TRANSFORMING CARE FOR SUBSTANCE USE DISORDERS

Oregon Conference on Opioids, Pain and Addiction
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DISCLOSURES

I have no conflicts of interests to disclose
OBJECTIVES

• Describe current state of safety net addictions care (in primary care and specialty system) in my community

• Posit options for future state of addictions care

• Understand opportunities for intersection and leverage between addressing addictions care and addressing homelessness
Current State of Addictions Treatment
Drug-Related Deaths in Oregon 2016

amfAR Opioid and Health Indicators Database, http://opioid.amfar.org/indicator/SA_fac
Drug-Related Deaths and Bup Prescribers

amfAR Opioid and Health Indicators Database, http://opioid.amfar.org/indicator/SA_fac
Drug-Related Deaths and Facilities with all MAT

amfAR Opioid and Health Indicators Database,
http://opioid.amfar.org/indicator/SA_fac
Drug-Related Deaths and MAT Capacity

Source: American Journal of Public Health. 2015


amfAR Opioid and Health Indicators Database, http://opioid.amfar.org/indicator/SA_fac
How are we doing in Primary Care?

- In general:
  - 1 in 10 patients who need AUD treatment receive it
  - 1 in 5 people who need OUD tx get it
- Most people (about 95%) who have an SUD don’t think they need treatment
- Three-quarters of opioid treatment programs were operating at or above 80 percent capacity in 37 states and the District of Columbia (2012 data)
- Rates of opioid use disorder were higher than buprenorphine treatment capacity in 48 states and the District of Columbia (all but Vermont and Maine)
- PCP’s report system barriers to treatment:
  - Interviews conducted with 78 providers who received DATA waiver as part of a pilot in Washington
  - 30 percent of the providers actually prescribed buprenorphine
  - Nearly 80 percent of those who did not prescribe cited a lack of psychosocial supports as a barrier
  - Half reported a lack of confidence in their ability to manage opioid addiction.
- Though self-reported comfort in discussing substance use is high for both patients and providers, those most likely to benefit (ie those with active use) are least likely to be comfortable discussing substance use.

Saloner et al. 2015
Jones et al. 2015
Hutchinson et al 2014
Ray et al 2013
What about the addictions treatment system?

When we give treatment, it works/saves costs

Average per-member costs, by diagnosis and treatment groups (count of members)

July 2016 to June 2017

<table>
<thead>
<tr>
<th>Diagnosis/treatment groups</th>
<th>Average dollars per member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dual diagnosis, no treatment (1,331)</td>
<td>$14,000</td>
</tr>
<tr>
<td>Dual diagnosis, with either/both types of treatment (2,024)</td>
<td>$8,000</td>
</tr>
<tr>
<td>Just SUD, no treatment (763)</td>
<td>$10,000</td>
</tr>
<tr>
<td>Just SUD, with treatment (716)</td>
<td>$6,000</td>
</tr>
<tr>
<td>Just MH, no treatment (7,575)</td>
<td>$4,000</td>
</tr>
<tr>
<td>Just MH, with treatment (5,865)</td>
<td>$2,000</td>
</tr>
<tr>
<td>No documented MH or SUD (44,112)</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

Slide courtesy of Devarshi Bajpai, Multnomah County, Addictions and Mental Health
“But I can’t get people into treatment!”

Slide courtesy of Devarshi Bajpai, Multnomah County, Addictions and Mental Health
There isn’t a treatment access problem

When people think “treatment” they think detox and residential treatment, especially for people who are:

• High psychiatric/medical risk
• High acute withdrawal potential
• Homeless

SUD clients, FY17

- Outpatient/MAT: 5,347 (93.5%)
- Detox: 871 (15.2%)
- Residential: 577 (10.1%)

Total unique clients: 5,721
All percentages indicate percent of the total unique clients. Unique clients is unique individual people, not episodes of care (where clients leave and return, visit multiple vendors, etc.).
Average Length of Stay in Large SUD Residential Programs

Length of Stay

- Tri-County
- Maryland
- Massachusetts

Slide courtesy of Devarshi Bajpai, Multnomah County, Addictions and Mental Health
Residential SUD treatment is not housing

• Residential treatment costs payer $4,500/month
  • Residential treatment costs providers closer to $6,500/month

• An average residential length of stay is 44.2 days, with an average cost of $6,850
  • This is not a cost effective way to address homelessness!

• Residential treatment should be focused on stabilization of acute symptoms, but if a client is homeless at discharge, relapse is almost guaranteed
Increasing residential capacity

- Health Share Multnomah served 577 individuals in residential treatment in FY17
- At Maryland lengths of stay we could have served 1,020 individuals, increasing our capacity by 77% without any new beds
- But we can’t do that without recovery housing!
Homelessness and OUD Impair Transitions

65% of AMAs are heroin users, while 30% are alcohol users

Most cite absence of housing on discharge as reason for not completing detox
Recap

• Treatment works and saves $
• Primary care is under-resourced to effectively provide SUD treatment at scale
• While we have plenty of outpatient treatment, we lack evidence-based practice in outpatient (ie. MAT capacity)
• For homeless individuals with OUD, risk of poor treatment and system failure is very high
• Residential treatment works, but should not be the default treatment option, especially for homeless individuals
• Treatment without housing is costly: in human and financial terms
A Future State for SUD Care

Primary Care
Specialty Care
Culturally Responsive Care
PCP: Ask your patients about SUD & recovery!
Transforming Care to address SUDS

Integrated mental health
Emphasis on trauma
Equity; cultural, historical and gender issues, non-stigmatized

Prioritize emotional and physical safety

Trustworthiness
Transparency
Clear, non-shaming expectations and boundaries

Collaboration and Mutuality
Collective Problem Solving

The Chronic Care Model

Provide evidence-based, ‘non-eclectic’ care

Portable assessment, serial, done in most appropriate setting with most appropriate clinician.
Access to other records, especially mental health

Proactive Peer Support
Recent test/UDS results
Other services accessed

MacColl Institute. Improving Chronic Care.
http://www.improvingchroniccare.org/downloads/chronic_care_model800px.jpg
Transforming Care to Address SUDS

**Transitions** are everything (e.g. O/D in the ER)
Must access and assess mental health
Flexible case management

**Clear Roles:**
Peers for outreach & engagement
Counselors do difficult conversations

**Clear Processes:** make a decision, now how is it documented, how it is followed up?

**Conversational capacity:**
Don't ignore hard choices; use difficult conversations as tools for clinical capacity...
What if conversations became well-facilitated, intentional, structured, decision-making tools?

**Decrease** access barriers (but not too much)

**Define** appropriate measures

**Match** caseload to specialization of counselor

- **Engaged Leadership**
- **Data-Driven Improvement**
- **Empanelment**
- **Team-Based Care**
- **Patient Team Partnership**
- **Population Management**
- **Continuity of Care**
- **Prompt Access to Care**
- **Comprehensiveness and Care Coordination**
- **Template for the Future**
For every 1,000 White adults in Multnomah County, there are 1.5 White adults in jail. For every 1,000 Black adults in Multnomah County, there are 9.2 AA adults in jail.

AA adults are 6.0 times more likely than Whites to be in jail (9.2/1.5 = 6.0)
Native Americans are 1.8 times more likely than Whites to be in jail

A study in 2015 found that African Americans in Oregon were convicted of felony drug possession at more than double the rate of white offenders.
Drug Overdose Deaths by Race -- 2016

Drug deaths among blacks in urban counties rose by 41 percent in 2016, far outpacing any other racial or ethnic group.

Urban counties are those classified by the N.C.H.S. as large central metropolitan areas. Rural counties are those classified as nonmetropolitan or as small metropolitan areas.

Seth et al. MMWR, 2018
Building Culturally Responsive Care

Treatment among communities of color is hindered by:

- Historical distrust of mainstream medical institutions
- Relative lack of treatment professionals from communities of color
- Culturally inappropriate settings and protocols
- Geographic distribution of treatment centers, even within metropolitan areas
- Complexities of enrolling in and using insurance

Treatment among communities of color is facilitated by:

- Investment in culturally-specific organizations
- Development of workforce that reflects served community
- Culturally appropriate settings and protocols (e.g. longer duration of treatment, focus on intersection of race/culture, identity, oppression and resilience)
- Geographic distribution of treatment centers, even within metropolitan areas
- Community-based outreach

Substance Use Disorders in Oregon – Prevention, Treatment & Recovery, Oregon Substance Use Disorder Research Committee, November 2017
The Imani Center at CCC

**Cultural Healing**
This group will explore cultural heritage issues pertaining to the African and African American experience as it relates to mental health and addiction, with particular emphasis on culturally specific themes. Specifically, the Cultural Healing Group will use the Creating Safe Spaces curriculum which is a trauma-informed, culturally specific mental health curriculum, as well as other teaching methods to present the group materials.

**Soulful & Centered Moments**
The purpose of this group is to reduce clients' stress and anxiety through teaching the practice of Mindfulness-Based Stress Reduction, which is an evidence-based treatment modality. Mindfulness-Based Stress Reduction was originally developed by Jon Kabat-Zinn and has been proven to produce positive health benefits and positive mental health outcomes in those that practice daily.

**Empower You**
This group is a Relapse Prevention-focused group designed to equip clients with tools to help them remain clean and sober in the community. Even more, this group will teach clients how to both express and manage their feelings in terms of race regarding entering/re-entering the workforce, making healthier decisions, and being productive members of society. Specifically, topics covered will be discussed in a culturally sensitive manner with particular focus on relapse prevention.

**Workflow**
This group is centered on the idea that in order to be successful in recovery clients must have a plan. In this group, clients will learn how to write out their weekly plan for recovery with particular emphasis placed on their Care Plans. Clients will also learn new skills each week to support daily success.

**F.O.C.U.S.**
The F.O.C.U.S. (Freeing Ourselves from Careless hostility and Understanding Systemic racism) group assists clients in learning Dialectical Behavior Therapy skills to effectively manage their anger from the Anger Management Workbook on the following areas: Investigating Attitudes About Anger, A New Perspective on Anger, Acknowledging Complexities of Anger, and Changing Your Experience of Anger. The group also uses the Getting Control of Yourself video. Each passage has a brief video segment that accompanies it and a lesson on Post Traumatic Stress Syndrome (PTSS), which explores the impact that intergenerational trauma and racism have had on African American people. The F.O.C.U.S. group discusses PTSS particularly as it relates to unresolved anger issues.

**The Recovery Process**
This group is a Relapse Prevention-focused group designed to equip clients with tools to help them remain clean and sober in the community. Even more, this group will teach clients how to both express and manage their feelings in terms of race regarding making healthier decisions and being productive members of society. Specifically, topics covered will be discussed in a culturally sensitive manner with particular focus on relapse prevention and mental health challenges in the early stages of recovery.

**Positive Changes**
This group is specifically designed to utilize the Cognitive Self Change model to support clients in learning life skills necessary to decrease their criminogenic factors. In addition, this group teaches additional life skills such as budgeting and renting, and provides clients the opportunity to complete Rent Well.

**Women In Transition**
This is a gender-specific group for women only. The group is designed to address both mental health and addictions issues with a strong emphasis on empowerment and connection with each other.

**Men In Transition**
This is a gender-specific group for men only. A wide spectrum of topics related to men and recovery will be discussed.

**Seeking Safety**
This is a trauma and recovery group which focuses on Cognitive Behavioral Therapy as a central part of group therapy treatment. Seeking Safety is an evidenced-based curriculum that teaches clients a wide array of safe coping skills including but not limited to how to manage PTSD symptoms, cope with emotional pain through grounding techniques, and identify characteristics of safe and healthy relationships.
Beyond the Clinic Walls

Supportive Housing

Supported Employment

Peer Mentorship
WHY HOUSING?

• From 2017 Multnomah County Point In Time Count:
  • 4,177 people counted
  • 1704 report chronic SUD (41%)
• From the 2017 Lane County PIT:
  • 1529 people counted
  • 254 report chronic SUD (17%)
• From 2017 Jackson County PIT:
  • 633 people counted
  • 90 reported SUD (up from 15 in 2015)
• From 2016 survey of Mult Co/Outside In syringe exchange clients:
  • 40% of syringe exchange clients were homeless
  • An additional 27% reported an unstable housing situation

Oregon Housing and Community Services. Point In Time Count Summary
https://public.tableau.com/profile/oregon.housing.and.community.services#!/vizhome/InformationDashboardPITCount_1/Point-in-TimeCount
RECOVERY HOUSING

Point of entrance: Self initiated Detox or Residential Treatment

Primary substance use disorder with frequent co-occurring mental health

Housing offered in community (congregate) supportive of life style change

Peer Mentor/Case Manager ratio: 1-30 and 24/7 front desk

Short-term rent assistance provided

Access to integrated primary and behavioral healthcare, outpatient treatment, MAT

EBP Supported Employment

Recovery community supports and fellowship

Support in securing permanent and often felony-friendly housing

Recovery Housing is a community that is supportive of lifestyle change. We have found that having shared community spaces (e.g. kitchens, laundry areas, etc.) helps support the recovery process. Recovery is about building a new community of social supports. The peer connections, living with other people on the same journey, is imperative for early recovery.
TRANSITIONAL RECOVERY COMMUNITY HOUSING

2016: 294 residents served in 95 short term units (200 exits)
- 71% successfully completed the program (147 residents)
- 70% exited to Permanent Housing (140 residents)
- 95% still housed and in recovery 12 months post exit
- 37% exit with employment
- 12% exit with other income

Permanent Recovery Housing: 89% remain 12 months or longer
- 37% employed and 44% with other income
CRIMINAL ACTIVITY AND SUBSTANCE USE

• 87 participants in recovery housing, outpatient treatment, peer mentorship

• Prior to entering CCC:
  • Spent $206/day on drugs
  • 93% reported criminal activity, with average monthly income of $1,978 ($2 million/year loss to Portland)
  • 29% of this cohort of clients regularly exchanged sex for drugs and 22% exchanged sex for money

• After entering CCC (average 325 days):
  • 95% reduction in drug use (no daily use)
  • 93% reduction in criminal activity
  • $5,729,750 not spent on drugs

6. Herinckx, 2008
## COST/BENEFIT OF HOUSING+PEERS+SERVICES

### Local Study
Cost of 6 month-stay in CCC Short-term Recovery Housing (includes rent, peer mentor, outpatient treatment and supported employment, supervision and indirect costs) $9,894

### COMPARED TO
Cost of 4 months of residential treatment $27,480
Cost of 6 months of criminal activity $11,868

### Regional Study
An analysis of Supportive Housing in Los Angeles County showed that people with stable housing cost taxpayers 79 percent less than their homeless counterparts.

6. Herinckx, 2008
7. Flaming et al, 2009
Of clients who completed Hooper Detox in 2015:

- **117** entered Recovery Housing
- **891** received “treatment as usual”

We tracked their outcomes for a year...
Clients who entered Recovery Housing after detox were:

- **3 times** as likely to complete SUD treatment
- **10 times** as likely to engage in primary care at OTC

n=1,046; all results are statistically significant at p < 0.001 level; adjusted for drug of choice, age, gender, and race/ethnicity
Total Health Care Cost

Differences are statistically significant, but sample size is small; average cost for 12 calendar months following month of detox admission.
Behavioral Health Care Cost

Differences are statistically significant, but sample size is small; average cost for 12 calendar months following month of detox discharge.
Supported Employment
EMPLOYMENT SERVICES

• Employment Access Center
  • 1273 clients in 2017:
    • 40% with co-occurring d/o
    • 70% with felony convictions
    • 100% in recovery housing
  • 790 employed
  • 500+ employers

One-on-one approach to address each customer’s needs and overcome barriers to employment
PRINCIPLES OF SUPPORTED EMPLOYMENT

• Multidisciplinary Team Approach:
  • Housing Case Managers
  • Mentors
  • Clinical Staff
  • IPS Employment Specialists

• The Pathway to Employment focuses on these principles:
  • Zero Customers Excluded
  • Integration of Vocational and Behavioral Health Treatment Services
  • Competitive Employment
  • Benefits Counseling
  • Rapid Job Search
  • Follow-along Supports
ALIGNING ECONOMIC OPPORTUNITY + HOUSING

2017 study from Worksystems (Multnomah and Washington County, City of Portland) compared employment services + housing assistance to those with only employment services

Those with employment + housing services:
• Were 38% more likely to complete the employment training program
• Were 67% more likely to obtain career track employment
• Experienced twice the amount of income gain

The report also shows a positive return on investment for the local community:
• Participants increased their annualized income by triple the total amount of the rent assistance disbursed.
• 76% of those who received rent assistance were still in stable housing 12 months after financial support ended (less likely to need ongoing public rent assistance)

Cost of employment intervention: $4,000
Cost of homelessness (per person per year): $40,000

5. Worksystems, 2017
8. USICH, 2017
“I think anyone who’s given the opportunity for stability has every opportunity for success... I have the opportunity to give back to what I tore up, what I took away from.”

—Robert, math teacher
Putting It All Together...
Summary

• We can do this, but need to address a few things
• We must eliminate the unacceptable racial disparities in access to and outcomes in SUDS care
• Expand treatment capacity in primary care and specialty care (especially with regard to MAT)
• Stick to the principles of trauma-informed care
• Adapt what we know about good primary care models to meet the needs of SUDS
• Social determinants of health play a central role in improving SUDS outcomes, and must be addressed
QUESTIONS AND DISCUSSION

Thank you!

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