

ROSC for Clinicians: Recovery Management Checkups (RMC)

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Evolution of the General Acute Care Model

- During the early 1900's, infectious diseases accounted for 60% of the deaths while only 20% resulted from chronic conditions.
- This high incidence of infectious versus chronic conditions drove the ways in which various systems of care developed in this country.
- Specifically, systems of care were organized around an episodic relationship in which a person seeks treatment, receives an assessment and treatment, and leaves the appointment or is discharged and assumed cured
- This pattern produced expectations by patients, service providers, and policy makers that patients receive treatment followed by rapid positive outcomes or results.

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Implications of an Acute Care Model for Addiction Treatment and Research

- Substance abuse treatment has historically been organized around single episodes of care with the expectation that when patients finished the treatment they would be "cured."
- Indirect focus on changing the social recovery environment (with TCs being a major exception)
- Passive referrals to address co-occurring problems
- Minimal or no post-discharge monitoring or check-ups
- Evaluation of outcomes over relatively short periods of time (6-12 months) with the expectation that improvements should continue after treatment.

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Conflicts with the Current Paradigm

- An emerging body of evidence from treatment epidemiology studies (e.g., DARP, TOPS, DATOS, UCLA, PENN, PETSAs) suggests that the typical pathway to recovery often involves multiple episodes of care over many years.
- Among people admitted to publicly funded treatment reported in TEDS, for instance, 60% of the people had been in treatment before (including 23% 1x, 13% 2xs, 7% 3xs, 17% 4 or more).
- Focus is expanding beyond matching at intake to matching along a continuum of care based on the response to treatment and the need for monitoring and continuing care is evident

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Conflicts with the Current Paradigm (continued)

- Evaluation of outcomes are increasingly looking at longer periods of time (2 to 5 years or more) and across multiple episodes of care.
- In a recent study looking at the pathways to recovery Dennis, Scott et al found the median time from first use to a year of abstinence was 27 years,
- And, the median time from first treatment to a year of abstinence was 9 years with 3 to 4 treatment episodes (Dennis, Scott, et al, 2005).

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Managing Chronic Conditions

- In the U.S., chronic conditions currently account for 70 to 80% of the deaths (Matarazzo, 1982; Sexton, 1979) and for 70% of all health care expenditures (Institute of Medicine, 2001).
- Over 10 years ago, the Institute of Medicine (IOM; 1993) report noted that ongoing management of chronic conditions can control the severity and progression of a number of chronic conditions.
- Recently, the addictions field has started to embrace the idea that addiction often resembles other chronic conditions and that the typical acute care models of treatment may be outdated (McLellan et al., 2000; 2005; Weisner et al., 2004).
- The purpose of this presentation is to review a Recovery Management Model developed recently to manage addiction over time and to improve patient outcomes.

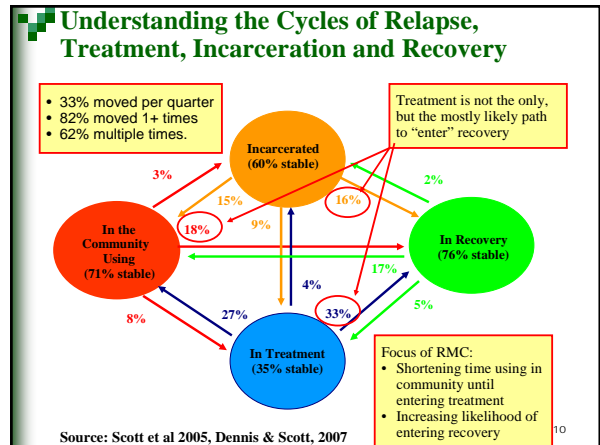
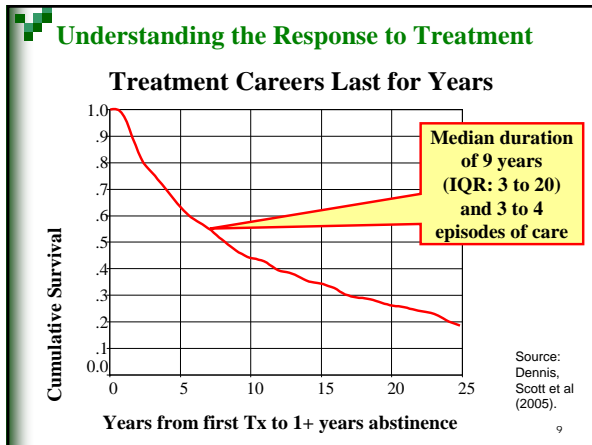
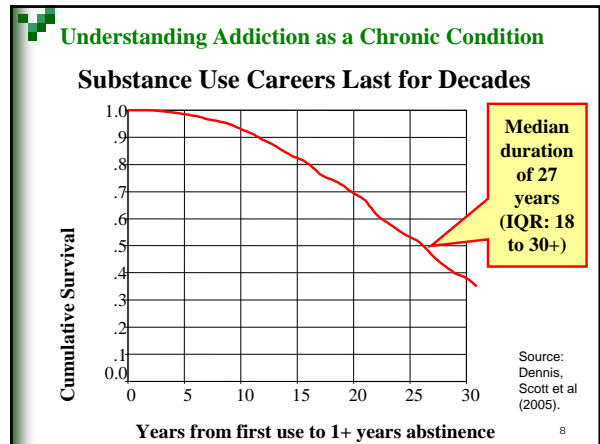
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Common Features of Early Re-Intervention Models

- proactively tracking patients and providing regular “checkups,”
- screening patients for early evidence of problems,
- motivating people to make or maintain changes,
- negotiating access to additional formal care and potential barriers to it, and
- emphasizing early formal re-intervention when problems do arise.

The core assumption of these approaches is that earlier detection and re-intervention will improve long-term outcomes.

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What predicted the transition from using to treatment?

<p>Less Likely with</p> <ul style="list-style-type: none"> Frequency of Use Treatment Resistance 	<p>More Likely with</p> <ul style="list-style-type: none"> Problem orientation Desire for help Prior weeks of treatment Amount of self help Self help “engagement” Recovery Management Checkups (RMC) by 2 to 3 times
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Need to be proactive

Need to address barriers

Need to be convince problems are solvable

Need to keep engaged in treatment

Need to engage in self help

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A subset of these factors also predict the transition from treatment to recovery?

<p>Less Likely with</p> <ul style="list-style-type: none"> Frequency of Use Treatment Resistance 	<p>More Likely with</p> <ul style="list-style-type: none"> Amount of self help Self help “engagement”
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Importance of linkage to recovery community

Importance of “degree of engagement”

In its current form RMC primarily relies on treatment to cause this linkage and engagement

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Managing Addiction & Recovery Requires

- Tracking
- Assessing
- Linking
- Engaging
- Retaining.

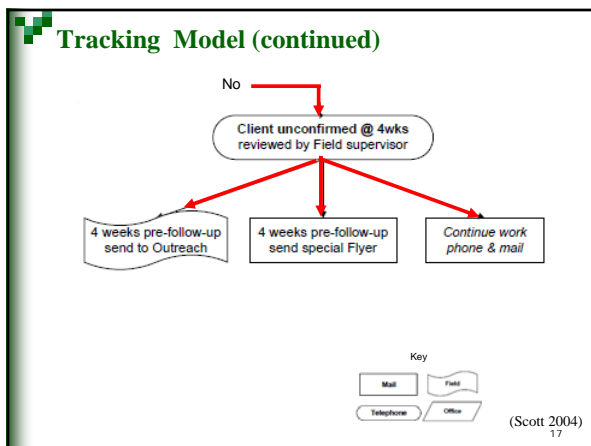
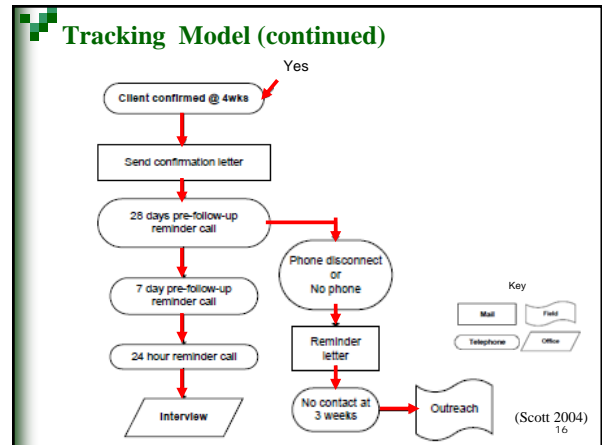
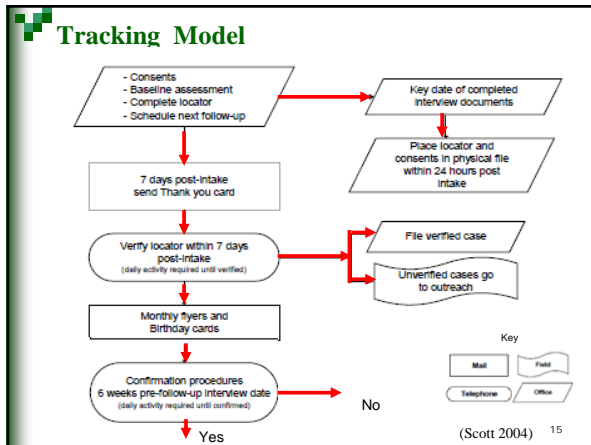
Which we call the **TALER Model**
(Scott & Dennis, 2003, in press)

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Some challenges for Managing Addiction & Recovery

- Substance-abusing lifestyles often lead to unstable living arrangements, alienation from friends and family members, and a high rate of social isolation
- High rates of multi-morbidity (e.g., health problems, psychiatric illness, criminal justice involvement, unemployment, homelessness)
- Friends, Family and System of care more likely to view relapsing as a moral failing or choice
- Low rates of insurance, personal resources and social support

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Some Other Key Facets of Tracking

- Weekly monitoring and staff meetings
- Recycling contact information
- Anticipating institutional barriers and design issues particular to a target population
- Split incentives
- Customer services

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Tracking Track Record

- Reliably achieves over 90% regardless of study, level of care, age, race, primary substance, mental health, homelessness, or geography in over 30,000 interviews
- Typically average 94-97% 3 to 9 years later, with 85-95% within 2 weeks of target date
- Average cost is generally under \$300/wave, less than most research studies (typically \$500-1,000 per wave) with follow rates more like 70-85%.
- Scott has been able to teach others to replicate this success in over a dozen different independent studies

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Assessing

- ERI experiments 1 and 2 used the Global Appraisal of Individual Needs (GAIN; Dennis et al 2003)
- In ERI 1 we used annual on-site saliva testing and a lab based urine tests
- Several problem were identified including:
 - Saliva and urine not agreeing, turned out to be related to delays in shipping and addressed with freezing
 - Urine and self report not agreeing (aka false negative & positive)
 - Rate of false negatives growing over time

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Assessing (Continued)

- In ERI 2 we switched to quarterly on-site urine cup, gave the results to the participant BEFORE asking detailed recency of use questions, and probed any inconsistencies.
- One step cup and laboratory tests agreed 99% of time in subsamples that were frozen before shipping
- False negative rates were low and shrinking over time
- Experiment 2 was more likely to identify people in need of treatment (30% vs. 44%, $d=.30$, $p<.05$).

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Comparison of False Negative Rates by Substance at 24 months

Substance	ERI 1 FN Rate (%)	ERI 2 FN Rate (%)
Opiates	~4%	~1%
Marijuana	~5%	~2%
Cocaine	~12%	~3%
Any Drug Tested	19%	3%

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Rates of False Negatives Also Dropping Over Time in ERI 2

Months from Intake	Any FN by Drug (%)	FN with No Drug Use Reported (%)
0	~4.5%	~3.5%
3	~4.0%	~3.0%
6	~3.5%	~2.5%
9	~3.0%	~2.0%
12	~2.8%	~1.8%
15	~2.6%	~1.6%
18	~2.4%	~1.4%
21	~2.2%	~1.2%
24	~2.0%	~1.0%
27	~1.8%	~0.8%
30	~1.6%	~0.6%
33	~1.4%	~0.4%
36	~1.2%	~0.2%
39	~1.0%	~0.1%
42	~0.8%	~0.1%
45	~0.6%	~0.1%
48	~0.4%	~0.1%

* False Negative defined as the percent with positive urine & no past month use reported

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Assessment: Definition of Need for RMC

Any of the following...

- Had 13 or more of 90 days of use
- Had 1 or more of 90 days of getting drunk or being high for most of the day
- Had 1 or more of 90 days where AOD use caused not to meet responsibilities
- Any past month symptom of abuse or dependence
- Self reported a need to return to treatment

Did not attempt with people already in treatment, incarcerated, or living out side of the Chicago area.

The revised urine protocol in ERI 2 helped to increase the percent identified in "need" from an average of 30% per quarter to 42% per quarter

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Linkage Meeting

- Linkage Manager (LM) uses motivational interviewing to:
 - provided feedback to patients regarding their current substance use and related problems,
 - discussed implications of managing addiction as a chronic condition, and
 - discussed treatment barriers.
 - assessed and discussed level of motivation for treatment
 - schedules treatment intake appointment and develops plan to keeping it
- Starting in ERI-2, LM also offered alternatives to treatment (e.g., 12 step, mega church or other recovery group, behavior change plans)

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RMC Treatment Follow-up Plan

My Linkage Manager, _____, is available:

- To help me get into a program
- To me by telephone.

I have an appt. for treatment _____.

Some things I want to talk to the treatment program staff about are:

My Linkage Manager will meet me at the treatment program and will be available to:

- Support me through the first stages of treatment
- Discuss my progress
- Monitor my length of stay

I agree that I will not leave treatment without contacting my Linkage Manager

We hope that Linkage Assistance and Engagement Support will be helpful to you.

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RMC Alternative Recovery Plan

My Linkage Manager, _____, is available

- To help me get into a treatment program.
- Discuss options other than treatment to address substance abuse
- To me by telephone.

Things I will do to improve my current situation and how often I will do them:

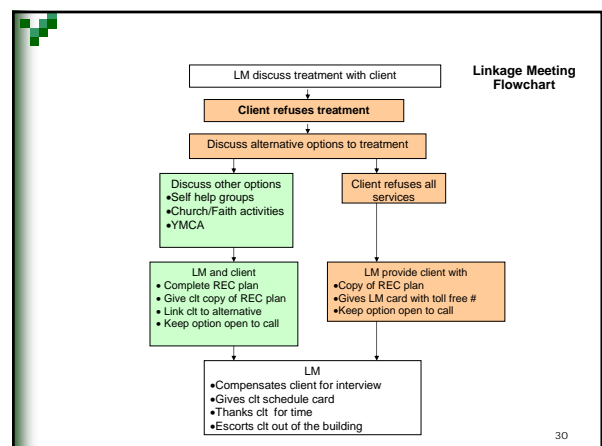
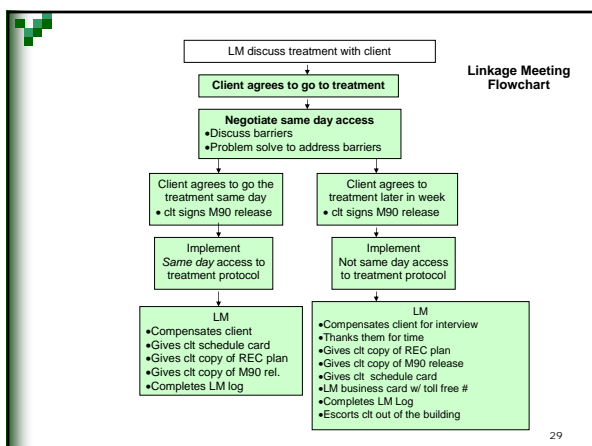
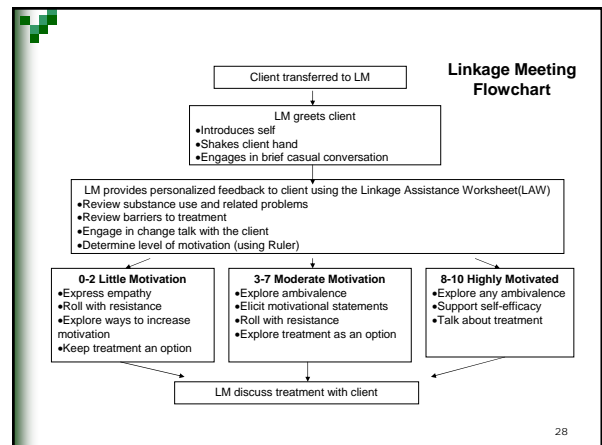
How often?

- Attend 12 step/self help meetings _____
- Attend church/ faith based programs _____
- Meet with Recovery Coach _____
- Support programs (housing) _____
- Call my Linkage Manager _____

We hope that Linkage Assistance will be helpful to you.

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Engagement

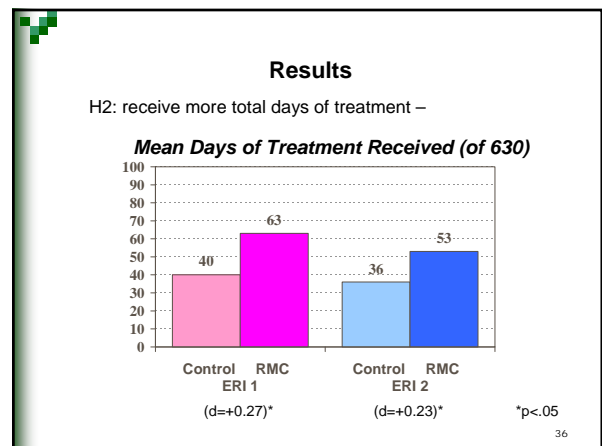
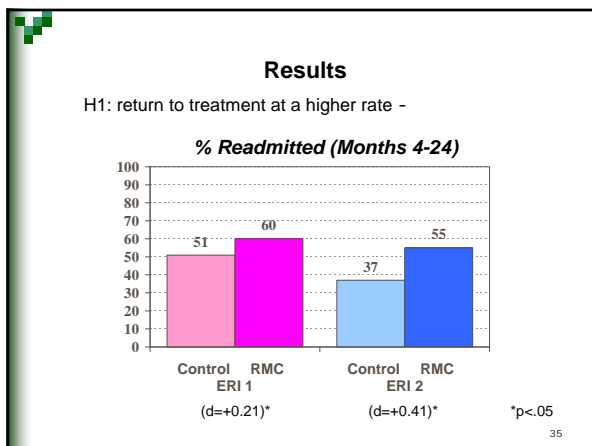
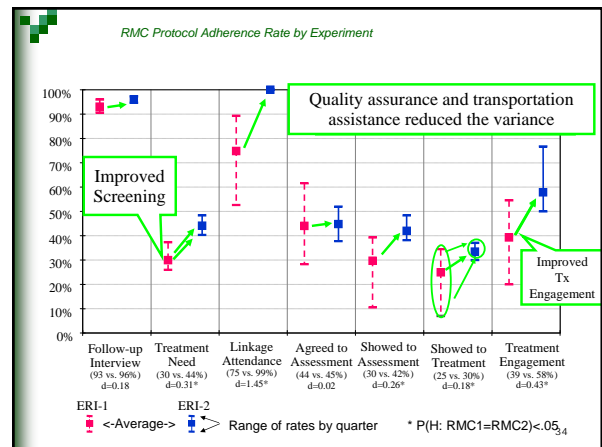
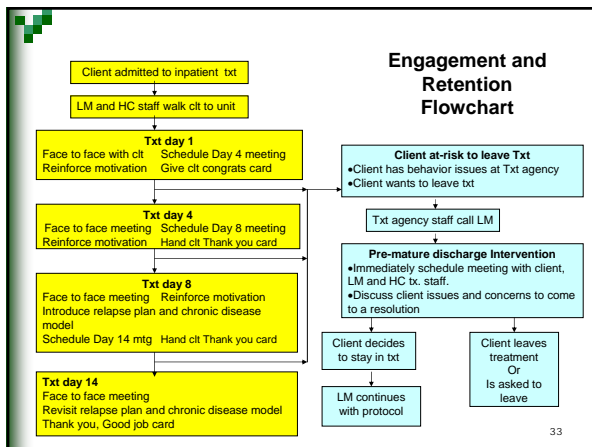
- In advanced we had negotiated an accelerate readmission process that allows the agency to accept our assessment and get someone in within 1-2 days
- On an individual level the Linkage Manager (LM) also..
 - Scheduled appointments for treatment and next quarterly checkup.
 - Transported patients to treatment intake and stayed through the intake process.

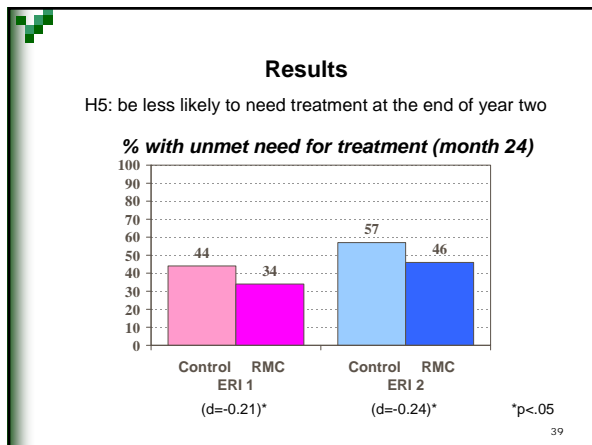
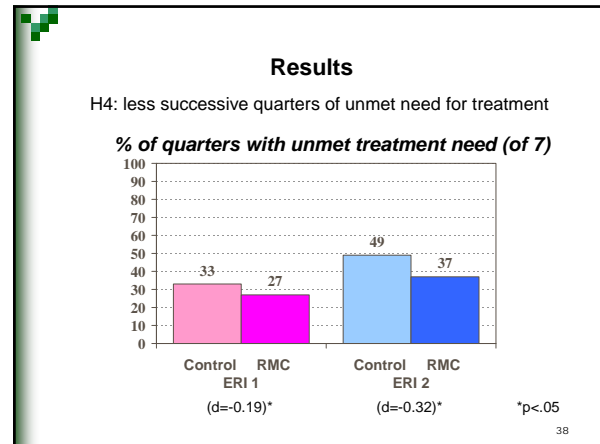
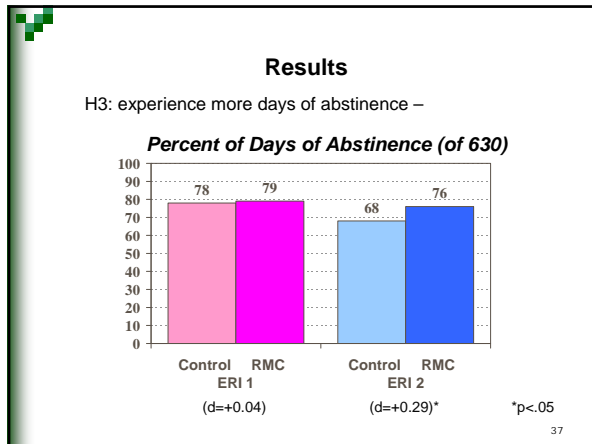
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Retention

- LM visited the treatment programs weekly to check in with clients currently there and contacted all at least weekly to proactively identify any unmet needs or concerns
- Treatment agency staff agree to contact LM before discharging a client
- LM attempts to act as an ombudsman and keep client in treatment
- If client leaves, LM tries to shift to an alternative plan

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- ### Results from ERI Experiment 2 after 4 years
- Relative to the control group, RMC helped to
- Reduce the time from relapse to readmission by 71% months (45 vs 13 months)
 - Increase the percent reentering treatment by 37% (51% vs. 70%)
 - Increase the days of treatment by 41% (112 vs. 79 days)
 - Reduce the successive quarters of being in “Need” of treatment by 21% (50 vs. 38% of 14 quarters)
 - Reduce the number of substance problems x months by 29% (126 vs. 89 of 720 problem x months)
 - Increase the days of abstinence by 9% (1026 vs. 932 of 1350 days)
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- ### Cost of RMC
- Relative to outcome monitoring only, adding RMC to Following up increased costs per quarter by 81% (\$177 vs.. \$321 per quarter)
 - The cost of RMC can also be thought of in several other ways including:
 - \$843 per person found in “need” of treatment
 - \$3,011 per person entering and staying in treatment at least 14 days
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- ### Some Limitations of RMC
- Biggest effects are the first few times we bring them back to treatment, after that it can become a revolving door
 - Treatment systems are not set up to handle people coming back to treatment for the 4th to 15th time.
 - Given that over a third relapse in 90 days, a quarter may be too long of an initial period
 - Need better linkage to 12 step and other recovery support services
 - Costs could be very different if done by non-researchers and/or with less detailed assessment
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Next Steps

- Just submitting year 4 findings
- Currently evaluating the cost, cost-effectiveness and benefit-cost of RMC
- Just completed a 5 year follow-up wave for ERI to evaluate the impact of “removing” RMC and to evaluate 5 year HIV sero conversion
- Just finished recruitment for a 3 year randomized trial of RMC with women coming out of cook county jailing using RMC plus new components targeting HIV risk behaviors and criminal activity
- Examining the indirect effect of RMC on other outcomes
- Planning a pilot study of RMC with adolescents

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