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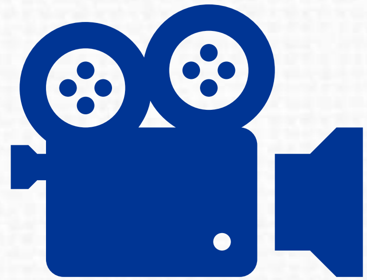

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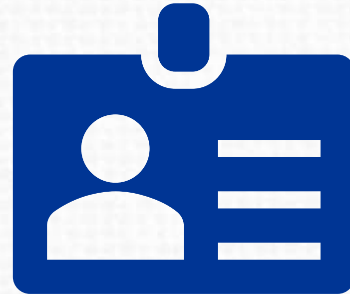

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Pose questions in the chat to **all participants**.

Please complete the post-session **evaluation**.

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Mutual Agreement

- Everyone on every Learning Network webinar is **valued**. Everyone has an expectation of **mutual, positive regard** for everyone else that respects the **diversity** of everyone on the webinar.
- We operate from a **strength-based, empathetic, and supportive** framework – with the people we serve, and with each other on these webinars.
- We encourage the use of **affirming language** that is not discriminatory or stigmatizing.
- We treat others as **they** would like to be treated and, therefore, avoid argumentative, disruptive, and/or aggressive language.

Mutual Agreement (continued)

- We strive to **listen** to each person, avoid interrupting others, and seek to **understand** each other through the Learning Network as we work toward the highest quality services for Centers of Excellence (COE) clients.
- Information presented in Learning Network sessions has been vetted. We recognize that people have different opinions, and those **diverse perspectives** are welcomed and valued. Questions and comments should be framed as **constructive feedback**.
- The Learning Network format is **not conducive to debate**. If something happens that concerns you, **please send a chat during the session** to the panelists and we will attempt to make room to address it either during the session or by scheduling time outside of the session to process and understand it. **Alternatively, you can reach out offline to your University point of contact.**

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Acknowledgements

- The COE project is a partnership of the University of Pittsburgh's Program Evaluation and Research Unit and the Pennsylvania Department of Human Services; and is funded by the Pennsylvania Department of Human Services, grant number 601747.

- COE vision: The Centers of Excellence will ensure care coordination, increase access to medication-assisted treatment and integrate physical and behavioral health for individuals with opioid use disorder.

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Retention Strategies

Learning Objectives

By the end of this training, you will be able to do the following:

Identify the benefits of **sustained client engagement** in substance use treatment and the care manager's role in supporting it.

Examine individual, social, and systemic **risk factors** associated with treatment and care management disengagement.

Apply evidence-based care management strategies to **prevent** and **respond** to disengagement

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Citation

Background

Client Engagement

Engagement = active participation

Enrollment = entering treatment

Retention = sustained participation over time

(Holdsworth et al., 2014)

Treatment Gap

- In 2022, an estimated **6.1 million people** in the United States had an opioid use disorder[1]
- In 2019, approximately **87%** of people with OUD did not receive MOUD[1]
- Completion rates for SUD treatment: ~65% for residential programs; only ~48% for outpatient programs[2]
- These gaps represent critical opportunities for care managers to intervene

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([1]CDC, 2024; [2]Vipond et al., 2023)

The Role of a Care Manager in Engagement

- **Comprehensive** needs and SDOH assessment
- **Individualized** care planning
- **Proactive** outreach and monitoring
- Linkage to **community resources**
- Supporting care **transitions**
- Facilitating **communication across providers**

(Earnshaw et.al, 2022)

Benefits of Engagement

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Survival

- Retention in MOUD treatment is associated with substantial reductions in all-cause and overdose mortality[1]
- Compared to those not receiving MOUD after a nonfatal overdose:
  - Opioid-related deaths decreased by 59% for those receiving methadone
  - Opioid-related deaths decreased by 38% for those receiving buprenorphine[1]
  - The period immediately following MOUD discontinuation carries the highest overdose mortality risk[2]

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([1]NIH, 2019; [2] Larochelle et al., 2018)

Improved Life Outcomes

- **Increased abstinence** rates
- **Decreased** overdose-related **ED visits**
- **Decreased arrests**

(Dever et al., 2024)

Reduced System Costs

- Low engagement = Higher costs
- **Care coordination** reduces unnecessary acute care by **connecting clients to the right support** at the right time[2]
- Engagement is both a **clinical** and **financial** imperative[2]

([1]Kindred Healthcare, 2021;[2]AHRQ, 2023)

Recovery Capital

- COEs build **recovery capital**
- **Outreach, peer support, and wraparound services** keep clients connected
- Care coordination bridges clinical care and **community-based support**

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(SAMHSA, n.d.)

Discussion Question

Think of a COE client who stayed engaged in care. What role did you play in keeping them connected?

Citation

Recognizing the Risk of Disengagement

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Early Warning Signs

- **Missed** or frequently rescheduled treatment **appointments**, particularly MOUD dosing visits[1]
- **Failure to respond** to outreach calls, texts, or messages[1]
- **Changes in housing** stability or **loss of contact** information[2]
- **Increasing crisis** calls, ED visits, or justice involvement[3]
- Client expressing **hopelessness, ambivalence**, or that treatment "isn't working“[1]
- **Loss of insurance coverage** or lapses in prescription coverage[1]
- **Caregiver** or **family reporting concerns** about the client[2]

([1]SAMHSA, 2020; [2]SAMHSA, 2023; [3]Brorson et al., 2013)

Individual-Level Factors

- **Younger** age, **low motivation**, and **limited insight** into SUD/OUD
- **Co-occurring mental health conditions** (depression, PTSD, anxiety) significantly increase dropout
- **Internalized stigma** is a key barrier to engagement and retention

(Vipond et al., 2023)

Relational & Social Factors

- **Weak therapeutic relationship** or perceived provider stigma[1]
- **Social isolation** and **lack of family** support predict disengagement[1]
- **Self-stigma** and **community stigma** are documented barriers to MOUD retention[2]

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([1]Brorson et al., 2013; [2]Davis et al., 2023)

Systemic & Structural Factors

- **Rigid attendance requirements, prior auth delays**, and **limited MOUD** access
- **Fragmented care** and **staff turnover** increase dropout risk
- COEs can identify friction points and **advocate on the client's behalf**

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Citation

Risk Factors

- Missing BARC-10
- Missing ASAM LOCA
- Substance Use Severity
- ASAM LOCA Score
- Criminal Justice Involvement

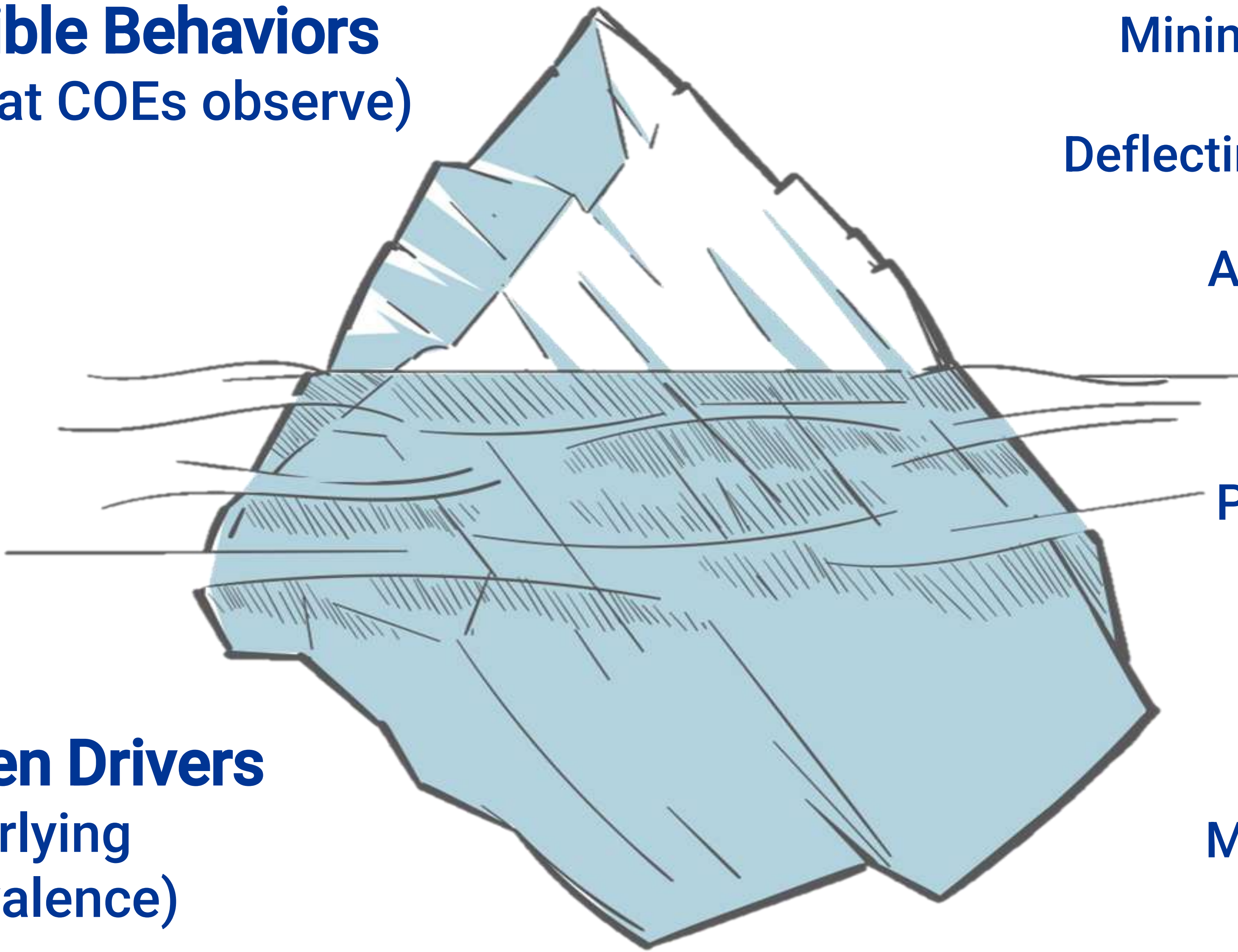
Citation

Ambivalence

*A client who **resists or minimizes** is not a lost cause — they are at a **decision point**. Whether they feel respected rather than managed is one of the most influential factors in whether resistance softens.*

(Hachtel et al., 2019)

Visible Behaviors
(What COEs observe)



Minimizing or denying use.

Deflecting with anger, humor, or silence.

Attending only under pressure.

Pessimism about treatment outcomes.

Disappearing after crisis stabilizes.

Mistrust of care team or system.

Hidden Drivers
(Underlying ambivalence)

How Ambivalence Presents

Minimizing or denying substance use severity (Doron et al., 2022)

Pessimism "This won't work" or "I've tried before" (Doron et al., 2022

Deflecting with anger, humor, or silence (SAMHSA, 2019)

Attending only under pressure from legal, family, work mandates, etc. (Hachtel et al., 2019)

Disappearing after crisis stabilizes (Doron et al., 2022)

Mistrust of the care team or system (Ifeagwazi et al., 2021)

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Coercion

Perceived coercion — not formal mandate — **drives poor outcomes**; even voluntary clients can feel coerced (Hachtel et al., 2019)

Mistrust is a major barrier for involuntary clients; prior negative system experiences predict hostile or withdrawn behavior (Ifeagwazi et al., 2021)

Coercive approaches **amplify stigma, lower self-esteem, and increase disengagement** (Luciano et al., 2023)

Coerced clients can stay as long and do as well as voluntary clients when the **relationship is respectful and autonomy-supportive** (NIDA)

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Citation

- SDOH

When Survival Competes with Care

- When survival competes with care, survival wins.
- These are measurable barriers, **not excuses**.

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(Stanojlović & Davidson, 2021)

SDOH Drive Disengagement

Housing instability disrupts contact, medication storage, and care continuity and is linked to worse OUD severity and lower MOUD uptake[1]

Transportation barriers are a direct dropout driver travel times over 60 minutes increase dropout risk by 59%[2]

Economic instability limits ability to prioritize treatment, medications, and follow-up[3]

Criminal justice involvement disrupts care continuity and reduces MOUD access among justice-referred clients[4]

Social isolation reduces engagement, follow-through, and accountability in care plans[5]

Food insecurity competes with care capacity and worsens mental health outcomes[5]

([1]McLaughlin et al., 2021; [2]Harwerth et al., 2023; [3]Stanojlović & Davidson, 2021; [4]Donahoe & Saloner, 2024; [5]Park & Berkowitz, 2024)

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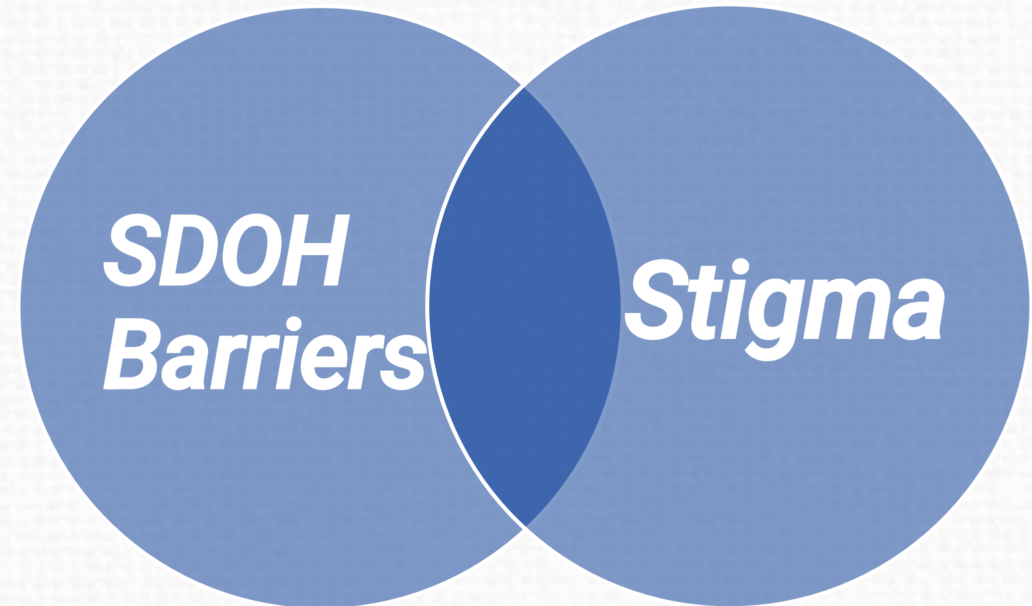
SDOH and Stigma

Clients facing SDOH challenges often also carry the weight of **multiple layers of stigma**

- **Structural stigma-** policies and systems that disadvantage people with OUD
- **Provider stigma-** feeling judged or dismissed by healthcare staff
- **Self-stigma-** shame that makes asking for help feel impossible

COE care managers sit at a unique intersection —they **can address both**



(Tsai et al., 2019)

Strategies to Prevent and Address Disengagement

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Addressing SDOH for Retention

- **Screen at every contact** not just intake[1]
- **Document SDOH barriers** in the care plan[1]
- **Connect to community resources-** housing, food, transportation, legal aid[2]
- **Advocate with the care team** when SDOH drives missed appointments[3]
- **Use flexible, low-barrier outreach** when instability disrupts contact[2]

SDOH-driven disengagement is not lack of motivation

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([1]Gottlieb et al., 2020; [2]Langabeer et al., 2025; [3]Wakeman et al., 2020)

Ongoing Needs Assessments and Care Plans

- High-performing programs use **systematic assessment** and **individualized care plans**[1]

- **Screen** with validated SDOH tools **at intake and regularly**[2]

- Document in **shared care plans**[2]

- Plans should reflect **goals, preferences, barriers,** and **strengths**[3]

- Address both the **SUD treatment pathway and the social needs** that affect it

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(Rattray et al., 2022; CMS, 2023; Sheridan et al., 2020

Protective Factors

Mental Health Services

Housing Services

Transportation Services

Food Services

Offsite/Virtual Services

Citation

Proactive Outreach and Monitoring

- **Don’t wait!** Proactive outreach is essential; **follow up on no-shows** within 24–48 hours
- **Check in regularly** (call/text/telehealth)
- **Use data/EHR flags** to identify disengagement risk early
- **Engage trusted supports** (family/peers)
- **Collect alternate contacts** (locator forms)

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(Rattray et al., 2022)

Reengagement

- **Act fast**[1]
- Use **nonjudgmental, open-ended** outreach[2]
- **Reassess and update** the care plan[2]
- **Ensure naloxone** and safety planning[2]
- Build **trust**[2]

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([1]Larochelle et al., 2018; [2]Pew Charitable Trusts, 2020)

Latterman Family Health Center

Dr. Heather Mikes, DO

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Philosophy

Everyone who comes to our clinic has made the important decision to work on their recovery.

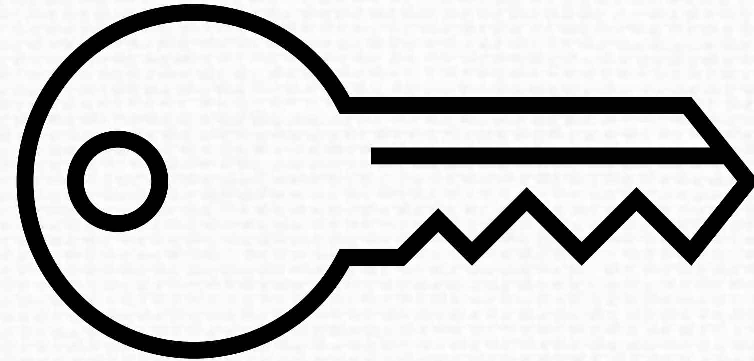
Signs of Disengagement

- Decreased communication
- Inconsistent attendance
- Transportation barriers
- Concerning Bio Feedback
- Circumstantial or MH crises
- Partner return to use

Citation

Four Key Areas to Retention

- When we think about how to support retention, we look at four key areas that shape our approach.
  - Scheduling
  - Environment
  - Relationship
  - SDOH



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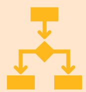
Scheduling

Missed visits are met with understanding, not shame.



Outreach is flexible, non-judgmental, and tailored to individual needs.

All forms of engagement and progress are celebrated.

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Citation

Environment

- Recovery is unique to each person
- Squirrel Hill has adapted to each person to ensure that journey is supported

Citation

Relationship

Meeting people where they are at

Staying flexible

Trust is earned, not owed

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Citation

SDOH

- Adapt to individual needs and goals from the start
- Transportation is provided if needed
- Using community partnerships

Citation

Addressing Ambivalence

MEET STAGE OF CHANGE

REDUCE PRESSURE

FOCUS ON RELATIONSHIP

BE A SAFE SPACE

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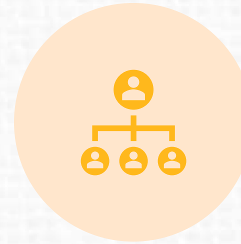
Re-Engagement

3 outreach attempts



Multiple methods

Normalize disengagement

Celebrate return

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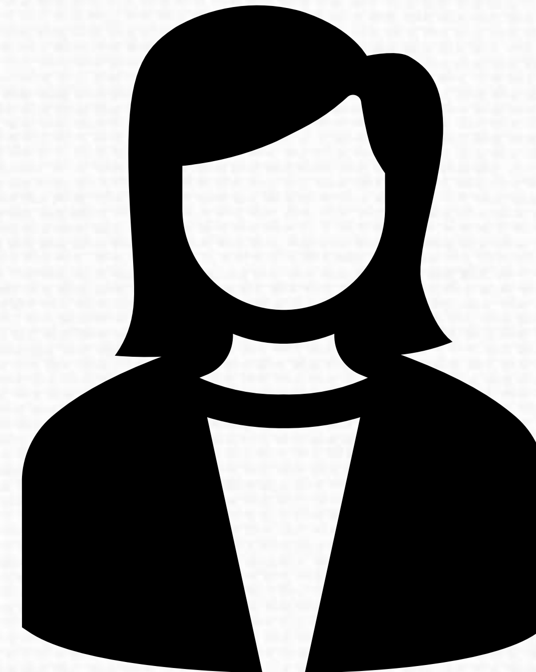
Client Example

- Jane has been struggling with making it to her appointments recently...



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Key Takeaways

Key Takeaways

Disengagement is a clinical problem driven by distress, stigma, and social barriers, **not lack of motivation.**

The relationship determines the outcome. **Respect and autonomy support** matter more than how a client arrived.

Survival needs compete with care and survival wins; address SDOH, not just diagnosis.

SDOH and stigma compound each other and COEs sit at exactly that intersection.

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Key Takeaways

The first 30 days are the highest-risk window; **proactive outreach is the strategy**, not the backup plan.

Screen continuously, not just at intake; SDOH circumstances change; care plans must keep up.

Resistance is ambivalence, not refusal. Respond with curiosity, not confrontation.

COEs are uniquely positioned to address what no other role in the system can.

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Group Discussion

What is one area discussed today that you feel your COE could work to improve? How?

Citation

Questions

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Citation

Wrap up and Next Session

- Please complete the **session evaluation**
- Slides and recording available on Tomorrow's Healthcare
- **Next Session:**

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