Increasing Access to Behavioral Health Services in Rural Alaska: The Power of Telehealth

Corina Pinto (00:07):

Welcome to this podcast from the Delta Center for a Thriving Safety Net. The Delta Center is a Robert Wood Johnson Foundation funded initiative launched in 2018 that brings together primary care associations, and behavioral health state associations to advance policy and practice in their states. I'm your host, Corina Pinto. Today, my colleague Rachel and I talk with John Solomon, a behavioral health counselor from rural Alaska. We chatted about the importance of expanding the telehealth system and reimbursement policy to support these services that increase access to care, especially for communities that have been historically marginalized.

(00:47):

John Solomon spent years as an indie rocker in Minnesota. Now he's using his voice to speak out as an advocate for telehealth in rural Alaska. John has seen firsthand how flexibility and reimbursement for telehealth during the COVID 19 public health emergency actually increased access to mental health and substance use care, while also creating new job opportunities for rural native Alaskan communities. John's story is relevant for any state still pushing for making telehealth flexibility permanent after the public health emergency ends.

Rachel Tobey (01:28):

Hi, I'm Rachel Tobey, and I am the Director of JSI's California office, but I also co-direct the Delta Center for a Thriving Safety Net. And Alaska has been the state that I have been coaching in this phase of the Delta Center, which has been a thrill. And they are the ones that introduced us to you, John, in particular, because they've been working on telehealth policy, and they said, "There's no one that can connect the actual on the ground need for telehealth better to the policy of expanding reimbursement for telehealth services than John Solomon." So, that's what brings us to you today.

John Solomon (02:09):

Wow. Big introduction there, I guess. So I'll just introduce myself then. My name is John Solomon. I am a licensed professional counselor, but currently I'm the behavioral health director for a tribal health organization. It's called Maniilaq. I'm based about 30 miles above the Arctic Circle. It's a region about the size of Indiana, so a very large region, but we are not on the road system. So what that means in Alaska is, if you want to get from village to village, you have to go in a bush plane. The tribal health organization, for our behavioral health program, we serve all of the people that live here. It's about 95% native Alaskan in

the villages. It's about 80% native Alaskan in the village that I'm based in, which is Kotzebue, Alaska. There's 12 villages that we serve. They range from 100 people in the village to... we have a couple that are up to about 1,000 people. Kotzebue is about 3,000. So we're the big city.

(03:17):

I came up to Alaska actually only about three years ago. I came up to be a therapist for the villages. And so, initially, I was coming up so that I could fly by bush plane into each village and do substance use counseling, trauma counseling. Basically any sort of counseling that was needed in a village, I was the one stop shop. I had a backpack and a sleeping bag, and you'd bounce around to the villages, and whoever walked in the door, I was going to be the person they were going to see.

Corina Pinto (03:51):

Do you mind sharing a bit about what drew you into counseling and recovery? And then we'll get into kind of the weeds of telehealth and the villages.

John Solomon (04:03):

So, like a lot of folks, my first interaction with counseling was that I was going through it myself. So I'm in recovery. I think I've crossed the... it's 11 years plus right now, so that's a good place to be. But I was a drug addict. I was a musician. I fell into what a lot of musicians fall into. So I ended up going to Hazelden Betty Ford, which is a treatment center. I was in Minnesota. From that experience I kind of fell in love with the idea of... beyond just like, "Oh, there's somebody... I have a substance use issue and I need help." It was the real introspection of, "Oh wow. Somebody can help me work on myself." And so eventually that translated into me deciding I wanted to learn more. And so I ended up going to... Hazelden Betty Ford has a graduate school, so after several years of being sober, and I went back to be the other side of Hazelden Betty Ford, which is the graduate school. So, I graduated in 2019, I think. Yeah. So 2019. So just three short years ago,

Rachel Tobey (05:14):

How did you pick Alaska as your place to do counseling?

John Solomon (05:18):

IHS has always been something that's really interested me, which is Indian Health Services. Because working with populations that don't always have the access to care that I was able to receive, living in Minnesota, and going to this very nice treatment center. So I wanted to spend some time after graduate school working with underserved populations, and Indian Health Services has pretty extensive a program of getting people into serve underserved populations.

Corina Pinto (05:46):

So you landed in 2019, and you started this work, and then 2020 happened. Could you share a bit about what that looked like for you on the ground as you were providing these services and... in the weeds now?

John Solomon (06:01):

Yeah. So it was very interesting in the fact that, I mean, it was interesting for all of us, but where we're at, we were aware of telehealth in a way that's different than the lower 48. I think the lower 48 thinks of telehealth as ease of access, it's more convenient. But up here, there are times that we have to use telehealth because of crisis and emergency, and just access at all. So we are aware of telehealth in that way. We had some ways that we could do it, but it was very regulated, very structured. A lot of what we were doing was not reimbursable. It was just something we had to do.

(06:42):

So, when COVID happened, I think we were uniquely set up to pivot quickly, because the clientele were a little bit more used to the idea of, "Hey, the doctor or the therapist or something is not going to be in front of me." It's not unheard of for them, at the time they were going to the clinic, to get on a video screen to see us, that were in another clinic somewhere else. So there was some familiarity with it. But then the thing that really changed was when they relaxed the rules so that we could use telephones, which became an astronomical change for us. So going... in the span of a couple days, we went from we had to fly to villages, or we had to get clinics to set up one room to another room, to suddenly being 100% access for anybody in any village. So it was an astronomical change in our world for just a couple days.

Rachel Tobey (07:42):

John, one of the things that Jerry shared was that this mechanism of flying out once a week to do a recovery group, or to see people in the clinic, was able to change to actually increase access to care, in terms of being able to talk maybe by phone, maybe by video to a therapist more frequently. Can you say something about that in terms of the change of workflows?

John Solomon (08:14):

Yeah. So I think the number that I always use when people ask me, "What did that mean? Give me something tangible that I can understand." I point out that one of the clinically best accepted practices in substance use counseling is group work. That's where you really see real improvement, is when you can have substance use groups. So that's from any treatment center anywhere you go in the country. Oh, you've got a substance use issue? Well, let's get you into a group. No matter what level you're at. But obviously if you have a village of 100 people, and the only way to see a therapist is once every two or three weeks, maybe there's a few people in that village that have substance use issues, but it's going to be your aunt and your high school ex-girlfriend. Let's get you all together and do a group? That's not going to work.

(09:04):

So the week that they relaxed those regulations, we were able to switch to a telephone model of substance use groups. And within two months, we went from a substance use program that maybe had 5 to 10 people in it, to a program that had 60 to 70. Our substance use groups increased by 800%. And it wasn't because suddenly people had substance use issues. It was truly that people were waiting in the villages, and they desperately wanted help, but there was no way for them to get that help, until one day they could call and get that help. And so we suddenly have this thriving substance use program that was graduating people out of it, they were completing their probation requirements, they were having family reunifications with the Office of Children's Services. It was an astronomical change in a short amount of time. And it was really shown that it wasn't COVID that had increased all these numbers, it was access to care that increase these numbers.

(10:17):

And so that translated long term to, "Hey, we're keeping more people out of our emergency. We're having to fly less people to our hub village." As COVID went on the need increased, and we've been able to respond to that. As anyone else, we struggle with our workforce, especially up here. It's such an astronomical change to get somebody up here, that we're able to now reach all the people that need help, no matter... As far as way as they are... We have villages that still don't have internet. People in the lower 48 can't conceive of that sometimes. It's like, nobody's going to be able to get on a video call if they're way out in the bush, so it's phone that we use.

Rachel Tobey (11:03):

And what have the patients and clients said about their experience using phone, for instance, in group work?

John Solomon (11:13):

It's been really interesting because, culturally speaking, where we're at, it tends to be a much more reserved population. There's not a whole lot of sharing of emotions, and there's very much a reserved way of interacting with people that's very family oriented. So you're not going to open up about the issues you have in your family, because it's very important to support family. So suddenly, though, you could get on a phone, and you didn't have to look at somebody in the face to talk to them, you didn't have to make the eye contact. The things that as a lower 48 therapist, eye contact, body language, all these things are part of therapy, but it's completely different up here.

(11:59):

One of the things I noticed as just a therapist at the time was I had a village where sexual assault was a real issue. It's a real issue up here in general, because a lot of it is substance use related, a lot of trauma, generational trauma that comes down. So I would go into this village and there were a number of girls from 13 to 18 that needed to see a therapist. They

wanted help, they wanted to talk to somebody, and then they walked into a room and here's a 40 year old white guy. And it was just not something... They didn't want to open up to me. But suddenly they can pick up a phone and it's just a voice on a phone. It's something that they can talk to. It wasn't this bearded, tattooed guy sitting in front of them, it's just a voice on a phone that could listen to them. So it really made a difference on the small scale that way.

(12:53):

And then in this larger scale, suddenly we had access to groups. Suddenly we could do these things that the lower 48 does all the time. And then just second nature to think, "Oh yeah, you have a substance use issue? You go to a group program." Where up here, it was the first time that people got access to this. So the clients have loved it, so much so that we started to track what their preferences are, because we want to give them the experience that they want. And we've seen... It's an informal tracking that we're doing right now, but it's roughly like 60% of people want telehealth. That's what they want. "I just want to do telehealth." And that's 90% of that is phone.

(13:37):

And then the other, there's like 30% that are, "Eh, it doesn't matter. I'll do either." And then there's a 10% that are like, "No, I want to see somebody in person." Well, that's something we can do. You know? 10% are like, "Yeah, no, I need to see somebody in person." Well, great, because now we're going to be traveling to villages and we can definitely handle 10% of the clientele that just need to see somebody in person. A hundred percent of the people we could not handle. So our numbers have gone up exponentially. Our staffing has gone up recently, but for a long time, we were just covering that with the same amount of staff. That just suddenly gave us this ability to, instead of spending our time getting in a plane, and sleeping in a clinic and... we were able to meet the needs of the people in the region.

Rachel Tobey (14:26):

Can you say a little bit more about the experience of the therapists you and your team that you were supervising, in terms of did they feel as clinically effective? And in terms of we hear a lot about provider burnout in these times as well. Was the work as satisfying for them as providers, in being able to provide more services to more folks, but not in the way that they had been used to doing so previously?

John Solomon (14:57):

I think that we all appreciate different practices, in the sense that you learn all these different ways to do therapy. Well, now here's another part of that. Now you're only going to use the voice. You're going to really have to clue into what's going on there. And interestingly, I think a lot of therapists were very hesitant, but now therapists that have gone through this process, and then are going on two plus years of doing this, they feel very confident in that telephone only, because you really start to train yourself to the things that, as a therapist, you thought you needed sight, and you thought, "Oh, I've got to be able

to see them to really understand what's happening." And I think it just opened up, culturally, mental healthcare in our region as well, because there was a lot more comfort level because, "I'm just calling a mental healthcare worker." Especially with the lower 48 Western healthcare kind of system where, like I had said, 40 year old white guy with a beard comes into your village to help you. Well, that's going to bring some things into the therapeutic process that really makes that initial therapeutic bond a lot harder. But if it's just, "Hey, I'm a voice on the phone. I can be what you need me to be at that moment."

(16:16):

And so it really helped start that therapeutic process a lot easier. And I think we've seen, not only access to care, but we've seen in our region people start to trust care more. They've started to be able to be open to this idea of mental health care more. It's been very, very affirming of what therapy is, I think. There's a lot with the legislation and the talk of what telehealth means. A lot of it goes back to this idea of this is kind of like, "Well, we don't understand it, so we should put some rules on it." When really it's like, what is therapy? Well, we're guiding people on how they're healing themselves. It doesn't change because suddenly we can see them in the room. We're just using different tools.

(17:02):

And so that's where we're at now. It's scary to me to think, "Oh, we're going to go back to this other way." Not because I feel like the other way is less effective. It's 100% effective if done right. Just like audio only is effective if it's done right. As a therapist, I know, like... Where is the real work happening? It's not me. It's not visually. That's not where the real work is happening. The real work is happening internally with the client. I don't need to see the client to say, "How does that feel in your body? Where do you feel that? What's happening physically?" I can have them engage with me. And that's what you want them to do anyways. So it's been a tool that suddenly therapists are seeing, "Hey, this is actually a really effective way to get people to vocalize how they feel, what's going on."

(17:52):

You could still have all of that in therapy. I know a lot of new therapists think, "I'm here to help. I've been trained. I've got this innate ability to be so insightful." And really, as you go on, you realize it's all the client that's doing the work. We're just here facilitating them doing the work. And so what does the client need to do the work? Well, they need you to guide them. They need you to be there, and support them, and kind of ask them the questions to get them to think about things. When it comes down to how we should regulate it? What should be reimbursable? I'm always like, "Well, why are we asking these questions? What's at the heart of these questions?" Is it because we don't trust mental healthcare? If a doctor says, "Hey, you need to do this." Are we going to say, "I don't know if you need to say that, or you need to say that in person, because saying that in person is going to mean more than saying it over the phone."

(18:48):

The work doesn't happen... We love to say it happens in the room, but it's not like the physical room. The room isn't doing it, it's what's happening inside. So I get real fired up

about this idea that we need to regulate more of what mental health, as a field, as we get better and better, as our, they say, evidence based practice, as our numbers, as we get better at proving, "Hey, look at this. Things are happening. Things are changing." The numbers of success rates of substance use care are going up. We're getting better. So why are we then saying, "I don't know. I don't trust that. Maybe you should go back to a different way"? It's because there's a natural mistrust of mental healthcare.

Rachel Tobey (19:28):

You mentioned having to do fewer flights to take people into crisis level care, or emergency room level care for potentially physical issues that are resulting from crisis that has gotten to that level. Can you say a little bit more about how you're tracking? How are you measuring whether or not it's working to get into that pantheon of best practices?

John Solomon (19:52):

What I've been able to track is service utilization because, being a rural provider in the Arctic, I would love to say that we have this extensive research and data program going on, but that's my goal for five years down the road. But I do see the anecdotal evidence. I do see the fact that our service utilization is going up exponentially. That's an indication of something. I can hypothesize what that's an indication of, and not all of it is the pandemic is making everybody need more services. It's that people are trusting us more, that people are seeing at work. We're getting a lot more referrals from our community partners, which are the tribal governments of each village, just even the primary partners that we have, the doctors that are going out to the villages, suddenly they're starting to trust our mental healthcare more, they're seeing results, and so they're sending more people there.

Rachel Tobey (20:50):

If telehealth legislation in Alaska passes as both the Primary Care Association and ABHA believe that it will, it will be codified so that you can continue doing the type of work that you've described, right? Both by phone and by video, when people prefer that. What does it mean for workforce? Especially in places like the Arctic Circle. Could you access therapists, or data experts in a much wider geography than folks like you, who might want to live in 10, 11 months of winter? Does it actually expand the workforce that can serve the population?

John Solomon (21:39):

I'm expanding our workforce right now saying as the world, as our agency is getting comfortable with telehealth, that means they're getting more comfortable with remote work. And as people get more comfortable with remote work, then we can say, "Hey, look, I don't need my billing specialist to be in my office next door to me to know that they're doing their work and they're effective." So if I can build more people that way... We've got therapists that are coming through and they want to do... The initial contract year's two years. Well, a lot of therapists do their two years, they'll do three years, four years, but

they've got other commitments in their life. It's a lot to think, "I'm going to move up to the Arctic, and I'm going to be there for the rest of my life."

(22:26):

But if we can get somebody for two or three years to come up here... And then they know the region, they know the clients, they know what it means to subsistence living. Well, we've saved two highly performing, very effective therapists that our region loved, because they had to move on back down the to the lower 48 with family and they had life happen. And so they've been able to be telehealth therapists, and we have clients that prefer telehealth, well, why wouldn't we be able to use these therapists that already know the villages? They know some of these clients. It's a natural answer to me.

Corina Pinto (23:06):

Before we close out, is there anything else you'd like to share about people you work with, the villages you see, anything that maybe those in the lower 48 might not be aware of the context of which you live in?

John Solomon (23:22):

There's books that could be written, and there have been books written about how different it is up here. And when people step off the plane for the first time, they're shocked at how similar it is. They're prepared for this crazy ideas of the... like, "Oh, it's so remote." And then they step off the plane and it looks like a hard luck town in New Mexico or something. It's not unfamiliar. But the difference is really, once you get under that surface, it couldn't be farther apart.

(23:53):

What's been really amazing in the last two years is that telehealth, and remote work, and this acceptance of more connectivity farther apart has given the community here the ability to now... Like, our substance use counselors are... 90% of them are native Alaskan folks living in villages, and so they weren't able to do substance use counseling before that. Because who could they counsel? They could counsel two or three people in their village. Well, now we've got counselors that are living in the most remote villages leading groups two, three times a day. And who are you going to feel more comfortable with? Is somebody they can talk to you about the Iñupiaq values. We have a group that's just based around the Iñupiaq values, where they talk about hunting success, and what it means, and it's a really amazing thing to witness. I just get to be a facilitator for the community, and then get to see how the community develops their healthcare. And it's been amazing. It's just... telehealth has allowed me to do that. So I will always be the loudest voice in the room when it comes to telehealth.

Rachel Tobey (25:06):

Well, it sounds like you've brought jobs to folks as well, that might not otherwise have had that opportunity, economically.

John Solomon (25:15):

Yeah, we're bringing opportunity. And my ultimate goal, or not my ultimate goal, but one of my goals is that these people that are now getting experience counseling substance use, they don't have to leave their village to then go to grad school and get their degree. Then they can live in their village and be master's level therapists that are counseling other villages. The problem we've always had is, "Oh, you've got to go to Anchorage to get a master's degree." Well, once you're there and you've got your master's degree, are you going to come back to a village and sit in an office to counsel two or three people? No. Now they have the ability to work to the potential.

Corina Pinto (25:58):

As a result of advocates like John, the efforts of the Alaska Primary Care Association, the Alaska Behavioral Health Association, and a multidisciplinary advisory group of consumer advocates, and policy and practice experts, telehealth legislation was actually passed by the Alaska legislator in May 2022. This new state law protects audio and video telehealth access and expands Medicaid coverage of those services. It also removes the current requirement for an in-person visit with a healthcare professional prior to treatment, and permits clients to have follow up telehealth visits from providers who are licensed in another state, but have an established relationship with the client. Congratulations, Alaska.

(26:42):

Please visit our website at deltacenter.jsi.com for more information and to download a transcript of this conversation. Thank you again for joining us.

John Solomon (26:53):

So, I'm very idealistic and optimistic about what this will mean for rural Alaska. And that translates to anywhere, but it really is about access to care, not ease of access. I think that's important for people to remember.