SUMHI Action Update 3-29-21

Lessons Learned during COVID-19

Welcome

Sally Kraft MD, MPH; V.P. for Population Health D-HH
Will Torrey, MD; Interim Chair, D-HH Dept of Psychiatry
Leaders, D-HH Substance Use & Mental Health Initiative (SUMHI)

The D-HH Substance Use & Mental Health Initiative envisions ***A healthcare system where mental health & substance use disorders are treated with the same urgency, respect and seriousness of purpose as other illnesses and where discrimination does not occur.***

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SUMHI Action Update Program

Lessons Learned during COVID-19

- **5:00-5:05 Welcome & Updates** *Sally Kraft & Will Torrey*
- **5:05-5:10 Your COVID-19 experience in a single word**
- **5:10-5:40 Four brief presentations on lessons learned**
  - Doorway & ATP - *Luke Archibald*
  - Psychiatry and mental health care - *AJ Horvath, Julie Balaban*
  - Hospice and palliative care – *Kathleen Broglio*
  - Perinatal care in recovery – *Julie Frew, Daisy Goodman*
- **5:40-6:10 Small group exercises exploring**
  - What has changed in our work? For better? For worse?
  - What do we want to take forward?
  - What do we need to do to make it happen?

  Facilitators: Jacqui Baker, Stephanie Cameron, Holly Gaspar, Angie Raymond Leduc
- **6:10-6:30 Back together to share themes and identify collective actions**

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Session Requests & Info

- Please chat message us now with your name, department or organization & email
- Mute, unmute to speak
- Submit questions/comments by chat
- Slides, other materials will be posted at SUMHI website, will send link.

CME Information

RSS: Substance Use & Mental Health Initiative

Session Date: March 29, 2021 Topic: SUMHI Action Update

Session Speakers: Luke Archibald, MD, Julie Balaban, MD; Julia Frew, MD; Daisy GoodmanDNP, APRN, CNM; Kathleen Broglio, DNP, APRN

Activity Code For This Session Only: j4JH

Use This Number to Text Requests For Credit: 603-346-4334

(Must login at http://www.d-h.org/clpd-account to setup account and register mobile phone number)

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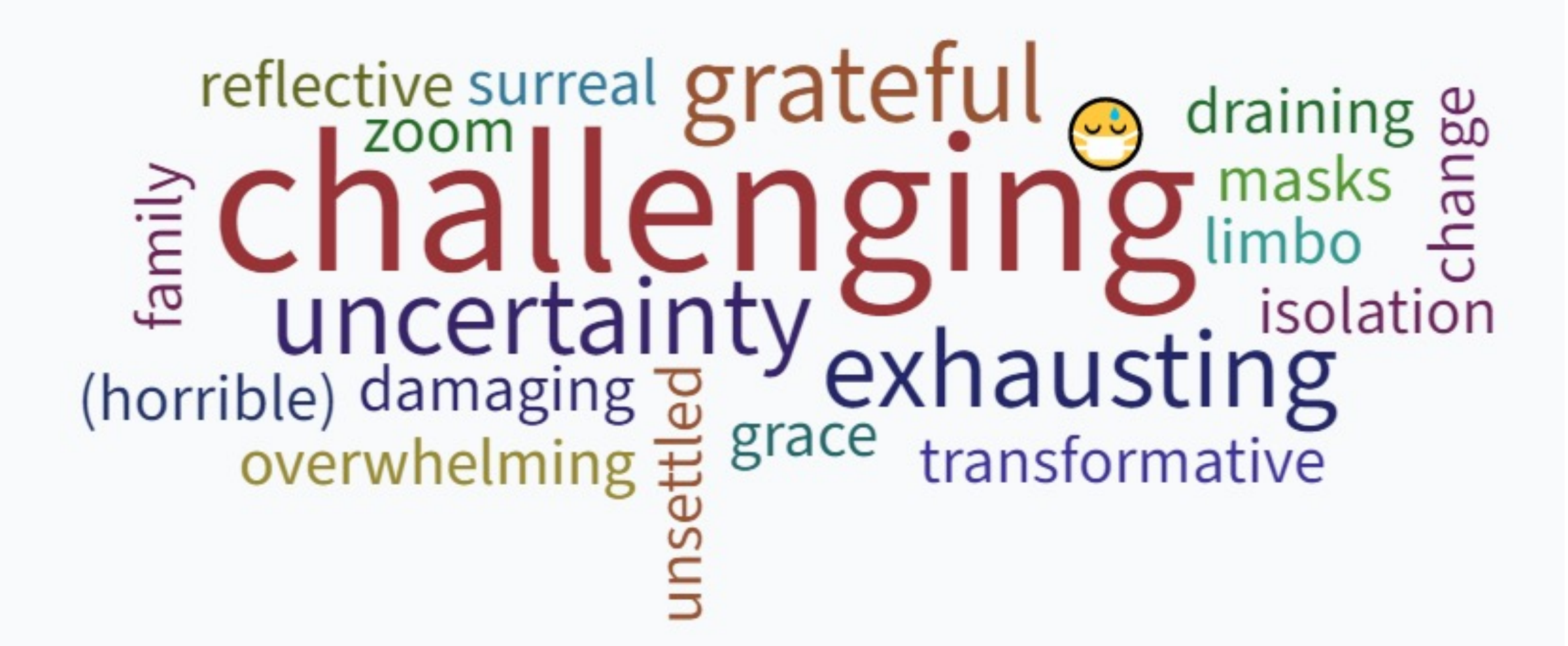
Learning Outcome Statement:

Participants will be able to identify and implement clinical strategies to better evaluate and address substance use and mental health disorders throughout the health system.

Conflict of Interest

The RSS Physician Director(s), planning committee member(s), speaker(s), author(s) or anyone in a position to control the content for Substance Use & Mental Health Initiative have reported NO financial There were no individuals in a position to control the content that refused to disclose. interest or relationship* which could be perceived as a real or apparent conflict of interest. In accordance with the disclosure policy of Dartmouth-Hitchcock/Geisel School of Medicine at Dartmouth as well as standards set forth by the Accreditation Council on Continuing Medical Education and the Nursing Continuing Education Council standards set forth by the American Nurses Credentialing Center Commission on Accreditation, continuing medical education and nursing education activity director(s), planning committee member(s), speaker(s), author(s) or anyone in a position to control the content have been asked to disclose any financial relationship* they have to a commercial interest (any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on patients). Such disclosure is not intended to suggest or condone bias in any presentation, but is elicited to provide participants with information that might be of potential importance to their evaluation of a given activity. * A “financial interest or relationship" refers to an equity position, receipt of royalties, consultantship, funding by a research grant, receiving honoraria for educational services elsewhere, or to any other relationship to a company that provides sufficient reason for disclosure, in keeping with the spirit of the stated policy.

What single word best describes your personal experience of COVID-19?



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COVID-19 Lessons Learned

Addiction Treatment

Luke Archibald, MD, Section Chief Addiction Treatment Center

Addiction Treatment Program (ATP): COVID-related changes

- Group visits (including IOP) = remain telehealth
- Individual visits = mix of in-person and telehealth
  - Provider visits = majority telehealth
    - 91% of remote provider visits are telephone visits
  - Gradually increasing in-person visits
    - April 2020 = 9% in person
    - February 2021 = 19% in person
- Urine drug screens obtained via separate nursing visits with limited face to face contact
  - Not required for every visit for routine monitoring

ATP: Subjective Telehealth Group Experience

- Overall preference for in-person group > telehealth group
- Telehealth sufficient for many
- Some prefer convenience of telehealth groups

ATP: Subjective Telephone Visit Experience

- Telephone visits unsatisfying to provider
  - No visual information
  - Unlike video visits, does not require patient to initiate the visit
  - No UDS at time of visit
- Telephone visits more efficient for provider
  - Fewer no shows
  - Can start on time with most recent UDS available (or not)
- Telephone visits preferred by most patients
- Assumptions on effectiveness
  - Telephone and telehealth sufficient for established patients
  - More frequent in person visits necessary for people new to treatment

ATP: Data on Provider Visits

- February 2020 snapshot
  - 337 unique people seen by physician
    - 264 (78%) completed an ATP visit in February 2021
    - 9 (3%) still enrolled with completed visit in March 2021
    - Other “good” outcomes: 7 (2.1%) moved away from NH/VT; 5 (1.5%) transferred to primary care; 6 (1.8%) transferred to alternative program; 3 (0.9%) apparent successful med d/c
    - 10.5% lost to follow-up
  - No difference between clinic programs
- February 2019 snapshot
  - 264 unique people seen by physician
    - 191 (72%) completed ATP visit in February 2020

ATP: Established Patients “Conclusions”

- High retention rates for established patients
- Slight positive effect in favor of telehealth for treatment retention (unclear if significant)
- Other measures of treatment effectiveness unavailable

ATP: Data on Provider Visits for New Patients

- April 2020 – December 2020
  - 74 new provider evaluations (total clinic)
    - 35 (47%) completed an ATP visit in February 2021
    - Many of these non-MAT visits (eg, patients in IOP with time-limited treatment)
- April 2019 – December 2019
  - 185 New evals
    - 93 (50%) completed an ATP visit in February 2020

ATP: Data on Provider Visits for New Patients

- April 2020 – December 2020
  - General clinic: 28 of 56 (50%) completed visit in February 2021
- April 2019 – December 2019
  - General clinic: 81 of 164 (49.4%) completed visit in February 2020

- April 2020 – December 2020
  - Moms in Recovery: 7 of 18 (39%) completed visit in February 2021
- April 2019 – December 2019
  - Moms in Recovery: 17 of 27 (63%) completed visit in February 2020

ATP New Patients: Conclusions

- No difference in general clinic 2019 vs 2020
- In person retention for Moms in Recovery 2019 > 2020
- Many limitations in this data
- Individuals with more complex circumstances may benefit from in-person, multidisciplinary engagement

Department of Psychiatry

Lessons Learn from the Pandemic

AJ Horvath, Director of Psychiatry Administration
Julie Balaban, Section Chief, Child & Adolescent Psychiatry
Director of Child Clinical Services

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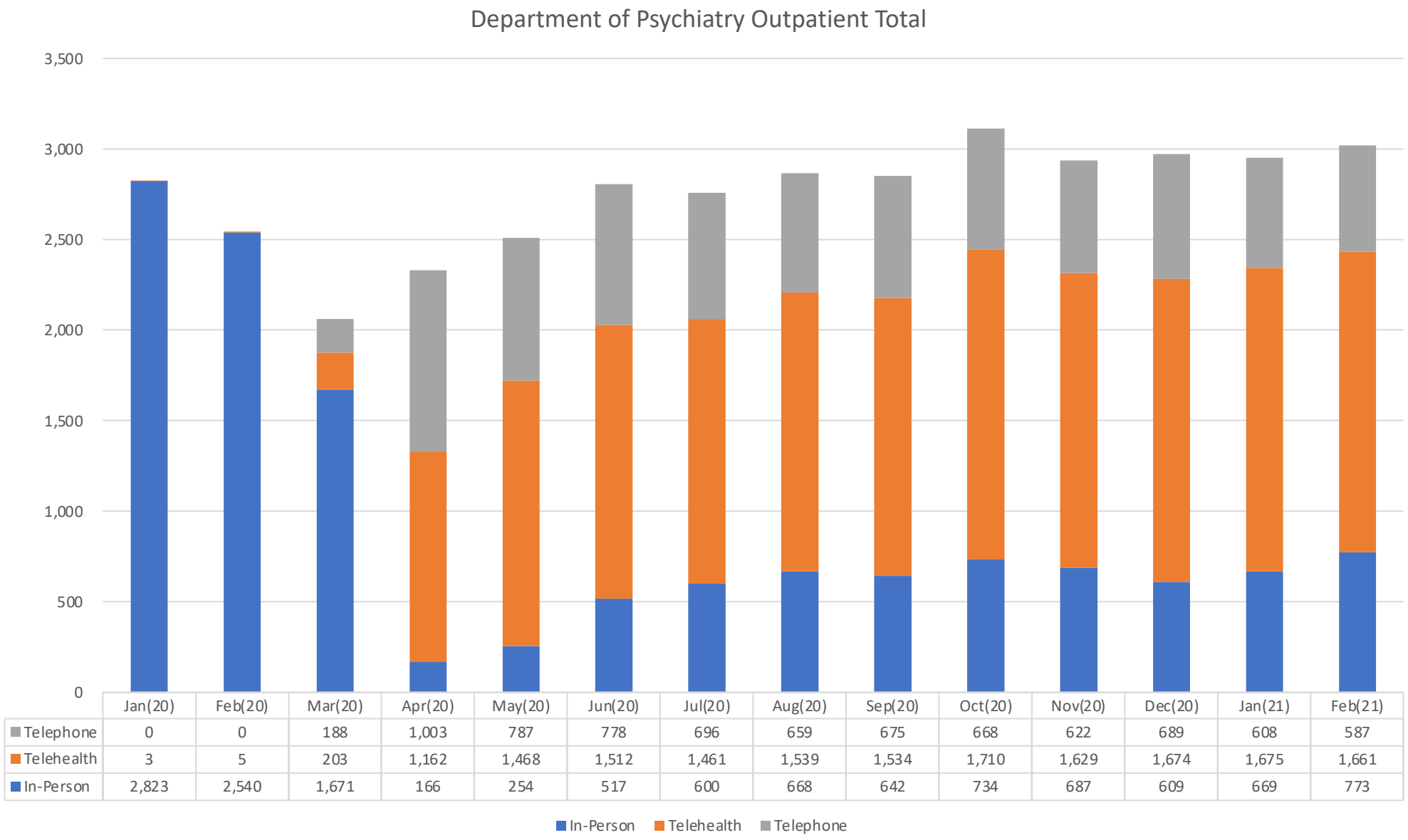
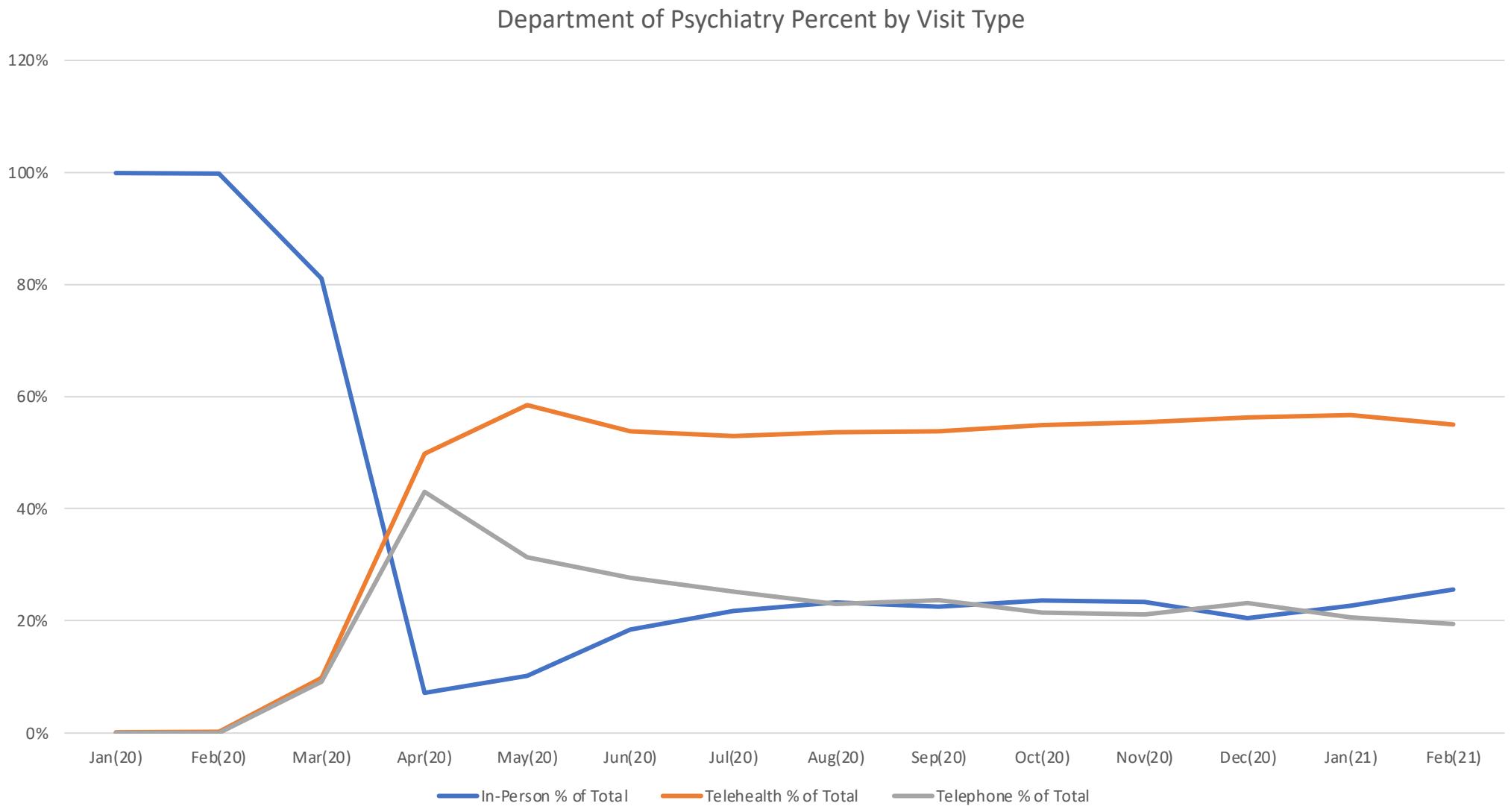


	Jan(20)	Feb(20)	Mar(20)	Apr(20)	May(20)	Jun(20)	Jul(20)	Aug(20)	Sep(20)	Oct(20)	Nov(20)	Dec(20)	Jan(21)	Feb(21)
Telephone	0	0	188	1,003	787	778	696	659	675	668	622	689	608	587
Telehealth	3	5	203	1,162	1,468	1,512	1,461	1,539	1,534	1,710	1,629	1,674	1,675	1,661
In-Person	2,823	2,540	1,671	166	254	517	600	668	642	734	687	609	669	773


Department of Psychiatry Percent by Visit Type
120%
100%
80%
60%
40%
20%
0%
Jan(20)
Feb(20)
Mar(20)
Apr(20)
May(20)
Jun(20)
Jul(20)
Aug(20)
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Oct(20)
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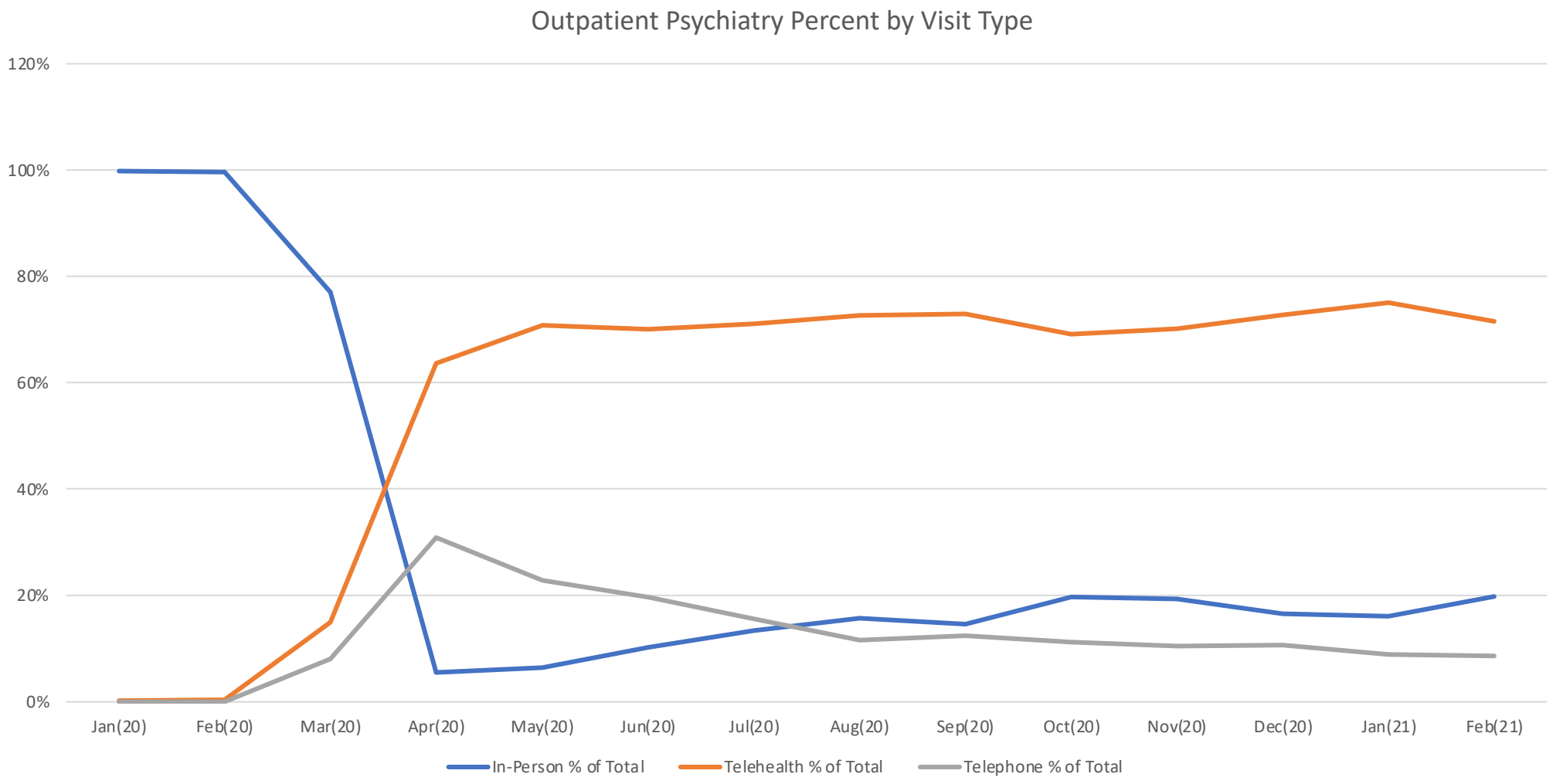
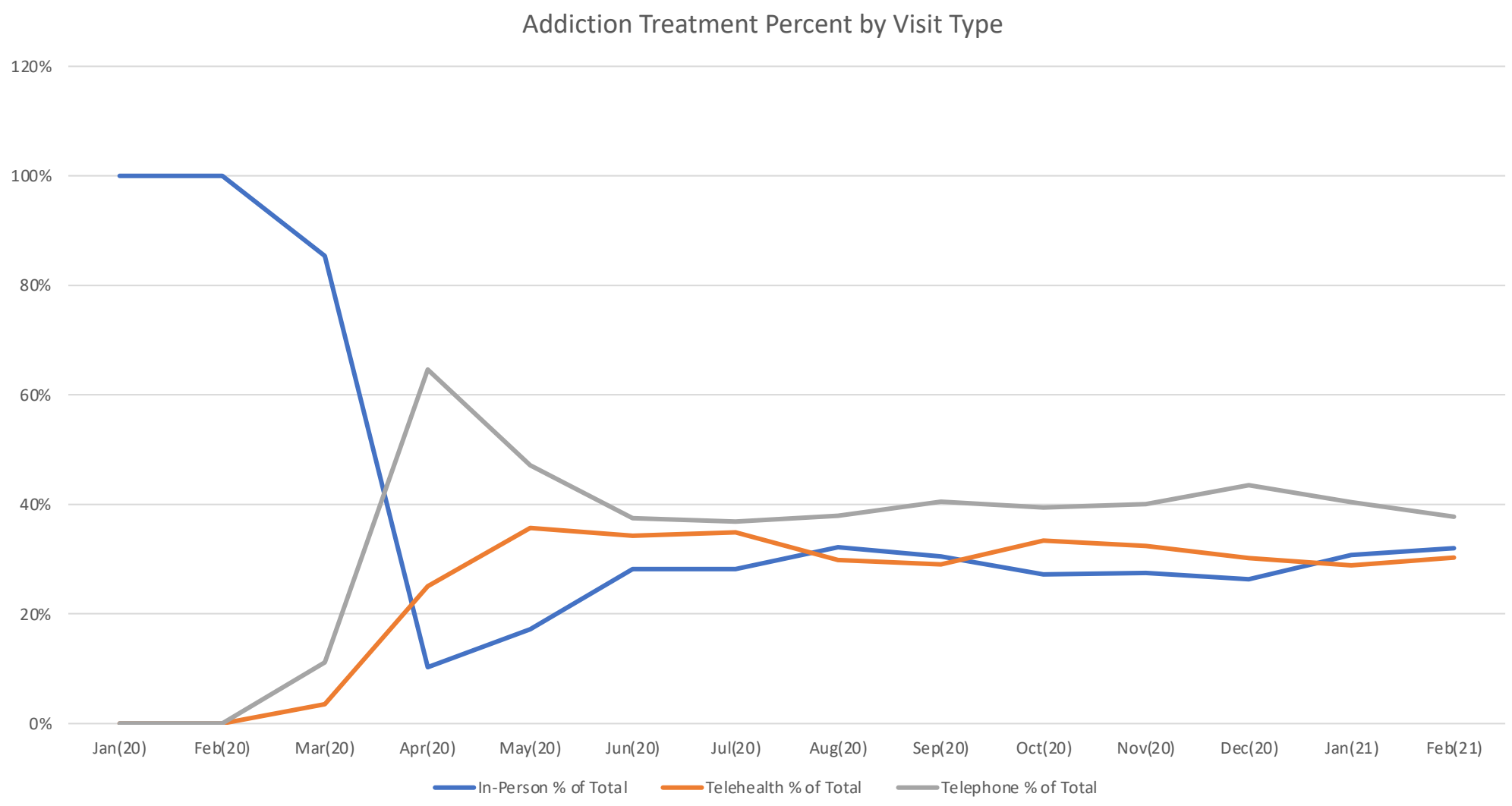
Dec(20)
Jan(21)
Feb(21)
In-Person % of Total
Telehealth % of Total
Telephone % of Total


Outpatient Psychiatry Percent by Visit Type
120%
100%
80%
60%
40%
20%
0%
Jan(20)
Feb(20)
Mar(20)
Apr(20)
May(20)
Jun(20)
Jul(20)
Aug(20)
Sep(20)
Oct(20)
Nov(20)
Dec(20)
Jan(21)
Feb(21)
In-Person % of Total
Telehealth % of Total
Telephone % of Total


Addiction Treatment Percent by Visit Type
120%
100%
80%
60%
40%
20%
0%
Jan(20)
Feb(20)
Mar(20)
Apr(20)
May(20)
Jun(20)
Jul(20)
Aug(20)
Sep(20)
Oct(20)
Nov(20)
Dec(20)
Jan(21)
Feb(21)
In-Person % of Total
Telehealth % of Total
Telephone % of Total

Lessons Learned

1. Technology matters. The quality of what is available is strongly associated with success.
2. Change is hard. Introducing new processes under stressful situations is even harder.
3. Despite #s 1 and 2, most patients can be tolerant, patient and grateful.
4. Because of #s 1 and 2, some patients became more stressed, and refuse to try again.

Benefits of Telehealth

- Easier for patients: Less travel means less expense and less time needed. Less travel also means less exhaustion and frustration
- Able to remain at home: Providers can see better what home is like. Patients are often more relaxed in home setting.
- Can include more people more easily: With our new/current platform, can have multiple participant sites, so more family members or service providers can be at the appointment.
- Easier to complete appointments that might be forgotten: If the provider can reach the patient, the visit can occur in almost all places right then.
- More ability to provide care regardless of weather, car breakdowns, etc.
- Flexibility of location helps providers to continue working when there are family urgencies, sick kids, etc.

Other Learnings

- Despite many structural barriers being removed under emergency orders related to the pandemic, the mental health crisis was not cured
- Telehealth alone does not increase capacity for care delivery. We still need increases in workforce and innovation in care delivery models
- Telehealth allowed us to continue care and not shut down completely
- Rural populations experienced higher barriers to telehealth
- Not all populations were impacted equally

COVID-19 Lessons Learned

Palliative Care

Kathleen Broglio, DPN, ANP-BC, ACHPN

Dartmouth-Hitchcock

Rural Palliative Care Patients' Attitudes toward Telemedicine Visits during the COVID-19 pandemic – a Descriptive Study

Kathleen Broglio, DNP, ANP-BC, ACHPN, CPE, FPCN

Kathryn B. Kirkland, MD, FAAHPM

Section of Palliative Medicine

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7-2020

Background/Aims

- Background
  - Early in the COVID-19 pandemic, there was a rapid shift to the use of telemedicine visit in our palliative care ambulatory setting
  - Given the sensitive nature of palliative care visits, clinicians questioned whether patients would find these virtual visits acceptable
- Aims
  - Describe patient experience with the use of telemedicine for outpatient palliative care visits
  - Identify factors associated with preference for telemedicine versus in-person visits

Methods/Demographics

- Anonymous survey sent via mail and email to 199 patients who had telemedicine visits during the months of April to June 2020
- Response rate 70 patients (35%)
- Patients who had died prior to start of study were excluded

Patient Demographics (*n* = 70)

Demographics, *n* (%)	All
Female	37 (54)
Male	31 (46)
Age, median (range)	65 (26-94)
Miles drive to/from medical center, median (range)	70 (4-200)
Type of visit with MD or NP, *n* (%)	
First time	5 (7%)
….Follow-up	44 (63%)
….Both first time and follow-up	20 (29%)
Telemedicine Medium, *n* (%)	
Telephone	23 (34%)
Video	30 (46%)
Both	15 (21%)
*Telemedicine visits prior to COVID-19, *n* (%)	10 (14%)

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Results

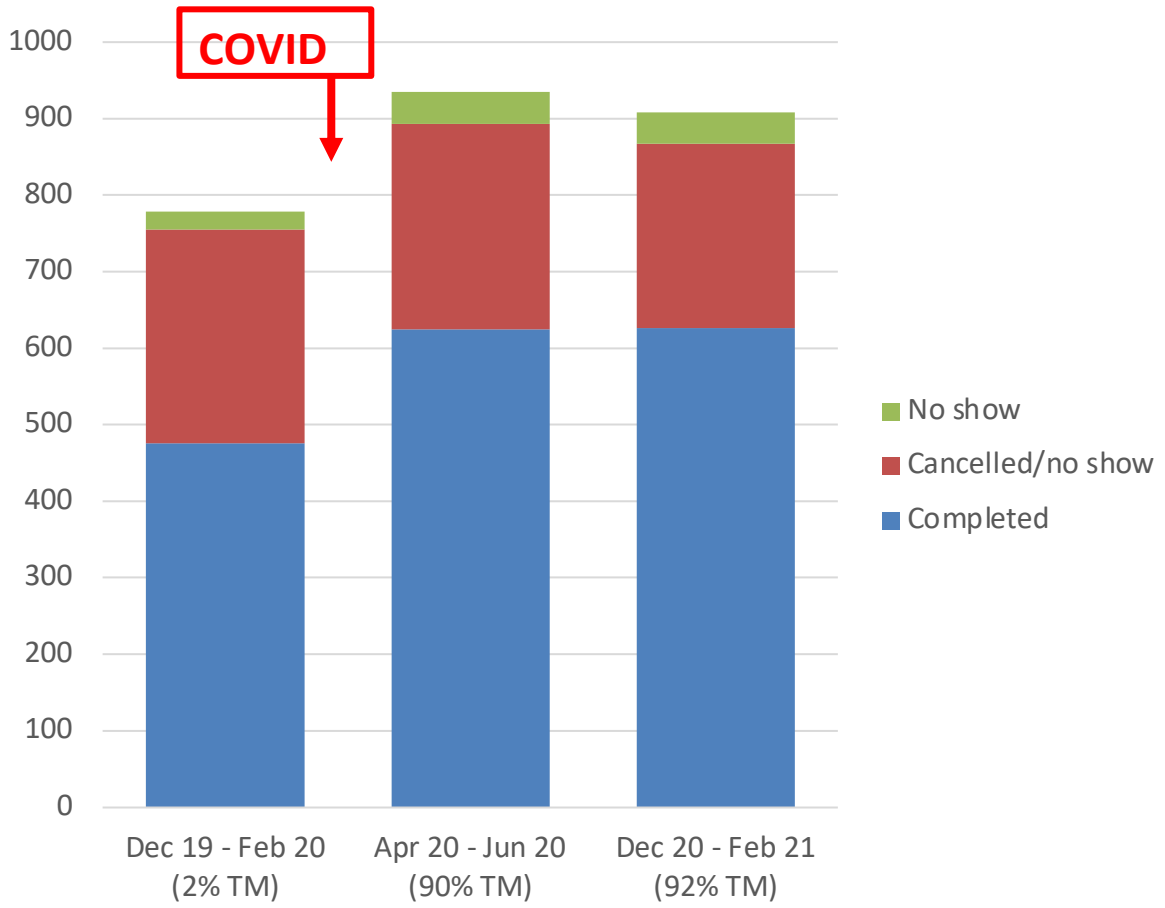
- 67 (96%) reported communicating easily with clinician
- 69 (99%) agreed that their needs met during the telemedicine visit
- 61% of respondents want to continue telemedicine visits even if no COVID-19 risk
- For patients who wanted to continue telemedicine visits, convenience and physical comfort were cited as the main reasons
- For those patients who preferred to resume in person visits reported more comfort with communication with a clinician in person, especially around sensitive topics

Additional Findings – Clinician Perception

- Clinicians reported attitudes were very favorable despite initial infrastructure challenges
  - Increased efficiency related to appointment structure (no need to find patients in different clinics, wait for them to be roomed)
  - Multiple clinicians/family members able to join in visit simultaneously
  - Easier ability to flex schedules to align with other specialists
  - Added time to pre/post-brief with palliative care fellows-learners as travel time to next visit eliminate

Additional Findings – Visit History

- Dec 2019 – Feb 2020 782 scheduled visits
  - 476 completed visits
  - 279 cancelled/24 no show (38.7%)
  - **2% visits telemedicine**
- April 2020- June 2020 944 scheduled visits
  - 625 completed visits
  - 268 cancelled/42 no show (32.8%)
  - **90% visits telemedicine**
- Dec 2020- Feb 2021 910 scheduled visits
  - 626 completed visits
  - 241 cancelled/41 no show (30.9%)
  - **92% visits telemedicine**



Conclusions

- Majority of patients find telemedicine visits acceptable/preferable
- Clinicians report increased efficiency related to telemedicine
- Ability to schedule more patients due to decreased room need
- Potential cost-savings (decreased room change overs, decreased staffing time rooming patients/cleaning rooms)
- Decrease in no show/cancellation rate

MAKING TELEHEALTH WORK AT MOMS IN RECOVERY AND THE OB/GYN PURPLE POD

JULIE FREW, MD

DAISY GOODMAN, DNP, MPH, CNM

BENEFITS OF TELEHEALTH

In response to the COVID-19 pandemic, both the Moms program and obstetric providers at Dartmouth-Hitchcock rapidly transitioned to virtual visits for as much care as possible

- Maximizes physical distancing
- Can improve access to care for patients who live far away
- Widely promoted and accepted for substance use treatment
- Alternating with in-person visits, a safe option for prenatal care for many patients
- Does telehealth provide a non-threatening opportunity for initial engagement?

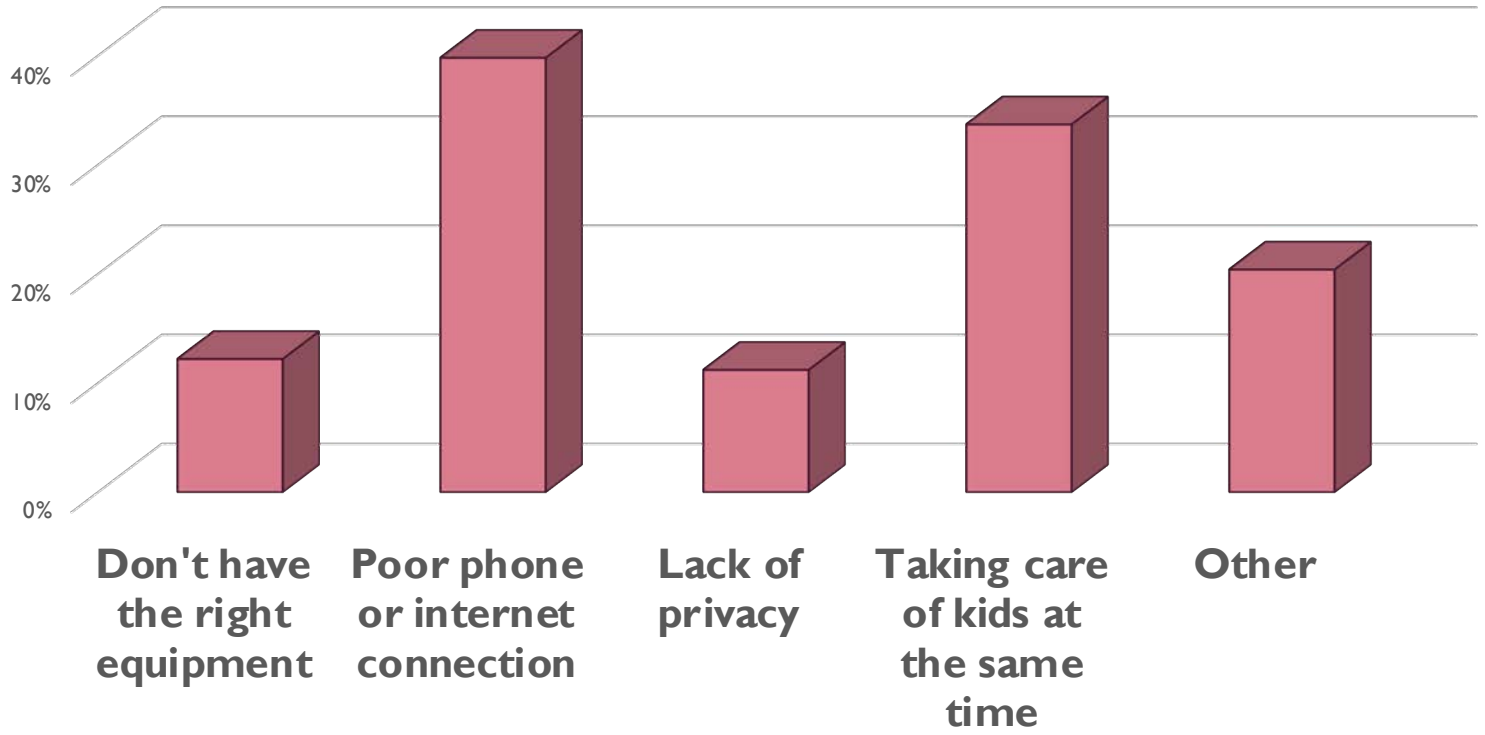
RISKS

Equal access to telehealth is not guaranteed

- No internet connection
- Weak phone signal
- Cost of devices, cell phones, “minutes”
- Lack of comfort with technology
- Lack of private space to conduct visit

BARRIERS IDENTIFIED BY PATIENTS PARTICIPATING IN TELEHEALTH FOR PRENATAL CARE (APRIL-OCTOBER, 2020)

Are there things that make telehealth visits hard?



LESSONS LEARNED

- Overcoming barriers requires flexibility and effort
- Community Health Workers/Resource Specialists play important technical assistance roles
- Patients have a variety of technology needs
- Asynchronous communication (texting)

SPARK CELL PHONE PROGRAM

- Pilot study of cell phone deployment to reduce disparities in telehealth access
- Pregnant patients screened at initiation of care
  - *(1) Does lack of a phone, data plan, or cell phone minutes keep you from being able to attend virtual appointments with your providers?*
  - *(2) If possible, would you use a cell phone as a primary communication tool with your care team?*

RESULTS

6 months later…

24 phones and 91 data cards have been distributed

Participants use phones for many healthcare-related reasons

- Initially, running out of minutes was a significant barrier
- The program now provides monthly unlimited data cards

Costs vs. benefits…

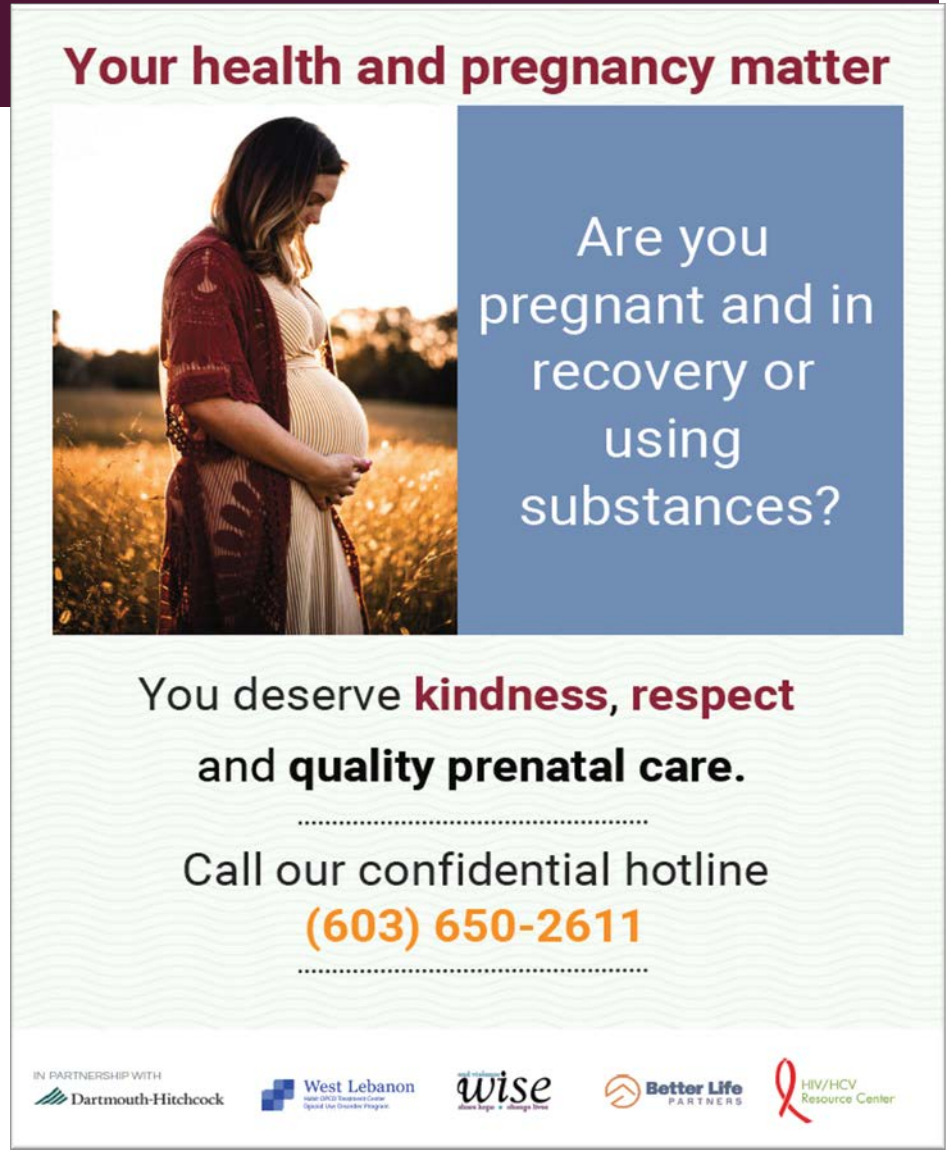
$60	(Straight Talk phone)
$50 x 12	(Unlimited monthly data)
$660	(Total per patient cost)

vs.

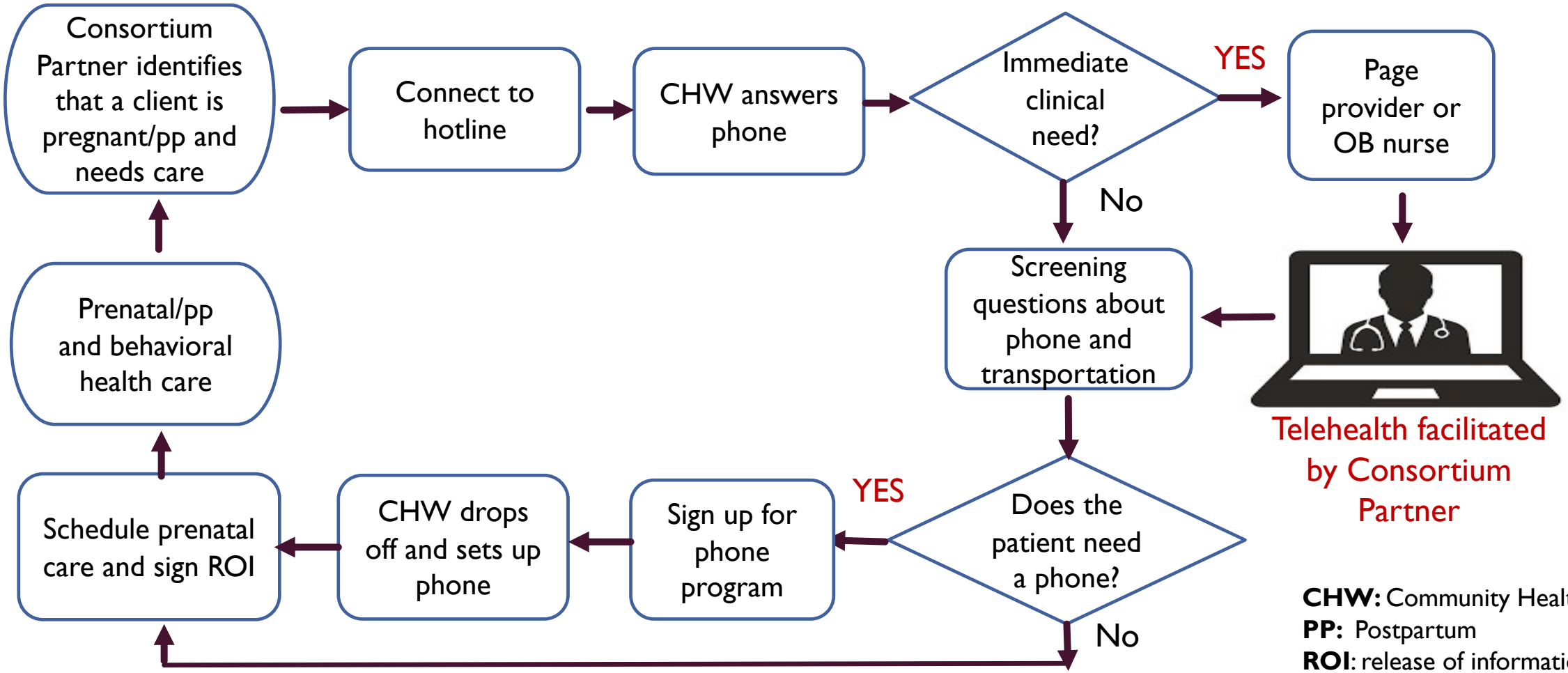
Benefits of getting help in the event of a psychiatric or obstetric emergency?

Getting The Word Out

- PERINATAL SUD HOTLINE



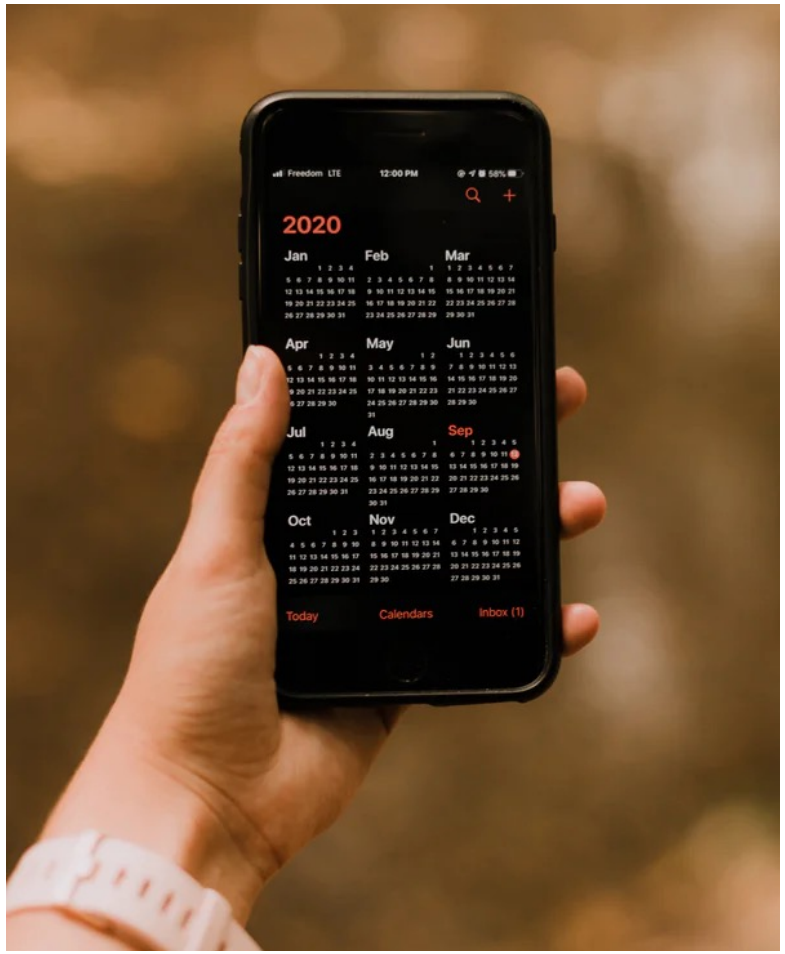
HOTLINE PROCESS



CHW: Community Health Worker
PP: Postpartum
ROI: release of information

LOOKING FORWARD

- Maintaining engagement requires effort and multimodal communication (texting, patient portal, telehealth visits)
- Advocacy for state/federal policy to support unlimited smartphone access is needed
- Audio-only telehealth is often the only feasible or acceptable alternative for patients

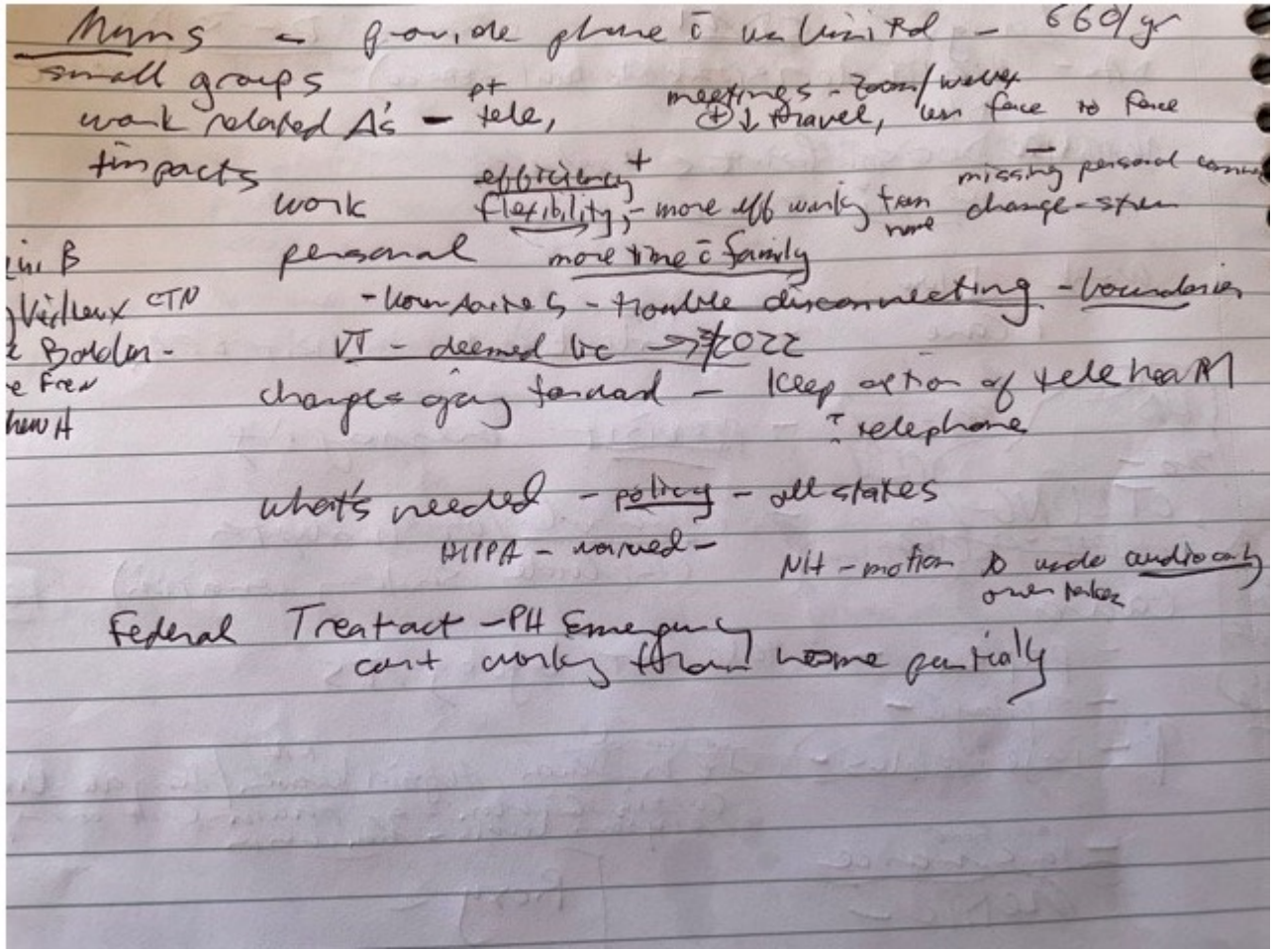


Lessons learned from COVID-19

- Small Groups
  - What work-related changes have you experienced during COVID-19?
  - What were positive & negative impacts of these changes on
    - Work quality, products, patient experiences, or outcomes?
    - Your own work & home life, health, and life in general?
  - What changes do you hope will continue going forward?
  - What is needed to make that happen?
- Facilitators: Jacqui Baker, Stephanie Cameron, Holly Gaspar, Angie Raymond-LeDuc
- Note-takers: Charlie Brackett, Mary Evanofski, Laura Fineberg, Sally Kraft

UNEDITED NOTES FROM BREAKOUT SESSIONS FOLLOW!

Baker/Brackett



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Cameron/Evanofski

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COVID-19 Behavioral Health Work Changes

For patients, for workers, for systems

What has changed?

- Repercussions of the boarding crisis - it's a people crisis
  - people with developmental disabilities became unregulated
  - People with mental health issues and underlying intellectual capacity not understanding and struggling
  - people with severe psychosis not willing or not able to take their meds
  - More people with suicidal ideation
  - Patients really violent sometimes
  - More adolescents and kids in the ED

Impact of change (pos & neg)

- Burden on ED
- Staffing is not adequate and staff exhaustion is high
- With more violence, families less willing/able to take their loved ones home
- Longer waits for NH Hospital; NH Hospital have no where to discharge patients to
- State to start Step Up & Step Down
- More training for staff in how to defuse and if necessary protect themselves in violence

COVID-19 Behavioral Health Work Changes

For patients, for workers, for systems

What has changed

- Housing even more difficult than ever
- Capacity of Comm Mental Health centers is stretched
- For Moms in Recovery – not having in person visits has been challenging
  - High dose fentanyl users requiring methadone
  - Moms in despair and sadly more suicide attempts
  - Even more evident that program success for individuals is about treatment AND fundamental social supports

Impact of change (pos & neg)

- More people and organizations talking about housing solutions
- Relationship between hospitals and community mental health centers is essential
- More apparent that finding out if a patient has a phone to contact provider when in need is fundamental.
- Even more collaboration between the ObGyn & Psychiatry Depts
- More apparent need for a residential program for MIR

COVID-19 Behavioral Health Work Changes

For patients, for workers, for systems

What has changed

- Training through video
  - Virtual meetings and videos have opened the door to out of state presenters of high caliber
- Working from home – rotation has freed up time with a reduction in commute time and ability to multitask home activities (making dinner)

Impact of change (pos & neg)

- Will continue to do some video training, expanding reach
- Most want to retain some ability to work at home some times.

COVID-19 Behavioral Health Work Changes

For patients, for staff, for systems

If you could keep one thing from the past year what would that be?

- Collaboration on several levels: between departments, between organizations and with the state
- Team thinking - we've learned that in the face of challenge, team thinking brings innovation
- Appreciation of the multimodal needs of patients
- Give phones to patients who don't have them
- Hope that the collective raised consciousness of the mental health crisis, so intricately enmeshed in the COVID19 pandemic, will continue to bring about discussion and policy changes

Gaspar/Fineberg

COVID-19 Behavioral Health Work Changes

For patients, for workers, for systems

What has changed?	Impact of change (pos & neg)
• Technological challenges early on (addressed quickly) • Never worked from home before! • Isolation from colleagues • Ability to attend more meetings when on telehealth • Household of 1 as a benefit in this situation (not always in others) • Added Stress of the impact of COVID-19-bringing home to others who are vulnerable • Technology more challenging for some (hearing impairment, etc.)	• Facilitation of Attendance and participation of mtgs, etc. – for clinicians, travel not a barrier between visits • Enhanced relationships in some circumstances

COVID-19 Behavioral Health Work Changes

For patients, for staff, for systems

What to keep?

- Maintain improved lifestyle aspects
- Ability to continue to work from home and provide telehealth svcs to patients
- Flexibility to be in-person, remote or hybrid of both
- Continuation of collaboration of different sectors (generated creativity!)
- More time with family – ability to manage personal/family issues while working remotely

What is needed to continue?

- CMS needs to continue to reimburse for patients visits
- Organizational & supervisor support, creativity in maintaining valuable components of in-person work ('water cooler' chat) while remote
- PROACTIVE Investment in the things that make coming back in-person valuable - does everyone want to continue WFH?

Raymond Leduc/Kraft

COVID-19 Changes

For patients, for workers, for systems

What has changed?

- Everything changed—all new processes, new structures (plexiglass!), new workflows, new everything!
- New clinical care –telehealth delivery
- Patients coming to ED with more complex problems due to avoiding care
- Greater volume of mental health disease in the ED
- Risk management being done via telemodalities—court cases being done virtually

Impact of change (pos & neg)

- Pride in making big changes, energized by making important change,
- Effective teaching remotely (yoga!).
- Able to work with geographically spread teams
- Decreased transportation problems for patient. Telehealth works well with established patients (not as good for new patients).

COVID-19 Personal Life

For patients, for workers, for systems

What has changed	**Impact of change (pos & neg)**
• More time at home • More appreciation of working AT WORK. Appreciates being at the office at times •	• Able to have more “routine calmness” i.e. more time at home, more time outdoors • More time to get things down at home • Understanding the importance of 3D work (in person) and 2D work (remote, zoom)

COVID-19 Practice Changes

For patients, for staff, for systems

What to keep?

- Decrease stigma around mental health. More people willing to seek care.
  - This has exacerbated the shortage of mental health providers
- Restructured leadership team at psych has been a positive. Brought forward additional leaders, a more democratic leadership structure, more problem-solvers

COVID-19 Behavioral Health Work Changes

For patients, for staff, for systems

What to keep?

- We can be innovative and cooperative. Let's not depend on a crisis to keep these attributes.
- Sense of humanity, we are in this together. Sense of caring, compassion, understanding.
- Pride in productivity despite the chaos, tumult.

What is needed to continue?

- Commitment to not letting old barriers get in the way
- Will to do the right things. Need to find the ways to sustain the successes of the past year.

COVID-19 Important Positive Benefits

What to keep?

- Decrease commutes—improved environment. We have had less impact on our ecosystem. But we want to get together!
- Improved education opportunities—national speakers, attending virtual conferences outside of one's own clinical department

What is needed to continue?

- Ways to work remotely but blended with in-person opportunities.
- Maintain virtual educational sessions. Ways to promote/advertise cross-department learning opportunities.

COVID-19 Behavioral Health Work Changes

For patients, for staff, for systems

What to keep?

- Improved leadership system, more democratic, honor the knowledge and expertise of the division leaders and gives them more power to be problems solvers
-

What is needed to continue?