Case Study:
Privatization and Performance in Northern California's Battle with the Opioid Epidemic

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Problem Background: The Rising Opioid Epidemic in America

Andrew Roland's best friend and longtime roommate, Miguel Herrera, shook his unresponsive body vigorously in a frantic attempt to wake up his friend. "Wake up, Andrew!! Please wake up!!" Miguel immediately called 911 and Roland's parents. Tragically, by the time the speeding ambulance had reached Shasta Regional Medical Center in Redding, CA, 23-year old Andrew Roland was pronounced dead. An autopsy later confirmed what Andrew's roommate and family had suspected when they found him unresponsive in his bedroom after failing to show up for his shift at a local Italian restaurant: Andrew had died of a heroin overdose stemming originally from addiction to opioid pain killers. The very pills that gave him physical comfort after he shattered his femur in a horrendous ATV accident led him down a path toward all-encompassing opioid addiction that ultimately took Andrew's life.

Unfortunately, Andrew's story of drug addiction and pre-mature death from drug overdose had become increasingly common across the United States over the past decade or so. What came to be dubbed the "opioid crisis" or "opioid epidemic" generated an explosion of

addiction to opioid pain killers and, subsequently, a precipitous increase in drug overdose deaths, oftentimes from overdosing on more powerful and deadly forms of heroin and fentanyl (Quinones 2015; Lopez 2017). The popular face associated with the opioid epidemic was centered in Appalachia and the impoverished rural (and largely white) communities of Eastern Kentucky, West Virginia, and Southern Ohio. However, relatively more affluent, diverse and urban coastal states, such as California, were not immune to the opioid epidemic (Abram 2017).

In particular, in recent decades, relatively rural and economically distressed counties of Northern California, such as Humboldt, Trinity, and Shasta County, had experienced acute opioid addiction issues as detailed by some astonishing and troubling statistics. For instance, during the timeframe of 2002-2014, people in Humboldt County died from drug poisoning at *more than double the national rate*, with approximately 32 of every 100,000 Humboldt County residents dying from drug overdose (Burns 2016). Think about a quick comparison with automobile deaths. During that same 12 year period from 2002 – 2014 in Humboldt County, 329 people died due to car crashes, while 564 residents died from drug overdose (Burns 2016). Similar dynamics of rising rates of opioid addiction and drug overdoses had played out over the preceding 10-15 years across neighboring Northern California counties, such as Shasta, Trinity, Butte, and Mendocino. Figure 1 and Table 1 provide some further visual evidence of the disproportionate problem faced by these Northern California communities relative to the rest of the state. As the moniker suggests, the boom in opioid drug addiction and overdose deaths had arguably reached *epidemic* levels. According to the National Center for Health Statistics (operating under the U.S. National Institutes of Health), roughly two-thirds (60-70%) of drug overdose deaths in the U.S. were directly attributable to opioid prescription pain pills or more illicit opiate forms of heroin and fentanyl (NCHS n.d.). While non-opioid based drugs, such as

cocaine and anti-anxiety medication (Xanax, etc.), can also lead to drug poisoning and death, they do so at much lower rates than opioid based ones.

The reasons behind the rise in opioid addiction and death in America were multi-faceted and complex, but a greater depth of understanding was beginning to emerge (Lopez 2017). On the supply side, beginning in the late 1990s, doctors and pharmaceutical companies began a new "pain management regime" that centered on immediately relieving physical pain oftentimes with pill-based remedies (and with good intentions from doctors) (Quinones 2015). Over the next 15 years, doctors became increasingly quick to prescribe and arguably "overprescribe" opioid pain killers to patients, with pharmaceutical companies incentivized to deliver the supply and increase sales. The ultimate result was a flooding of the U.S. market with a heightened supply of opioid drugs and medications. On the demand side, millions of Americans arguably experienced high levels of physical and mental pain and genuinely needed soothing relief. Opioid pain killers and more powerful forms of heroin and fentanyl were one direct way of dealing with that real mental and physical anguish (Quinones 2015). Similar to the unfriendly physical toil involved with coal mining in Appalachia, workers in Northern California counties had labored for decades in the lumber, agriculture, and shipping industries, accruing injuries and ailments, such as crippling back and knee pain. Not only was that work oftentimes physically demanding when it existed, but economic distress and increased unemployment from the Great Recession that followed the financial crisis of 2008 likely played a role in Northern California counties (Khazan 2017). For instance, at the height of the Great Recession in February 2010, the unemployment rates for Shasta and Redding Counties stood at 18.5% and 17.1% respectively, several points above both the state and national averages (Bureau of Labor Statistics). An established body of research examining rural Appalachia and inner-city areas of Midwestern and Northeastern cities

demonstrated that deep unemployment and concentrated poverty can foster unhealthy mental emotions of distress and feelings of hopelessness (see Gaventa 1982; Wilson 2012). When citizens feel alienated and dislocated from meaningful work opportunities and marginalized from mainstream society, they can recede to the background and pursue "escapism", with an increased susceptibility to opioid drug addiction and overdose (Khazan 2017). This dynamic combination of demand and supply factors likely sat at the heart of the opioid epidemic in America. There are no easy solutions to multifaceted and complex social problems such as opioid addiction and overdose deaths, but states and localities were beginning to take steps to proactively address the epidemic.

Prop 36: Increasing Demand Amid Shrinking State Support

On November 7th, 2000, California passed Proposition 36, known as the "Substance Abuse and Crime Prevention Act", requiring that eligible non-violent drug offenders be able to serve their time in a sanctioned drug treatment program instead of being incarcerated (Burns 2016. In subsequent years, demand for drug treatment services increased rapidly even when state funding and resources to implement Prop. 36 were stretched thin or nonexistent. For instance, when the program began in the year 2000, the state was directing $120 million per year toward the program out of Sacramento (Burns 2016). This robust level of funding remained intact for the next seven years of Prop. 36's existence. Funding levels subsequently dropped to $108 million in the 2008/2009 fiscal year and were reduced further to $63 million the following year as California's budget was strained during the Great Recession (Burns 2016). Prop. 36 funding was cut entirely from the budget in 2010 and complete lack of state financial support has remained the norm ever since (Burns 2016). Even as the state reduced funding for local drug treatment initiatives, the opioid epidemic emerged, heightening demand for treatment services in

Northern California in particular. Local governments, obligated under Prop. 36 to provide drug treatment options, began to seek new and innovative administrative arrangements for treatment service delivery at the street-level (Burns 2016).

"With the opioid epidemic in full bloom, the demand for drug treatment is significantly outweighing the resources available to provide services," proclaimed Nancy Starck from Humboldt County DHHS[1] (Burns 2016). According to human service administrators like Nancy, on their own, single counties in Northern California lacked the resources and established processes to successfully advance patients through comprehensive drug treatment and recovery and into a successful life after post-treatment (Burns 2016). Starck continued, "Humboldt County alone doesn't have the resources or expertise to devote to treatment services, so we started to think creatively about how we might provide drug treatment to non-violent offenders under Prop. 36"[2] (Burns 2016). Local public health officials started talks with administrators in other rural Northern California counties who faced similar drug epidemic issues. "Instead of going it alone, we thought we might try to do this as an organized regional consortium, and get several neighboring counties involved that are facing similar opioid related drug addiction and overdosing problems. We thought this type of coordinated multi-county approach might be the most effective strategy for leveraging our limited rehabilitative resources."[3] (Burns 2016). Thus, in response to relentlessly increasing demands for drug treatment activities, especially related to opioid addiction, in 2010 five Northern California counties – Humboldt, Trinity, Butte, Mendocino, and Shasta County – formed the *Nor Cal Rehabilitation Services Consortium*

[1] Quotations in this section are paraphrased from comments by Nancy Starck, Legislative and Policy Manager at the Humboldt County Department of Health and Human Services, originally quoted in Burns 2016.

[2] Quotation paraphrased from Nancy Starck in Burns 2016.

[3] Quotation paraphrased from Nancy Starck in Burns 2016.

(NCRC)[4]. Many county-level officials felt a regional consortium could potentially accomplish several important goals that piecemeal, single-county approaches could not. First, the counties could pool collective expertise and more aggressively (and successfully) seek grants from foundations to fund service provision. Next, a consortium could increase the counties' bargaining leverage over individual service providers when negotiating price-setting/reimbursement arrangements, lowering the average costs of providing services. Additionally, a more centralized consortium had the potential to coordinate monitoring and oversight capabilities on a regional basis, ultimately increasing accountability over service providers and yielding improved efficiencies in service provision.

Following the dramatic state budget cuts in 2010, adequately funding drug treatment services under Prop. 36 became a continual challenge. Over time, a patchwork of payment sources emerged to fill the void. Poorer probationers eligible for drug treatment services under Prop 36 could have drug treatments covered by Medi-Cal or certain policies obtained through the Covered California health insurance marketplace, while more affluent probationers could be ordered by the courts to pay for services themselves (RehabCenter.net). Still funding challenges remained for counties that wanted to provide a range of services for growing caseloads of probationers, such as those in Humboldt and neighboring counties facing acute opioid problems. In 2016, he NCRC received a $15 million dollar grant from the esteemed California Health Care Foundation to establish and expand drug treatment service options for Prop. 36 probationers (Burns 2016). These funds allowed the NCRC counties to fund drug treatment services for those who had exhausted other financing options, and also helped reduce wait times and waiting lists for treatment that had lengthened since state funding was eliminated in 2010.

[4] This Consortium name is fictionalized. Nine total California counties participated in the organized drug treatment partnership in Northern California, but no official title existed for their arrangement (Burns 2016).

Due to a lack of internal service delivery capacity and experience among its member county governments, the NCRC contracted with a mix of private, non-profit and for-profit drug treatment service providers to deliver treatments at the front lines. The specific menu of treatments included, but was not limited to: case management intake and meetings, behavioral therapy sessions and wellness workshops, dispensing medicine, and 12-step meetings. A centralized consortium had potential advantages when contracting for human services delivery. Through offering higher total caseload numbers and a larger contiguous service area than any one county alone, the NCRC sought a higher frequency and quality of bids from potential providers. Additionally, the NCRC envisioned that its centralized monitoring and accountability mechanisms could offer particular advantages for overseeing private sector service providers.[5]

Privatization and Performance in NCRC Drug Treatment Provision

In 2011, after eliciting several competitive private sector bids through a "request for proposals" (RFP) process, the NCRC awarded its initial contracts for drug treatment to a long-established community-based 501(c) (3) nonprofit organization, Angel's Wings Rehabilitation Services, originally founded in 1973. In subsequent years, however, demand for opioid drug treatment services outstripped Angel's Wings capacity and contractual obligations. In order to more rapidly increase service delivery capacity to meet the heightened demand, starting in 2014 the NCRC began contracting with a newer, less-proven for-profit organization, Treatment Strategies Inc., founded in 2011. Eventually, the NCRC's contracted providers came to serve approximately 700 program clients each year, split roughly evenly between Angel's Wings and Treatment Services Inc. NCRC case workers placed clients with one provider or the other, based primarily on geography or client distance to the nearest treatment facility. Additionally, the

[5] One "paradox of privatization" is that third-party outsourcing requires greater government oversight capabilities and taxpayer accountability mechanisms that are potentially better achieved under a more centralized consortium arrangement (Van Slyke 2003).

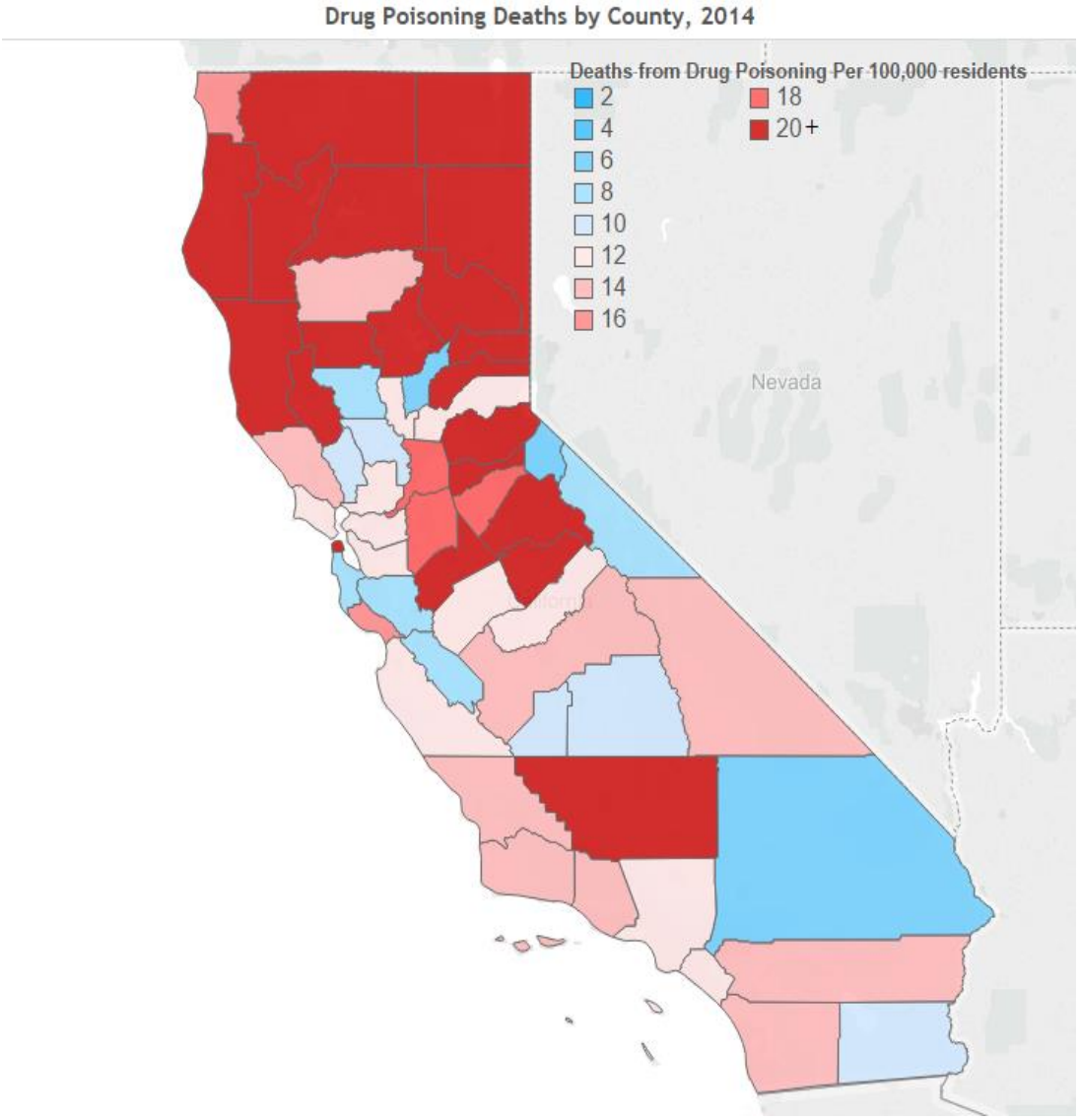
California Health and Human Services Agency, which determined initial rehabilitation eligibility, managed a lengthy annual waiting list of 200-300 prospective program clients who were eligible for drug treatment services but had yet to receive a formal placement.

The complexity of multi-county, integrative, public-private arrangements for drug treatment services created some challenges for NCRC. It created basic, input-based contracts that reimbursed frontline drug treatment providers with a negotiated cost per client in exchange for the provision of a certain number of specified treatment/therapy sessions and necessary medication (e.g. doses of methadone, etc.). This type of input-based contract had the advantage of being relatively straightforward and easy to administer; treatment provider reimbursements were based simply on the number of clients served and the amount of services they received. For each individual service a contractor provided, it received a set rate as instituted by NCRC administrators in contract negotiations. Each provider could provide a range of services for clients. Eligibility for drug treatment under Prop. 36 was strictly controlled by judges within California state courts, who allowed offenders to become probationers and eligible for rehabilitation. While the state tightly controlled initial gatekeeping and client eligibility, and private insurers might refuse to cover certain treatment activities, the frontline treatment providers themselves had relatively wide discretion in providing specific services and therapy pathways after NCRC case workers referred a client to them. For instance, individual case managers could recommend various intensities of service activities, or approve specialized support services like outside counseling sessions with mental health professionals.

While NCRC administrators were satisfied that frontline implementation of rehabilitation services was available, they had serious concerns about the *quality* of drug treatment services being provided, most especially the amount of attention providers paid to the clients who were

hardest – and inevitably – the most costly to service. Put another way, the NCRC administrators were concerned that private providers, especially the for-profit ones, were "cream skimming" by limiting the intensiveness of therapy provision or focusing services on clients who were easier to serve and presented few personal and professional barriers, while neglecting more difficult client cases that required more intensive resources and attention. While occasional anecdotal client success stories appeared in the local Northern California media about clients "getting clean" and turning their lives around, little information was available about the systematic quality (or lack thereof) of program outcomes experienced by the clients served by private drug treatment providers under the NCRC.

Figure 1. Drug Poisoning or "Overdose" Deaths by California County, 2014



Source: Centers for Disease Control and Prevention, Data Visualization Gallery. Figure originally appeared in (Reese 2016).

Table 1. Drug Poisoning or "Overdose" Deaths (Per 100,000 population) for Select Northern California Counties

	2016	2015	2014
National Average (U.S.)	16.3	15.3	14.7
Humboldt County	33	35	32
Butte County	30	33	27
Shasta County	26	29	27
Trinity County	23	22	22
Mendocino County	20	19	18

Source: Robert Wood Johnson Foundation, County Health Rankings & Roadmaps.

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