

## **Medicaid Innovation Accelerator Program Webinar**

### **National Webinar**

#### **Complex Care for Individuals with Substance Use Disorders and Other Chronic Conditions**

**April 3, 2019**

#### **Introduction**

Katherine Vedete: Welcome. State Medicaid agencies addressing the opioid epidemic must also address the other Medicaid conditions those individuals live with. We'd like to share care models states are taking and enhancing to address those with comorbid conditions. We'll start with a presentation about the need for such models, then an example from Rhode Island on their approach, and then questions from participants. Today's facilitator is John O'Brien, a senior consultant at the Technical Assistance Collaborative (TAC), the IAP contractor. He brings more than 30 years of experience in behavioral health systems design planning and implementation. He's worked with Medicaid, mental health and substance abuse authorities in numerous states to develop federal Medicaid waivers, Medicaid state plan amendments, and federal grant applications. He directs TACs Work on substance use disorders with an emphasis helping states increase access to services, integrate with primary care, and reduce unnecessary costs by using Medicaid and other sources to support effective systems.

Dr. Corey Waller is a principal at Health Management Associates. He is a nationally recognized addiction expert and an actively practicing addiction, pain and emergency medicine specialist. As a principal at HMA and chairman of the Legislative Advocacy Committee for the American Society of Addiction Medicine he is directly responsible for consultation regarding treatment systems development and education, as well as all Washington, D.C.-related matters for ASAM.

Linda Hurley is the president and CEO of CODAC Behavioral Healthcare. She has worked in substance abuse treatment and behavioral healthcare for more than 25 years. She has been with CODAC since 1991 and in 2016 was named CODAC's president and CEO. Under Ms. Hurley's leadership CODAC was the first opiate treatment program in the nation to receive health homes certification and was the first OTP in Rhode Island designated a center of excellence. Ms. Hurley has been a leader in working to effect policy change in Rhode Island, serving on numerous boards and coalitions. She has also been called as a consultant for state and federal agencies including the Substance Abuse and Mental Health Administration in the U.S. Senate.

#### **Discussion- Dr. Corey Waller**

Dr. Corey Waller: One thing we'll really be looking at today is the workforce required to develop solid interventions for not only addiction but all-encompassing versions of complex care. Complex care is a general term but once you get a sense of who it applies to, it's that high-cost complex group of patients that require multiple interventions from a full array of services. In order for us to be able to get to the point where we can intervene on them on a regular basis, we should really understand what workforce is required to be able to deliver that care. What I'll focus on once I get the slides up is a calculated version of what workforce we really do need to build in order to be able to deliver care to that subset of the chronic population with addiction, because right now that's one of our biggest issues is being able to deliver consistent care and create access for patients with addictive disorders. Not just opioid use disorders (OUD).

As we start to dig into this subset, if you go to the slide with labels and mathematics, we've all seen this a hundred times. Overdoses is an issue. I don't have to dig into that. We're all well-aware. (next slide) Here's a slide I really want to focus on. We had to identify how we tell a state, a locality what workforce they need to build and shoot for to create the appropriate amount of access for patients with SUD. Amongst that group a vast majority of those at least will start as a complex patient because they'll have a lot of other things going on.

I want to quickly walk through this. A is the number of patients with an overdose. Using the CDC's extrapolated data for the number of patients needing care per overdose in a region, we then extrapolated out what is the number of patients totally needing treatment in a region. Then we looked at what is the portion of the population that needs to be delivered to a given level of treatment, meaning outpatient, IOP, residential care or level 4, utilizing the ASAM levels of care. And then broke out the number of FTEs one would need to be able to hire to get really a functional system. That means prescribers, case managers, social workers and therapists as well as peers in order to be able to staff it. Then we did a coefficient of treatment gap, meaning about 15% have access. We wanted to build up that so at least those wanting treatment, which is about half, would have access to a provider to be able to get them taken care of.

(next slide) These for a quick overview are the ASAM's levels of care. These are really meant to help all providers understand where a patient should be treated based on not only just the severity of the illness but many of the other social correlates: risk of housing, risk of violence, chances of relapse. All those things go into what we call a multidimensional assessment. From that we can evaluate from an evidence-based pathway what level of care they need to be able to go to.

So when people talk about they just need to go inpatient, for opioids that's really not the case. In fact, most people don't need to go inpatient. For alcohol, if you're a doctor, pilot, lawyer or homeless, those are the cohorts of patients we found do really well on inpatient, whereas the majority of other people can actually be treated in the outpatient arena and have similar outcomes in one year without having to go away for 30, 60 or 90 days and lose their job, put their family at risk, all those things moving forward.

(next slide) The ASAM had developed a product called Continuum, which ultimately allowed for a computer-based evaluation of ASAM criteria, so it was systematic and consistent, for how they evaluated patients. On average just about 110 questions. In the algorithm there's about 1,100 questions. But depending on the patient's OUD, alcohol use disorder and other issues they may only answer about 100. So it takes about an hour.

From that it spits out a level of care, sometimes two levels, depending on a couple of factors. We now have about 70,000 patients who have been evaluated with that instrument. From that we can break out what portion of those patients needed to be in a Level 1 outpatient treatment, like a primary care doctor. And as I talk about OUD, that's a PCP who can write for buprenorphine. Then if we look at Level 1 opioid or narcotic treatment program, about 10% needed that very high-intensity delivery of medication and about 25% to Level 2, which again is intensive outpatient and partial hospitalization. Then Level 3, only about 20% needed to go to Level 3, and Level 4, which is really medically managed detoxification and stabilization only needed to go there. And most of that was because of polysubstance and severe co-occurring disorders.

(next slide) Utilizing those numbers we were able to start to build out what the extrapolated number of people needing treatment would be. I just picked a number, 2,500 people died from overdose. There are a few states that have that as the number of people that died, and there are even some regions in the U.S. you could apply this to. Then I cut that in half because only about 50% of people at any given time

are ready for treatment. So you don't want to build a system with the capacity for 100% of people with the disease. As desirable as that would sound, it doesn't make sense because then you would have a bunch of empty appointments and places wouldn't be able to sustain. So, what you need is for those ready for treatment, in treatment and have access to treatment, which is about 50%. Quite honestly that's equivalent to the vast majority of other diseases—diabetes, hypertension. The show-up rate in an emergency department when somebody comes in with chest pain, gets referred for a stress test, only about 40% of people actually show up for the stress test. So 50% is where we felt.

That gave us A, our starting point, the number of people with an overdose, 1,250. Then we extrapolated that out using the CDC drive number of 292. This number has moved between 170 and 350 of the people estimated to need care. One of the caveats to this math is if you're in a location that you have done a really good job putting naltrexone into the system, then you're going to have a decrease in the number of deaths. So we're reworking the math to look at ED visits for overdose or reversals in a community so that we can use that same math. But if we take an average community, that gives us about 365,000 people who need to be cared for. If you had 2,500 people overdose, the people you're going to need to have access for that are ready for help is that 365,000.

(next slide) So OUD is actually really unique within healthcare for a number of reasons. It is the only healthcare disorder that we actually have legislated and licensed numbers of patients we can max out at, for medication-assisted treatment (MAT) specifically. So if I have a primary care doctor they can only have 100 people that they're treating for this. No matter how many people need help and how much extra capacity they have, because the X waiver for primary care only allows them to go up to 100. If you're an addiction specialist you can see 275, and if you're an opioid treatment program you have limits for methadone. There are currently no limits for buprenorphine and the limits for methadone are around 300. I will say after administrating over opioid treatment programs, if you have more than about 300 patients quality starts to get a little questionable because of volume requirements, severity and relapse. So 300 is probably an accurate number not only licensure-wise but clinically as well.

Then when we look at Level 2, you can average from prescribers you have about 300 people in an IOP and they're to handle MAT while they're in the IOP or partial hospitalization. Then you can see the number of therapists and case managers and peers. These are derived based on licensure maximums that the vast majority of states has as well as the general caseload that's found to be sustainable.

(next slide) Using those numbers, we broke it out into this. If you look at the left upper part you can see there were 1,250 overdoses we used as a base, which gave us 365,000. If you divide those based on the percentages that went to those levels of care we talked about for Level 1 and opioid treatment programs, you can see we need about 90,000 in primary care, about 110,000 in IOP, 55,000 in residential, about 36,000 for opioid treatment, and Level 4 would be about 73,000. Level 4 is short-term. Remember nobody goes there and stays there. The vast majority of people intern to a level of care and slowly progress down to Level 0.5. So this is a moving number, it's not static.

If you look, right, you can see the total workforce required and from that you can see a lot of people. You have 900 prescribers, 900 social workers, and 305 case managers just at Level 1. As you go down you can see the totals of each of those individuals that you would need for each of those levels of care for a community that had a total of 2,500 overdoses with 50% of people wanting help. Then you subtract the current, which is about 10-15%, and then on the right-hand side the workforce you need to hire tomorrow, which of course hiring this workforce tomorrow is impossible, but just looking at these numbers these would be the goals so you can then maximize the workforce without supplanting current workforce.

(next slide) This just breaks down that last box over to the right. How many communities do you think you could get 776 primary care prescribers to write for 100 patients for buprenorphine? If this was a crowd I would see a lot of nodding heads and rolling eyes because we know that that's going to be difficult. So you're probably going to need to triple or quadruple that number of people who have the capacity to write buprenorphine and take a lesser number of patients. But as you move up with specialists or IOP in that, the one I want to point to is the number of specialists required to treat those with addiction in the community I just talked about. That's a large number, but that's still less than the average number of cardiologists available in a community of the same size. So this is no different than another standard line of service.

(next slide) If we look at what this costs, and this is a Monte Carlo simulation of costs over three years, in the middle there basically we're sitting at around \$4 billion of total expenditure to staff and pay all those people over a period of that time. That doesn't count capitalization of brick and mortar. It doesn't count leasing and the accoutrement of administration because I didn't add the cost of administrating all of this. But \$4 billion in what the health insurers would need to be able to cover in order to sustain the addition of that workforce to be able to take care of the people that have addiction in the appropriate system.

Now for primary care this is obviously not new people. This is you would need to recruit that 776 existing or more to be able to do it. So you don't have to find brand new docs for this. The one where you'll need to find brand new prescribers, not just doctors but prescribers, is in that specialty space, and that specialty space is going to be the hardest one to fill because we only have at this point a little over 100 fellowship programs for addiction, a total of 3,000 Board-certified addiction professionals in the country. So this is going to take a while to build that one out.

(next slide) What I want you to see on this one is imagine this as the specialty of cardiology. You walk out of one of these buildings. You look to your right and what you see is a left ventricular heart failure specialist. To your left it's a right ventricular heart failure specialist. Then there's a guy across the street who does heart transplants and puts in left ventricular assist devices, does heart catheters, medical management, cardiac rehab. Whatever you need you can find for cardiology. If you can't find it they generally will send you somewhere to get that if you're in a rural community.

In fact, when I work clinically in the ED if I'm working in an area in the country that doesn't have access to this, generally speaking I can fly somebody from an ED to a referral hospital if they're having a heart attack. We will dispatch somebody with a helicopter to pick somebody up and take that. That's cardiology. We've built that over years. We've made sure that we have enough specialty level people, enough to where they've subspecialized into areas, and that generally anyone with a heart problem can get access to a cardiologist.

Now if we were to compare that to addiction, which visually is represented on my next slide, then this is what we get. We get a couple of areas that sequester a whole bunch of patients into one small place. They keep them there for 30 days and then they set them loose. And some of these patients will gather together and congregate for safety. They'll try to hold together as a group. Some will wander off and get eaten by the wolf, but ultimately all of them have in common that they're going to get fleeced at some point. This is the unfortunate reality of the current state of addiction medicine. Some people will give up all their 401k's, all their money saved, sell their houses, take out extra mortgages to cover 30, 60 or 90 days' worth of an inpatient stay for someone who probably would have been better matched to an IOP outpatient treatment and other support systems.

So what does it take to build that cardiology model level of care? (next slide) If we're going to do that then it really takes everything we have here. You need treatment education, outpatient treatment, IOP,

residential, medically managed, and that's just the addiction-specific treatment. But then we have to integrate screening and referral into all the places in which people come in. Less than 10% of ob-gyns screen for addiction currently. But yet we have a "crisis" in neonatal abstinence syndrome, but we're not even screening for the disease of addiction.

Then if we go to the referral. If somebody's in a hospital and they're status post overdose the referral many times is just a piece of paper with phone numbers, whether or not those phone numbers are up-to-date. So we have to build that out in a robust fashion, and quite honestly it needs to be reimbursed so that people are incentivized to build those systems. We need data collection and evaluation, so we can identify the numbers of patients that we're seeing, track outcomes, do the same quality evaluation we would do within a healthcare system. Then digging into the social determinants and prevention, these are huge areas. For addiction or other chronic diseases we don't have to fix poverty. We don't have to fix homelessness. We just need to understand that for anybody to transition from a high-cost complex sick patient, especially those with addiction, that it is going to be really difficult at least temporarily to not house them or to get them transportation or to get them some stabilization in food safety so that we can get them to that next level.

But if you're not treating addiction or not treating their behavioral health conundrum or chronic pain or cognitive disorder, then these are patients who will languish in the murky middle of healthcare treatment unless we stabilize some of those social correlates, as well as start putting in prevention programs. Not only for the patient themselves but for their family and the people that have contact with them on a regular basis such as the children of someone with addiction who would then have a higher predilection of developing addiction over time.

Then when you look at clinic structure, what if these clinics exist in a jail? What if they exist in a prison? What does the structure of that look like? What we've done in the past in those places is we've taken all the data science and math and we've manipulated it to fit the current criminal justice system. But what we have to do is manipulate the current criminal justice system to fit the data. And those are things that take time and we have to do it, and then we have to pay for it. We have to actually come up with good billing codes that are not miniscule that take into account the fact that we do need a peer to get a patient from point A to point B sometimes. We're going to need...[voice cuts out]

(next slide) So when we look at this we find that what I've broken out is the percentage of time required for a patient who has different types of addiction. So if you have an OUD, about 60% of your input from the healthcare field is going to need to be medical. That's prescribing, looking for infection, looking for all the other side effects of the use disorder, so there's a lot of prescriber time in that. Then you have a portion that is care management and a portion that is behavioral therapy.

If you look at each of these—opioids, alcohol, methamphetamines and marijuana—each of those has a pretty different portion that is required to be able to deliver to that. So building a system for just opioids doesn't make any sense. Because if a patient only needs 60% doctor time then they're going to have a lot of unused time. But when you add in these other pieces, then you're going to be able to fill in those gaps and make sure that you have a full schedule with behavioral health and care management, and be able to have all of these on board. So as we build these systems for complex patients with addiction, we can't build just an OUD treatment system. They have to be addiction and it needs to be directly connected to healthcare in general.

(next slide) Then if we look here at the average, if you add all those together it creates a balanced picture of how you start to build out an intervention. That means if you're going to build an addiction treatment area within an FQHC or a hospital you know that you're going to need around 30% of that time dedicated

to medical, about 50% of that time dedicated to behavioral, and about 20% of that time dedicated to case management. And if you build that out that really is your FTE allocation for any addiction intervention that allows for everybody with any addiction to come in, be seen and treated.

In short, we know how to calculate and identify what workforce we need. We know we need to train them. We recognize there's a significant gap between where we are and where we need to be. But this is just a moving cycle to get there because we do have money coming down the pipeline but if we don't build this system of care or line of service for these patients over the next few years, that money will no longer be coming down. And when that occurs, we will be stuck, because then we will have to claw and scratch to get there rather than capitalizing on building systems with the current finance structure that we have in place.

(next slide) These are all my references. I apologize for the connection issues that occurred. Thank you.

### **Conclusion- Dr. Corey Waller**

John O'Brien: Thank you. That was enlightening and refreshing on how you figure out the needed workforce given not just OUD but other SUDs in general. One question came up and you referenced it. But as you were developing your projections and looking at maximum caseloads and basing projections off maximum caseloads, you did indicate that is probably going to be your lower end of the number of practitioners you might need, especially for prescribers given that many prescribers out there may not necessarily be able to have that maximum caseload. So it's more likely that that 700-plus in terms of prescribers is going to be a lot higher given those caseloads. I wanted to see if we were hearing you correctly.

Corey Waller: That's accurate. As a point to that, I think it's really important that we look past the doctor and recognize that we're going to need to really incorporate a lot of our nurse practitioners and physician assistants and APNs to really be a part of the workforce specialty trained at some level in addiction to help us because that's the low number. Because if you take into account all of the patients with addiction, which is a pretty significant chunk of the population, probably about 15% if you're adding in all the new nictines and everything coming down the pipeline and all the THCs that are going to come, so yes, that would be low end. Probably accurate for the specialist. I don't think we would need more true specialists but definitely addiction-competent primary care practitioners.

John O'Brien: Now Linda Hurley, then we'll open for general questions.

### **Discussion- Linda Hurley**

Linda Hurley: I'm really happy with the way our presentations are coordinating. Where you had the slide that centered around I think you said the syndrome and all of the pieces that are necessary to provide sustained comprehensive care for SUD when facing all the complexities, that's the theme that really runs through the three models I'll be presenting from Rhode Island so thank you for that.

We're talking about complex needs here. In the initial discussions I had with folks that were putting this presentation together, we were talking about the complexity of needs for those with SUD with a focus on OUD. In defining those needs, what we found was there is a pattern of polysubstance use that is now the norm. It is very seldom that we find someone that is simply utilizing one substance. I included a couple references here over the next few slides that are current literature.

Actually, this past one, past year opioid misuse is associated with other substance use and alcohol use disorder, that is actually 2019 information from the *American Journal on Addictions*. We find as we move along through literature searches that when looking perhaps here at the detox readmissions, we're

looking at combinations of alcohol and anxiety disorders. Then you have polysubstance that increases readmissions for those populations. So we could go through several literature sources to show that the bottom line here is that we have a growing, growing severity in what we're finding in polysubstance diagnoses.

Again if you look at the slides that Dr. Waller showed us it means that we really need to be cognizant that one size doesn't fit all here. So if I am presenting with alcohol use disorder with marijuana use and my primary is opioid use, we have to know that of the case management, behavioral healthcare and medical we need to be flexible with what is being presented, because this really is the foundation of some of this complexity. This speaks to PTSD, pain and OUD. We also see that medical comorbidities are increasing. I focused a bit on pain here for what was in the *Journal of Substance Abuse Treatment* in 2017. Sixty-four-point-four percent (64.4%) of patients with OUD reported having chronic pain conditions, and following that report there were reported diagnoses related to that.

This is new. The CDC put this advisory out last week, March 25<sup>th</sup>. It just talks about the growing incidence of infections. In Rhode Island we're seeing a huge spike in endocarditis, which is directly related to intravenous drug use. Also hepatitis A I believe we're seeing that nationwide. In Rhode Island it's very strong. So again we're speaking to the complexity of polysubstance use. We're speaking to the complexity of the comorbidities and the added complexity that when you have polysubstance use you are creating increasing numbers of medical comorbidities, and that pattern will show as we move into the mental health and psychiatric disorders.

I'm not going to read all of these to you but the patients in recovery from heroin in a study that was in *Comprehensive Psychiatry* showed that individuals with OUD or recovering from heroin use were three times more likely to have dissociative disorders, suicidal ideation and major depressive episodes. They are much higher with prescription opioid and folks with polysubstance disorders than any of the others with prescription opioid misuse only. So again you see the combination of polydrug use with OUD exacerbates the number of diagnoses both for mental health and psychiatric as well as medical.

You can see here the rates of psychiatric depression and anxiety diagnoses and their symptoms. This is the last reference I'll point out. This is from the 2015-2017 survey that SAMHSA does. What's most important here is if you look at the third bullet, individual adults with OUD receiving both mental health and substance use treatment in the past year were 24.5%. And any mental health disorder. And then those with severe mental health was 29.6%. So we're looking at about 25% of those are really getting their needs met. And that's what we've known across the board. We have to do better.

We're also seeing increasing numbers of fatalities because of the availability of fentanyl. In Rhode Island last year 50% of the overdose deaths were fentanyl-related. Also the CDC and others have been reporting that life expectancy in the United States for the last two years is decreasing. Correspondingly opioid overdose deaths and an increasing number of suicides, so we see an increase in these. This is a summary of what we just said.

So the needs themselves, when we speak to the complexity, is treatment for polysubstance disorder. It needs to be competent, comprehensive and compassionate. I really was impressed with those slides Dr. Waller presented on the types of services needed when individuals are presenting with various SUD. There needs to be an understanding and acceptance of the utilization of medicine for these diseases, which still is certainly far from across the board. We need an informed and immediate access to care, to all levels of care as they were defined earlier, and informed and immediate access for all medical comorbidities with an increasing focus on pain management.

What did we do in Rhode Island? This is Rhode Island. We're about the size of a peanut. We're small. In terms of MAT for OUD we have about 6,000 individuals utilizing methadone with about 5,000 utilizing buprenorphine and a very small number actually at this point utilizing naltrexone or Vivitrol. We did three things.

First, in 2014 Rhode Island created a comprehensive health home certification for opioid treatment programs. Those are treatment programs that provide at a minimum methadone as the medication for OUD. We then created centers of excellence for the treatment of OUD, which included all three FDA-approved medications. Both have comprehensive wraparound services with community networking. In 2015 and moving forward, the enhanced MAT in the Rhode Island Department of Corrections.

So we'll start here with what did the health homes look like? Health homes, as I said, was comprehensive wraparound services with a community network. Truly an ecosystem was created based on this model. I'm going to stress here that the only way this model could have happened was through remarkable collaboration. I'm not going to speak to all the entities that came together but it was state multi-departmental. We had multidisciplinary. We had all stakeholders. It was also multi-stratified in terms that partners were federal, partners were state, partners were local, partners were consumers, and partners were providers. This again speaks to that.

It was in 2013 that it happened. As I said there was a remarkable collaboration with a goal of meeting all biopsychosocial spiritual needs of those with OUD and it had to be sustainable. Therefore, third-party payers, Medicaid, was at the table. When I talk about process and collaboration, you can see where the collaborations were, but it wasn't all vertical or horizontal and separate. Because the providers were on CMS calls and SAMSA calls. We had consumers meeting with the behavioral health oversight regulatory body in Rhode Island. The collaboration was remarkable. It was long-term and it was comprehensive in creating this program.

The opioid treatment program was chosen because the individuals that were accessing the DEA-registered opioid treatment programs were those with obviously OUD but high utilizers, high levels of comorbidity and high utilizers of Medicaid dollars. They had very poor connection to primary care. We did a survey and about 60+% reported that the emergency room was their primary care, which has changed. So that population was chosen to test this model.

We used CMS' service principles, which are across the board patient-centered, family, community, accountable, and data-driven. The health home team that was created, this was much more general but there was a small percentage of pharmacist time, a little bit more percentage of physician time. Since the creation of the health homes model in Rhode Island we have added mid-level practitioners, RNs, a medical liaison working in the community creating the glue, case managers, and peer recovery support specialists. That team works with a group of 175 patients and they coordinate with existing counseling and the medical team.

Flexibility was critical. I think that's why this was a sustainable effort. The rates and codes that were established for this allowed it to be sustainable. We created specialty teams that reflect the pattern of co-occurrence or comorbidity. We have a team that has a specialty in cardiac issues. We have another team with a specialty in HCV. Although the focus is on effective medical care, in order to see a difference in that there is also vocational, educational, housing, food stability and all aspects of the social determinants that are necessary for success in treatment. They're all addressed.

Four years later what do we have? We have at least the clinic patients, because that's what we could measure with a degree of assurance and integrity, their connection to a primary care physician was increased by 64%. The number of primary care physicians now a part of our referral network, which was



very difficult to do initially, was increased by 73%. Those are two major, major pieces. We also have much more in-house assistance including housing.

A really interesting piece has been that the BP and body mass index check-ins have become part of the culture of the entire environment, both patients and those providing the service. We find that patients have been raising awareness and empowerment regarding their health. They're asking for additional services.

The last way we measured, here we are four years later and this looks good, I'm going to just go to this, is that 94% or more of the participants strongly agreed or agreed that the services they were receiving were being provided in a respectful environment where they were part of the decision-making, where their families were part of the decision-making, where what they believed to be their goals were part of the decision-making, and that it was comprehensive. They felt they were being given enough time and that their needs were basically being met. Additionally we found that 94% agreed they were learning skills more effectively to address their daily living skills or daily problems.

I think what stands out the most here is 84% agree that they would follow through if referred to a provider outside of the clinic on their own. We had managed both the stigma of what the patients held towards treatment in the community because of their disease as well as started to work with the physicians in the community so that the stigma in treating the patients with OUD has clearly begun to decrease.

So there was a very important culture shift. Patients believed that the entire program is a partner in their health. We've really created a strong community network for healing here in Rhode Island and it is an ecosystem of interconnective recovery services and it spans the entire continuum of care. Is it perfect? No. But I've been in the field a very long time and the difference between five years ago and today borders on miraculous.

And internally, because this is what happens, we internalize culture change, CODAC and other entities treating OUD have expand the service array based on the success of the health homes.

The centers of excellence that developed next developed late in '15, early '16, and that was based on the Governor's commitment to decreasing overdose deaths by one-third. We haven't reached that. What we have reached is we've decreased but haven't reached that. Originally we had the third highest overdose rate in the country. We're now down to nine or 10 but there can be some other variables at play in that. So, the centers of excellence is a specialty center that utilizes evidence-based practices and provides treatment to and coordination of care for individuals with moderate to severe OUD.

Due to time I'm not going to go into the details of this but this centers of excellence piece expanded on the health home and one of its goals was to provide statewide capacity for the provision of buprenorphine and MAT, really hoping that a hub and spoke model would work for this single population, not one size fits all. What happens is if someone is receiving buprenorphine and needs wraparound services for care they'll be in a center of excellence. It will be a health home but the difference is the medicine is a buprenorphine product. When that individual is stable on their medication and feel that they have good recovery supports then they can simply return back into their community and go to their primary care doc or another data wave doc that can provide the medicine for them.

What we did add in is that there is a 24-hour requirement that if that individual runs into trouble, there is a bump in the road, the doctor feels something is wrong or there's a relapse, we will admit them back into this much more intensive level of care, outpatient care, within 24 hours.

The last bullet describes we're a consultative network to support physicians and providers in providing care. Because we have been told by those providers that it's intimidating.

I just listed the certification standards so you can see how comprehensive they are. Right now in Rhode Island there are 14 centers of excellence and 16 OTP health homes. All of these are providing treatment, medicine, wraparound services with an individualized, person-centered culture of community and recovery.

Now we have the enhanced MAT in the Rhode Island Department of Corrections. What makes this different? Why is this different? What makes it different is that we identify anybody in need of treatment. We initiate MAT for patients that are in need of treatment. We have increased retention and treatment post release in order to decrease mortality, which we have done in Rhode Island with this program. We screen and assess everybody. So if an individual is in treatment with a primary care doctor in the community utilizing buprenorphine products and they come in, their medication is not disrupted. We will continue to provide that medicine for them just like we do high blood pressure. Same thing if they're receiving methadone or a naltrexone product.

If someone comes in demonstrating withdrawal or has a documented history of OUD, we will begin MAT. We will induct or initiate them immediately. And if somebody has been sentenced, they've been in prison for a while and are no longer physiologically dependent on opioids but their brain hasn't healed totally yet, they're craving, they're starting to get very anxious about leaving prison and their safety, then we will initiate MAT for them with whatever product—methadone, buprenorphine or naltrexone—they prefer 90 days prior to release. So all three medications for all three populations.

The OTP itself is co-located right in the prison and there are full treatment recovery supports and therapy while someone is incarcerated. The discharge planning is seamless. It goes into community transition the day of release. That can sometimes be tricky. So we've worked really hard, multiple grants have gone into creating what is truly a seamless system.

Last April published in *JAMA Psychiatry* were our outcomes. Here they are. In 2015, 21-25% of the individuals who died from opioid overdose had recently been released from the Department of Corrections. Twenty-five percent. So we knew we had a remarkably highly vulnerable population here. In the one year of initiating this enhanced MAT program, we saw a 65% decrease in overdose deaths with a relative risk reduction of 61%. The slide says it all.

In conclusion, Rhode Island overall has seen a plateau in overdose deaths in spite of increasing availability of fentanyl. The plateau has been positively affected because of the corrections program. Our health home model and center of excellence model have increased quality of care and patient quality of life at a minimum based on individual satisfaction surveys. And all three models I believe whatever level of success they are currently demonstrating, they represent comprehensive ecosystems addressing all aspects of needed recovery services across the lifespan. I think this is the most critical piece here.

As we saw in Dr. Waller's presentation this is not an easy disease. It is complex and it is interrelated and the answers are not simple either, but they require collaboration and I will say over and over again they require collaboration. They require the insight and time it takes to really determine what it is that different populations need, and in order for there to be sustainability, there has to be a commitment for effective reimbursement.

## Open Question and Answer

John O'Brien: Thank you. There are a number of questions in the chat box. One directly related to what you talked about was the responsibilities of the medical liaison in the health homes. Can you talk a little about the responsibilities of the liaison, the case manager and the RN on the care team?

Linda Hurley: They're each full-time positions. There are three FTEs, where the others present on the list and the two that I added are not. The medical liaison is critical in network building. And I think that utilizing an OTP population is probably a good one to use because it is the most stigmatized. The reality is that originally the patients who were coming to us in an opioid treatment program setting are the patients that showed financial risk because they had the lowest show rate in getting from us to a referred physician, and they also have a pretty low rate of following through with treatment recommendations. So the medical liaison's job was to go out and start to mend those relationships on both sides.

The medical liaison will meet with a patient when the RN, the counselor, the care manager have come together and said Linda needs to get to the specialty medicine. She needs to go through her primary care doctor. She doesn't have one. So the medical liaison finds someone in Linda's community and goes out, meets with the office manager, meets with the doctor if possible, meets with the nurse care manager in the office, meets with the individual who is going to receive services and meets them there.

In the beginning, the first year the liaisons were absolutely critical. They would go into the session with the patient, make sure that all the treatment recommendations documentation got to the medical director at the OTP. Both entities, the patient and the referred primary care doctor or specialty doctor's office were reassured that the connections were being made. We found it was astounding. It was a great move to have created that position. They were busy all the time. In the beginning they were making calls and going out to offices and just introducing themselves. Then it grew into meeting the patients there, making sure that all that was smooth. Just in case somebody did show up intoxicated someone was there. It also shows the primary care physicians that as with all of us our fears are sometimes based on very limited numbers of events.

John O'Brien: I have a question for Corey. It is around the model and specifically looking at the percentage of case management time for certain substance use disorders and the extent to which there is any information you might have about the assumptions of why we're seeing more case management needed for alcohol and marijuana versus OUD or meth?

Corey Waller: Those were gathered basically from telephone interviews with about 104 different treatment programs in how they allocate their time. Because there is no good, randomized control trial evaluation of that we had to do structured interviews with programs to really identify how they're best allocating their time. When we find methamphetamine and marijuana use disorder, those generally don't have MAT with it, so what we fill that time with is structured treatment and evaluation through either behavioral health or contingency management strategies, which many times are not run by social work. They're run by care management, who can also help to get them in the same way the liaison does plugged back into primary care, plugged back into mainstream medical care for the other issues.

So like methamphetamine you have significant medical impact from that that is general medical—cardiac, hypertensive, things like that that methamphetamine causes. That's how we got to that number. I wish there was better research on it but we just had to do structured interviews with programs at each level.

John O'Brien: We're at time. There was one question about Medicaid funding for care managers. I suggest you look at the CMS IAP website and there is information around MAT and specifically around the various approaches that certain jurisdictions took to be able to stand up and maintain including the nurse case

management model. Take a look at that. If you've got more questions I would direct you to your state Medicaid agency.

Complete the evaluation form following this if you haven't.

Thank you.

[end of tape]