CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicaid Innovation Accelerator Program

Complex Care for Individuals With Substance Use Disorder and Other Chronic Conditions

National Webinar
April 3, 2019
3:00pm – 4:00pm EST

IAP Medicaid Innovation Accelerator Program

Logistics

- Please mute your line and do not put the line on hold
- Use the chat box on your screen to ask a question or leave a comment
  - Note: chat box will not be seen if you are in full-screen mode
- Moderated Q&A will be held periodically throughout the webinar
  - Please submit your questions via the chat box
- Please complete the evaluation in the pop-up box after the webinar to help us continue to improve your experience

Welcome and Overview

- **Katherine Vedete**
- Senior Advisor, Medicaid Innovation Accelerator Program (IAP)
- Center for Medicaid and CHIP Services
- Centers for Medicare & Medicaid Services (CMS)

Purpose and Learning Objectives

- Consider strategies for enhancing care models for individuals with substance use disorder (SUD) and other chronic medical conditions
- Introduce state participants to current approaches that states are taking to support care models and innovative strategies that address comorbid conditions

Agenda

- Understanding the epidemiological need
  - Epidemiological data
  - Population needs
  - Constructing an ecosystem to support the needs
- Approaching treatment for complex care
  - Rhode Island models
  - Leveraging new and existing resources to improve care
- Participant discussion
  - Presenter Q&A

Facilitator

- **John O'Brien, MS**
- Senior Consultant
- Technical Assistance Collaborative

TAC TECHNICAL ASSISTANCE COLLABORATIVE

6

Speaker

- **R. Corey Waller, MD, MS**
- Principal
- Health Management Associates (HMA)

HMA
HEALTH MANAGEMENT ASSOCIATES

7

Speaker

- **Linda E. Hurley, MA, CAGS, LCDCS**
- President and CEO
- CODAC Behavioral Healthcare, Rhode Island

codac Behavioral Healthcare

8

IAP Medicaid Innovation Accelerator Program

HEALTH MANAGEMENT ASSOCIATES

Building the Workforce

R. Corey Waller MD, MS
Principal, HMA

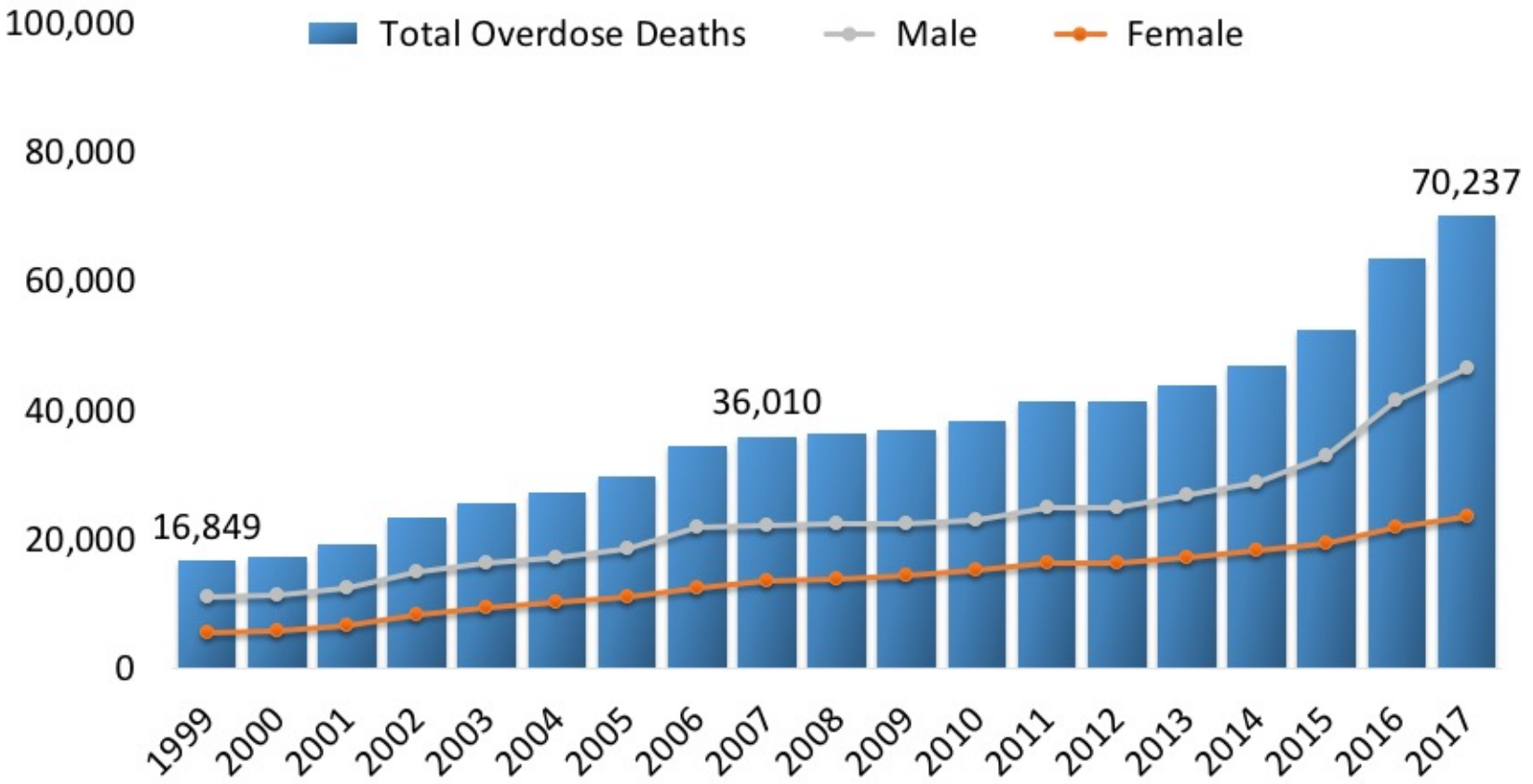
Disclosures

None

Objectives

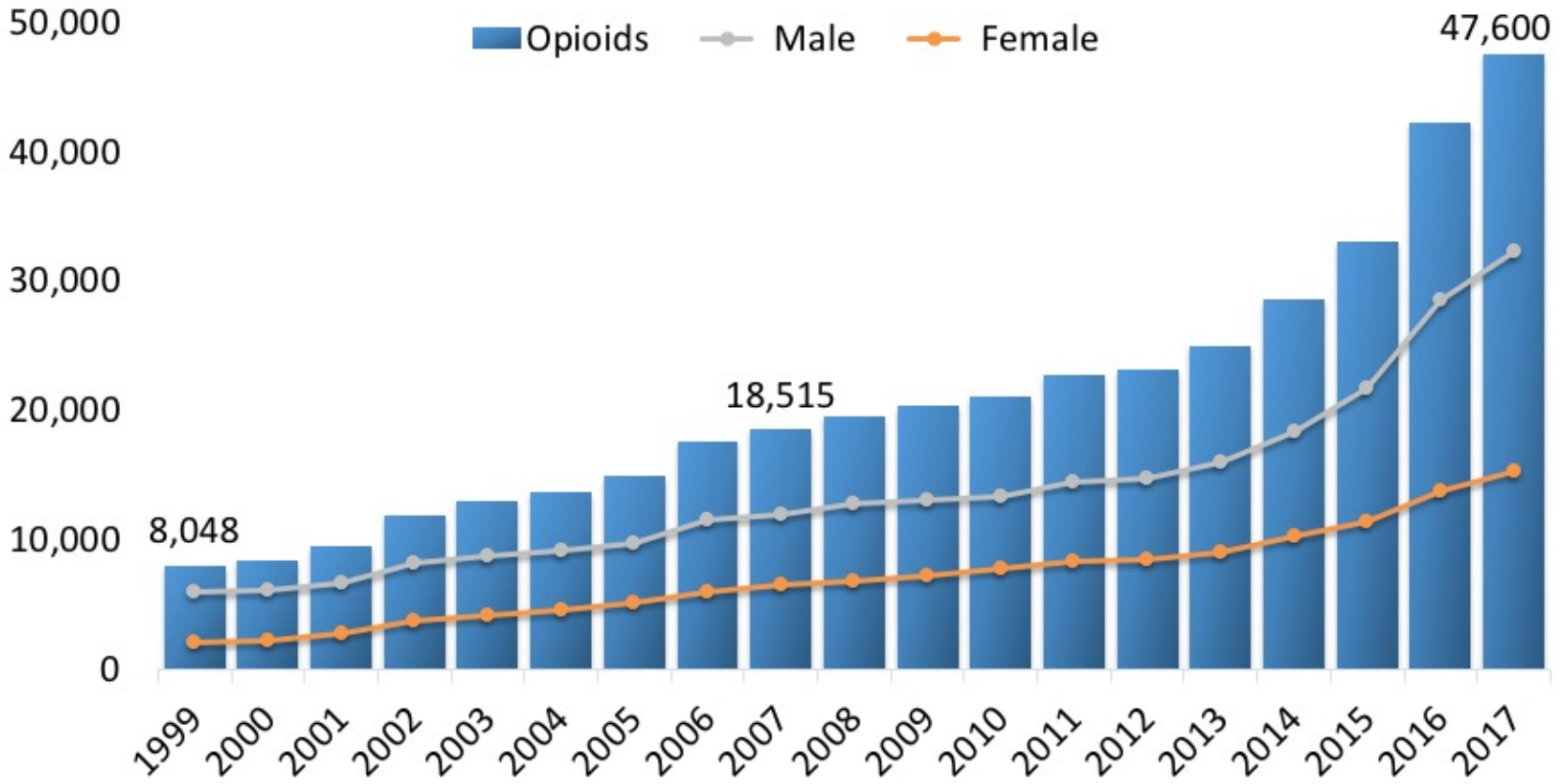
- The participant will understand the system needs on the basis of publicly available data
- The participant will be able to describe the overall needs of the population
- The participant will be able to see how a one-size-fits-all approach will not work for a “national” fix
- The participant will see how a comprehensive approach is needed to address the complex care needs of the population

Figure 1. **National Drug Overdose Deaths** Number Among All Ages, by Gender, 1999-2017



Source: : Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018

Figure 3. **National Drug Overdose Deaths Involving Any Opioid,** Number Among All Ages, by Gender, 1999-2017



Source: : Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018

Understanding the Gaps in Treatment

A = Number of patients with an overdose in a given geography

B = Centers for Disease Control and Prevention extrapolation factor of those with need of treatment for opioid use disorder per overdose (between 230 and 350—we chose 292)

T = Number of patients needing treatment

P = Proportion of population attributed to a given level of treatment

L = Number of patients requiring treatment at a given level of care

F = Fractional full-time equivalent (FTE) need per patient at a given level of care

N = Needed FTE per clinical level

C = Coefficient of treatment gap (15 percent of patients have access, so multiply by 0.85 to find the gap)

G = Total remaining gap of workforce per clinical level

Proposed Equations:

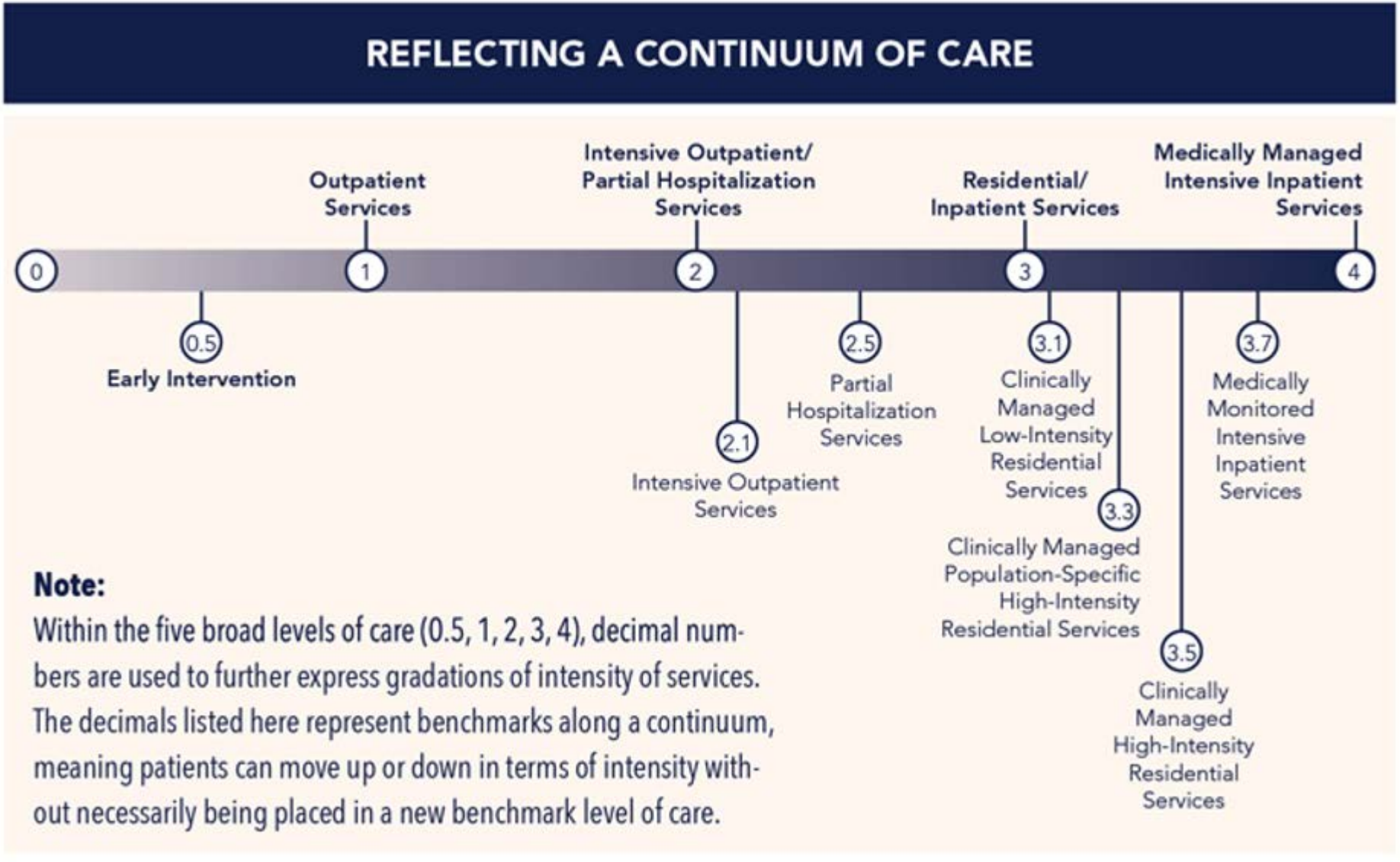
A x B = T

T x P = L

L x F = N

N x C = G

American Society of Addiction Medicine Levels of Care



How do we divide the patients?

Nationwide, more than 70,000 patients have been evaluated by the Continuum screening platform. This has the benefit of aggregating all of the data into a single database for evaluation. To date, the data have yielded the approximate distribution of patients to the following levels of care:

- Level 1 – 25 percent
- Level 1_{OTP} – 10 percent
- Level 2 – 25 percent
- Level 3 – 20 percent
- Level 4 – 20 percent

Understanding the Workforce

- 2017 – Around 2,500 people died from overdose in (pick a state)
- Those “ready for help” were about 50 percent (1,250)
- 1,250 = A
- 1250 x 292 = 365,000 (L)
- Fractional FTE is based on the following assumptions

Proposed Equations:

A x B = T

T x P = L

L x F = N

N x C = G

Staffing Levels per Patient

Level of Care	#pts/ Prescriber	#pts/Therapist	#pts/RN-CM	#pts/peer
Level 0.5	500	500	1000	NA
Level 1 Primary Care	100	100	300	NA
Level 1 Addiction Specialist	275	90	200	50
Level 1 OTP	300	65	150	50

Level of Care	#pts/ Prescriber	#pts/Therapist	#pts/RN-CM	#pts/peer
Level 2.1	300	50	100	50
Level 2.5	300	45	100	50

Level of Care	#pts/Prescriber	#pts/Therapist	#pts/RN-CM	#pts/peer
Level 3	30	30	30	NA

Level of Care	#pts/Prescriber	#pts/Therapist	#pts/RN-CM	#pts/peer
Level 4	20	20	20	NA

Abbreviations: DO, doctor of osteopathic medicine; MD, doctor of medicine; OTP, opioid treatment program; RN-CM, registered nurse-case manager.

Total Number of Overdoses	1,250										
Total Number of Individuals Needing Treatment	365,000										
		Total Workforce Required					**Workforce Less Existing**				
Treatment Required by Level of Care		**ASAM Level**	**MD**	**MSW**	**RNCW**	**Peer**	**ASAM Level**	**MD**	**MSW**	**RNCW**	**Peer**
ASAM – Level 1	91,250	Level 1 – Primary Care	913	913	304		Level 1 – Primary Care	776	776	258	
		Level 1 – Specialist	332	1,014	456	1,825	Level 1 – Specialist	282	862	388	1,551
ASAM – Level 2	109,500	Level 1 – OTP	122	562	243	730	Level 2 – IOP	310	2,327	931	1,862
ASAM – Level 3	54,750	Level 2 – IOP	365	2,738	1,095	2,190	Level 3 – IOP	1,551	1,551	1,551	
ASAM – Level 4	73,000	Level 3 – IOP	1,825	1,825	1,825		Level 4 – IOP	3,103	3,103	3,103	
Patients in Opioid Treatment Program	36,500	Level 4 – IOP	3,650	3,650	3,650		Level 1 – OTP	104	478	207	621

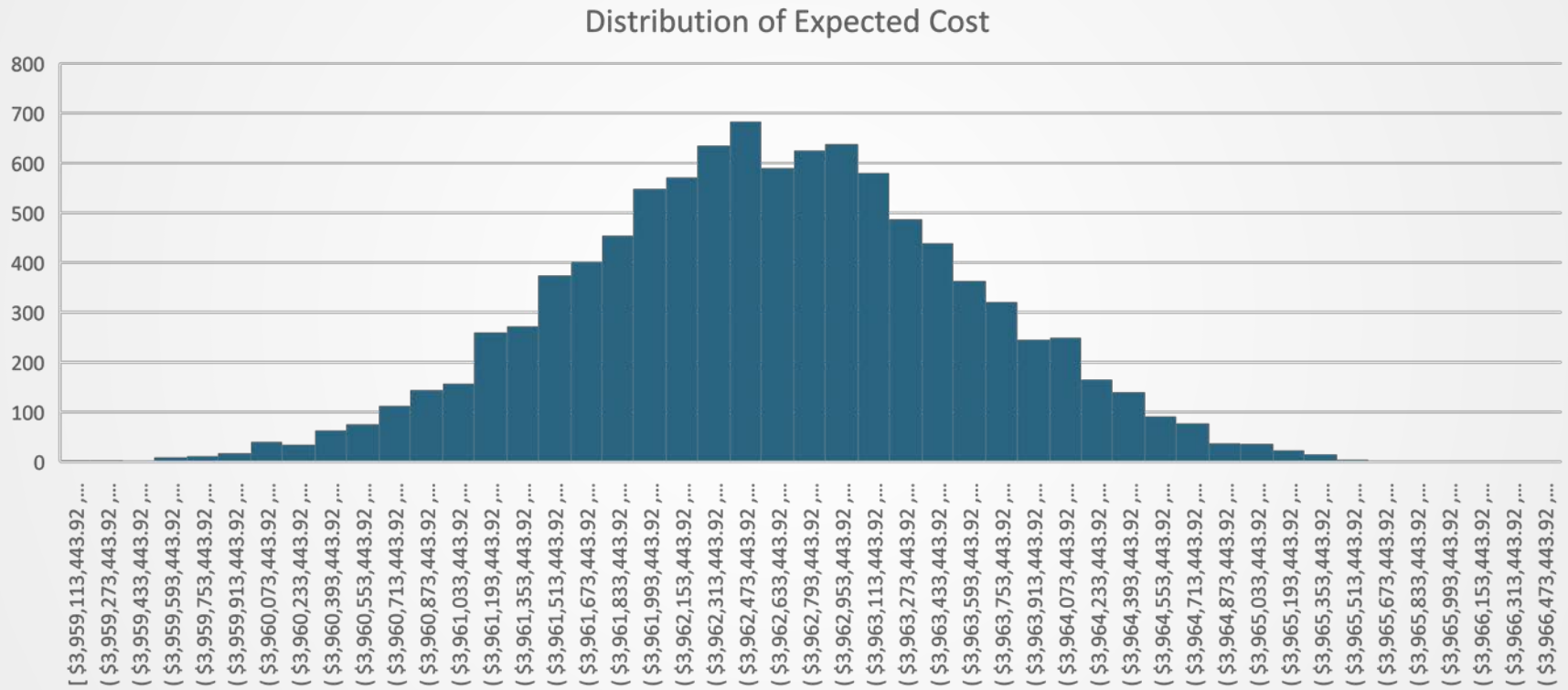
Abbreviations: ASAM, American Society of Addiction Medicine; IOP, intensive outpatient program; MD, doctor of medicine; MSW, master of social work; OTP, opioid treatment program; RNCW, registered nurse case worker.

Number of Projected Providers

ASAM Level of Care	MD	MSW	RNCW	Peer
Level 1 – Primary Care	776	776	259	
Level 1 – Specialist	282	862	388	1,551
Level 2 – IOP	259	1,939	776	1,551
Level 3 – Residential	2,585	2,585	2,585	
Level 4 – Inpatient	3,878	3,878	3,878	
Level 1 – Opioid Treatment Program	259	1,193	517	1,551

Abbreviations: MD, doctor of medicine; MSW, master of social work; RNCW, registered nurse case worker.

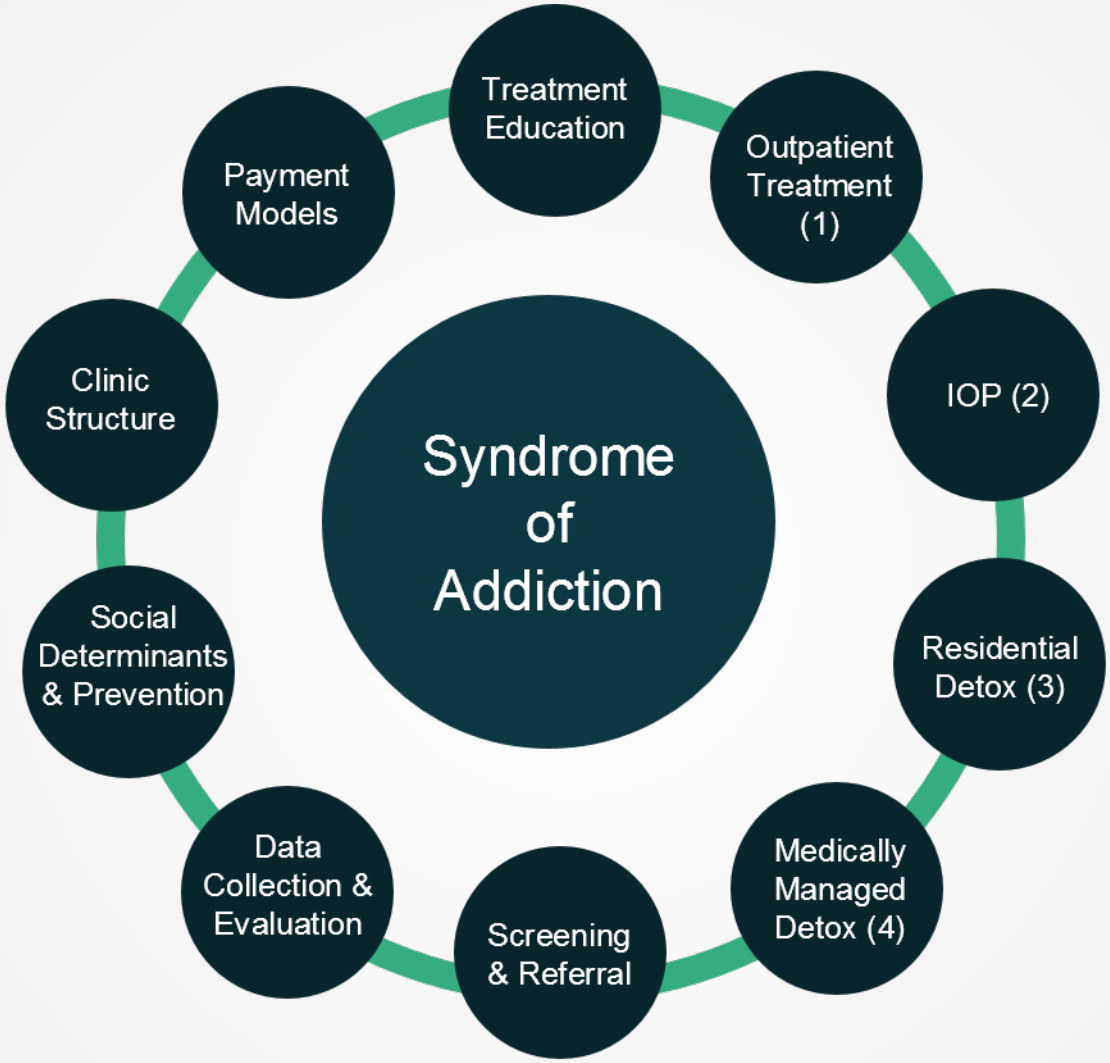
Monte Carlo Simulation of Cost



HEALTH MANAGEMENT ASSOCIATES

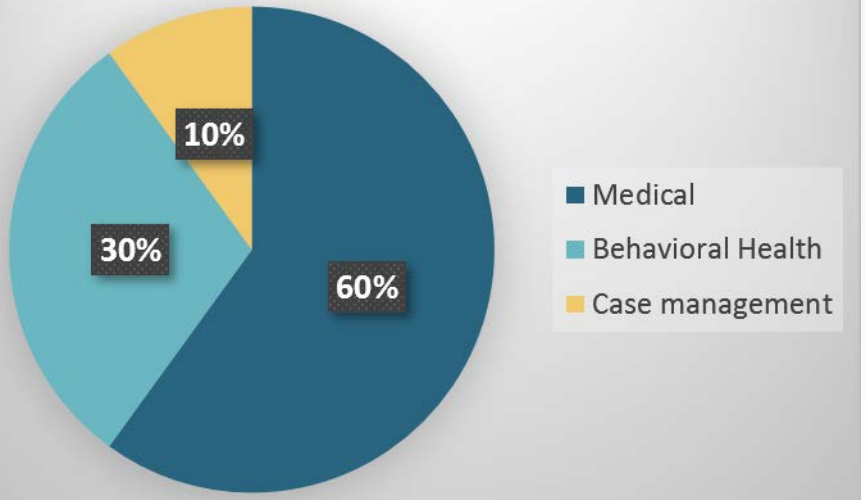
Health Management Associates

Health Management Associates

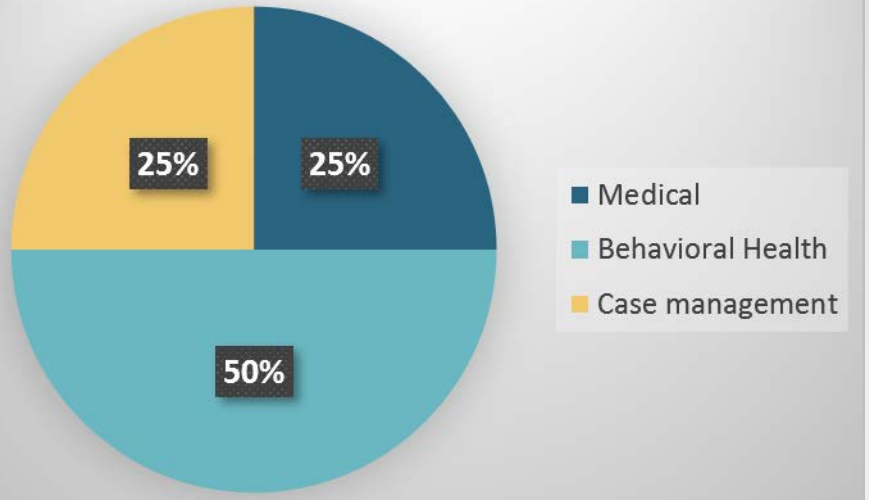


Abbreviations: IOP, intensive outpatient treatment.

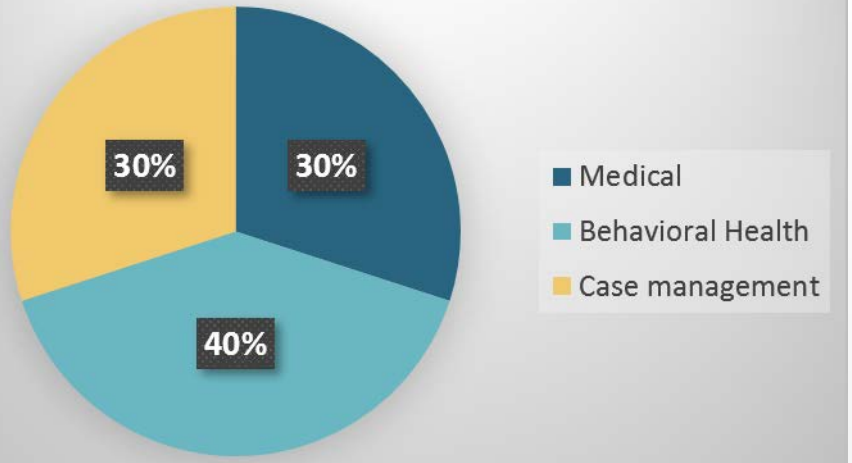
Opioids



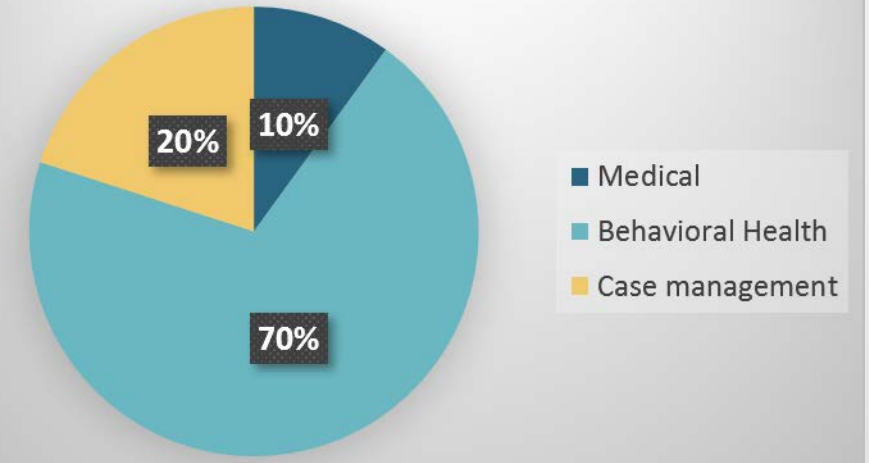
Marijuana



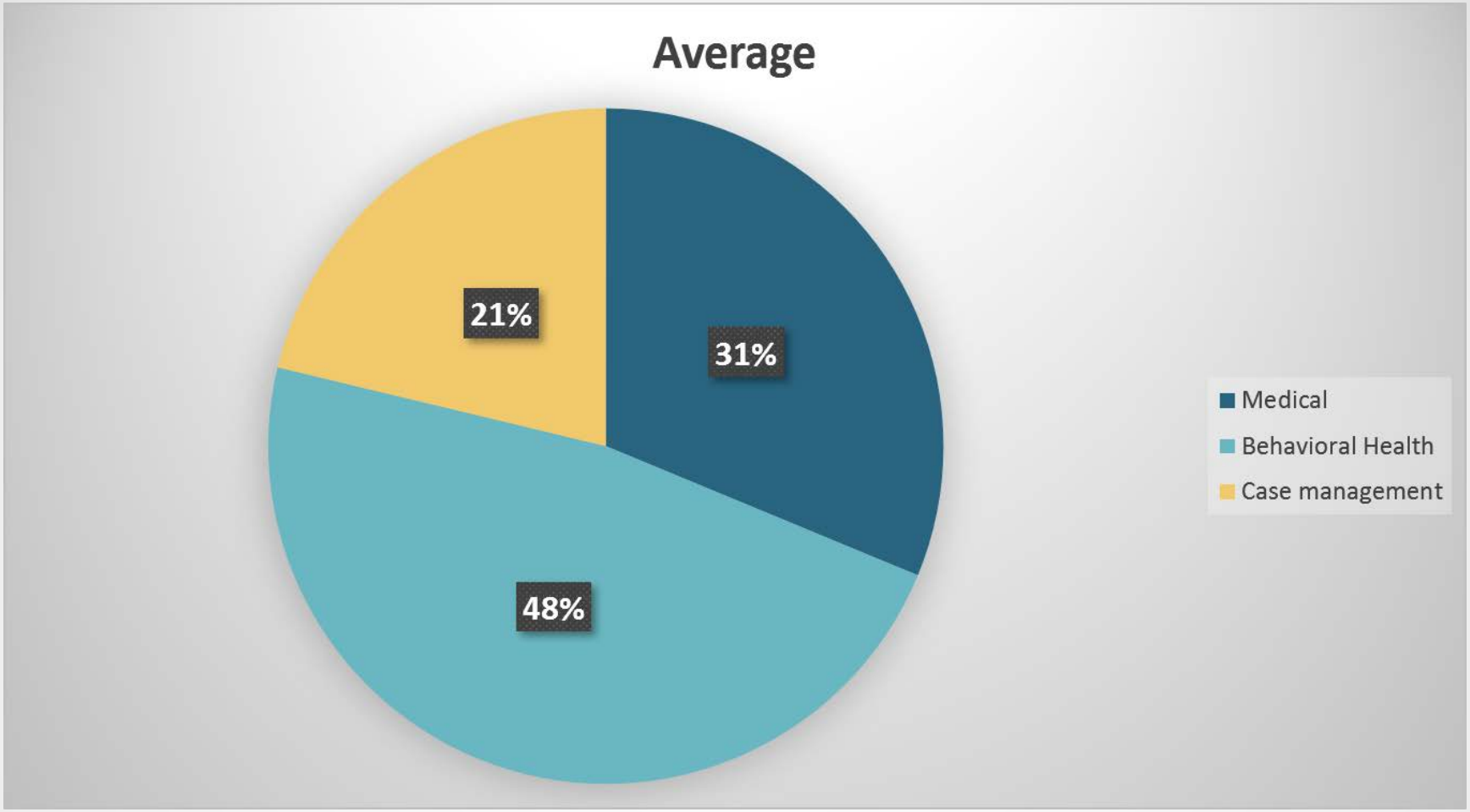
Alcohol



Methamphetamine



HEALTH MANAGEMENT ASSOCIATES


Average
21%
31%
48%
Medical
Behavioral Health
Case management

References

1. Williams, A., Nunes, E. V., Bisaga, A., Levin, F. R. & Olfson, M. Development of a Cascade of Care for responding to the opioid epidemic. *Am J Drug Alcohol Abus* 1–10 (2019). doi:10.1080/00952990.2018.1546862

2. Mack, K. A., Jones, C. M. & Ballesteros, M. F. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas - United States. *Morbidity and Mortality Weekly Report. Surveillance Summaries (Washington, D.C. : 2002)* **66,** 1–12 (2017).

3. Han, B. *et al.* Prescription Opioid Use, Misuse, and Use Disorders in U.S. Adults: 2015 National Survey on Drug Use and Health. *Annals of Internal Medicine* **167,** 293–301 (2017).

4. Beaudoin, F. L., Merchant, R. C. & Clark, M. A. Prevalence and Detection of Prescription Opioid Misuse and Prescription Opioid Use Disorder Among Emergency Department Patients 50 Years of Age and Older: Performance of the Prescription Drug Use Questionnaire, Patient Version. *The American Journal of Geriatric Psychiatry* **24,** 627–636 (2016).

5. Parker, M. A. & Anthony, J. C. Epidemiological Evidence on Extra-Medical Use of Prescription Pain Relievers: Transitions From Newly Incident Use to Dependence Among 12–21 Year Olds in the United States Using Meta-Analysis, 2002–13. *Peer J* **3,** e1340 (2015).

6. Hawkins, E. J., Malte, C. A., Grossbard, J. R. & Saxon, A. J. Prevalence and Trends of Concurrent Opioid Analgesic and Benzodiazepine Use Among Veterans Affairs Patients With Post-traumatic Stress Disorder, 2003–2011. *Pain Medicine* **16,** 1943–1954 (2015).

7. Palmer, R. E. *et al.* The Prevalence of Problem Opioid Use in patients Receiving Chronic Opioid Therapy: Computer-Assisted Review of Electronic Health Record Clinical Notes. *PAIN* **156,** 1208 (2015).

8. Mosher, H. J. *et al.* Prevalence and Characteristics of Hospitalized Adults on Chronic Opioid Therapy. *J Hosp Med* **9,** 82–87 (2014).

9. Clarke, H., Soneji, N., Ko, D. T., Yun, L. & Wijeysundera, D. N. Rates and Risk Factors for Prolonged Opioid Use After Major Surgery: Population Based Cohort Study. *BMJ* **348,** g1251 (2014).

10. Degenhardt, L. *et al.* The Global Epidemiology and Burden of Opioid Dependence: Results From the Global Burden of Disease 2010 Study. *Addiction* **109,** 1320–1333 (2014).

11. Manchikanti, L. *et al.* Opioid Epidemic in the United States. *Pain physician* **15,** ES9-38 (2012).

12. Ruetsch, C. Empirical View of Opioid Dependence. *Journal of managed care pharmacy : JMCP* **16,** S9-13 (2010).

13. WALSH, M. J. *et al.* Epidemiology of Alcohol and Other Drug Use Among Motor Vehicle Crash Victims Admitted to a Trauma Center. *Traffic Injury Prevention* **5,** 254–260 (2004).

References Continued

14. AuthorsPemberton, M. *et al.* Comparison of NSDUH Health and Health Care Utilization Estimates to Other National Data Sources.

15. Reliability of NSDUH.pdf.

16. Johnson, K. *et al.* Federal Response to the Opioid Crisis. *Curr Hiv Aids Reports* 1–9 (2018). doi:10.1007/s11904-018-0398-8

17. Andrilla, H. C., Moore, T. E., Patterson, D. G. & Larson, E. H. Geographic Distribution of Providers With a DEA Waiver to Prescribe Buprenorphine for the Treatment of Opioid Use Disorder: A 5-Year Update. *J Rural Heal* (2018). doi:10.1111/jrh.12307

18. Samet, J. H. & Kertesz, S. G. Suggested Paths to Fixing the Opioid Crisis: Directions and Misdirections. *Jama Netw Open* **1,** e180218–e180218 (2018).

19. Molfenter, T. *et al.* Test of a workforce development intervention to expand opioid use disorder treatment pharmacotherapy prescribers: protocol for a cluster randomized trial. *Implement Sci* **12,** 135 (2017).

20. Schuman-Olivier, Z., Greene, C. M., Bergman, B. G. & Kelly, J. F. Is Residential Treatment Effective for Opioid Use Disorders? A Longitudinal Comparison of Treatment Outcomes Among Opioid Dependent, Opioid Misusing, and Non-Opioid Using Emerging Adults With Substance Use Disorder. *Drug Alcohol Depen* **144,** 178–185 (2014).

21. Reif, S. *et al.* Recovery Housing: Assessing the Evidence. *Psychiat Serv* **65,** 295–300 (2014).

22. McCarty, D. *et al.* Substance Abuse Intensive Outpatient Programs: Assessing the Evidence. *Psychiat Serv* **65,** 718–726 (2014).

23. Reif, S. *et al.* Residential Treatment for Individuals With Substance Use Disorders: Assessing the Evidence. *Psychiat Serv* **65,** 301–312 (2014).

24. Broome, K. M., Knight, D. K., Joe, G. W. & Flynn, P. M. Treatment Program Operations and Costs. *J Subst Abuse Treat* **42,** 125–133 (2012).

25. Chuang, E., Wells, R., Alexander, J. A., Friedmann, P. D. & Lee, I.-H. Factors Associated With Use of ASAM Criteria and Service Provision in a National Sample of Outpatient Substance Abuse Treatment Units. *J Addict Med* **3,** 139 (2009).

26. Lewis, D. C. Access to Narcotic Addiction Treatment and Medical Care. *J Addict Dis* **18,** 5–21 (2008).

27. Levine, H. J., Turner, W., Reif, S., Janas, D. & Gastfriend, D. R. Determining Service Variations

28. Centers for Disease Control and Prevention. 2018 Annual Surveillance Report of Drug-Related Risks and Outcomes — United States. Surveillance Special Report. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Published August 31, 2018. Accessed [date] from https://www.cdc.gov/ drugoverdose/pdf/pubs/2018- cdc-drug-surveillance-report.pdf

Discussion and Questions

Meeting the Complex Needs of Medicaid Beneficiaries With Substance Use Disorder: Effective Models

Linda E. Hurley, MA, CAGS

President, CEO

CODAC Behavioral Healthcare

Defining the Needs

1. Patterns of polysubstance use disorders are now the norm

- Past-year opioid misuse is associated with other substance use and alcohol use disorder (AUD)[1]
- Alcohol and anxiety disorders are linked and often lead to increased detox readmissions; however, polysubstance abuse results in the most readmissions
- Without treatment, the comorbidity of panic and AUD could lead to treatment-resistant AUD[2]

Defining the Needs, Cont'd.

- Opioid use disorder (OUD) is higher among those with post-traumatic stress disorder (PTSD) than those without[3]
- PTSD and musculoskeletal pain increase the odds of OUD[3]
- Patients with comorbid PTSD/OUD use more health care services and have more comorbidities than patients with PTSD[3]

Defining the Needs, Cont'd.

2. Medical comorbidities are increasing

- Comorbidities are increasing as onset is occurring later and earlier in life span
- Comorbidities are increasing as the population receiving care is aging
- OUD patients (64.4 percent) also have chronic pain conditions[4]

Defining the Needs, Cont'd.

- New from the Centers for Disease Control and Prevention (CDC)—growing incidence in bacterial and fungal infections in those who inject drugs: endocarditis, invasive staph methicillin-resistant *Staphylococcus aureus* (MRSA), strep, candidemia[5]
- Widespread outbreaks of hepatitis A in drug using and/or homeless individuals nationwide
- Official CDC advisory was posted March 25

Defining the Needs, Cont'd.

3. Co-occurring mental/psychiatric disorders are high

- Depending on the study, anywhere from 43 percent to 80 percent of those with OUD have a co-occurring mental disorder
- 50 percent+ of those with a mental disorder diagnosis also have a substance use disorder (SUD)
- Patients in recovery from heroin use are 3X more likely to have dissociative disorders[6]
- 33 percent of individuals with SUD are diagnosed with dissociative disorder[7]
- Most past-month opioid misusers report using other substances[3]
- Prescription opioid and polydrug users have the greatest odds of suicidal ideation and major depressive episodes compared with all other categories of prescription opioid misuse[1]

Defining the Needs, Cont'd.

- Patients seeking substance use treatment have high rates of psychiatric, depression, and anxiety diagnoses and symptoms[8]
- Among the anxiety disorders most closely linked to addiction is antisocial personality disorder; 84 percent of individuals with this disorder also meet the criteria for SUD[9]

Defining the Needs

The 2015–2017 National Survey on Drug Use and Health found that among adults with OUD[10]—

- Co-occurring SUDs ranged from 26.4 percent for alcohol to 10.6 percent for methamphetamine
- Prevalence of any mental illness (AMI) was 64.3 percent and serious mental illness (SMI) was 26.9 percent
- Receiving both mental health and substance use treatment services in the past year was reported by 24.5 percent of adults with OUD and AMI and 29.6 percent of adults with OUD and SMI

Defining the Needs

- OUD is increasingly becoming a fatal disorder, because of the remarkable toxicity and availability of fentanyl
- Increasing numbers of **opioid overdose deaths** combined with **increasing numbers of suicides** have resulted in decreasing life expectancy in the United States for the past 2 years (CDC)

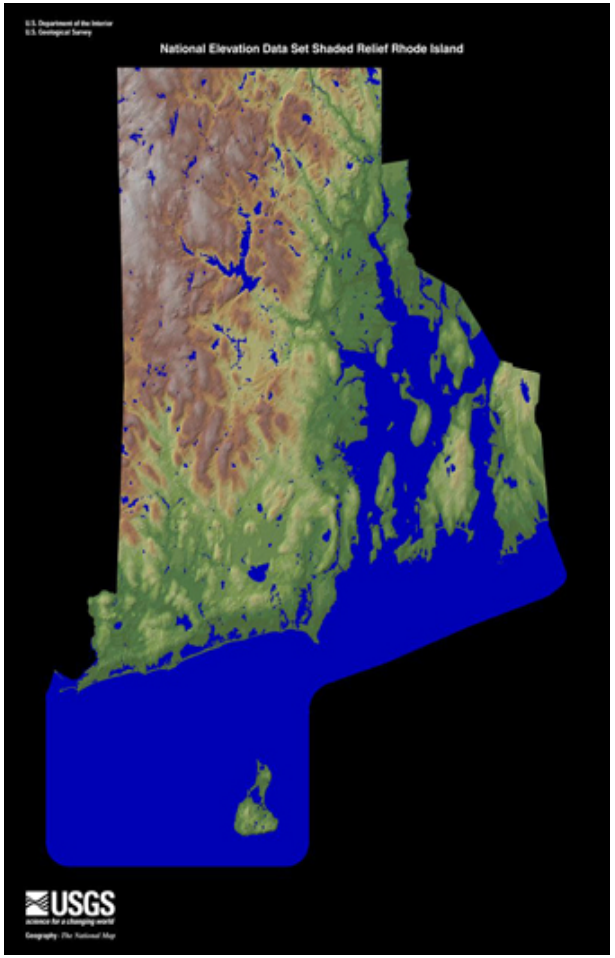
Summary from the Literature

- Co-occurring mental and substance use disorders are common among those with OUD
- Access to inclusive service delivery models that address the comorbidities of the population with OUD continues to be urgently needed

Summary of Needs

- Treatment for polysubstance disorder: competent, comprehensive, and compassionate
- An understanding of the utilization of medication for these diseases
- Informed and immediate access to care for mental disorder diagnoses
- Access to all levels of care
- Informed and immediate access to care for all medical comorbidities—including pain management

State of Rhode Island and Providence Plantations



"The Ocean State"

- Population: 1,050,292
- Width – 37 miles
- Length – 48 miles
- Average number of individuals receiving medication-assisted treatment (MAT)—
  - With methadone: 6,000
  - With buprenorphine: 5,000

What Models Have Been Created?

- First – Developed a comprehensive Health Home certification for opioid treatment programs (OTPs)
- Then – Created a certification for Centers of Excellence (COEs) for the treatment of OUD
- Now – Enhanced MAT in the Rhode Island Department of Corrections

OTP Health Homes: How Did We Do It?

The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) convened a state-wide planning partner group consisting of—

- Rhode Island Drug and Alcohol Treatment Association
- Opioid Treatment Association of Rhode Island (OTARI)
- Non-OTARI affiliated OTPs
- Rhode Island Quality Institute
- Executive Office of Health/Human Services
- Managed care organizations
- Rhode Island Medicaid Office
- Recovery Advocates (RICares)

OTP Health Homes: How Did We Do It?

- **We sought contribution of patients through surveys and focus groups**
- We focused on key requirements:
  - **“States will be expected to develop a health home model of service delivery that has designated providers operating under a ‘whole-person’ approach to care within a culture of continuous quality improvement”** (11/16/2010 state Medicaid director letter)

OTP Health Homes

- In 2013, OTPs in Rhode Island were required by legislation to be certified Health Homes
- This was following a yearlong, comprehensive stakeholder, multidisciplinary effort to create a system that would meet all bio-psycho-social-spiritual needs of those Rhode Island residents with OUD—and be sustainable
- Remarkable collaboration

Parallel Process in Collaboration

Federal Level

CMS----------SAMHSA

Rhode Island State Level

EOHHS/Rhode Island Medicaid----------BHDDH/SOTA

BHDDH/SOTA----------OTP Providers

Local Level

OTP Providers----------Consumers

Abbreviations: CMS, Centers for Medicare & Medicaid Services; BHDDH, Department of Behavioral Healthcare, Developmental Disabilities and Hospitals; EOHHS, Executive Office of Health and Human Services; OTP, opioid treatment program; SAMHSA, Substance Abuse and Mental Health Services Administration; SOTA, State Opioid Treatment Authority.

Recognizing the Opportunity for OTP Clients

- Patients receiving methadone maintenance would benefit from health care coordination
- OTP clients usually present with multiple comorbidities
- OTP clients often have poor connections for primary care, do not attend wellness appointments, and are not connected to necessary specialists
- OTP patients often fear stigma associated with MAT and substance use histories and often have difficulty accessing health care
- Goals of Health Home align with recovery-oriented systems of care

Principles and Standards Driving Practice Change

Health Home Service Principles:

- Person/Family-Centered Care Coordination
- Comprehensive Whole Person Care
- Evidence-Based (Self-Management Goal)
- Accountable (Health Home fixed point of responsibility)
- Continuity and Transition Management
- Proactive Outreach/Engagement
- Data-Driven Outcome-based Approach
- Community Provider Engagement/Collaboration Strategy

- Standardization of CMS six service components, together with the health information technology linkage component, enabled OTPs to develop the capacity to manage and/or coordinate a continuum of specialty and primary care health services along with long-term care services and other supports

A Health Home Team per 175 Patients

- Pharmacist
- Physician
- Registered nurse
- Medical liaison
- Case manager

Coordinating with the existing counseling and medical team

Flexibility Was Critical

- Three categories of acuity-based services with 30-day evaluations
- Specialty teams may reflect a pattern of co-occurrence or comorbidity
- **Although the focus is on effective medical care, vocational, educational, housing, food stability, and all aspects of social determinants for success in treatment are addressed**

… Four Years Later

- CODAC patients increased connection to a primary care physician (PCP) by 64 percent
- The number of PCP physicians now part of our referral network has increased by 73 percent as of 2016
- Strengthened relationships with the housing community resulted in “in-house” housing assistance
- Blood pressure and body mass index check-ins are part of the culture, also raising patient awareness and empowerment regarding their health
- Requests for tobacco cessation services are increasing
- Family treatment/involvement increases with added treatment options

Patient Satisfaction Survey – CODAC

- 16 statements examining patient experience, satisfaction, and engagement
- Five-point Likert scale: strongly agree to strongly disagree
- Administered over period of 30 days [five clinics]
- 95.0 percent or more of participants strongly agree or agree with the following statements:
  - Care and information was provided to them in a way they understood
  - They were comfortable receiving Health Home services at the clinic
  - They felt respected and listened to by Health Home staff
  - The Health Home staff saw them as a whole person and addressed multiple needs as necessary
  - They were involved in their care and included in the decision-making regarding their care
  - The Health Home staff helped them obtain information needed to take charge of managing their health and/or illness

Patient Satisfaction Survey – CODAC

- More than 95.0 percent of participants either strongly agree or agree with the following statements describing satisfaction with Health Home services:
  - The amount of time the Health Home team staff spent with them
  - Their beliefs about health and well-being were considered as part of the services received
  - Their health information was kept confidential and shared only as necessary with other health care providers involved in their care
  - The Health Home staff encourages them to develop specific goals to improve their health
  - The assistance received by Health Home staff in identifying and/or contacting mental health, primary care, or specialty health services
  - They are treated the same as other patients who receive care at the clinic
- 94.0 percent of participants agreed that they were learning skills to more effectively address daily problems, and 84.3 percent agreed that they would follow through if referred to a provider outside of the clinic

Impact of Culture Shift

- The outcome is that the OTP is truly a partner in our patients' health—within a culture of healing
- That culture has become a community network for healing- an ecosystem of inter-connective recovery services spanning the entire continuum of care
- Internally, CODAC has expanded our service array, broadening our model on the basis of the success of the Health Home

Then COEs

Centers of Excellence for the Treatment of Opioid Use Disorder

Rhode Island's Strategic Plan on Addiction and Overdose

- On 8/4/15, Governor Raimondo issued Executive Order 15-14 to establish a task force to create the strategic plan
- Goal: To reduce overdose deaths by one-third within 3 years

The COE Model of Care

- “A COE is a specialty center that utilizes evidence-based practices and provides treatment to, and coordination of care for, individuals with moderate to severe opioid use disorder.”

Goal

- The goal is to enhance statewide capacity for the provision of buprenorphine in MAT by providing a hub and spoke model of referral with PCPs to incentivize community physicians to begin or expand a Drug Addiction Treatment Act (DATA)-waived practice
- This model provides a center for stabilization of OUD conditions with comprehensive referral systems for “step down” into the community
- The model provides a consultative network to support physicians/providers in providing care for this complex disease

Certification Standards

Requires the use of—

1. An opioid SUD specialty, multidisciplinary team
2. At least two of the three Food and Drug Administration (FDA)-approved medications for the treatment of OUDs
3. A broad range of treatment options
4. A full range of ancillary recovery support services
5. Referral capacity: ongoing coordination and follow-up
6. Timely access—24 to no more than 48 hours
7. Individualized patient-centered care
8. Effective and timely referrals for patients to their community providers once stabilized
9. Effective and timely readmission when indicated

Availability

- There are currently more than 14 COEs in Rhode Island
- There are 16 OTP Health Homes in Rhode Island

Both providing treatment, medicine, and wrap-around services within an individualized, person-centered culture of recovery

And Now … Enhanced MAT in Rhode Island Department of Corrections

Objectives:

- Identify people in need of treatment
- Initiate MAT for patients in need
- Increase retention in treatment postrelease

In order to:

- **Decrease mortality**

Rhode Island Model With a Colocated OTP

- Screen and assess everyone upon commitment and prior to release
- Provide MAT for up to 48 months for three populations:
  1. Initiate MAT upon commitment
  2. Initiate MAT prior to release
  3. Continue MAT for those receiving care prior to commitment
- Provide comprehensive MAT services—all three FDA-approved medications, treatment, recovery supports, group therapy, and so forth, with seamless community transition upon release

JAMA Psychiatry

- Mortality due to opioid overdose in Rhode Island
- January–June 2016 versus January–June 2017
- Compared opioid overdose mortality in general population with opioid overdose mortality among individuals with an incarceration in the 12 months prior to death

Decedents: Recent Incarceration	No. of Overdose Deaths in First 6 Months of 2016	No. of Overdose Deaths in First 6 Months of 2017	Decrease	
			No.	%
YES	26	9	17	65
NO	153	148	5	3
TOTAL	179	157	22	12

Relative Risk Reduction = 61%

((9/157)–(26/179))/(26/179)

In Conclusion

- Rhode Island has seen a plateau in overdose deaths, in spite of increasing availability of fentanyl
- The plateau is positively affected by the success of the Department of Corrections program
- The Health Home model is increasing quality of care and patient quality of life
- All three models represent comprehensive ecosystems addressing all aspects of needed recovery services across the life span

Thank You

Please feel free to contact us. CODAC staff or I will be happy to answer any questions.

lhurley @codacinc.org

CODAC Behavioral Healthcare

1052 Park Ave.

Cranston, RI 02910

References

1. Grigsby TJ, Howard JT. Prescription opioid misuse and comorbid substance use: past 30-day prevalence, correlates and co-occurring behavioral indicators in the 2016 National Survey on Drug Use and Health. *The American Journal on Addictions*. 2019;28(2):111-118.
2. Tómasson K, Vaglum P. The role of psychiatric comorbidity in the prediction of readmission for detoxification. *Comprehensive Psychiatry.* 1998;39(3):129-136.
3. Bilevicius E, Sommer JL, Asmundson GJ, El-Gabalawy R. Posttraumatic stress disorder and chronic pain are associated with opioid use disorder: results from a 2012-2013 American nationally representative survey. *Drug and Alcohol Dependence*. 2018;188:119-125.
4. Hser YI, Mooney LJ, Saxon AJ, Miotto K, Bell DS, Huang D. Chronic pain among patients with opioid use disorder: results from electronic health records data. *Journal of Substance Abuse Treatment.* 2017;77:26-30.
5. Centers for Disease Control and Prevention, Health Alert Network (HAN). Update: widespread outbreaks of hepatitis A among people who use drugs and people experiencing homelessness across the United States. June 11, 2018. https://emergency.cdc.gov/han/HAN00418.asp
6. Somer E, Altus L, Ginzburg K. Dissociative psychopathology among opioid use disorder patients: exploring the "chemical dissociation" hypothesis. *Comprehensive Psychiatry*. 2010;51(4):419-425.
7. Karadag F, Sar V, Tamar-Gurol D, Evren C, Karagoz M, Erkiran M. Dissociative disorders among inpatients with drug or alcohol dependency. *The Journal of Clinical Psychiatry.* 2005;66(10):1247-1253.
8. Goldner EM, Lusted A, Roerecke M, Rehm J, Fischer B. Prevalence of Axis-1 psychiatric (with focus on depression and anxiety) disorder and symptomatology among non-medical prescription opioid users in substance use treatment: systematic review and meta-analyses. *Addictive Behaviors*. 2014;39(3);520–531.
9. DuPont RL. Anxiety and addiction: a clinical perspective on comorbidity. *Bulletin of the Menninger Clinic*. 1995;59(2).
10. Jones CM, McCance-Katz EF. Co-occurring substance use and mental disorders among adults with opioid use disorder. *Drug and Alcohol Dependence*. 2019;197:78-82.

Discussion and Questions

Key Takeaways

- There is not a one-size-fits-all approach for treating SUDs and those with comorbid conditions; need an ecosystem
- Treatment for polysubstance disorder and co-occurring disorders must be comprehensive, competent, and compassionate
- There are multiple effective models for treating individuals with SUD and comorbid conditions

Thank You!

Thank you for joining us for this National Dissemination Webinar!

Please complete the evaluation form following this presentation.