

Chris Asplen:

Thank you. Good afternoon, folks. This is Chris Asplen. I'm the executive director of NCJA. We're going to wait just one more minute while folks continue to hop on the webinar. But thanks for joining us today.

All right, everybody, why don't we go ahead and get started. Again, good afternoon to everyone. My name is Chris Asplen. I am the Executive Director of the National Criminal Justice Association. We really appreciate your being with us this afternoon. It's my pleasure to welcome you to our webinar today on technology for treatment and recovery. This is really the third webinar in a series on technology and the Coronavirus. First was on court technology. The second was on supervision and monitoring technology. Both are available on our website. Watch your inbox for future webinars in this series. We'd like to thank our partner on today's webinar, the Bureau of Justice Assistance for their support of this session, and all the webinars in this series.

Before we get started, let me go through the usual round of logistical items and caveats. First of all, we will be recording today's session, the recording and the slides from the session will be emailed to everyone who registered and will be posted on the NCJA website as well. Due to the number of people joining us today, we have muted all of the participants to reduce the background noise. If you have questions, we encourage you to submit them using the question and answer box at the bottom of your screen. We have included time for question and answer period at the end of the presentation. So if your question doesn't get answered as part of the presentation, feel free to include it there and we will try to get it answered.

If you'd like to communicate with NCJA staff during the webinar, please submit your comment using the chat feature as contrasted with the Q&A feature. Finally, at the end of the session, we will be launching a short poll. We encourage you to fill this out to help us continue to improve our webinar series offerings. So let me take a little bit of time and introduce you to our speakers today. First of all we have Dr. Tisha Wiley. She is the chief of the Services Research Branch and Associate Director for Criminal Justice at NIDA, the National Institute on Drug Abuse, which is part of the National Institutes of Health.

Dr. Wiley leads the Justice Community Opioid Innovation Network, a five year \$150 million initiative focused on transforming responses to the opioid crisis in the justice system. She also leads the Services Research branch, which is collectively responsible for a portfolio of more than 450 grants focused on addiction health services research, totaling over \$365 million annually. She spent her career working on complex issues at the intersection of addiction and justice and human service systems, with a focus on system change, technology, cross system collaboration and adoption of evidence based practices.

Dr. Todd Molfenter is a senior scientist at the Center for Health Enhancement Systems Studies, or CHESS at the University of Wisconsin Madison, and a faculty member of the University of Wisconsin Madison College of Engineering. The CHESS Center and Dave Gustafson created the A-CHESS App, the precursor to the Connections App. He also serves as the Deputy Director for NIATX's, an organizational change and technology adoption resource center housed within CHESS. He has spent the last 20 years studying planning and leading system and organizational change efforts.

Jessica Halsey is the founder of the Addiction Policy Forum. She began working in the addiction field in 1992. The impact of addiction in her own family was the impetus for her focus on substance use disorders. First in a community coalition in Southern California, followed by an appointment by President Bill Clinton to serve on the Drug Free Communities Commission and serving as a legislative aide in the US House of Representatives on drug policy issues. She founded the Addiction Policy Forum in 2015 to end stigma, help patients and families in crisis and translate the science around addiction.

So now, let me just take a quick second to talk a little bit about the Coronavirus response in the context of what we call CESF funding or the Coronavirus Emergency Supplemental Funding, which is really what is sponsoring this webinar and lead us here today to talk about things like technology problem solving opportunities in the context of the Coronavirus. As many of you know when the cares Act was passed in the spring as a response to the coronavirus the CEFS was part of that. And it was \$850 million, which was allocated to the States through the Byrne JAG formula in efforts to prepare for Coronavirus, prevent Coronavirus, and otherwise deal with the implications of the Coronavirus and its impact on the criminal justice system.

Now that \$850 million, as I mentioned, was allocated through the Byrne JAG or the Byrne Justice Assistance Grants formula, a formula program through to states and to localities, for programs that would help judicial systems deal with this crisis. And it was through the state administering agencies that those funds were administered. Technology is just one of the opportunities, or one of the potential things to be funded over CESF. There were a lot of other such as PPE, and court system technologies, monitoring technologies, along with a number of other applications that were to assist in, again, the prevention and preparing for Coronavirus continuation. So with that, let me turn it over to Dr. Wiley who will give us an overview of the technology surrounding addiction treatment and recovery. Dr. Wiley I turn it to you.

Tisha Wiley:

Great, thank you so much for having me. I'm really excited to be here with you today. I want to start just by giving you kind of the overview of the things I want to talk about today. I'm going to start by talking a little bit about what is evidence based for substance use disorders and what's specifically effective and justice populations. And then I talk about some of the challenges we've encountered in translating those effective interventions into things that the field can use. We do have some success stories. So I'll highlight a few of those for you as well. And then I'll close by just sharing some thoughts about future directions.

So to start off with in terms of what is evidence based. I know the focus here today is on technology. But I do want to emphasize that for opioid use disorder our single most powerful intervention we have is our portfolio of medications for opioid use disorder. That includes buprenorphine, methadone and naltrexone. And so I'm not going to go into detail on these medications today. But I think it's important just to acknowledge those at the outset. We actually have funded some technologies, though, around those medications and making it easier to deliver them. That includes smart pill boxes, as well as technologists for directly observing those therapies. I think those are probably being used right now in the field as we have been scaling up medications.

I want to acknowledge it's not all about opioids, I know stimulants are a bigger issue in lots of places around the country. We do not have any FDA approved medications at this time for stimulants. We have evidence based medication based therapies for alcohol, as well as tobacco, although I know that is less of an issue in the justice setting. But I want to say for the things that we don't have effective medications we do in many cases have a number of really robust behavioral interventions for those substances.

Most of the research we have funded over the years typically looks at this in the general population. But over the years, we've seen that many of these interventions can be adapted to justice populations, and into justice settings as well as many of them have proven to be very adaptable to online delivery or technology based delivery. And when you take a step back and look at the overall portfolio, what the overarching story is that many interventions do retain their effectiveness when they are adapted to online interventions, and in some cases, those interventions are even more effective.

We've heard a lot of anecdotes from the field during this really rapid transition to telehealth. And we hear that issue or that observation and that these interventions are just as effective or even more effective, echoed over and over again. And from April to September of this year, NIDA has actually funded about \$12 million to look at the effects of COVID. And many of those grants are actually looking at this rapid evolution to telehealth. So hopefully we'll have some data in the coming years to back up some of those anecdotal observations that are consistent with the previous literature.

Just to give a flavor of the kinds of things that we do know to be effective behavioral interventions, many of which have been adapted to technological interventions. These include things like motivational interviewing, motivational enhancement therapies, contingency management, cognitive behavioral therapies, family engagement, therapies and mindfulness. When I talk later you'll hear about how those have been adapted, I think, when Todd and Jess talk you'll see how some of those foundational therapies are incorporated into the kinds of work that they've been able to do.

So before we go into the specifics, I want to turn now to sort of the challenge of translation in this space. I think one of the really real challenges and translating our effective interventions has been how to get that out to the field. I'm really glad that we have Todd here to talk about A-CHESS and Connections. Because I think that's really one of the big success stories we have in our portfolio. The scientific roots of the intervention that A-CHESS is, was among some of the first studies that actually demonstrated that digital interventions were equally effective as in person interventions. And actually one of the few that have demonstrated that also in justice populations.

And for those of you that aren't aware, some of those basic foundations is also incorporated into reSET, which is the first FDA approved digital therapeutic. Again, so I don't know what Tom will talk about in his presentation today. But I just want to acknowledge that the group that he works with has really helped push the field in this direction. One of the other components I know Jess will talk about in their Connections app is CBT for CBT. And again, I'm not going to spend time going into the details of those. But just want to highlight that as a trailblazing example. Why I mentioned these are sort of trailblazing is because what has happened in a lot of the research we fund is that the research that demonstrates the effectiveness goes and lives in the academic literature, and it never makes it to market.

Our small business program has really been working in the last few years to change that. But there's often a challenge in sort of the incentives and the career path between the small businesses that really want to take these things to market, and the researchers that invest their lives and careers in developing these interventions. So I just want to acknowledge that I think that there's a real struggle, I think we're starting to make some progress on that. And I think that Connections is a really great example of overcoming some of those barriers. But there are a lot of challenges just in taking the research literature and getting it out of the journal articles and actually into the hands of people that need them. And of course, the COVID crisis is highlighted why it's important that we figure out how to do that.

So I am going to give you a couple more highlights from our portfolio of things where we have been able to successfully do that. Just sort of setting up for you the framework that we think about some of this, we use the Care Cascade framework, because there's lots of different touch points. So we can think about prevention before people, especially for young people and adolescents, how we keep them from using drugs and what kinds of interventions we can put in place for that. Once people have a substance use disorder, we need to think about how we identify those people that have a need, refer them to treatment, once they get to treatment, engaging them in treatment and retaining them in treatment. And really over the longer term recovery support.

I think in the Justice context, there's lots of different issues that come and play particularly as people transition between community settings and justice settings, because that creates a transition and care and can create lots of critical vulnerabilities. So we're just starting to see... We've seen a lot of expansion of people thinking about medications and the continuity of medications as people return. But I think these kinds of tools that Connections can offer in other ways of facilitating that transition and care as people move from secure settings back to the community is really particularly critical in the justice context.

Chris mentioned that I lead something called the Justice Committee Opioid Innovation Network here at NIDA. JCOIN is a big investment that NIDA have made in response to the opioid crisis, really trying to identify new approaches. Now within JCOIN we don't have a lot that's focused specifically on technology although we are hoping to have the opportunity to study the Connections apps JCOIN. But right now we have only one grant within the JCOIN portfolio that's actively using technology. That's a study in Kentucky, that's using technology as part of a region service, it's focused on women and trying to assist them with a smooth connection to care. It uses a telehealth and technology platform.

But it is part of a portfolio of studies within JCOIN that are looking at some variation of linkage facilitation. And while Kentucky was the only research group within our network that started off planning on using technology as a platform, what we've seen during COVID is that a lot of these other studies have had to pivot to telehealth. And so they're all right now, in that process, all these studies within JCOIN, we funded them back in 2019, did a lot of work to share sort of common measures and protocols. And virtually every study was ready to launch in early April. And virtually all of them have been waiting until just about now to go into the field.

And so as you might imagine those investigators are really actively trying to figure out how to navigate those challenges. So I think when we fast forward another couple years, we'll find that those studies, even though they didn't start off planning to use technology, we'll be using technology in a lot of interesting ways. I think there'll be a lot of interesting lessons learned from that once we make it through this phase of this.

But outside of JCOIN, we do have a few things that are sort of out there in the world right now. And so I want to highlight some of those for you. In terms of that first step of that Care Continuum, NIDA, through our clinical trials network has developed something called the taps tool that's on our NIDA website, which is drugabuse.gov. And it's a free screening tool. It's validated by research. If you need a tool for screening people, and this can be delivered through a technological platform that is out there. You are welcome to use it, we would love to see more folks use that.

A second example, I want to give you about how we've used technology, the research that we've supported, is a company called Open Beds. We started supporting Open Beds, maybe five or six years ago, through our small business innovation program a couple years ago, it was acquired by Appriss health, and it really matured. I think what's interesting about Open Beds, this is a technology that is meant to sort of pull all the loose threads together. So it started in hospitals. But I think they've also worked with drug courts and other agencies that are referring people out to services. And what it does is basically creates a real time network. So you can see where the open beds are. It's more than just open beds. But it started with that sort of literal translation of where there were opening slots for people to get referral.

So you weren't sending people to programs that had extremely long wait lists. So it was a way to sort of pull that information together. So they're out there I think really maturing as a product. And that's something that is supported by a lot of NIDA's investment through our small business program. Another example, really, this time we're focused on the recovery support side of things is a company called Sober Grid. They have both an Android and an Apple app that you can use. And it's really just a

platform for people to get recovery... I think you'll see that one has a lot of common roots, I think with the Connections app, but it's different. In Ohio they've layered in recovery peer coaches, but for people who do want to use that it's actually free for people to use. And they've used that as a platform actually to better understand how people engage with their peers in that process of recovery using this online technology platform.

The fourth example I want to highlight from our portfolio, I just want to mention a lot of our work has also been around adolescents. So Tony Spirito has done a lot of work around family based intervention for adolescents and young adults, specifically around marijuana. But this isn't something you can go buy right now, this is sort of an example of something we've got really promising results coming out of this, but it doesn't exist out there in the ecosystem for you to actually go and get that. But I do think it's something that over time, I hope that we will see that come to market as a point, as you all need to identify things that can solve these kinds of problems, but really promising work coming from that.

And then I have two last examples I want to highlight from our portfolio. These are also things that you can't quite buy yet but that are under development. For the first time ever, our small business program actually made an announcement last year that specifically highlighted the social determinants of health as a key area that they were interested in funding apps to support. And it also highlighted justice as an area of interest. And through that last year, we made two awards that were specific with justice populations. So those companies are right now doing their initial research and hopefully moving to a place where they can bring the products to market very soon.

The first product is by a company called the Center for Progressive Recovery. They are developing an AI powered chat bot that will deliver a brief negotiate interview focused on increasing uptake of buprenorphine and justice involved populations. So I think that's one really exciting example. And then another company called Q2I just received its funding to develop a smartphone based app that can provide information and connection to services as people return to the community. So again, those are products that we've just funded that are under development.

And so with that, I want to turn just to sort of a few thoughts about where we need to go. I want to say, I'm really excited to actually have the opportunity to talk to you all today, because I think it's really important for us to listen to what's important from your perspective. So that we can think about how we bring our resources to be responsive to those needs in the field. And so, as I mentioned earlier, we're going to have a chance, I hope to study connections through JCOIN, and I hope we'll be able to build on that platform. But I really think a place that I love to see the field go, we had a meeting about two years ago here at NIDA about lots of these different technologies in the tech and justice space.

And there are lots of different pieces of technology, but they haven't all been pulled together. So I would love to see at some point technology used as a platform to deliver treatment while people are incarcerated, as well as facilitating really smooth transitions to care when they return to the community. So using the technology to deliver therapeutic content and ensuring that they have continued access to that therapeutic content when they return to the community. I think there's lots of the technological infrastructure you need to do that is in place, like the tablets that are being used in jails and prisons to deliver educational and entertainment content. And we can think about giving people phones as they return to the community and use that to facilitate those connections to care. So I'm hoping one of these days, someone's going to bring me an application that does all of those things. But I'd really love to see the field go there. So with that, I will pass the torch so you can hear about the really exciting work that Todd and Jessica are doing.

Todd Molfenter:

Fabulous. Thank you, Tisha. Yeah what I'm going to talk about or just going to get things set up in Jessica to talk about this Connection smartphone app. And in this is an app we developed in our center over the past 15 years. And I'm going to talk a little bit about its origins and in the research behind it. And then Jessica is going to talk about how it's being applied out in the field right now.

And so this goes back, well I was first exposed to this idea, and it was developed here at the CHESS Center at the University of Wisconsin. When it was originally developed, it was called the A-CHESS App. I don't even know if it was called an app in the beginning because there wasn't apps per se. And we had been doing work on computers and we're some of the initial folks that would do discussion groups and things like that is part of research.

And so one day about 18 years ago, when I was a PhD student with Dave Gustafson, he's in my office, and we're talking about different things. And then at one point, he abruptly pulls one of those old flip phones out of his pocket, and pointed at me and he says, "This is the future of healthcare." And I have to say, I was a young, impressionable PhD student at that point. And I still didn't know what the hell he was talking about. I was just looking at him like really Dave, but he emphatically said it and he's quite a visionary.

And I think, really, his vision was that at some point these TracFone, we're going to become smartphones and these smartphones were going to become a very important part of our lives. And for any of us who recently have thought they've truly thought they have lost their smartphone, understands how important that is to us now. And really the vision that when we're getting treatment, we're sitting there in front of a person for an hour, if it's IOP, longer. If you're in residential that's a different situation.

But really, there's a whole set of things that are happening to a person outside of treatment. And so can we use these smartphones, to really make it so recovery really sources are available to a person 7/24? And really, when we first started this, it was really tricky. I mean, if you look at Pew foundation data, 2011, believe it or not just 35% of us had smartphones at that point. And now it's over 80%, well over 80%. And I think because of that, and other kinds of technology advances, it's made this whole telehealth boom, possible. But also, there is a group that's being left behind there, because not quite everyone has this technology, but a lot of people do.

And Tisha mentioned this earlier, is in telehealth, in general, we're seeing a lot of research that goes back to like 2012, that shows that telehealth interventions can be as effective as in person. And so there's just a really good, good, rich background there that says telehealth is something that could be helpful, can it replace in person, maybe, maybe not, I think you have to sort of look at the situation, the person. But it is a great adjunct at the very least. The original research we did was looking at people actually leaving inpatient settings and wanting to continue their recovery. When Dave set up the A-CHESS App, it's interesting, I mean, here at the University of Wisconsin, we are a bunch of engineers.

But he, when he was setting it up, it was more about well hey, we have these different technology functions we can put an online library, and we can do discussion groups, we can use the GPS function that to help people avoid places they don't want to go. But before doing all that there's two sets of theory that he used. The first was self determination theory, which really says a person, to be able to stay in recovery needs to be motivated, feel competent in doing that, and feel socially connected. And the other theory was more or less theory of relapse prevention.

And so as Dave put together, Gustafson put together this A-CHESS App, he sort of took these theoretical elements and sort of baked them into the technology. He used evidence to create evidence. And the evidence we have seen from it is our initial study was around people leaving residential treatment. That's a very risky time for people, people put a lot of energy and resources into their recovery at that point. And really could use some additional assistance. And so what we would do is we

would give people phones at that point, a lot of folks didn't have smartphones, we gave them smartphones, with this A-CHESS App loaded on it. And we were looking at drinking, and through that trial, and that had 349 subjects in it or individuals, we had 51% fewer risky drinking days in the prior 30 days, four months, eight months and 12 months. So it really went out quite far.

And those who had A-CHESS would have about half the risky drinking days of those who did not. And so that was really inspiring, as a way to help people with the recovery. In fact, in the early days, it was called the A-CHESS Recovery app. As Jessica will talk about, it is now being integrated into treatment too. Another trial that was done, this was done in Hazard, Kentucky, that's a Appalachian portion of Kentucky. And they gave 42 women the A-CHESS App. And what they found with these women who had the A-CHESS App, is they were in treatment, a little less than twice as long as those who did not have the app. And so it was 410 days in treatment versus 262 days. And if you look at service utilization, that same sort of ratio is there.

So as you're sort of listening to what Jessica describes, I mean, you have a tool here that helps people in their recovery. It also helps people who are in treatment to get into treatment, and stay there. And then the very last study that's about to be published. And it was done between Dave Gustus and Jim McKay, Jim McKay has a very strong background in using telephone case management. During and after treatment services and they had intervention where they looked at A-CHESS plus telephone case management, A-CHESS by itself and telephone case management by itself.

HS and telephone case management, and A-CHESS both had significantly different differences in heavy drinking days, compared to telephone case management and the control. So just another example. So what we have with this app, and others are starting to come along that they can claim this, but you have an app here that's been evidence based going back to the residential study I was telling you about. That study was published in 2014. And so there's been a number of other studies on this. And so this app has, has a really good evidence base to it. And something we're proud of is there's usually pretty good utilization of the app once people get engaged with it.

What I like to do next is turn it over to Jessica. She's going to talk about the Connections app and what they've, what they've done is taken this app and even added some things to it to make it even better and more helpful for people in recovery. Jessica.

Jessica Halsey:

Thanks, Todd. I'm going to share my screen and walk through sort of a mini demo of Connections, of A-CHESS, and some of the items that we've added to this at Addiction Policy Forum. So let me get my screen going real quick. Is that working for everyone? Excellent. So the kind of the impetus for this is when the pandemic's shut down, sort of happened, and we were shutting down, not just restaurants and movie theaters, but also recovery support programs and treatment programs. In some cases, we knew within about three hours that the folks that we serve, patients and families struggling with substance use disorder, that this was going to be very difficult. So we worked with CHESS Health, who licenses and puts this app mostly out to treatment providers. We work with them to get this app, Connections app out to our community, and rather short order.

So we were really proud that we could work quickly to make something available, because the need was so great. And indeed it was, people really struggled. We did a little bit of, even a survey about this just of how hard it was to manage your recovery or your treatment, when so many of the services or the social supports you needed were turned off. So we have been working as a provider with licenses and putting connections out to individuals for free since March of this year. We've learned a lot of lessons and had a lot of inspiration on sort of where we could go to use this in a broader way to help individuals.

So a little bit, that's about APF. So in terms of the justice involved piece, we also ended up hearing from quite a few drug courts or diversion programs, who were very concerned about, "We're shut down right now, our courthouse is actually shut down, I'm worried about the people that were under our supervision, we've lost touch with a few. We cannot provide the same services or continue services that they were receiving." And so there was this need and this gap that became very apparent, even within justice involved populations of having sort of a safety net to support recovery and to support treatment.

So A-CHESS is where this came in. You've just heard Todd do a much better job and Tisha on the research behind this, and that really was the number one reason why we went with A-CHESS. There had been, I think, six clinical studies, and tons of journal articles in peer reviewed journals. And it really had the data, where we knew that this worked, so we weren't experimenting with something new, but could with some confidence tell our families and our patients that this was something that had evidence behind it to support that this is going to help them during such a difficult time, like 2020. So that's really why we went with this model. We also like that this combines not just A-CHESS but CBT for CBT, which is an online cognitive behavioral therapy program, that also has a lot of evidence and data behind it.

Further making this the smart or only choice for us is NIDA's investment in these technologies, I think we really has a patient advocacy group, we really try to follow the science that NIDA puts out and it gives confidence to our families who are trying to get more increasingly comfortable with asking and being curious about the research and participating. So the data is what led us there. The other thing was it was cost effective. There's other solutions that are out there, that we as an organization can't deploy to 2,000 people, if the per user cost is going to be super high. If there's funding for some of those, we'd love to add some contingency management or incentives to this. But this was a way for us to deploy really helpful tools at a cost that was doable to us. And something that we could add the components that we're good at to the platform as well.

So here's a quick overview about what it is that we are doing here with Connections. It really is three things combined into one, you have Connections App A-CHESS. and that's what we call it for the patients. So if you are in person, either in treatment or in recovery, and you're downloading the app, and you're part of our platform, because we are one of many service providers, treatment providers, recovery providers nationwide that has a license to do this. But you come to us and you have access to A-CHESS. You also have access to CBT for CBT, which is available standalone as well. So that's a second add on component. And in addition to that, on the right side, you get our counselors.

We have found, since we started working on this, that the content you put in and the engagement that you create every day with your patients, really drives their engagement levels. So every day there is a new prompt, we have counselors that are dedicated to this, we respond to any situations that need our attention, whether that's a relapse, or a risky location or someone has failed some of their BAM surveys, or daily check ins, making sure that those are backed up by the trained individuals. And developing the content that they need is really sort of been the focus of our component that we've added to this. Some may call it peer navigation. The level of care that we provide is sort of a combination of a certified alcohol and drug counselor. So a CADC was also a peer navigator. So combining having a credential to have counseling sessions are really engaged with someone who's struggling, combined with peer navigation, I think is a really strong and powerful combination to make sure that you can serve a whole host of needs that come up through your app.

Now in terms of breaking down what's in this app here, so here's like a screenshot. And unfortunately, I think I messed up my animation. So I'm going to go out of order. And we'll just keep it interesting on a Thursday afternoon. So the first part here is what they call e-therapy. So that's the codename for CBT for CBT. And what I love about the e-therapy piece is that when we onboard

someone, I can choose the alcohol module. So if you have an alcohol use disorder, there is a tailored module for you from CBT. If you have just a substance use disorder, we can turn on general, but there's also one for buprenorphine. If you're receiving bupe treatments because you have an opioid use disorder, we can tailor your CBT module for you. And we like to make sure that we have that level of detail as we bring people on.

Sobriety tracking and milestones. Sobriety means different things to different individuals. So letting our participants and users of the app put in their own milestones, you can celebrate and post the milestone to your wall and get everyone on the app celebrating with you. You can share it publicly if you wanted. But it's a piece in the planning phase that is helpful to some. We also have messaging. It's interesting, we have folks that are social on the wall, we can message back and forth and you can message one of our counselors. But having that ability to engage with your recovery coach or someone on our end is available to anyone anytime of the day.

And then the social piece. It's been interesting for us. In some ways the more people we add, the more they help each other. So this does become a community right. So it is not just our counselors who are responding to. Todd says "I'm having a really tricky day today. This is what I'm struggling with. This is what just happened." It's not just Jess and Kayla or Sean, APS staff who are going to be weighing in when this is a public message board. There's a community that's really been built. Similar to being in the rooms and some of the support group structures that so many people rely on to make sure that this is a supportive community from so many different directions.

You can put in your plan, you can journal, take surveys, I'm a big fan of the medication reminders and appointment reminders. And it's been really great to see what a large percentage of participants have been using those functions. And then there's content. We really believe that building the content, and that's what APF I think is good at and can bring to the table here. We try to translate complicated things into digestible little snack packs, and making sure that we're doing that for our recovery community so they can understand. We have pieces in there that explains how this affects your brain and how you can recover, to triggers and relapse prevention. And we're digging in on some modules right now around the five dimensions of recovery, which we're big fan of.

And then constantly making sure that new content is there. The more content you have, and the more engagement you put out on a daily basis, the more interaction you'll receive among your participants. In terms of... These are the pieces that Todd and Dave and others built. But having this pretty amazing, weekly, brief addiction monitor survey, the BAM, in addition to a daily check in which is very simple, "Can you make it through today or not," gives us the data that we need as a provider to swoop in if we need to, and see if someone needs to be checked on.

We don't necessarily engage someone if a daily check in, there's one sort of failed daily check in. But if we see a few that day, that week, plus a weekly BAM that's failed, it generates a red pin that is used by us on the provider side to make sure we wrap up that patient with a little bit more support at that time. This is sort of a non-real person with the example of the things that we see. So as you see the red pin, here are days that the daily check in was failed or a BAM. And this is sort of the pathway and the alerts for us to say this is our moment to engage and provide an extra level of care for this participant. Very quickly, this is a lot of app functionality to go through in 10 minutes. So I'm trying to highlight the things that I love the most about it.

I think this just underscores that patients need a lot of things in recovery. They need to connect to people, which was even more difficult during COVID. And it's continuing to be difficult. There's still disruption on recovery support access meetings, there's still disruption in treatment. So I think the need is still very significant there. You need to have tools to motivate you, have access to content that you can trust and rely upon. And having all these things in one place and building upon it, I think is truly

powerful. I mentioned the sobriety streaks, it's pretty cool that they have these pendants that you can post. We're thinking and tinkering with some ideas about how we can celebrate with people a little bit more.

There's high risk locations. We don't necessarily engage on these all the time, it could be just that you have to drive by a certain bar to go to work. That used to be a troublesome place for you. But it may not any longer. So we've worked with the individuals on how we use this data. But it does have this GPS functionality that can be very helpful. And the recovery help button. I think when we were meeting with NIDA initially, and really talking about why doesn't the whole world use A-CHESS. that was like my first question. "The whole world should use A-CHESS." We have 20 million people in recovery. And every single person should have this on their phone if they have a smartphone.

And the reality is that the intermediary here, which for this project Addiction Policy Forum is serving that role. Is to have the person that is watching that dashboard, is putting out the content and is answering the recovery help button. If you fail your daily or weekly, one of the options that pops up is to press your beacon button. And that's "I need help, I need to talk to someone." And so we're providing that functionality for not just our current programs, but we received a grant to recruit about 30 justice organizations, justice agencies to make this available to justice involved individuals. So to see if we can figure out that intermediary piece, if we can have larger expansion and uptake of this technology.

This is one of our counselors. This is Kayla, and her very cute puppy. As an example of the peer navigation piece that APF provides. I also, it kind of is covered up by at least my format for the screen. But we also put a lot of video content and explainers. And we found that it's a resource or a content piece that seems really useful to the A-CHESS participants. So we're continuing to build on those and guide from there. We also have daily prompts and engagement. And sometimes this isn't all like "Let's talk about relapse prevention or triggers or what you're sort of level of care is and if you're sticking with it." Sometimes these are icebreakers and getting people to connect, these are discussion boards and putting new threads together. We've got movie lovers and sports lovers. And here's all the folks that found out that they're from the Midwest and just discussion and forming those bonds in addition to more content filled pieces.

Now the CBT piece, again, I think that the power of this experiment here with having the navigation plus A-CHESS plus CBT is pretty powerful, we hope. I love that the seven components here that our participants who really complete each of the modules for CBT, cognitive behavioral therapy, really seem to benefit from it. We have testimonials and messages. I love how Dr. Carroll put this together, she's at Yale, and they work together really well between A-CHESS and CBT. So these are integrated solutions. So the client, the participant, doesn't have to navigate around different links or apps. But this is all on that home screen of their safety net for their recovery support that they might need.

Heard all about a little bit of background about this. I thought these are a few screenshots with people's avatars and screen names, just how much they love this and the platform that I think is so inspiring. I think Kayla collects these almost on a daily basis. But to see how helpful this is, particularly during the pandemic. There will be some that do not need this after maybe this fall or maybe next spring or next summer. But for now, shoring up and I think providing even more opportunities to engage in this type of safety net is critical. And a little bit about the pilot we have right now. For a lot of you, in your role of being in charge of your whole state, then there might be other ways to engage and use A-CHESS. There are systems that you have or whether it's a correction system or a county jail or diversion programs, drug courts or statewide Drug Court Association, they might not need an intermediary like APF.

If you have your own treatment staff and recovery staff then it can be managed and licensed directly to a state or to an organization. There are a few pilots I believe underway with CHES Health where a state has turned this on for their whole system. And there's a contract that makes that provider capacity come to life and function. For this project that we're working on, we are acting as the provider for up to 30 agencies and to see how this works and to sort of fine tune how we can provide digital therapeutics and telehealth support to justice involved populations. And they will have access to all three of those components CBT, A-CHES, as well as our peer navigation. If any of the organizations in your states are interested in participating in our rather small pilot, we're still very excited about it. And the deadline is open until next Friday, October 30. And we will provide the app and the services for free to up to 1,000 participants from those agencies over the next seven months. So we're excited about how that's moving forward.

In terms of who can do... I think any agency can really use this on the justice side. I agree with Tisha I would love to figure out how to get a locked down version of this on a tablet to use six months in and use during transition and be on a phone upon release. I think there's a lot of utility to drug court participants, as well as both deflection and diversion participants. Reentry programs that are even nonprofit based I think would be helping. And of course, anyone in the SUD space that's looking for that level of support. I've heard in particular, finding ways to keep CBT going in systems, whether it's treatment or corrections is tricky. And having that in the palm of your hand, and also having the case manager who says, "Todd, you have only finished three of your seven modules for CBT. And I'm just checking in to see how you're doing." It's that engagement and knowing that there's a real person that goes with these amazing tools that I think can be very powerful for agencies. So that's my live almost demo.

Chris Asplen:

Thank you, to everybody. Thank you, Todd, and Tisha and, Jessica. We do have a couple of questions that have come in. And I've got a couple of questions myself. So let me start with some of the participants' questions first. First of all, can this technology, can it be used for general case management? Or is it really, really just for these kinds of recovery applications? Or is there another case management product?

Jessica Halsey:

Todd, I don't know...

Todd Molfenter:

Yeah, I'll start and Jessica... When we developed it, it was meant for the patient to be the primary user of it. And so, I mean, it's truly a patient recovery app. What we see is a lot of case managers, recovery specialist, people like that, who interact. Because in the app, there's two... The patient, or the person in recovery, can access the app. And then if they're in treatment, they can note that their counselor or case manager or peer recovery specialist, they can note that person. And then that person can also see what their weekly BAM is and things like that. And so I think it's something where the case manager can sort of watch what's going on and interact with the person in new and different ways. But as far as like, an app that can help with case management and getting people linked to resources and things like that. I don't think that, at least for the A-CHES portion, that wasn't the intended purpose of it.

Chris Asplen:

How about, is this an app that can be used once folks have completed treatment, but are still in early recovery?

Jessica Halsey:

Oh, yes, I think it is useful if you're currently in treatments. Those who haven't engaged in treatment and are looking for ways, then they can access our counselors to help with a care plan. We have a lot that are newly in treatment, or their treatment was disrupted. And we have individuals who never went through formal treatment, and sort of have a self guided pathway, but have relied heavily upon mutual aid support groups as their long term recovery support piece. And the absence of that during the shutdown was very difficult for them.

And the thing I can note about that, and I think is important for [inaudible 00:58:41] members is that the length of time in recovery, it was surprising to our folks that there was like an assumption that the length of time in recovery should be more protective. But the reality was, when you take away "I go to the gym five days a week and yoga three days a week and I go to Celebrate Recovery two days, or I do Smart Recovery or Refuge in Recovery, or NA or AA or..." There's literally 17 different brands. The cutting off access to that was very difficult. So regardless of where you are in the continuum, this app, it will help you.

Todd Molfenter:

Yeah, and just to add to that briefly, the initial research we did was for people who had been discharged from residential services and so were sort of... Sometimes they were involved with outpatient but a lot of times they were on their own and this app was truly a lifeline for them.

Chris Asplen:

Jessica, where can people go to learn more about applying to be a pilot site?

Jessica Halsey:

If you go to addictionpolicy.org or send me an email at jhalsey@addictionpolicy we'll get you in the lineup.

Chris Asplen:

On the alcohol side of things are there, for example, links to AA and NA meetings and such?

Jessica Halsey:

We do have the capability to do that. How we manage that is if folks want additional services, our counselors actually help them send a customized list based on their parameters. So you get that true peer navigation or recovery navigation that comes with this. So it's not just self select, and walk through our resources, but our counselors will get people to the... If they need a list of meetings, they need meetings that are online. If you're IOP closed, and you need a new one, Kayla or Sue or Shawn are going to find it for you.

Chris Asplen:

So Jessica, you made a kind of a really good point a couple of times, about the extent to which it's not all about the technology. There are still... The people who are attached to it, the counselors that are attached to it are still as important as ever. But it seems to me that what we're being able to do,

obviously, is to maximize their impact and the extent to which they can reach out and help more folks. I guess my question, however, is actually for Tisha. Is there the backroom research or I should say, maybe the macro research being done on things like cost benefit analysis, when we look at fewer hospitalizations. What's the research that's being done that proves to us that we are saving money, ultimately? We're saving public funds, ultimately, by the utilization of these things? Because we're reaching more people, with fewer people. We're preventing hospitalizations, etc. Is somebody doing that number crunching?

Tisha Wiley:

Yes, I think a lot of the studies we've been funding lately have been looking at cost effectiveness. Certainly, this is where sort of the divide between the ways in which these kinds of apps get funded comes into play for our SBIR Program, which is the mechanism that actually takes a lot of the research and takes it out into the real world where you can buy it. They're not doing the cost... Sometimes they're doing the cost effectiveness analysis, but mostly they're figuring out how can they take it to market. Where we're funding their research, though, sort of on the back end of proving that these things work. Seeing that they work well, on these platforms.

That research we are seeing a lot of cost effectiveness kinds of analysis coming into play with that. And I think for each thing that's being studied, you'll see those cost effectiveness analyses come out. I will say in the justice space, though, we've even seen sort of reduce of old analyses that maybe didn't show cost effectiveness, but they had missed incorporating in key things like health care utilization versus justice utilization. I think those issues are actually really complicated to do a good cost effectiveness analysis in the justice space, because you have a lot of the costs that cut across the different systems. But just one more plug for JCOIN, across all of the studies that we're funding in JCOIN, every single one of them has a cost effectiveness piece embedded in that. So that is very much part of the culture of the kinds of things that we are... The research that we fund these days.

Chris Asplen:

Great. Thank you. Okay, so we've got time for probably one more question. But before so we're going to open up a short poll we're going to ask you to fill out while we ask that question. So have insurance companies gotten on board with any of this? And is there an anticipation to talk to? If not, are we talking to insurance companies about the possibility of supporting this kind of effort?

Todd Molfenter:

Yeah, this is Todd just to start. So far, the insurance companies haven't paid for this app directly. And actually allow the providers who are using it are on sort of case [inaudible 01:04:12] and things like that, and then they appreciate this as a way to improve recovery and reduce recidivism, and things like that. But no there hasn't been insurance companies directly paying for it at this point.

Jessica Halsey:

There has been... Some other apps are working with insurance company to go that route of having coverage within the health system. This has mostly been deployed through treatment programs and providers who make this an offering as part of their service provision, instead of going through the health system. But I think there's lots of room there. We've mostly been reaching out to grants and foundations and other funders to interest them and investing in this and really building that safety net for this community.

Tisha Wiley:

And just to add to that, I think that's why Pear Therapeutics went the route again, the FDA approval, because of some of the doors that opens for reimbursement. But there's a lot of complexities. And I'll just say that NIDA's definitely working behind the scenes with the FDA around how that approval works. Better understanding that, and Jess could probably speak better than I can about this, because there's definitely been discussions about what kinds of outcomes are needed to demonstrate the effectiveness for the FDA approval of the digital therapeutic. So just highlighting that is something that lots of people at NIDA and lots of researchers are thinking about and working on.

Chris Asplen:

So thank you for all of this, we are at time, we have to finish up. Thank you, for all of you, for all the work that you're doing. It's such a wonderful thing to see the extent to which we're being able to leverage the technologies, we're being able to leverage the funding and the research to really improve people's lives. And we're interested in doing a lot more of that. So thank you, everybody, for joining us. If we haven't answered your question live, we will do so by following up with you. In terms of getting the research that is available, we'll make sure that you have the websites wherein you can look at all the studies that are necessary for you to make informed decisions if you're interested in this kind of pursuit. So again, thank you, Todd and Tisha and Jessica, thank you to Bethany on my staff for helping to put this together. And we really appreciate your time. Everybody, stay well stay safe. And thanks again for joining us.

Jessica Halsey:

Thank you.

Tisha Wiley:

Thank you.