“The Nation’s Drug Overdose Epidemic: Impact on BIPOC Communities”

September 15, 2022

Edwin C. Chapman, MD DABIM FASAM
Private Practice
Washington, DC

“I have no disclosures”
The New Jim Crow
Mass Incarceration in the Age of Colorblindness
MICHELLE ALEXANDER

PRISON – INDUSTRIAL COMPLEX
“THE NEW JIM CROW”
Michelle Alexander

OPIOID USE DISORDER

INJURED
INHIBITION
INCREASED
INFECTION
INTESTINAL
INNOCULATION

DISCHARGED
UN or UNDERTREATED

COMMUNITY

- Infectious Diseases - Social Costs
- Other Medical Costs - Drug Crimes
THE CYCLE OF DESPAIR

Patient Silence Due To Shame

- Media Bias & Under Reporting
- Faith Community Stigma & Myth
- Incentivized Prison Industrial Complex
- Medical Provider Rejection
- Inequitable Insurance & Pharmaceutical Payment
- Family & Community Ostracism
- Government Apathy & Inept Health Policies
-
Death rates are rising for middle-aged white Americans, while declining in other wealthy countries and among other races and ethnicities. The rise appears to be driven by suicide, drugs and alcohol abuse.

Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century Anne Case1 and Angus Deaton1
Woodrow Wilson School of Public and International Affairs and Department of Economics, Princeton University, Princeton, NJ 08544 Contributed by Angus Deaton, September 17, 2015 (sent for review August 22, 2015; reviewed by David Cutler, Jon Skinner, and David Weir
Figure 2. Unadjusted Trends and Adjusted Difference-in-Differences Estimates of the Association Between Automotive Assembly Plant Closures and Opioid Overdose Mortality Rates

A. Unadjusted trends

B. Difference-in-differences estimates

Figure 3. Difference-in-Differences Estimates of the Association Between Automotive Assembly Plant Closures and Prescription Opioid Overdose Mortality

A. Prescription opioid overdose mortality

B. I illicit opioid overdose mortality

A. Prescription opioid overdose mortality. B. I illicit opioid overdose mortality. Models are identical to those presented in Figure 2B, except that the dependent variables are opioid overdose mortality per 100,000 individuals aged 18 to 64 years from prescription opioids and illicit opioids. See Figure 2 caption for further details.

1000000 (95% CI, 0.41-12.3; P = .04), while the estimated association for older non-Hispanic white women (35-65 years) was smaller in magnitude and not statistically significant. Excess mortality risk associated with plant closures was also greater in counties that experienced a larger increase in opioid prescribing, as measured by the difference-in-differences estimates (Figure 2B).
Association Between Automotive Assembly Plant Closures and Opioid Overdose Mortality in the United States: A Difference-in-Differences Analysis

Ashwander S. Venkatesan, MD, PhD; Elizabeth F. Bán, MD, MS; Rouke L. O'Brien, PhD; Alexander C. Tao, MD, PhD

Figure 4: Difference-in-Differences Estimates for Opioid Overdose Mortality for Non-Hispanic White Adults, Stratified by Sex-Age Subgroups

The estimates imply that, 5 years after a plant closure, opioid overdose mortality rates were 85% higher, in relative terms, than what would have been expected had exposed counties followed the same outcome trends as unexposed counties. The burden of this increase in opioid overdose mortality was primarily borne by non-Hispanic white men.

Our findings illustrate the importance of declining economic opportunity as an underlying factor associated with the opioid overdose crisis. In particular, our findings, combined with a growing body of research demonstrating adverse associations between trade-related industrial decline and drug overdose mortality, lend support to the view that the current opioid overdose crisis may be associated in part with the same structural changes to the US economy that have been responsible for worsening overall mortality among less-educated adults since the 1980s. Declining economic opportunity is one hypothesized mechanism associated with these longer-term trends. Given our study context, this argument

A. White men aged 18 to 34 y. B. White men aged 35 to 65 y. C. White women aged 18 to 34 y. D. White women aged 35 to 65 y. Models are identical to those in Figure 2B except here the dependent variable is opioid overdose mortality for each listed sex-age subgroup among non-Hispanic white adults. See Figure 2 caption for further details.
The Opioid Epidemic: a Crisis Disproportionately Impacting Black Americans and Urban Communities

Marjorie C. Gondré-Lewis, Tomilowo Abiyo, Timothy A. Gondré-Lewis

Abstract
The opioid epidemic has existed for decades, but a sharp rise in opioid overdose deaths among young adults aged 20–29 continues as a major public health crisis. The opioid epidemic is a public health crisis that continues to disproportionately impact Black Americans and urban communities.

W. Montague Cobb
NMA Health Institute Report 2022
PAIN and/or PHYSICAL PAIN and/or PSYCHIC PAIN leads to ADDICTION RISK.
Opioid deaths increasingly involve synthetic opioids

Annual percentages sum to more than 100 across substances because a single death may involve multiple substances.
Opioid-related Fatal Overdoses: January 1, 2016 to December 31, 2021

Report Date: March 16, 2022

Figure 3: Percent of Overdose Deaths Involving Opioids, 2015-2021
Emergency Preparedness and Response

Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic

➢ 50% INCREASE in OVERDOSE DEATHS DUE to SYNTHETIC OPIOIDS (FENTANYL)

Distributed via the CDC Health Alert Network
December 17, 2020, 8:00 AM ET
CDCHAN-00438
A study published Thursday reveals a growing racial disparity in opioid overdose death rates. Deaths among African Americans are growing faster than whites across the country. The study authors call for an "antiracist public health approach" to address the crisis in Black communities.

The study, conducted in partnership with the National Institute on Drug Abuse at the National Institutes of Health, analyzed overdose data and death certificates from four states: Kentucky, Ohio, Massachusetts and New York. It found that the rate of opioid deaths among Blacks increased by 38% from 2018 to 2019, while rates for other racial and ethnic groups did not rise.

Chapman knows too well the problems faced by the African American population when it comes to drug addiction and treatment, "beginning with the fact that our epidemic was ignored for the most part, followed by insurance barriers and access to treatment," he says.

"Our population was always treated as a moral, criminal problem, which means that the patients that we're treating in the African-American community have that added burden," he says.

From his experience in his clinic, he says he's found it is more complex to treat Black patients, because you need additional resources, like help navigating the health care system, counseling and help finding housing or a job.

Chapman says Black communities also have a "provider access problem." He notes that relatively few addiction treatment specialists focus their practice on treating Black patients. "Then there is the stigma within the provider community about treating these patients because they're always perceived as being criminally inclined or not desirable as a patient," he says.

Conversely, Chapman adds, "there's the shame and stigma that the patients carry, so the patients don't seek treatment."
Why overdose deaths spiked among people of color during the pandemic
SURGE IN OVERDOSE DEATHS (2019-2020)

SOURCE: CDC VITAL SIGNS REPORT

- Overall: 30%
- Black: 44%
- American Indian / Alaska native: 39%
- White: 22%
- Asian / Pacific islander: 22%
- Hispanic: 21%
I. Disproportionate increases among Black, AI/AN persons

• Relative rate increases in drug overdose deaths highest among Black (44%) and AI/AN (39%) persons, followed by White persons (22%) from 2019-2020.

• Death rates (overdose deaths/100 000 population) among Black men aged ≥65 yrs were nearly 6-times as high as those among White men of the same age in 2019 (35.7 vs 6.2), increasing to nearly 7-times as high in 2020 (52.6 vs 7.7).

• Rate among AI/AN women aged 25-44 yrs increased to nearly twice that of White women of the same age in 2020.

• Largest relative increase in overdose death rate (2019-2020): AI/AN women aged 25–44 years (88%).

AI/AN, non-Hispanic American Indian or Alaska Native
2. Greater disparities in overdose deaths in counties with more income inequality

Death rates (overdose deaths/100,000 population) increased with rising county-level income inequality, particularly among Black persons, among whom the overdose death rate was more than twice as high in areas with the highest income inequality (46.5/100,000) as in areas with the lowest income inequality (19.3/100,000).
3. Substance use common, but treatment was not.

- Documented history of substance use was commonly reported for most decedents, with the highest proportion among White (78.3%), AI/AN (77.4%), and Hispanic (74.8%) decedents.

- Proportion of decedents with evidence of previous substance use treatment was low overall.

  - Lowest proportions among Black (8.3%) decedents, followed by Hispanic (10.2%) and AI/AN (10.7%) decedents.
4. Drug overdose death rates were higher in areas with a higher potential capacity for opioid treatment and mental health treatment; varied by race and ethnicity.

- Among Black individuals, drug overdose rate in 2020 in counties with the highest mental health provider availability (46.7) was >2.5-times as high as that in areas with the lowest rate of mental health providers (17.2).

- Rates of opioid-involved deaths in 2020 among Black, AI/AN persons in counties with at least 1 opioid treatment program were more than twice those in counties without programs:
  - Black: 34.3 vs 16.6
  - AI/AN: 33.4 vs 16.6
The Opioid Epidemic: a Crisis Disproportionately Impacting Black Americans and Urban Communities

Marjorie C. Gondré-Lewis1 · Tomilowo Abijo1 · Timothy A. Gondré-Lewis2

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Fig. 5 Opiod-related deaths in Philadelphia, PA. A Comparison of OODs and heroin deaths from 2013 to 2020. B Deaths where heroin was implicated. C Racial disparity of the opioid epidemic; black bars, individual deaths recorded as Black, African American, or of African ancestry; white bars, deaths recorded as White, Caucasian, or European heritage. D Comparison of OODs to homicides from 2013 to 2020. The large ovals highlight data influenced by the COVID-19 pandemic in 2020.

Fig. 6 Opioid-related deaths by race, per capita. A Deaths were expressed per 100,000 Black or White people based on census data for each state. In Illinois (top left), Maryland (top right), Michigan (bottom right), and Washington DC (bottom left). B Average of the 2018 or 2019 per capita deaths for all regions. Black solid graphs are deaths recorded as being Black, African American, or of African ancestry; white/open graphs are deaths recorded as White, Caucasian, or of European heritage.
The Opioid Epidemic: a Crisis Disproportionately Impacting Black Americans and Urban Communities

Marjorie C. Gondré-Lewis - Tomilowo Abijo - Timothy A. Gondré-Lewis

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Fig. 4. Racial disparity of the Opioid Epidemic. Illinois (top left), Maryland (top right), Michigan (bottom left), and Washington DC (bottom right). Black bars, individual deaths recorded as Black. African American, African ancestry; white bars, deaths recorded as White, Caucasian, or European heritage. The large oval highlights data influenced by the COVID-19 pandemic in 2020.
Disparities by Sex and Race and Ethnicity in Death Rates Due to Opioid Overdose Among Adults 55 Years or Older, 1999 to 2019

Figure 2. Rates of Opioid Overdose Deaths per 100,000 Persons 55 Years and Older by Sex and Race and Ethnicity, 1999 to 2019

Non-Hispanic Black Men
The High Price of the Opioid Crisis, 2021

Increasing access to treatment can reduce costs

Untreated opioid use disorder (OUD), a chronic brain disease, has a serious cost to people, their families, and society because of increased health care spending, criminal justice issues, and lost productivity.

Each year, opioid overdose, misuse, and dependence account for:

- **$35 billion in health care costs**
  Patients who experienced an opioid overdose accounted for $1.94 billion in annual hospital costs.

- **$14.8 billion in criminal justice costs**
  Each dollar invested in addiction treatment reduces drug-related crime, theft, and criminal justice costs by $4-$7.

- **$92 billion in lost productivity**
  The losses stem from premature death due to overdose, “productive hours” lost to OUD, and opioid-related incarceration.

Nearly 70,000 Americans died of an opioid overdose in 2020. Improving access to evidence-based treatments for OUD has been associated with savings of $25,000 to $105,000 in lifetime costs per person.
THE CYCLE OF REPAIR

Reconciliation through Truth & Medical Treatment

- Advocacy & Legal Surveillance
- Medical Support & Medication for Opioid Use Disorder (MOUD)
- Individual & Community Education
- Employment & Financial Support
- Housing, Food, Clothing & Transportation Support
- Post-Incarceration
- Post-Hospitalization
- Homeless Shelter
- Self-Referral
Opportunities to Improve Opioid Use Disorder and Infectious Disease Services

Committee on the Examination of the Integration of Opioid Use Disorder and Infectious Disease Prevention Efforts in Select Programs

Carlos Del Rio (Chair), Hubert Professor and Chair, Hubert Department of Global Health, Rollins School of Public Health, Emory University, and Professor of Medicine, University of Washington School of Medicine

Julie A. Baldwin, Director, Center for Health Equity Research, Northern Arizona University

Edwin Chapman, MD, Private Practice, Washington

Hannah Cooper, Chair, Substance Use Disorders, Rollins School of Public Health

David Gustafson, Professor Emeritus, Industrial and Systems Engineering, University of Wisconsin-Madison

Holly Hagan, Professor and Codirector, Center for Drug Use and HIV/HCV Research, York University College of Global Public Health

Robin P. Newhouse, Distinguished Professor and Dean, Indiana University School of Nursing

Josiah "Jody" D. Rich, Professor of Medicine and Epidemiology, Brown University

Sandra Springer, Associate Professor of Medicine, Yale School of Medicine

David L. Thomas, Chief, Division of Infectious Diseases, Johns Hopkins University School of Medicine

National Academy of Medicine Gilbert S. Omenn Fellow

Ellen F. Eaton, Assistant Professor of Infectious Diseases, Department of Medicine, University of Alabama-Birmingham

Study Staff

Andrew Merluzzi, Associate Program Officer

Anna Martin, Administrative Assistant

Misra Dabi, Financial Business Partner

Rose Marie Martinez, Study Director

Box 8-2

Barriers to Integration of Opioid Use Disorder and Infectious Disease Services

Prior Authorization Policies: State-level policies often require providers to obtain permission from insurers to prescribe buprenorphine (a Food and Drug Administration [FDA]-approved medication for opioid use disorder). Prior authorization prevents the timely, effective delivery of evidence-based care for opioid use disorder, thereby increasing the risk of infectious disease through continued drug use.

Drug Addiction Treatment Act (DATA) Waiver Requirement: Providers are required to apply for the ability to prescribe buprenorphine under the Drug Addiction Treatment Act (DATA) of 2000 (which amended the Controlled Substances Act) and also undergo mandatory training on prescribing practices. Once the DATA waiver is received, providers are limited to a certain number of patients they can treat with buprenorphine. This requirement decreases access to effective medications for opioid use disorder and increases the risk for infectious disease.

Lack of Data Integration and Sharing: Due to infrastructural difficulties and federal policies, medical care providers—especially infectious disease providers—may not be able to access patients’ information surrounding substance use and treatment, thereby inhibiting comprehensive care plans.

Inadequate Workforce and Training: There are several barriers to integration from a workforce perspective, including the geographic distribution and inadequate training of providers who can treat patients with opioid use disorder and infectious disease and restrictions about which providers can deliver certain kinds of care in certain settings.

Stigma: Self-stigma and societal stigma surrounding both opioid use disorder and infectious disease may prevent patients from seeking or accessing care, and provider stigma may inhibit a productive patient–provider relationship.

Payment and Financing Limitations: Services that are helpful to patients seeking integrated care for opioid use disorder and infectious disease (e.g., harm-reduction services, case management, telemedicine, and peer-recovery counselors) are difficult to obtain or sustain financially.

Same-Day Billing Restrictions: Some states do not allow providers to bill for a physical and a behavioral health visit in the same day, thereby requiring patients to return for another day or forcing programs to provide care without the opportunity for reimbursement.

Limits on Harm-Reduction Services: Harm-reduction services serve as an entry point for further medical care, reduce the risk of infectious disease outbreaks, and allow for a culture of patient-centered care. Limiting these services, on the other hand, is a barrier to integrating opioid use disorder and infectious disease prevention and treatment.

Disconnect Between the Health and Criminal Justice Systems: Care for infectious diseases and opioid use disorder in criminal justice settings is fragmented and inconsistent; the process of maintaining coordinated care while patients enter and exit the criminal justice system is inadequate.
QUICK TAKEAWAY:
• Rhode Island’s new medication-assisted treatment (MAT) program for inmates slashed their overdose death rates upon release by 60%.
• The program’s impact was so dramatic that it largely accounted for a 12.3% drop in statewide overdose deaths during the period studied.
• Key to the program’s success was seamless transition to community MAT upon release.
• Without treatment, 40% of those who died did not make it through their first month of liberty.
• For inmates released during the first six months of 2017, 89% of overdose deaths were caused by fentanyl.
The VICIOUS CYCLE of INCARCERATION with NO MAT TREATMENT

PRISON INDUSTRIAL COMPLEX

ENTER

NO MAT Rx

Recidivism
Recidivism
Recidivism

SPECIAL ARTICLE

Release from Prison — A High Risk of Death for Former Inmates
The VICIOUS CYCLE of INCARCERATION with NO MAT TREATMENT

Release from Prison — A High Risk of Death for Former Inmates

Figure 1. Mortality Rates among Former Inmates of the Washington State Department of Corrections during the Study Follow-up (Overall) and According to 2-Week Periods after Release from Prison. The dashed line represents the adjusted mortality rate for residents of the State of Washington (223 deaths per 100,000 person-years), and the solid line represents the crude mortality rate among inmates of the state prison system during incarceration (201 deaths per 100,000 inmate person-years).
From July 2016 through September 2017, opioid overdoses increased for:

- Men (↑ 30%) and women (↑ 24%)
- People ages 25-34 (↑ 31%), 35-54 (↑ 36%), and 55 and over (↑ 32%)
- Most states (↑ 30% average), especially in the Midwest (↑ 70% average)

SOURCE: CDC's National Syndromic Surveillance Program, 52 jurisdictions in 45 states reporting.
“If the soul is left in darkness, sins will be committed. The guilty is not he who commits the sin, but HE who causes the darkness”...
The Bishop in “Les Miserables”

Victor Hugo
“A Lawyer (physician) is a social engineer or a parasite on society”

Howard University School of Law
Brown vs. Board of Education
(mentor to Thurgood Marshall)
OPIOID USE DISORDER

VIOLENT with OPIOID USE DISORDER

MAT

NON-VIOLENT DIVERTED to COMMUNITY TREATMENT

DISCHARGED with MENTAL HEALTH & MAT SUD TREATMENT

REVERSE ENGINEERING the PRISON – INDUSTRIAL COMPLEX Thru SUBSTANCE USE TREATMENT

COMMUNITY
Law Enforcement Assisted Diversion (LEAD)
AFROCENTRIC “VILLAGE” HEALTH ECOSYSTEM of CARE for INTEGRATED and COLLABORATIVE OPIOID TREATMENT

2013 – PRESENT
HOWARD UNIVERSITY “URBAN HEALTH INITIATIVE” for COMPREHENSIVE OPIOID FAMILY CARE TREATMENT

1. TEAM-BASED MEDICAL TREATMENT MODEL
“Social Engineering” Pastors, Psychiatrists, Psychologists, Social Workers, Physicians, and Lay Persons planning meeting on “Black Mental Health in the DMV” (District of Columbia, Maryland, and Virginia)
A TALE of TWO CITIES: In Black & White

DC OPEN AIR DRUG MARKET

Homeless?
Addicted?
Mentally Challenged?
HIV or Hepatitis Infected?
At Risk to Be Physically Harmed or Murdered!!

1647 Benning Road, NE
Washington, DC
(Rear Parking Lot)
NATIONAL
The Opioid Crisis Is Surging In Black, Urban Communities
March 6, 2019 - 5:00 AM ET
Heard on Morning Edition

MARISSA PEÑALOZA

17th St & Benning Road, NE
Washington, DC

Overdose Outside Office
April 21, 2020

Drug Related Murder Scene
March 9, 2022

Narcan Save Inside Office
September 9, 2022

Our Offices
Today

A man walks on Benning Road in Northeast Washington, D.C., in front of the Greater Northeast Medical Center, where Dr. Edwin Childman works.
Profile of Patients on Buprenorphine in 2015:

(1) Average Age - 52yrs
(2) 2/3 Male vs. Female
(3) Average years incarcerated - 10
(4) > 50% require mental health medication
(5) 10 - 12% HIV+
(6) 60 - 65% Hepatitis C+
(7) 90% Smoke
(8) 25-50% Homeless or Insecure Housing

**LIFE EXPECTANCY CUT SHORT**
by 20-25 YEARS
American health care system

Mainstream medical treatment

Drug treatment

Mental health treatment

Differences in:
- Funders
- Payors
- Regulators
- Locations
- Providers
- Patients?

“STRUCTURAL INCOMPETENCY”
1. MEDICAL TREATMENT COMPONENT

2. COMMUNITY SUPPORT COMPONENT
2. COMMUNITY SUPPORT COMPONENT
INTEGRATED TELEHEALTH OPIOID TREATMENT PATIENT FLOW:
HIV, HEPATITIS C, MENTAL HEALTH, and SUBSTANCE ABUSE, and HEALTH HOMES DEMONSTRATION PROJECT

**INTAKE PHASE**

**MEDICAL INTAKE SCREENING**

**MENTAL HEALTH SCREENING**

**SOCIAL ECONOMIC INTAKE SCREENING or REEVALUATION SCREENING**

**MENTAL HEALTH TREATMENT**

**PRIMARY CARE**

**INFECTIOUS DISEASE**

**INTEGRATED CARE**

**MEDICAL OUTCOMES**

**SOCIAL ECONOMIC OUTCOMES**

**COST SAVINGS**

* Decrease Non-Medical Costs
* Decrease Medical Costs

**TELEHEALTH NETWORK INTEGRATION**

2013

**INTEGRATED CARE**

**DRUG TREATMENT**

**MENTAL HEALTH TREATMENT**

**PRIMARY CARE**

**INFECTIOUS DISEASE**

**MEDICAL OUTCOMES**

**SOCIAL ECONOMIC OUTCOMES**

**COST SAVINGS**

* Decrease Drug Related Morbidity & Mortality
* Decrease Mental Illness Related Morbidity/Mortality
* Increase HEDIS Compliance
* Decrease Personal Viral Loads
* Decrease Criminal Activity / Child Neglect
* Decrease Hospitalizations
* Decrease Community Viral Load
* Decrease Community Viral Load

**“Individual Responsibility Plans” (IRP’s)**

**INTEGRATION NETWORK**

**TELEHEALTH NETWORK INTEGRATION**

* Decrease Medical Costs

**LCHC = Leadership Council for Healthy Communities [Faith-based Organization / Multiple Churches in DC & Suburban Maryland]**

Edwin C Chapman, MD  7/28/2013
Is Telemedicine The Key To Making Addiction Treatment Work?

by Guest Post 03/07/2016 0 Comments

March 7, 2016

Telehealth is one component in an innovative opioid treatment research project being conducted in Washington, DC. In a departure from the norm, the program is oriented around the practice of Edwin Chapman, MD, in partnership with Howard University’s Urban Health Initiative.

In this impoverished corner of the nation’s capital, Dr. Chapman’s patients in the study average 52 years of age and 10 years of incarceration. About 60 percent live with hepatitis C, 10 percent are HIV positive and all are long-term users of opioids, primarily heroin.

Chapman’s experience showed him that the opioid replacement buprenorphine effectively stabilized his patients’ addiction issues enough that they could face other life challenges so long as they had access to comprehensive care, including psychiatric services. While access to the opioid replacement was available, care and counseling were not.

So Chapman and Howard Professor Chiledum Ahaghotu, M.D., worked together to create the Buprenorphine Integrated Care Delivery Project model.
CHAPMAN HYBRID INTEGRATED-COORDINATED CARE MODEL:
MENTAL HEALTH + SUD + PRIMARY CARE + SDoH

2016
One-Stop private practice treatment model using tele-health integrating substance use disorder + mental health + primary care + social services.
REMOTE PATIENT MONITORING (RPM) for HIGH RISK, HIGH COST COMPLEX PATIENTS

Complex Medical Issues
Social Determinants of Health
Criminal Justice Issues
Mental Health Issues

BARRIERS TO SUCCESSFUL TREATMENT
- Stigma
- Need to alter
- SA/OD changes
- Found an
- Issue of food/energy/basic
- Medication adherence
- Homeless
- Transportation
- Inpatient

SOCIAL WORKER/CARE COORDINATOR
PEER COACH
REMOTE or IN-OFFICE PRIMARY CARE PROVIDER
REMOTE or IN-OFFICE PSYCHIATRIST and/or PSYCHOLOGIST

Edwin C. Chapman, MD, PC © 2021
REMOTE PATIENT MONITORING (RPM) for HIGH RISK, HIGH COST COMPLEX PATIENTS

Annual Per Capita Cost of Behavioral Health Comorbidities
Medicaid-only Beneficiaries with Disabilities

- No Behavioral or Substance Use Disorders (SUDs)
- SUDs and No Behavioral Disorder
- Behavioral Disorder and No SUDs
- Behavioral Disorder and SUDs

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Coordinate Care

Contrary to the current system of care, patients treated by P-COAT providers would be expected to receive three types of coordinated outpatient services: • Office-based outpatient medical treatment using either buprenorphine or naltrexone; • Appropriate outpatient psychological and/or counseling therapy services; and • Appropriate coordination of services such as care management, social support, and other necessary medical services to treat the patient’s condition. Some physician practices and provider organizations would be able to deliver all three services. However, many physician practices would only be able to provide medical treatment and care management services, and they would need to collaborate with addiction specialists or behavioral health organizations when available and feasible to ensure a patient can receive the full range of medical, psychological, and social support services in a coordinated manner. P-COAT is designed to accommodate multiple care settings involving integrated and coordinated care delivery. P-COAT accommodates an add-on for technology-based treatment and recovery tools.
LCHC FUNDED EVENTS, GRANTS and CONTRACTS

2012-2014 - HIV/AIDS, HEPATITIS, STD, TB Administration funded
HIV/AIDS Education Grants for (1) Clergy Leadership and (2) at risk women

May 27, 2014 – sponsored “Leadership Forum on Hepatitis C”, Louis Stokes Library, Howard University College of Medicine

2014-2015 – DC Health Exchange funded ACA Citizen Insurance Sign-ups

2015-2018 - CDC funded “Racial and Ethnic Approaches to Community Health” (REACH) Grant to reduce chronic disease, promote healthier lifestyles, reduce health disparities, and reduce health spending
1. Hosting Conversations on Opioid Awareness and Workshops to Understand the Signs and Symptoms of OUD

2. Promoting a Day of Recovery

3. Discussion of Treatment and Recovery Services

4. Training Community Members on Naloxone
The Opioid Epidemic: a Crisis Disproportionately Impacting Black Americans and Urban Communities

Marjorie C. Gondré-Lewis¹ · Tomilowo Abijo¹ · Timothy A. Gondré-Lewis²

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Abstract
The opioid epidemic has existed for decades, but a sharp rise in opioid overdose death rates among young and middle-aged adults over the past two decades, and continues as a major health crisis to this day. Although the news media often label opioid addiction as a rural problem impacting a White/Caucasian demographic, surveillance reports indicate that the opioid crisis disproportionately impacts African American and urban-dwelling individuals, which have been largely underreported. The focus of this report is on specific trends in OOD rates in Black and White residents in states with a significant Black urban population and declined as hotspots for OOD: (Maryland (MD), Illinois (IL), Michigan (MI), and Pennsylvania (PA)), and Washington District of Columbia (DC). We compare OODs by type of opioid, across ethnicities, across city/rural demographics, and to homicide rates using 2013–2020 data acquired from official Chief Medical Examiners’ or Departments of Health (DOH) reports. With 2013 or 2014 as baseline, the OOD rate in major cities (Baltimore, Chicago, Detroit, Philadelphia) were elevated two-fold over all other regions of their respective state. In DC, wards 7 and 8 OODs were consistently greater than other jurisdictions, until 2020 when the rate of change of OODs increased for the entire city. Ethnicity-wise, Black OOD rates exceeded White rates by four-to-six-fold, with femtal and heroin having a disproportionate impact on Black opioid deaths. This disparity was aggravated by its intersection with the COVID-19 pandemic in 2020. African Americans and America’s urban dwellers are vulnerable populations in need of social and political resources to address the ongoing opioid epidemic in under-resourced communities.

Fig. 1 Factors contributing to disparities in neuropsychiatric and cognitive health care. Social determinants of mental health (SDoMH) are derived from structural and systemic biases, local disparities in neighborhood environment and public resources, and inter-personal experiences of abuse, violence, and racism. These SDoMH combine with existing chronic disorders including SUD and genetic risk to create an amplified gene x environment interaction to lead to or perpetuate 1) a greater rate of SUD.
INITIATE MOUD!!
(Buprenorphine vs. Naltrexone?)
(Injectable?)
1. INSTITUTIONAL PEER SUPPORT

Decrease Recidivism

Neighborhood
Housing Instability, Transportation, Toxic Exposures, Safety, Violence

Interpersonal
Adversity in Childhood
Negative Life Events
Lack of Social/Emotional support
Living Alone
Mistrust of Systems and Providers
Experience with Manifested Racism

COMMUNITY EDUCATION & SOCIAL SUPPORT

1. Hosting Conversations on Opioid Awareness and Workshops to Understand the Signs and Symptoms of OUD
2. Promoting a Day of Recovery
3. Discussion of Treatment and Recovery Services
4. Training Community Members on Naloxone
INITIATE MOUD !!
(Buprenorphine vs. Naltrexone?)
(Injectable?)

1. INSTITUTIONAL PEER SUPPORT

Decrease Recidivism

Neighborhood
- Housing Instability
- Transportation
- Toxic Exposures
- Safety
- Violence

Interpersonal
- Adversity in Childhood
- Negative Life Events
- Lack of Social/Emotional support
- Living Alone
- Mistrust of Systems and Providers
- Experience with Manifested Racism

3. COMMUNITY PEER SUPPORT
(LCHC-SAMHSA Grant)

2. TRANSITIONAL PEER SUPPORT

INITIATE MOUD !!
Buprenorphine
(Sublingual vs. Injectable?)

1. INSTITUTIONAL PEER SUPPORT

2. TRANSITIONAL PEER SUPPORT
INSURANCE COMPETENCY

O’NEILL INSTITUTE LEGAL REQUIREMENTS for EQUITABLE INSURANCE COVERAGE:

(1) Universal Insurance Coverage with **NO WORK** or **COMMUNITY SERVICE** Requirement;
(2) Equitable Services Regardless of Neighborhood;
(3) Affordable Coverage;
(4) High Quality Services
(5) Cost Effective Care;
(6) Education, Transportation, Infrastructure, and Social Safety Net
No room on the street: D.C. orders homeless out of underpass in fast-developing neighborhood

By Joe Heim and Justin Wm. Moyer
Jan. 10, 2020 at 5:41 p.m. EST

Health Affairs
content.healthaffairs.org
doi: 10.1377/hlthaff.2015.0393
Health Aff January 2016 vol. 35 no. 1 20-27

Formerly Homeless People Had Lower Overall Health Care Expenditures After Moving Into Supportive Housing

Bill J. Wright1*, Keri B. Vartanian2, Hsin-Fang Li3, Natalie Royal4 and Jennifer K. Matson5

Author Affiliations

*Corresponding author

Abstract

The provision of supportive housing is often recognized as important public policy, but it also plays a role in health care reform. Health care costs for the homeless reflect both their medical complexity and psychosocial risk factors. Supportive housing attempts to moderate both by providing stable places to live along with on-site integrated health services. In this pilot study we used a difference-in-differences analysis to evaluate outcomes for a supportive housing facility in South Carolina. The analysis showed that costs decreased for the people after they moved into supportive housing. Costs were driven primarily by decreased emergency department use. Data suggest that the savings...
White opioids: Pharmaceutical race and the war on drugs that wasn’t

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Abstract

The US ‘War on Drugs’ has had a profound role in reinforcing racial hierarchies. Although Black Americans are no more likely than Whites to use illicit drugs, they are 5–10 times more likely to be incarcerated for drug offenses. Meanwhile, a very different system for responding to the drug use of Whites has emerged. This article uses the recent history of White opioids – the synthetic opiates such as OxyContin® that gained notoriety starting in the 1990s in connection with epidemic prescription medication abuse among White, suburban and rural Americans and Suboxone® that came on the market as an addiction treatment in the 2000s – to show how American drug policy is racialized, using the lesser known lens of decriminalized White drugs. Examining four ‘technologies of whiteness’ (neuroscience, pharmaceutical technology, legislative innovation, and marketing), we trace a separate system for categorizing and disciplining drug use among Whites. This less examined ‘White drug war’ has carved out a less punitive, clinical realm for Whites where their drug use is decriminalized, treated primarily as a biomedical disease, and where their whiteness is preserved, leaving intact more punitive systems that govern the drug use of people of color.
Buprenorphine treatment more accessible in high-income, non-minority neighborhoods

Hansen et al. Drug Alcohol Depend 2016
<table>
<thead>
<tr>
<th>Variable</th>
<th>2004-2007</th>
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<th>2012-2015</th>
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<td></td>
<td>Visits Without Buprenorphine (n = 244,274), %&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Visits With Buprenorphine (n = 183), %&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Visits Without Buprenorphine (n = 204,527), %&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Visits With Buprenorphine (n = 718), %&lt;sup&gt;a&lt;/sup&gt;</td>
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<td>White</td>
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<td>90.5</td>
<td>83.1</td>
<td>94.9</td>
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<td>6.6</td>
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<td>37.8</td>
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<td>Female</td>
<td>58.8</td>
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<td>41.2</td>
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<td>41.7</td>
<td>60.3</td>
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<td>Age, y</td>
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<td>&lt;30</td>
<td>29.9</td>
<td>40.0</td>
<td>25.4</td>
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<td>23.8</td>
<td>47.5</td>
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<td>47.2</td>
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<tr>
<td>&gt;50</td>
<td>46.3</td>
<td>12.5</td>
<td>53.2</td>
<td>22.4</td>
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</tbody>
</table>

Abbreviation: OR, odds ratio.

<sup>a</sup> Analyses were completed using survey design elements accounting for visit weight, clustering, and stratification to generate nationally representative estimates.

<sup>b</sup> Adjusted odds ratios (AOR) were generated using logistic regression (1 = buprenorphine prescribed; 0 = no buprenorphine), including the variables reported in the Table. The AOR reflects the OR for buprenorphine treatment for a given visit characteristic during 2012 to 2015. The 2004 to 2007 visit characteristics are provided for comparison; they are not included in the logistic regression.

<sup>c</sup> White (Hispanic and non-Hispanic), black (Hispanic and non-Hispanic), and other (Asian, native Hawaiian/Pacific Islander, American Indian/Alaskan native, and multiple race, both Hispanic and non-Hispanic).
Our fentanyl surviving (AA) patients do better on buprenorphine 24 mgs – 32 mgs:
(1) Decrease cravings, (2) Increased negative urines for opioids, (3) Increased retention in care

Howard University College of Pharmacy: MOUD Medication Competency in the “Age of Fentanyl”
UNEVEN ACCESS TO ADDICTION TREATMENTS THROUGH MEDICAID

Despite the importance Medicaid places on providing access to health care, many states have inconsistent policies toward paying for medications used to treat opiate addiction. The American Society of Addiction Medicine surveyed each state’s Medicaid program to determine which medications are covered and if any limitations exist. It found that many states’ Medicaid programs either won’t pay for drugs like methadone, place dosage limits on a patient’s prescription for buprenorphine or require counseling that may be unobtainable.

2022 EXAMPLES of BUPRENYRPHINE DOSING:
Vermont increased 16 → 32 mgs
New Jersey increased 16 → 32 mgs
Washington State increased 16 → 32 mgs

2015 EXAMPLES of BUPRENYRPHINE DOSING:
Vermont increased 16 → 32 mgs
New Jersey increased 16 → 32 mgs
Washington State increased 16 → 32 mgs
Contingency management increased abstinence

People in contingency management programs were more likely to be abstinent at the end of the treatment than those in other programs.

- Contingency management + community reinforcement approach: 2.84 times more likely*
- Contingency management alone: 2.2
- Contingency management + 12-step program: 1.82
- 12-step program alone: 1.35
- Cognitive behavioral therapy alone: 1.17

* Compared with the control group.


Cost comparison

Maximum rewards for a typical contingency management program: $600

- Average cost of one stimulant-related ER visit: $570
- Typical cost of one ambulance ride: $1,211
- Typical cost for two weeks in prison: $1,360

Note: All costs for 2019.
Sources: Health Care Cost and Utilization Project (ER visit); ValuePenguin (ambulance ride); Federal Bureau of Prisons (prison costs); author's calculations
DC OPEN AIR DRUG MARKET

Homeless ?
Addicted ?
Mentally Challenged ?
HIV or Hepatitis Infected ?
At Risk to Be Physically Harmed or Murdered !!

1647 Benning Road, NE
Washington, DC
(Rear Parking Lot)

A TALE of TWO CITIES: In Black & White
“CASH CONTINGENCY MANAGEMENT”: Would you **PAY THEM** to enter and remain in treatment?

Why Don’t We Allow “Safe Injection” Sites?

Do **YOU** Understand “Harm Reduction?”
“CASH CONTINGENCY MANAGEMENT”: Would you **PAY THEM** to enter and remain in treatment?

Way Don’t We Allow “Safe Injection” Sites?

Do **YOU** Understand “Harm Reduction?”

- Syringe & Needle X-Change
- Condoms
- Educational Literature
- Fentanyl Test Strips
- Narcan
- Referrals to MOUD
“I did not know that I suffered with the disease of diabetes” ... 

“I did not know that I suffered with the disease of hypertension” ... 

“I had hepatitis C and Medicaid did not want to pay for it” .... 

“It took 5 times for the doctor that I was referred to by Dr. Chapman to get Medicaid to pay for it!!” ... 

“Medicaid paid $90,000 for 3 months treatment and... I no longer have the hepatitis C virus” ...
CHAPMAN, PC BUPRENORPHINE PATIENTS
LONGEST DRUG FREE PATIENT (2005-2022) NOW AGE 75

17 Years

#1 GOAL
Improved Medical Outcomes
AVERAGE AGE CHAPMNN, PC
BUPRENORPHINE PATIENTS
INCREASED from 52 → 60 (2014-2022)
CHAPMAN, PC BUPRENORPHINE PATIENTS
AGE RANGE 2020

27 Years (x5)
82 Years (x1)
60 Average Age

#1 GOAL
Improved Medical Outcomes
#2 GOAL
Improved Patient Satisfaction

18 MONTHS = 75%

6 MONTHS = 95%
MEDICAL OUTCOMES

#3 GOAL
REDUCED
MEDICAL
&
NON-MEDICAL
COSTS

SOCIAL ECONOMIC
OUTCOMES

LOSS MITIGATION

Decrease Drug Related Morbidity & Mortality

Decrease Mental Illness Related Morbidity & Mortality

Increase EPSDT & HEDIS Compliance

Decrease Personal Viral Loads

Increase Criminal Incidence / Child Neglect

Decrease Non-Medical Costs

Decrease Medical Costs
There are “elephants” in our community!!!: The 1999 “60 minutes story”

Peer coach in my office

Has new condo

Community mentor to many

Certified counselor & Narcan trainer
The Future:

(1) **Overcoming STIGMA** — thru improved professional and community education

(2) **Overcoming Patient Barriers to Care** — According to the CDC report released on 7/19/2022, only 1/12 African American OUD patients who die from opioid overdose have ever been in treatment. How, then, does one encourage someone to enter treatment and/or remain in treatment?
   (A) Contingency management - the future role of direct payment to patients for entering and remaining in treatment.
   (B) Bounty payments - the potential role of direct payment to family, friends or associates for successfully bringing a new patient to treatment.

(3) **Overcoming Structural Barriers**:
   (A) Personnel —
      (i) If only 6% of social workers, 5% of physicians, 4% psychologists, and 2% of psychiatrists are African American, how can the community most effectively and efficiently expand services to an exponential increase in mental health and SUD needs?
      (ii) Psychiatry & Psychology - Is there a potential role for NATIONAL CREDENTIALING and DIRECT PAYMENT from CMS as opposed to the current fragmented, disincentivized, private payer system?
      (iii) What is the future of bundle payments for MOUD (MAT + Social Services + Psychiatrist/Psychologist + Peer Support)?
   (B) Overcoming Housing Regardless of Current Drug Use Status & Transportation
   (C) Overcoming MOUD Dispensing Barriers — Using “X-waivered provider / pharmacists collaborative agreements,” can local pharmacies & pharmacists be the answer to reducing travel time and distance for MOUD access and dispensing?

(4) **Overcoming Regulatory Barriers** —
   (A) Training for Buprenorphine
   (B) Prior Authorizations for buprenorphine
   (C) Same day billing for multiple services
   (D) Data Sharing of Mental Health and Substance Use Disorder Records
   (E) Disconnect between the Health and Criminal Justice Systems including MOUD in Jails and Prisons
   (F) Buprenorphine provider / patient caps
   (G) Buprenorphine dosing caps
   (H) Limits on Harm Reduction

(5) **TeleHealth** — How can we maintain, in perpetuity, the indispensable COVID proven role and value of this tool anyone, anywhere, anytime?

(6) **Revamping Payment** — Value based carveout measured and compensated based on “Retention in Care”
   (A) ASAM-AMA Patient Centered Opioid Addiction Treatment (P-COAT)
   (B) Alternative Bundled payments with monthly capitation

**SUMMARY**
QUESTIONS?

Without education, there is no hope for our people and without hope, our future is lost.

— Charles Hamilton Houston —

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