing they mandated is increased access to harm reduction, so those are the locks own kits. This is especially important in rural areas, there are many networks out there involved in harm reduction and getting Narcan in people's hands, one of the major things the government did is remove the need for a church and for Narcan where naloxone is the generic name for Narcan. Naloxone cannot be attained without a prescription however it is often cost prohibitive. Patients can't afford the often $40-$50 per dose of this life-saving medication so there are many grant programs out there that you can get naloxone vending machines or things called naloxone boxes that would sit outside your clinic and there are organizations that can come and fill that with Narcan or you can get free Narcan to fill it. So look into that. Anytime you see a patient via telehealth for bupenorphine, you should also be sending Narcan so they have that with them. Next slide, please. So really, the take-home here is finally the government is waking up and realizing that the only way we are going to tackle the opioid epidemic is through sustained efforts in reducing barriers to care and increasing access to harm reduction strategies such as more take-home doses of methadone, increased access to bupenorphine, and free access to Narcan. And a lot of that is going to be facilitated by increasing any access to our patients they can get, so they don't put barriers where they have to go to a treatment program or methadone clinic where they have to go to the hospital or have to see an addictionist, they can be able to go to their practitioner who can prescribe and ultimately save their life. Thank you. AMNAH ANWAR: Thank you so much, Doctor Sarver for going over this, there is a question I think nobody answered, just a reminder there will be time for question and answers at the end of the presentation. After we have had some panel discussion. Now I'm going to hit it over to Doctor Wiseman who's going to talk a little bit about provider focused issues with access and accessibility for substance use disorder treatments in telehealth and other modalities and also provide a bit of information of her work in rural Indiana that she is doing. Doctor Wiseman? DR ERRIN WEISMAN: Thanks, happy to be here with you all today please use a Q&A box, I do love to answer questions, I call it the Jenni checkbox, just even if it's adjacent to what we're talking about I think is a great form and a lot of great people here we can provide some great answers, select pop over to the

next slide. I am Doctor Errin Weisman, I'm in southwestern Indiana, I practice addition medicine and primary care in an FQ HC setting. My facts are Indiana focused because that is where I am at so if you want to grab your states information, I have a resource page at the end you can get on there and see on the website the national Institute of drug abuse with the most updated data for the country you're in. Right now Indiana ranks 14th nationally in overdose deaths and this is from 2020 data and we are still waiting to populate and see, we know we had significant increases during the COVID period, people went without medications, mental health worsens, supplies change stand so unfortunately I'm afraid Indiana will probably stay the same if not get a little bit worse, and these numbers you want to be at the bottom when it comes to ranking in overdose deaths. Interesting enough, as we started to go into more rural areas the cornfields around me we are seeing Indiana youth upwards of 12 1/2% that are using substances, and unfortunately Indiana ranks in the lower third of being able to provide behavioral health services to individuals who are suffering with addiction. For anybody who's out there doing this kind of work I am sitting in the middle of these statistics right now. The city I work in has the Walmart see you know it's a big deal but other than that I live in a county that has more livestock than people. So this has been super interesting work for me, I'm originally from southwestern Indiana, I used to tell people I love talking about drugs. Indianapolis houses one of the DEA's headquarters and I would go up quarterly, I got interested in it as a student to listen to their presentations and it was something that always tend to just be of interest, and when I was training in the early 2000's it was like no, you don't want to get the X waiver because then you have to take care of those type of people, or you are a young physician, you need to establish this before you have those kind of people come in. What I realized very very quickly within the first month of practice outside residency was that those people are my people and they are my neighbors and they are the people I go to church with, I see in the library in the grocery store, they are my kids friends parents, it's everywhere in rural Indiana, so many blue-collar workers, we are down here with a bunch of coal mines, injuries happen, heavy labor, farmers, they got started on opiate type medications and it just kept growing from there, then we locked down with different opiate walls prescribing methods, inspect, changed how are prescribing methods happened and folks who were used to getting their pane medications on a regular basis no longer had that and had to find other sources. It is so interesting now when I sit down and talk with patients to understand their journey and where that came from, I have women who tell me yeah, I got started on Percocet when I was a teenager because I had really bad periods. The first time I used was with my mom she used to pay me in pills that I could sell to other kids but I tried them and decided I didn't want to use those as my allowance that I just

wanted to keep them for myself. Just incredible stories that you hear about growing up, middle income country girl, it's very different from my own life experience. But yeah, I am so intrigued and I love serving this population. I've been in medicine, and practice for 12 years now and I've been very interested to serve my rural communities to see how much is changed also how much has stayed the same as well so I will be giving a little bit of perspective on the boots on the ground where doctors Sarver gave us so many updates, I'm glad he did that, I am not a data nerd and I would rather tell real-life stories to go to the next line will tell more about that. So Doctor Sarver mentioned that what I call the three A's. Is there the availability for treatment, accessibility for treatment and acceptability for treatment. And the last A on a continuous basis to men community. Head to the next slide. When I'm talking about availability I'm talking about on the provider side and what barriers you and I come in contact to. This is off a couple different studies, but when providers, physicians, nurse practitioners, PAs, were asked what are your barriers to care, what are you issues for prescribing MOUD these were the answers, providers lack of time office space and train staff they felt like the lack of specialty backup was in there some of them said there was a lack of patient need, I would have to push back on those folks a little bit because if you don't ask you don't know. Resistance of partners in leadership, lack of confidence, DEA concerns, attraction of drug users to their practice, regulations, attitudes beliefs and perceptions of bupenorphine and using it and lack of Mental Health Services was concerned for a lot of providers. Many times I'm talking with colleagues I have to address each one of those and what I say is if you have prescribed in archon in the past, any kind of benzodiazepine you can prescribe buprenorphine. Let me tell you what the profile is the you can feel confident with it. Always a there's a time and place to send anyone to a specialist but if you work in a whirl area like I do right now it's a 14 month wait to get into a rheumatologist a little over 10 month wait to see a neurologist. There are so many specialties I want to get my people into, but I end up being their specialist. Whatever encourage folks in your thinking about taking care of folks with substance use disorders they don't evidently need to go see a fellowship trained addiction physician. These are things you can get started by having really open and honest conversations, going into the patient visit with curiosity, like hey instead of saying what's wrong with you today, asking what happened in your life, or one of my favorite questions when I go to see a new patient is tell me about your relationship to whatever substance, maybe they mentioned to the nurse. Tell me about that, where did it show up in your life? Then I let the patient talk and I have collected so many incredible stories, one day I'm going to write them all down for everybody to read of course HIPPA compliant, people coming to the office and if you close your mouth and listen they will tell you what's going on.

And the good news is we have the data to say MOUD is safe for patients how many other things can we say we give you this medicine and I can tell you with data supporting it that I can protect you from dying. You know, of course stats for MIs, we now treat people and cure hepatitis so it's a great time to be in medicine right now and provide these medications and really see big changes in people's lives because I see when we use these medications it calms those areas of the brain for folks so they can then you know look at their Social Determinants of Health and what I tell them is I want to help you live a nice boring life, no more legal involvement, no more running from debt collector yours, I want to help you so you can go on a Florida occasion when you want to and not have to sit back and be in a state because you got legal troubles and can't go or not have the finances to be able to go. I recently started helping a couple who come in and see me, they really want to buy their own home but they were just so overwhelmed they didn't even understand where to go and they said hey, I've got a great resource, the USDA is really promoting homeownership in rural areas, let me get in contact with their local USDA office and they are going to be great. Before you even go talk to a bank. Because so many patients have really had trauma with our everyday life, walking into an ER, a physician's office, the bias that has may be poured upon them. These folks were scared to go into a bank. What are people going to think of me? Are they going to run a background check on me? Am I going to be able to qualify for a loan? So I love this work one because I tell people the medicine is not the hard part, it's helping with everything else, but just being invested in people's lives, that's the availability piece, so I challenge you to say are there any things on this list you're sitting back and like that one gets me a little bit. If so, put it in the Q&A and I would love to talk about it more, hit me with the next slide. Alright, this one should say patient focused barriers to care, my little typo, but accessibility, this is what we are really getting out with today's webinar. The distance to clinic or treatment center, right now from where I sit in the city that has the Walmart and Applebee's, another big thing in rural areas where's the Dairy Queen and sit down restaurants? It is an hour drive to any OTPF. Any place where someone can access treatment with methadone. And Indiana is one of the most restrict of states when it comes to methadone treatment, the federal government is more liberal than we are here. So here in Indiana people aren't able to get to those monthly take-home's until far far into their treatment because of state law, so many of my patients are driving at least an hour there and at least in our home every single day for week's to months on end and it is just not conducive with life, I've got three kids at home I've got to get people up, got a good pop tart in them and get them to school, right? And if I have to start my day 2 to 3 hours earlier than that my kids would be beat, absolutely, we really have to focus on that, and I know there are creative

solutions with doing satellite centers with no teepees and I'm excited to see that here in my state as well again in rural areas we have the lowest ratio of population to providers and that's both in primary care and psychiatric care so for them to actually see a qualified individual they are less likely to get to them because there's less of me and my colleagues around. The other concern is the ability to pay we have centers that provide buprenorphine in our area, but they don't take Medicaid they don't take insurance, it's all cash-based pay and that's a big barrier for folks when folks are living what we call very close to the earth, to make sure they get those appointments so they can get their medication. There's a lack of insurance coverage or they don't have insurance at all, either because they are working poor in can't afford insurance premium provided by their working as many businesses in rural areas are small businesses single owner owned businesses as well, so the ownership cannot provide those type of insurance coverages, they go to the marketplace and they say Doc, I can't even afford that either, so it is a big challenge when maybe we are talking about doing injectable buprenorphine, they're not going to build to afford that without some kind of coverage. Transportation, Doctor Sarver mentioned there is no Lyft here, your friend, your mom, your grandma, the girl you dated in high school, those kind of folks you call on favors to get help from. And then even if you get a ride, they may not be dependable it's been raining the last couple weeks maybe the car won't start, it's huge issue with transportation, I've had people ride bikes over 8 miles to a clinic, I've had them come in horseback, one guy brought a mule in a car one time, all sorts of different ways, hitchhiking to try to get to the clinic to see us. People are so ingenious and they figure it out but also why do we have those barriers that we put in place that people have to figure out? Another big one is childcare, moms, parents, fathers can't get away. In rural areas there's a significant increase of grandparents taking care of children as well, grandchildren. That also leads to some challenges because do you really want your kid to sit in a room when you're talking about your substance use? Maybe if they are a little older and they can comprehend and understand what's going on, but that's not always the case. There's lots of times were they say hey sorry Doctor Wiseman I had to bring my kids. I get it we keep books around, toys, gadgets coloring books, to keep them entertained but it's not the best ideal situation. There's limited time for patients and competing priorities. They may be working their second or third job just trying to make it in life, let alone trying get to an appointment that's at 1130 in the middle of the day they worked the night shift they are trying to sleep they're going to get up and wanting to work another job then go back to the night job, and the other thing is the inability to miss work, again talking about employment is so important for people's health and the potential to no longer have employment is very scary for a lot of our patients. Next slide.

Another thing about up a lot of times, something I'm super passionate about, is going in and talking to community members, key members, law enforcement, teachers, schools, probation officers, churches, that's been a big one, church is a big deal in rural and underserved areas, just talking about what do you think about medicines to help folks with substance use disorder? What you think substance use disorder is? People always have a story so they are cousins brother went to treatments over yonder and he came back really goofed up, we should never send anybody to treatment. Those are the kind of stories they live with. I know one patient on my primary care side would say we don't go to the hospital because that's where you die. Well if you don't take care of yourself that is kind of a true statement, unfortunately. But also really getting folks to understand what prevention is. There are a lot of concerns about lack of being anonymous in a rural community. Everybody knows everyone's business and Sunday morning prayer list it's never a good idea to see your name on them, but also believes in treatment, doesn't work? The board is not needed or your week if you have to accept medicine or if you are not really in sobriety because if you have to take medication for it. There's also disconnect about the distance. I will tell you rural people in Indiana using these screens they get a little nervous about it if you are not local, if you don't speak the same way they do they are a little leery at times so the trust building takes a little bit. Alright, next slide. So that's all the stuff that we are up against when you are trying to establish a new type of practice in an area that is underserved and rural, at least from my perspective, so one of the great things I've been working with the Indiana Rural Health Association, my organization is called life spring health systems, we were able to partner with them to get a grant that Amnah mentioned earlier, it's quite a distance, pale Indiana to Rockport, Spencers County excuse me, you're talking over 90 minutes to get from place to place and the same thing over to cordon and Harrison County so we cover a little bit of distance. The grant we are doing is trying to get medications and substance use awareness and treatment into these five counties, how we have structured hours as we have a life spring office and each of those five areas, some of them are no bigger than a house that's been converted, for instance in English Indiana in Crawford some of them are a little bit bigger, like our pay Oley office but most of our offices there have a therapist, they also have case managers, they've been seeing patients but they haven't had the medical side of substance use disorder treatment. So our structure is we have a medical student – medical Assistant, her name is Stephanie is wonderful she drives each of these locations one day a week, then me, a nurse practitioner and Kayla also being here today, thank you Kayla, we tell a med into those locations, doesn't always work that way? No, patients don't always come to the centralized location, we tried to get them there because then we feel like it helps

them establish a small little community where they can get the social supports in the counseling, the group medications with us, we could help meet any other needs maybe they have going on, case managers can transport them from home to the office but at times you know it just doesn't work. So we do have to do telemedicine to their smart phone or worst-case scenario but you know the best visit we can do, we will do a phone call and talk how are you doing? Checking in with them. What do you know since we talked last? How have your cravings been? Tell me a little bit more on the slip-up that you mentioned. We go about the policy honesty overprotection we believe and harm reduction, we are not there to be the justice system we are really there to offer them options, and our first five months that we in here I underestimated the need that will be. I'm in Dubois County, a lot of people come in that are just as preferred, that have been my patient somebody told me to come talk to Weisman, fine. So we have a but of alcohol use is a very German Catholic County and sometimes I feel like sometimes I stepped into appellation County we talk about people who do not have running water in their homes, they are heating with multiple sources, you know, could be a coal stove, fire stove, they don't have air conditioning. Like I said they ride their mule into town. It's been really interesting to try to navigate that and understand the different communities. One thing we did early on in this process was actually going and getting in the community, talking to pharmacists, because it seems like every area has a CBS so getting into CBS and talking to those pharmacists, see what their perceptions are, try to have an open discussion and say hey this is what we are doing and this is our practice and here's our number, please call us anytime. And getting pharmacists on our side has been really really helpful to help our patients as well. There's still a lot of pain clinics in the area, so a lot of the times I wouldn't say we butt up against them but try to have patients understand that you really need to think of your payment plan if you're going to be started on buprenorphine or something like that and how we can treat their pane with maybe something different than hydrocodone or oxycodone or something like that. The other thing is, we've got into some really high polysubstance situations in helping folks navigate SUD. I'm so grateful I went through clinical fellowship and addiction medicine in the last couple years to help navigate during this project because they can be absolutely overwhelming and someone sits down and starts talking about what they are putting into their body or what they would like to put into their body that they are using instead. We've also got really honed into doing home inductions, having a lot of harm reduction conversations next slide for me. So with the few minutes I have, and you guys in the panel can cut me off so we can do Q&A I just want to share a little bit about, and these are changed for the HIPPA compliance, these are a few patients we've had in the last couple of months. Sammy Joe is a 16-year-old male he started

using THC and stealing opioid pills from his grandma at 14. He's in trouble with school and tells me "I can't go back until I'm clean" is high school actually does urine drug testing on students and based on urine drug testing decides whether they can stay in school or not. He has been admitted into the big town of, can't remember if it was India or Bloomington, for mental health stay, he did IOP, and he presents because his their fist in one of our office said why don't you go see Doctor Weisman and see if she can help with any of your medications. When I got this young gentleman into my office his mom came with him and his mom broke down in the office and told me about how many of their family members have overdosed and died and that those who hadn't died were on the Suboxone and she really didn't want Sammy Joe to be on the Suboxone but she didn't know what else to do. Another patient we had in the same office was Sherry Sue, she was in a major motor vehicle accident, if one in the car was intoxicated polysubstance is, the driver and passenger in the front seat were dead on impact she was in the back without a seatbelt on she was taken to India or Louisville, she required extensive treatment the first week but was slowly after multiple surgeries able to be weaned back, she had bilateral tibia and humerus fractures that his arms and legs and the love of her life was the front passenger seat driver. She came into me with polysubstance, now she's got major injuries, so dealing with pane as well and she is in the deepest, darkest grief and depression that I have seen in someone in a very long time. She's also lost her source of income which was the love of her life. They no longer have a car because it is demolished and she feels like family is just pulling away from her now, like she's a black cloud. Another patient we had in a different office, Smithy, 28-year-old male he canceled his appointment on the day, I believe this was with Kayla, he was supposed to get one of our buprenorphine subcutaneous injections but later on his friend decides to load them up and bring him into the office because they know that's where they can get help. Get them back there, Stephanie lets Kayla know this guy does not look good and so he appears sedated lethargic, Stephanie tells Kayla, "Wow, his pupils are small, he's really pale. He's breathing but he doesn't look very good." So we literally have this patient show up in our telemedicine just to screen room sometimes I feel like I am Doctor Quinn medicine woman figuring things out but I have to say as hard as it is is also a joy to take care of these folks, so with that being said I am open to any questions or any discussion I know any of our panelists are open to that as well. AMNAH ANWAR: Like Aria mention, if you have any questions with them in the Q&A box, I have a question for you if anything comes up, both of you have used telehealth because in rural that's kind of what we promote as the modality to overcome the barriers to access like transportation childcare stigma and all that. But there are issues to telehealth access in rural as well with those issues Doctor Sarver mentioned other resources,

but how have you overcome those barriers that come with the use of telehealth and what are some ways in which you would think if somebody else wants to adopt telehealth to provide medication for opioid use disorder or other medications to treat substance use disorder and provide the prevention aspect as well, have you done that or what can be done? DR RYAN SARVER: Actually want to go, Doctor Weisman? DR ERRIN WEISMAN: Doesn't matter. DR RYAN SARVER: I will say in two different systems, rural was very different, and I was in Indiana I transferred to VA and Janeway this year so previous to that, reimbursement rates for telehealth were very low. So uptake for telehealth was a big barrier for health systems, and currently CMS is working on that to improve reimbursement for telehealth but I think that's probably the number one barrier on the administrative side to have in telehealth, really come full force and the modality that we can just choose as akin to a face-to-face visit, I will tell you VA is much different if the federal government so I can choose to do a telehealth visit whenever I want and I see a lot more telehealth patience than I did in the private sector. One of the things VA is doing for those elderly patients who are not technologically savvy or for patients who don't have access to this technology is they actually have someone go out to the house with either a tablet or laptop which is case management, then you can have a telehealth management visit with that patient. If that is not feasible, the patient can travel to the nearest healthcare facility that is VA affiliated and they can do a telehealth visit, and that really could be used by the private sector or other healthcare facilities where we have – I don't know about you Doctor Weisman, you probably have an iPad you use for interpretive services, right? I assume that's what's being used that's what I use in most of the rural locations where we didn't have somebody who spoke Spanish or Haitian Creole, you can do that you have the case management go out to a patient's home and use that for telehealth. I think we really need to get creative there are technological solutions out there we just need to get CMS to make them reimbursable so our administrators will find them acceptable as well. DR ERRIN WEISMAN: You do get creative. Usually there is a library, restaurant, gas station that has Wi-Fi, so we find those spots in each of the areas we are at, and I will tell patients if you can get to that parking lot you can get on the Wi-Fi and talk to me. Just because this area of Indiana we are in it does get very hilly, and you can't get a signal down in the hollers, so we have the ability as Doctor Sarver was saying, we have a case manager we actually have a phone designated it's it's you on the desk called the texting phone, it's literally just a work issued cell phone and we get permission from patients to be able to text them directly and sometimes that's all they have, they don't have any minutes left on their phone so they can't call into the office so we call up the texting phone. Case management can take that to them as well and do it telehealth visit but we get creative and sometimes I've

even gone back to old-school home visits I will tell folks if I'm in the local area I'm going to be in the white spring English office if you can get here I will see you we may not put them on the schedule because you know, the creek rises and they can't get out than it is what it is, but just trying to make that availability, and what I really found is if you keep making effort for people and keep showing up for them they will put the effort in as well. Just knowing I'm going to bird-dog them until I get a visit with them or get to see how they are doing, we're to the point at times where we will just send a letter as well like this is the phone number, when you can call us call us here, let us know what you can get in touch and it works, we get registration I think every office does we utilize that as well so I think it is just getting out of the mindframe of this is how medicine has to look and just saying OK, let's get creative here, some of the best solutions have come from my MAs, my team, and it's my job to listen to them and promote these ideas as well. AMNAH ANWAR: Thank you for your response will stop and think we have time for one more question and that's where I think with my work in rural Indiana and the initial pushback I think sometimes even now the provider pushback is that they don't really have the supporting framework to provide substance use disorder treatment, they don't have that supporting network of other providers or even the connection with experts that they can reach out to if they have any specific questions regarding treatments of those main complex patients. I think my main question for you would be while delivering care via telehealth, in the absence of that support and network, or even sometimes case management, what are the barriers – I don't want to say the barriers but one of the solutions that you have found to be useful when reaching out to those patients and treating them just using the telehealth and any other services you just mentioned. DR ERRIN WEISMAN: I would definitely utilize the echoes that are available, echoes are a learning system for which folks show up and specialists show up in the zoo meetings like we do today and me as a primary care Doctor can show up and ask questions and essentially get a face-to-face consult with someone, so I would look up echoes. P CSS is provider sponsor poor old, I think SAMSHA has it, it's easy to get a login there and folks can come if you are a provider get questions answered, you can go back through and see all the questions about all the different substances, how would you approach this, I'm prescribing Usachlorophone they are on clonazepam, help is out there for those who ask. DR RYAN SARVER: There are also some great discussion portals and as primary care provider you can ask a question in their forms on their were other foundation specialist will answer the questions and there's also a great resource of utilize before as far as telehealth resources I usually promote Docsimity because it is free and HIPPA compliant but I believe a lot of them are HIPAA compliant, so check with your administration what's compliant or if you are a solo practitioner,

Docsimity, they have the ability to private text and private call your patient so your patient doesn't get your private number and you consent and email to their phone and they could pop in a little video like yours was great resource. AMNAH ANWAR: I think there was a question about putting some of those resources in the chat the information on the other so if we are not able to do that, I will get those for you Doctor Sarver and DoctorWeisman. One more question from the Q&A, do you recommend the use of an in-person visit at some point over the course of treatment, when using telehealth. And if so, at what point? DR RYAN SARVER: An in-person visit is always going to be superior to a telehealth visit. You are going to gain way more clinical information by being able to see your patient face-to-face. But it should never be a barrier to saving their life. Really you have to triage based on that, if all they need is buprenorphine and Narcan you should not mandate you see them face-to-face. At some point it will be useful in your relationship to see them face-to-face but again the number one thing is saving lives, so if that's going to be a barrier to their care, don't mandate that. AMNAH ANWAR: Doctor Weisman to have anything to add? DR ERRIN WEISMAN: Just like we're doing Zoom today, online friends are still friends, I think I still have meaningful patient interactions through the computer screen. I do occasionally go to the sites when I am available, I am a hugger, to go and give them a huge hug, congratulate them, celebrate a big sobriety milestone with them, yes we would all love to do things in person, however like Doctor Sarver was saying, this work is still meaningful, you still get a lot of good information, you still get the trust you build, that doctor-patient relationship and this is the way that it needs to happen, great. I mentioned before I do some online coaching about physician burnout, I talked to physicians all around the country, I would say the relationship that I have with those folks are just as meaningful, can I get a good year exam from the computer screen? Absolutely not. So sometimes I say this is bigger than telehealth I need some to lay hands on you whether that be urgent care or if they are willing to make the drive into Jasper I will say if you can, I will see you, and I think for folks when they do come and make the drive here I know what it takes to get them here and how much I just appreciate them doing that. AMNAH ANWAR: What I'm hearing is if telehealth is the only thing available then it's not mandatory to have that in person, as it is needed for some other ailments or any other services that they need. DR ERRIN WEISMAN: As of right now, yeah. AMNAH ANWAR: I think we are out of time, just put in the information for Luke, he is the Director of the Upper Midwest telehealth center, and you can wrap it up. ARIA JAVIDAN: Just a announcement our next meeting is held by the Southwest telehealth center infiltration at the NT CRT webpage, we ask you take a few short minutes to compete the server that will pop up at the conclusion of the webinar, your feedback is very valuable to us, thank you again to the Upper Midwest

Telehealth Resource Center for hosting today's webinar and to Doctor Sarver and Doctor Weisman for the presentations today. Have a great day, everyone.