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NAADAC VIRTUAL TOWN HALL:
UNDERSTANDING THE IMPACT OF COVID-19
ON THE ADDICTION PROFESSION

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>> SAMSON TEKLEMARIAM: Hello everyone, and welcome to today's webinar on understanding the impacted of COVID-19 on the addiction profession, a virtual town hall event. It is great that you can join us today. My name is Samson Teklemariam and I'm the director of training and professional development for NAADAC, the association for addiction professionals.

I'll be the facilitator for this virtual town hall.

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COVID-19-virtual-town-hall-webinar.

We are using go to webinar for this virtual town hall event. You'll notice the go to webinar control panel that looks like the one you see here right on my slide. Here are some important instructions. You've entered into what's known as listen only mode. Your mic is muted. If you have trouble hearing the panel for any reason, consider switching to a telephone line using the audio option which is right next to the orange arrow in your control panel. You can use that orange arrow anytime to minimize or maximize the control panel. If you have any questions for the panel, just type them into the questions box. We'll start by providing questions to the panelists from the ones you entered when you did your registration for this webinar. Then we'll start pulling from your questions from the live audience, and you'll also notice on that same tab, a handouts tab, with a copy of our slide deck. There's not a lot in the slide deck. It's just for our Q and A, but if you want to download that and also in the handouts tab is a quick reference guide on how to get your CE from there event.

Lastly, in the questions box, throughout this webinar, please share any innovations that you have found successful. Anything that you tried to leverage something positive from this new environment and all the changes we've experienced, just enter the word innovations in all caps in the questions box. Then your name and your location. And then share your experience. We'll collect and gather your ideas, and share them with the panel and the audience towards the end of this webinar.

All right. So now let me introduce you to our panelists for this virtual town hall event. First Dr. Thomas Britton has been involved in the behavioral health field for only 25 years and his extensive work history provides a rich background of the president and CEO of the nation's largest nonprofit treatment provider specializing in substance use treatment. The Gateway Foundation. Tom is committed to lifelong learning, completing a doctorate in public health at the Gillings school of global health, a master's degree in addiction treatment and master in marriage and family therapy. He's also taught and lectured throughout the country and is considered an expert in the intersection of addiction and the larger concept of addiction and public health policy.

Also with us today is Lisa Dinhofer, who mentors companies to regain stability. She is a certified thanatologist with a subspecialty in trauma, trained council, trained mediator and a crisis communication specialist with more than 18 years of professional experience training, consulting, coaching, debriefing and public speaking.

Lisa currently serves as a designated coach for 1,000 days sober and strive, she has personally experienced the trauma and

heartache from a loved one struggling with opioid addiction. She served at Hood College and a president of Koden consulting services and founder of crisistamerclub.com.

Lastly we are fortunate to have with us Dr. Andrew Kolodny, the co-director of the opioid policy research at Heller School, Brandeis university. His primary area of focus is the prescription opioid and heroin crisis devastating families and communities across the country. Andrew is also the executive director of physicians for responsible opioid prescribing, an organization with a mission to reduce morbidity and mortality caused by overprescribing of opioid analgesics. Andrew previously served as the chief medical officer for Phoenix house, a national nonprofit addiction treatment agency and chair of psychiatry at Maimonides medical center in New York City. He began his career working for the New York City Department of Health and mental hygiene in the office of the executive deputy commissioner.

NAADAC is really honored to provide this virtual town hall event, and hopefully create a connection. We've all been missing, where we can do what those in the addiction professionals have been doing since -- profession since its inception, share our experiences with one another.

So panelists, if you're ready, let's turn our web cams on. And I'll start with your opening statements. So let me go ahead and turn you web cam on. Thank you, Andrew and Tom and Lisa. Let's start with some opening statements. I'm going to let Tom Britton start. Tom, the floor is yours.

>> THOMAS BRITTON: Thank you. Good morning, everybody. And I want to send my thoughts and support. I know a lot of people are really struggling out there. As Samson said, I'm Dr. Tom Britton, president and CEO of Gateway Foundation headquartered in Chicago. I'll start and give you a sense of what our environment of care looks like and I'll talk a little more operationally because of the management we're doing in this environment. Gateway Foundation treats about 10,000 people a day. We're in nine states and we have community-based services which are level 3.5 residential treatment that includes withdrawal management (audio difficulties) outside world, and then we also treat people in correctionally controlled environments. And so we have everything from very high security watch prison environments to what looks more like a campus but they're under control so it's a unique challenge in responding to the challenges of coronavirus.

The first thing I want to talk about (inaudible) management and how we respond to keep our environment safe. We were an early adopter in virtualizing all our outpatient services, so by the second week of March, we were providing video based care to about 2,000 patients that we were seeing face-to-face the week before.

And that went pretty well for us. We had about a 90 percent retention of clients which we were pleased with. On the

residential side that's a bigger challenge because we have medically compromised group of people that are coming from areas that they might have been exposed so we integrated very quickly intensive screening protocols, quarantine protocols and response protocols so if there was anybody at risk we moved them from the environment or isolated them from the environment. Out of our hundred locations of not having a meaningful breakout. We've used tracing (audio difficulties) and strategies so when we had a positive staff or client, because there has been no public access to testing. Administering PCR tests which is the nasal swab to that 350 people in our umbrella to try to understand who is positive for the virus. And that's been very effective.

As we look to what we're doing now, in kind of like a recommendation, if you are in a residential environment, we've now built a model where any new patient comes in the door, they're in an admission unit where we test them. We're getting results back in two to three days, and if they're positive, we have identified two units that are positive specific units, and everything else is general population. So it's really kind of a way to split people into two places. But continue giving life saving care to those that are at vulnerable risk of dying from their addiction. Coronavirus is a big deal, but they'll die from overdose if we don't treat them. We've worked intensive to (inaudible) support our staff in this process. It's been really traumatic for everybody. And it's been really, really scary. You know, and so I think that Lisa's going to talk more about that and I can answer some questions about how do you support workers in this environment and frankly how do you take care of yourself, and I'm one of those people that is in long term recovery so I have some tools available to me and a network available that some people don't have.

So with that I'll stop and turn it to the next presenter.

>> SAMSON TEKLEMARIAM: Thank you so much, Tom, for being here. Thanks for your opening statement.

Next, Lisa?

>> LISA DINHOFER: Thanks so much, Samson.

In addition to the intro that you gave on me, I have a 20 year background in a high mortality sector of health care, where I'm accustomed to not only living that on call lifestyle but working with people in that, and as Thomas alluded to, my concern and a lot of what I'm doing right now with respect to COVID is focusing on the impact of a workforce, the mental health care in the workforce, whether it be in the health care sector and the already incidence of physician and nurse suicide, the fatigue, the emotional overload, in a treatment setting or an in a corporate setting. This is having really mental health impact on everybody. Whether you're a frontline worker or not, and I'm really looking right now at helping to support people who are on the frontlines who are essential workers, and helping them understand why they are

experiencing what they're experiencing, helping people understand this is a collective experience of grief and trauma, and it's impacting all of us, and while you may believe, well, I'm home and I may be in a comfortable setting in my home, you are being impacted. And also the understanding that not all of us are being impacted in the same way. So right now I'm really looking at the supportive staff.

>> SAMSON TEKLEMARIAM: Thank you so much, Lisa, for being here and for your statement.

Andrew?

Oh, sorry, Andrew, you're still muted.

>> ANDREW KOLODNY: So thanks for having me, Samson.

You know, up until COVID-19, I would -- when talking about the opioid crisis, I would describe the crisis as the worst public health catastrophe since the Spanish flu outbreak a hundred years ago. I may not be able to say that anymore. I am very concerned about the impact of COVID-19 on the opioid crisis. We've lost about 500,000 lives from opioid related overdoses since 1999. And we were starting to make some progress. Overdose deaths over the past year or two have stopped going up. Maybe even come down just a bit, and we started to see some of the resources from the federal government that are necessary to tackle the problem. We've seen litigation against opioid manufacturers and distributors for their role in causing the crisis, which could result in more funding for states and counties to tackle the problem. And I'm worried that COVID-19 is jeopardizing all of these gains. I'm concerned that the federal government and states and cities may not have the same resources available, because of lost tax revenue to address the opioid crisis. I'm concerned that there's going to be less attention paid to this issue going forward. And even the litigation against opioid manufacturers, a lot of that litigation is on hold, so the desperately needed funding from judgments or settlements is now further away, and so there are many reasons to be concerned. And also it's frustrating because certainly the opioid crisis has been a public health emergency. It was designated a public health emergency by the federal government. Yet we never really saw emergency action being taken the way we are certainly now with COVID and I'm glad we're seeing it now, for example, with addiction treatment. We've seen some deregulation of addiction treatment in the context of the COVID public health emergency in ways that could potentially expand access to treatment. Yet we didn't see that previously, and that's frustrating, and hopefully we'll be able to maintain some of the gains that are made during this crisis.

>> SAMSON TEKLEMARIAM: Thank you so much, Andrew.

Thank you all for that opening statement.

So before -- I know you're here to hear from our panel, but we want to hear from you first, so I'm going to launch a polling

question. We would all love to hear your answer to this question. The question will pop up on your screen in just a moment here. There it goes.

So you should see this pop up on your screen. The polling question asks what has been the hardest thing for you this epidemic. You'll see five answer options there. The uncertainty of it all. Negative impact on my job, job loss, job change, grief and loss, disruption in routine resulting in decreased physical health, or emotional, mental wellness, isolation, loneliness and disconnection.

Once you are finished with this polling question, please also take a moment to share in our Q and A box, if you're a leader or a people manager, what you have observed as the impact on your staff, if you do wish to answer that question in the Q and A box, just type the word leader in in all caps, and then share your experience. The question is if you're a leader, people manager, owner, CEO, what have you observed from the perspective of leadership as the impact on your staff?

Now, also and this is for anyone, please share with us in the Q and A box any innovations you have seen as successful. We would love to have an opportunity to share your experiences at the end of this town hall event. We're going to share what you send to us. Make sure you type the word innovation in all caps in the questions box with your name, your location, and what innovation you've seen as successful.

All right. It looks like almost 70 percent of you have answered this poll. I'm going to go ahead and close the poll. I will share the results. So we all can see your results on screen here.

And there they go. All right.

And then I'm going to turn this over to our panel, for our panel, each of you could respond to this -- these results, or you can also share what was your initial reaction to COVID, and how did you begin to adjust your mindset after the initial shock of it all?

So whoever wants to go first, Andrew, Tom, or Lisa.

>> THOMAS BRITTON: Well, this is Tom. I can jump in.

I think as -- I think that the reaction, as I think about my organization, has been really different based on the role one has in the organization. So for our frontline workers and our health care workers, I think that the biggest thing for them was the fear and uncertainty of the risk they're placing themselves in. And not knowing who is positive and not positive, and not having access to the personal protective equipment necessary to be safe, and so that's why we as an organization did a lot of support and education to them early on of what do we know, what do we not know about the virus and the way that it's communicated from one person to another.

I think for me personally, the hardest thing to really

figure out and I think this was the challenge of the lack of federal and state response, was what is the best way to respond as a program, as an outpatient program or a residential program, to keep people safe but yet continue treatment?

>> SAMSON TEKLEMARIAM: Perfect, thanks, Tom, Lisa or Andrew?

>> LISA DINHOFER: I'll jump if there. It's interesting that the largest portion of responses here is the issue of uncertainty and I just did a webinar yesterday for score about navigating long term uncertainty in the aftermath of disruption, and we have all been -- we've all been put in a place of uncertainty involuntarily, and the cause of uncertainty really matters in how you view it and how you work with it. And the cause of our uncertainty has come from a place of grief and loss and fear and heartache, and I think the key to managing uncertainty is a few things.

Number one, to really work with our own perspective about how we look at uncertainty, most of us in Western countries, we're acculturated to view uncertainty with reactive fear, right? And there are times when uncertainty is just a holding place. It's a pause. And what we knew before to what is coming. And what is coming is not always necessarily horrible. We are looking at an illness that we cannot say and that is asymptomatic so that creates a lot of uncertainty and the key to that is managing our anxiety around that, how we view our own coping skills and how often we use those coping skills around that. And asking some very deep questions using this space of time, this pause within uncertainty to ask some very important questions about how we want to move forward, and really planning for the aftermath, because everything that we do and say right now is already informing what our personal aftermath will look like if we're business owners, what the aftermath in our companies will look like. So we're actually working on both simultaneously.

>> SAMSON TEKLEMARIAM: Very interesting. Thank you so much, Lisa.

Andrew? Oh, Andrew, we can't hear you. You're still on mute.

>> ANDREW KOLODNY: Sorry about that.

So I wasn't surprised to see that the majority of folks selected the uncertainty of it all as what's hardest. I think that's what I would have selected as well.

There is a tremendous amount of uncertainty. The world is going to look different, the world already looks different, and post COVID, even though this will come to an end, the world will be a different place, and it's impossible to completely predict how things will change going forward. And so that is certainly something that would (inaudible) some anxiety and I found Lisa's first response reassuring and maybe there are cultural adaptations

to uncertainty that can be helpful, but certainly not knowing what the future is going to look like certainly would make many people feel anxious.

>> SAMSON TEKLEMARIAM: Thank you all so much.

So I'm going to go into a few of the questions that you all sent us, in your registration. So my first will be for Dr. Thomas Britton. This question comes from Lisa sparks in Nevada. Lisa asks what are the best -- or Lisa, sorry, from sparks, Nevada. We don't share last names on here.

So sparks, Nevada. She asks what are the best protocols for reopening for outpatients?

>> THOMAS BRITTON: That's a great question.

And she'll be mad at you because you said Nevada instead of Nevada just so you'll know. That will tell you I used to work in Reno.

I think it's one of the most important questions. So what we're doing number one is looking to the state guidance around the stay at home orders and making sure we're in compliance with those orders. We by definition are an essential health service so we could open if we wanted to, but I think it's really wise from a structure standpoint to really listen to what they're doing. And so how we're going to roll out is we will (audio difficulties) outpatient services and limit that to fewer than ten people, ten or fewer people, setting up our group rooms in a way where we're able to socially distance people and doing screenings before they walk in the door and we're literally going to do the screenings outside the building before they walk inside the building and we are continuing to do all the testing with our employees and finding out to make sure that they're safe and sound from that.

We're continuing to offer virtual group therapies as well. And so our intention, like in our total network, we have 2,000 clients right now receiving outpatient care virtually, is that I don't need to bring all 2,000 people back the first day. And educating our clients as well about what is the reality and not the reality, and the final thing that we're doing is we're requiring masks for all clients and employees during any group environment until really we feel that the crisis is pretty stabilized.

>> SAMSON TEKLEMARIAM: Thank you so much, Tom.

And the next question is for Lisa. So Lisa, this question comes from Shanda in Seattle. Shanda asks can you share some tips on how to tend to a crisis call to tending to your children directly after that call?

Oh, and Lisa, I think your mute didn't go off there. Sorry about that.

>> LISA DINHOFER: Sorry about that.

>> SAMSON TEKLEMARIAM: There you are.

>> LISA DINHOFER: That's a great question. And a tough one, and I'm assuming that this person posing the question is

taking these calls at their residence and not in a building. Obviously their children are with them.

So I think this has to do with planning, pre planning, around when you are on your shift to take those calls. I really caution against the toggling between your personal life and your professional life in taking crisis calls. I think you have to create some boundaries around this is when I'm on shift, this is when I'm available to take calls, and there needs to be -- there needs to be boundaries around when family, when children can actually, you know, go up and talk to you and, you know, be with you, just like school teachers are doing right now between their trying to teach and their own children.

And to set some boundaries with those family members that are helping you with child care and hopefully you do have that, of what you're going to need in terms of head space, if you will, after you get off of your shift, and that's typically not going right back into parenting again. You need a little bit of time. So if you -- if the weather is cooperating and you can actually go outside for about 15 minutes and just kind of make a transition in your head before you transition back into being a parent. I also like rituals and I work with people on rituals all the time who have to transition from a personal life into a professional life and back, especially if they're in an on call situation, and that is having a ritual that you do all the time in the same way for when you're leaving your personal world into your professional world and right now I don't mean leaving physically but emotionally and cognitively, so that creates a trigger and a response within your brain and your body, okay, I'm now going from my personal world into my professional world, and then having a ritual to do the exact opposite. Leaving your professional world into your personal world, and for this ritual to be effective, it's got to be done with consistency. So the brain creates a new habit, a new way of doing this at a point in time where you don't even need to prompt anymore. And that literally creates changes within your brain and your body to make those transitions.

But after you get off of a crisis call, the expectation that you're going to right away be able to snap right back into your personal world and be a parent that's got the appropriate amount of patience for what children require of us I think is an inaccurate expectation, and we need to create some good guardrails and boundaries around that.

>> SAMSON TEKLEMARIAM: Thank you so much, Lisa. And thank you for that question from our audience.

Our next question comes from raven from reading California, raven asks you, Andrew, how is the COVID-19 crisis impacting people with opioid use disorder?

>> ANDREW KOLODNY: That's a great question. Opioid use disorder, people who have opioid use disorder are at increased risk

of contracting COVID, both for biological reasons, if you're taking opioids, particularly high doses, heroin or high doses of methadone, or even if you are a pain patient on chronic opioids, opioids suppress the immune system. It's one of the side effects of being on opioids, and so people with suppressed immune systems may be more likely to contract COVID.

It's not just the biological though. For people with OUD, they're more likely to experience homelessness and being in shelter situations where people can contract COVID and even in our treatment system and our treatment settings in residential treatment, in detox units, it's possible for people to contract COVID, and there have been outbreaks of COVID infections in detox units.

So simply having OUD increases your chance of becoming infected.

It also increases, we don't know this for certain, but there's good reason to believe that having OUD if you're infected with COVID, increases the likelihood of a more severe outcome. Again because of the immune suppression, it's possible that you could wind up with a more severe case of COVID, and other effects of OUD, for example, if you are taking opioids as we know, opioids can reduce your breathing rate. And with COVID infection, it's been -- there's been a description of what is sometimes termed a silent hi pox I can't, and people can have very low oxygen levels in their blood with a COVID infection and not realize it. They don't know they have shortness of breath like we see with other types of lung diseases. So if your oxygen rate is already low because of COVID and you're taking a drug that can reduce your breathing rate, that can even increase the risk of an opioid related overdose in people who are COVID infected.

There's many reasons to be concerned right now about people with OUD in the context of the COVID epidemic.

>> SAMSON TEKLEMARIAM: Thank you all so much.

We're going to do another polling question in just a moment but we got this question in from the audience, I think it applies to all three of you could share some thoughts. So this comes from Kevin from Iron Mountain, Michigan. Kevin asks how do you attempt to stop burnout rate for addiction professionals due to the quarantine? Kevin from Iron Mountain, Michigan, and any -- either of you may respond to this, how do you attempt to stop the burnout rate for addiction professionals due to the self-quarantine?

>> LISA DINHOFER: I think I'll jump in there, Samson.

First I'd like to, you know, make the statement that people on the frontlines serving those struggling with addiction in treatment centers, they're already suffering and experiencing burnout and emotional labor overload. So they came into this, right, already having those issues. And I'm not saying that they were at a deficit, but they're already putting a lot of energy into

the responses and the results that come from that, and I think the quarantine is yet another stressor on top of a pile of stressors they were already dealing with.

A lot of people get burnout confused with compassion fatigue or emotional labor overload. Burnout is actually about the system within which you do the work. It's not about the work itself. It's the system within which you do the work. And some key responses to burnout is feeling helpless and apathetic and disengaged and aggression, unfortunately also is a key factor. And depression within burnout.

So to understand -- to try to look at how much of this you are already experiencing before you went into quarantine and to also understand quarantine is going to create, isolation is going to create its own symptoms, I wouldn't necessarily call it burnout from isolation, isolation is an issue in and of itself where you're having a constellation of these coming together and I would suggest the very same things that we talk about with burnout to begin with, and that is very active, every single day being militant about setting time aside for effective self-care every single day, and again that may require talking with your family about what you need and the kind of support you need from them so that you can practice this self-care so that you have this basis for doing that. And there's a whole slew of things I could talk about for self-care but I don't want to take up too much time.

But the key to this is self-care, and the acknowledgement that it's happening, and watching for the symptoms and taking them very seriously, not when they have gotten to the point where you're on your knees, but when you first begin noticing.

>> THOMAS BRITTON: I really appreciate the distinction Lisa made between burnout and compassion fatigue. What we're experiencing right now is more the emotional -- it's interesting, when you think about acute stress disorder is the short term (inaudible) it's the long term entrenched and there's primary and secondary trauma, and I think that something clinicians have uniquely (inaudible) cosmic pain, the ability to tap into the larger stream of kind of communal pain, and I think that's what makes us good helping professionals, and in a moment like this, that's what makes it really, really hard for us to be balanced and safe in self-care, and, you know, employers have limitations of what they can influence really, and so I think part of how we are thinking about it is number one, trying to role model throughout the entire organization, so whether one is in executive leadership or supervising or a line staff worker is really trying to say how do we take care of ourselves in the moment, and one of the most powerful things we can do is share what's going on inside of our head rather than carrying the weight because when we talk out loud, other people help us carry it together, and so that's one of the things we're really trying to promote is having more check in

meetings and more burst meetings and I'm doing more communication as the CEO than I've ever done. I've recorded several videos where I'm speaking more personally than I have ever spoken before, and really just kind of connecting and relating to the struggle of this and we are also supporting supervisors in identifying people that are really showing symptoms of, you know, burnout, compassion fatigue, and significant overwellness, I don't know if that's a word, and we have to step in and if anybody on this call sees somebody who is clearly struggling, you have an obligation to say I'm worried about you, how can I help you?

>> ANDREW KOLODNY: So I don't have much to add. I think Lisa and Tom's answers were terrific. Maybe the one small concrete bit of advice I'd give to folks who are experiencing burnout, who are feeling very stressed is that one of the best ways to try and relieve that stress, when you're unable to change your circumstances, is with exercise, and so, you know, even 20 minutes a day, even a brisk walk every day is something that can be very helpful, but really I think that Lisa and Tom's responses were excellent.

>> LISA DINHOFER: Samson, can I say one more thing about this? There is something about what Andrew just said that reminded me of a conversation I had a couple days ago with a group of school superintendents who are really just on their knees right now trying to figure out, right, and they are very burned out. And one person asked me a question very similar to what you just did, and when I was speaking with her and giving her suggestions, reactively she kept saying but I don't have time for that. I can't do that. You don't understand. I can't. And what I said to her is, and she was listing how many days in -- 28 days straight in a row working, and the number of hours and everything else. And the gist of what I began saying to her is, you have to find a way. You have to make the time. You have to prioritize this. Because if you don't, you may not be here in the fall. You may wind up having a heart attack or a stroke because of an elevated blood pressure. So it's not going to matter what the school system does in the fall. You have to prioritize this. And I think helpers too often suffer from this notion of I don't have the time. I have to prioritize my patients, my clients, the people I'm in service to, and the notion that if you prioritize yourself over all of those people, that includes your family, that somehow you're not being a good helper or you're being selfish. This is the biggest fallacy in the world for being a helper. And you start by helping yourself and keeping yourself healthy, by prioritizing and having enough self-compassion to say, yeah, I need to -- I need care too, and making it a priority and committing to yourself to doing that, so you'll take the walk. You'll do whatever you can do right now to keep your psychological well being where it needs to be.

>> SAMSON TEKLEMARIAM: That's excellent. Thank you guys

so much. And yes to piggyback off what Lisa said, in our profession we sort of have a saying or understanding that positive habits are just as easily able to form as negative habits, right? So just making that quick decision to take that five minute walk, almost forcing yourself to, it's incredible how that can build a positive routine.

So let's take a quick polling from the audience, just so we can get a better idea of where you all are coming from. So I'm going to launch this poll on your screen. It should pop up in just a moment.

The question, there it goes. The question asks how -- has your organization switched to telehealth, and has telehealth expanded or decreased access to care. The question is has your organization switched to telehealth and has telehealth expanded or decreased access to care? So you'll see five answer options there. Please make sure to read them all the way through, and please go ahead and select the one that best reflects your current situation.

Now, as a reminder, once you're finished with polling question, please continue to take a moment and share your questions in the Q and A questions box. If you're a leader or people manager, and what you have observed as leadership as the impact on your staff. I'm going to collect some of those thoughts and ideas. I'll share them with the panel and audience later. If you choose to respond to that from the perspective of a leader, please put leader in all caps and then share what you've observed as the impact on your staff.

Same thing for those who have other ideas or innovations. If you've experienced an innovation or if you've done an innovation in your company, you know, what innovation have you seen that's successful in making the best out of this new environment, out of this adjustment? Please type in the word innovation in all caps, don't worry if you can't spell it, and then type in your name and your location, and share your innovations or your idea and why it was successful. We'll share those thoughts at the end of the webinar and make sure we can all hear those ideas and give some time for the panel to respond.

So about five more seconds here. Almost 60 percent have responded to -- there it goes. I'm going to go ahead and close the poll in just a moment.

There we go. And I'll share the results and I'll turn this back over to our panel. There they go. Okay. It took a minute for them to jump up.

For the panel, please feel free to respond to these results however you would like and at the same time if you'd like, you can also share what your successes have been during this time or what you've seen that works that's had some positive results as you respond to this poll.

>> THOMAS BRITTON: I think Samson, something that I would

share is kind of two things. So with the virtual group counseling, it's been really a fantastic intervention that's increased access to care. The places where we have seen people struggle is I think where we have a higher ratio not coming from the break and (inaudible) face-to-face meetings so it's important for group meetings to track those people that drop off at some point, and reach out to them afterwards and kind of reconnect them.

I think the other piece that's really important is the trust that community has been extremely successful in creating a virtual environment for continued 12 step support, and I have put, you know, really a precedent for us to educate people, link people, and I think the social isolation for people in early recovery of not having group counseling, of not having 12 step meetings, is one of the biggest threats to their ongoing recovery and so we really, really push that.

I think the final piece that I would share is it is only in the last few weeks that we've integrated telehealth into our admission pipeline. So that we can join with new clients before they walk in the door using video. And we're finding that those patients that we talk to through video have a much higher show rate than those who do not. And I think part of that is it's more engaging, but I think it also settles some of the fears of those potential clients about the risks of coming into treatment versus not coming into treatment.

>> LISA DINHOFER: Samson, I'll pipe in here.

I was already doing a lot virtually, so that was not really an adaptive challenge for me. But to piggyback off of something Thomas said a moment ago, what I've seen is an uptick in leadership's understanding and concern for how do I take care of my staff, do I need to be doing that, and the limitations of that.

So what's been interesting for me is I used to have to try to make the business case for people in leadership, why protecting the psychological safety and psychological well being of their people is good business, both with your financial bottom line as well as the ethical and moral issues that go with that.

Now I don't have to make that case at all. Leadership is starting to, I think, realize that, reach out for help, and they're suddenly realizing they don't necessarily know what to do. They want to do something, and they don't necessarily know what to do. And I'm thrilled to hear what Thomas is doing with his people, and if I could clone him and put him in a lot of other organizations who are not as enlightened and are still so worried about the financial bottom line that they don't understand the effort and the energy put into your people is paying attention to your bottom line, but still that false binary notion of people versus profit, unfortunately there's still some leadership out there struggling with that, and I think that they're going to have a hard time reviving and thriving because as Andrew said before, the world has

changed, and what customers and the public want now from companies and organizations is different. They want to know what did you do for your people? How did you take care of them? How did you respond to this? Those are going to be questions that are going to become very important to not only consumers but people looking to work for organizations.

>> SAMSON TEKLEMARIAM: Andrew, your mic is muted. There you go.

>> ANDREW KOLODNY: Sorry I keep doing that.

So I thought the responses to the poll were interesting. 85 percent of the respondents said that their programs had moved toward telehealth services. That's a big number. And when asked about whether or not it had expanded access or decreased access or didn't know, the most common response was that it had expanded access. And that's reason to be hopeful. Certainly for the opioid crisis. The -- in the short run, to really bring overdose deaths down, we need much better access to effective treatment, and if this shift toward telehealth is expanding access to treatment, that looks very good. This also suggests, as Lisa was just mentioning, that the treatment system may wind up looking very different post COVID. If 85 percent of programs have now made this transition very rapidly, a transition that would have been difficult in the past and there might have even been regulatory barriers, and there's a sense that this has been helpful, I think that we may not go back.

Now, there are certain aspects of treating addiction that are very difficult to do through telehealth, for example testing urine would be a challenge. But there are work arounds, there are ways of coming up with systems. So I will suspect that COVID has shaped the addiction treatment services in the United States post COVID.

>> SAMSON TEKLEMARIAM: Thank you so much, Andrew, and so the next question from the audience, Andrew, is for you, so this question comes from Johnny from Abilene. Johnny asks does the effects of opioid use on COVID-19 include prescription opioids? Is there a difference?

>> ANDREW KOLODNY: Great question. And no, there really isn't. Something that many people don't realize is that there is very little difference between heroin and oxycodone and hydrocodone and oxymorphone and hydromorphone. Those prescription opioids that I mentioned are what we would term semi synthetic, you actually -- synthetic, you actually make OxyContin from opium and you're tweaking the molecules so it gets into the brain faster. That's what you're doing when you create a semi synthetic opioid.

Heroin is also a semi synthetic opioid. It's made from morphine, so it can get into the brain faster and have a more (inaudible) effect. So there's essentially no difference. Buprenorphine is unique. There may be less immune suppression from

that. There's certainly much less respiratory depression, but those risks that I described earlier for immune suppression, the people who are taking opioids, that's true both for heroin and prescription opioids, even for methadone maintenance, particularly people who are on high doses of methadone maintenance.

>> SAMSON TEKLEMARIAM: Wow, excellent.

The next question is for any of you. I'm sure Tom will have something to say, but this is more about PPE. So Shawana asks are wearing masks and gloves enough if you sit four feet distance for an in-office session?

>> THOMAS BRITTON: I can -- I'll give the first stab. The bottom line is every single thing that's happening is all risk reduction. It's not prevention. There's nothing one can do outside of not being near the person at all. What the CDC's currently guidelines are focusing on is it depends, first you want to evaluate what is the symptom presentation of the person, and if they have any positive symptoms they shouldn't be there period, or they should be in a quarantine environment where the staff has the full (inaudible) we also know that the highest viral load within the shedding of the virus is within the 24 to 48 hours for symptom presentation, which is what's made this so (audio difficulties) and we also have kind of the ultimate question that the asymptomatic population, the folks that test positive but never have symptoms, they don't really know yet very well if at some point in this case they're contagious, so what we are encouraging is that unless you're in an environment where you can test your patients, that you follow really the strict social distancing guidelines of fewer than ten people and six feet and masking, both the provider and the client.

>> ANDREW KOLODNY: I think there -- I agree with Tom's response. There's a lot we don't know about how COVID-19 is transmitted, and we've even received conflicting messages from the World Health Organization and the CDC, messaging that you shouldn't wear a mask or you don't need a mask, and then recommendations that people do wear masks. It's unclear the extent to which people contract COVID-19 from touching a surface, and then bringing their hand to their eyes or their nose or their mouth, versus inhaling the virus.

There are anecdotes of people who may have contracted COVID without touching anything. There are anecdotes of people who have spread COVID just -- who are asymptomatic by speaking or singing, and so, you know, the guidance we're getting to some extent is more art than science. It's likely that if a person has COVID-19 and let's say they're asymptomatic, we do know that you can spread it when you're asymptomatic. There is good reason to believe that if that asymptomatic COVID positive patient is wearing a mask, that they're less likely to transmit the virus, but if someone is in an area where COVID-19 is prevalent, to be in a room with people for

an extended period of time, without really knowing their status, is risky, and I think should be avoided as much as possible.

>> LISA DINHOFER: So Samson, what piqued my ears in that question is less about the PPE and more of the genesis around its fear. Right? And we are entering into a period where it's -- my perception, that that fear is going to ramp up, because staying at home and being told to stay at home can mitigate somewhat of that fear in terms of exposure, if you're not leaving your house, but once we are in the full on, quote, unquote, reopening and everybody has to start making personal decisions about how much they want to expose themselves, but also if you work for an employer, what your employer is now going to require you to do, and what they either can or cannot provide in terms of assurance of maintaining your health. I think this is the next big challenge of this ongoing crisis. This is not a discrete crisis, like September 11 happened on one day, and we were right away into recovery from that. This is not discrete like that. This is a long evolving, long occurring crisis, and we're not even close to the aftermath yet. And I think the next phase of this long evolving, non-discrete crisis is the fear, as we are asked, compelled, required to now go back out into the world without what we really want in terms of assurance, and that is tests, you know, validated, effective tests, and a validated vaccine. And how are we all going to manage that fear as providers of care to people? It's going to be a struggle, and I think it's going to be an interesting conversation and we need a lot of empathy and patience as people who are running businesses and how we respond to the people who work for us and provide service.

>> THOMAS BRITTON: And Samson if I could add something to that too. To Lisa's point about the next wave (audio difficulties) soon is as testing is more available, and there's testing that gives you much faster results, you know, in the thick of this some results were taking ten days, which is virtually a meaningless test if you have to wait ten days, is what do you do with those who had the virus or who tested positive in a screening environment, like we tested 350 people who we believed were exposed to it (audio difficulties) remember having any symptoms and they ended up not presenting any symptoms. To the CDC released -- so the CDC released some guidance yesterday, and to Andrew's point, the World Health Organizations (audio difficulties) but what they have released most recently for positives is that we believe somebody can test six weeks as a positive result after symptom presentation. And so they talked about using a symptom strategy versus a testing strategy. So one thing to talk about recently was wait for a second test that's negative before you return them. But if it's six weeks, we know that's not practical and we know they're not contagious. So it's really going to be more practical to have a symptom presentation, symptom strategy, and their most recent is

that if it has been three days since the last symptom, at least ten days after the first symptom, that somebody could return if they had a positive test. I personally think that is too risky, because we're trusting upon somebody's self-report of how many days it's been without symptoms. So our result for those who had a positive test is waiting ten days without symptoms. For people who are asymptomatic and had a positive test, we're also waiting ten days because there's science right now if they test positive, it's average four days but it's a big outlier to be ten days. So I think as testing gets widespread which obviously I hope it certainly does, and it's important also for the group to understand that the antibody testing right now has not been validated or supported by the FDA or the government in a way that we should trust using it as really kind of a prophylactic measure. It'll be confirmation perhaps later but I don't think we are at a place where we should be using antibody testing in this process.

>> SAMSON TEKLEMARIAM: Thank you all so much. So I'm going to share some thoughts from the audience about the leadership question that we asked earlier. Impact on staff. And their innovations. I'll share it to you all. I'll let you all as the panel have your closing statements, maybe respond to those audience -- to what the audience is saying.

So the first one was we asked them about -- from a leadership perspective, what did they see as the impact on staff? So some of these are not as shocking. They showed up in other poll. The uncertainty of it, frustration, increased irritability. My staff have had a hard time with routine and having a lack of physical contact. One program director said that they have strong feelings towards the isolation, not being as connected with other staff. And find it difficult at times to get clients to participate in evidence based practices, especially those with homework. One, a people manager said that they had to furlough a lot of employees. Another manager said that they had a lot of employees who are working as first responders now or assisting first responders and nurses, and looking for supervision, but they don't know how to provide it. So that was a lot of the leadership. So I know that was a lot of information there, but that was our question about the impact on staff from a leaders' perspective.

Some of the innovations, some great ideas, this is for everybody in the audience to hear. Enis from Sudan shared that at a trauma center, they changed to telehealth services and plan to have a 24/7 help line via chat for anyone experiencing any crisis related symptoms or issues. They're rotating the phone service and the chat service between their staff, especially based on time zone. And it's helping them also balance self-care as they're helping to support each other, their employees, by taking off shifts from that chat support.

Another innovation is coffee time with staff over Zoom. I

thought that was a great idea. They do weekly small team meetings, but that coffee time is not a meeting. It's just a little bit more unstructured for small talk.

The last innovation comes from Katie from Grand Rapids. She completed a list of YouTube videos that are free for all their patients and they direct parents to that YouTube channel that have information on coronavirus and mental health, coronavirus and substance use concerns, providing tips and coaching, like a resource page. Sorry for the long list. Those were innovations. I'll turn it to our panel, whoever wants to go first, please share your closing statements. I know we're a little bit past time here. Any (inaudible) or innovations that were shared.

>> LISA DINHOFER: Samson, I'll jump in here.

If you look within the than toe logical literature, what we're all experiences worldwide is known as a non-finite loss. This is a loss that has no seeming ends, and it is a non-death, non-finite loss, and that doesn't include the grief from actual death, but the characteristics of a non-finite loss are factors that create this loss that are external to us that we have no control over, and are ongoing, seemingly without end. A disconnection from the mainstream, an ongoing feeling of helplessness and powerlessness, and the two biggest factors of a non-finite loss is coping fatigue and support fatigue. Now, typically this is about the coping fatigue for someone experiencing this, and the support fatigue of the people around that person. But we are all experiencing both of those. And I firmly see now, we are firmly into the fatigue portion of this. People are losing their ability for self-regulation. Some people are going into despair. Other people are going into strong resilience building. But even after 25 days, the research shows that if you've been dealing with a chronic stressor, 25 days or longer, you begin to develop fatigue and difficulty in resilience. So I think what these observations tell us, it aligns with what the literature says on a non-finite loss, and the coping support that we're all doing simultaneously are the hardest parts to endure and we're all going to have to understand that, be accepting of it and come up with ways, and there are lots of ways to manage both of those, the coping and the support.

>> ANDREW KOLODNY: So for my opening statement, I talked a bit about my concern about how COVID was going to worsen the opioid crisis, which is the area I focus on. I guess for a closing statement, maybe I could try to be a bit more hopeful. I think there may be ways in which we can learn from the COVID experience to better tackle the opioid crisis. One of the challenges with the opioid crisis is, and current challenges, poor surveillance, where 20 years into this epidemic, 25 years into the epidemic, we still don't have good numbers on the prevalence of opioid use disorder. We have this federal estimate of 2.1 million Americans with OUD,

but we know that that number is very incorrect for a variety of reasons. We don't have good incidence rates. Meaning how many people are getting newly addicted each year, and for the opioid addiction epidemic, these are really important surveillance -- this is very important surveillance data that we need to tackle the problem. If you think about HIV, for example, we have an estimate of how many Americans have HIV infection, and every year we get an estimate of how many newly infected Americans there were with HIV. And if you look at COVID, every day in the newspapers and on television, we're getting the data on the number of new cases, the number of deaths, the number of hospital admissions. So this way of thinking about it in terms of a disease epidemic for which you need surveillance to adjust an appropriate response, maybe we could learn from that for adjusting the opioid crisis.

We heard during the polls that you did, 80 percent are in programs have moved to telehealth and (inaudible) we may make gains through this temporary deregulation system that may come to an expanded treatment system. Maybe there will be ways where we deregulate it and if it's helped people gain more treatment, we can keep some of these changes. So we can improve access to treatment going forward.

>> THOMAS BRITTON: So I think what I would close with, Samson, is really kind of two things. One from an operational standpoint is that you don't need to figure this out by yourself and I don't think it's possible to do your best job if you try to figure it out yourself. (Inaudible)'s website has done a good job of pulling together resources that are unique to our industry and giving concrete recommendations. The CDC is doing a pretty good job on their website of giving kind of updated adjusted materials and I think creating a forum like this, I'd be happy, Samson, for us to do something like this every couple of weeks. I think it is a time we as a community really need to stay connected. And I think on a personal note, one of the benefits of working from home, so I have two young boys. (Audio difficulties) and I've learned something in this. First graders have wiggle breaks, they get together during the day and do some kind of wiggling behavior. So we've integrated into our routine, so I danced more to Katie Perry in the last seven weeks than I've ever planned to. But it's one of the best times of my day. So I encourage you to find a wiggle break.

>> SAMSON TEKLEMARIAM: Well, this has been incredible. Thank you so much, Dr. Thomas Britton, Lisa Dinhofer, and Dr. Andrew Kolodny.

I will text the questions and try to ask the question and get it documented so we can write it up in a Q and A document. We will put it directly on this website you see on your screen. That is the dedicated web page for anything you need pertaining to this webinar, this town hall event, including your online CE quiz. You

do have to take an online CE quiz to get your CE. It's a very simple short ten question quiz. It will be available one hour after this webinar, so around 2 p.m. Eastern you'll be able to go to this website, click on online CE quiz, you'll see it there. And you'll be able to get everything you need to get your CE. As a NAADAC member, here's benefits of becoming a member. Lots of benefits. You can always visit NAADAC.org/join to join. Thank you for joining us today, and please note that a short survey will pop up at the end. Please take time to share your feedback, notes with us, we want to thank you all for participating in this virtual town hall event. Thank you Tom, Lisa, and Andrew for your valuable expertise and dedicated time in connecting with our audience.

Everyone feel free to stay connected with us on LinkedIn, Facebook.

>> THOMAS BRITTON: Thank you.

>> LISA DINHOFER: Thank you so much. Take care everybody.
(End of town hall.)

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