How providers can materially improve care for patients with SUD

Substance use disorder (SUD) is a challenging condition to treat, and a growing population of patients with addiction have unmet treatment needs. Providing effective treatment requires meeting the needs of patients with many types of addiction and levels of acuity. It also requires treating patients over the course of their chronic condition, which often includes a series of remissions and relapses.

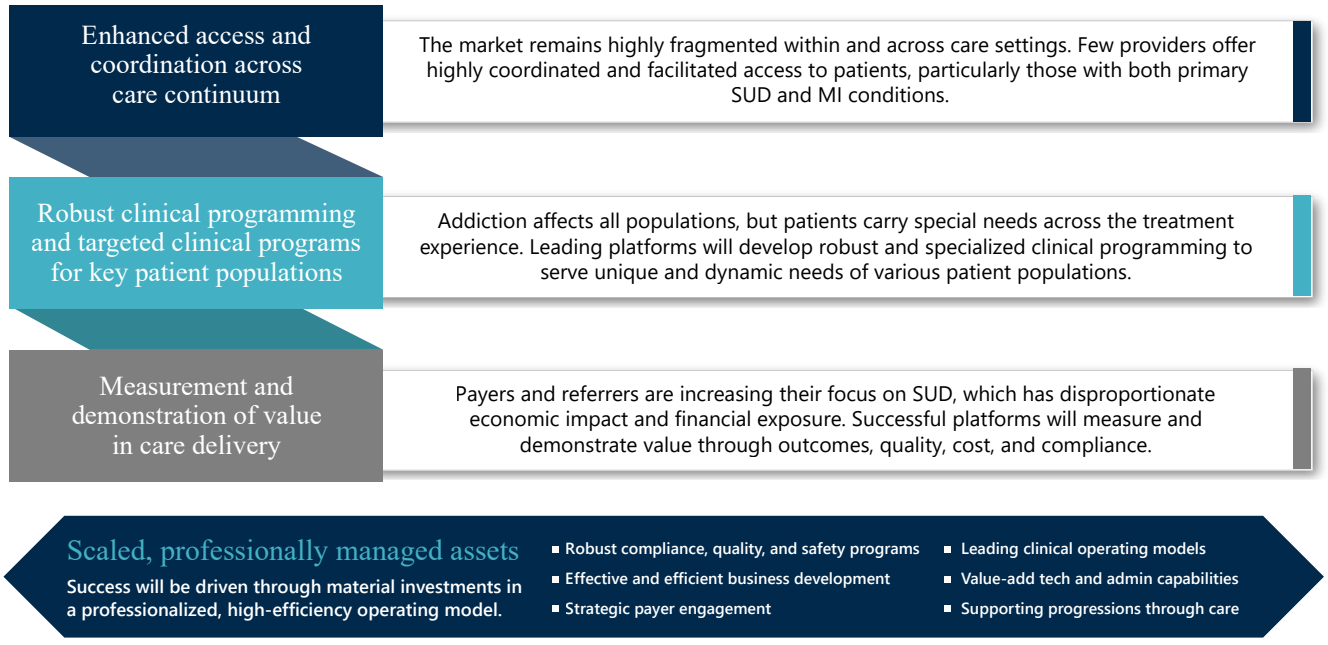
The vast majority of SUD providers offer a limited range of services that mostly serve local geographies. This has resulted in a largely fragmented market with variable quality and access. That exacerbates the already fragmented state of care for patients with behavioral health conditions, particularly for patients who have co-occurring SUD and mental illness (MI). However, the trend is beginning to shift as patients, providers, and payers recognize the need for solutions that are comprehensive, integrated, high-quality, and cost-effective.

To be successful in this industry over the long term, providers need to achieve the following goals:

1. Enhance access and coordination across the care continuum and acuity levels.
2. Develop robust clinical programming that includes targeted programs for specific populations.
3. Measure and demonstrate value in care delivery.

Providers that are professionally managed with the resources to scale can fulfill these goals most effectively.

FIGURE 1: SUCCESSFUL PROVIDERS OF SUD CARE SHOULD FOCUS ON THREE GOALS



A growing demand for services remains unmet

SUD conditions are common and have a profound impact on many individuals and their families. In 2022, more than 70 million adults suffered from a SUD condition. Approximately 49 million (70%) had a SUD without a co-occurring mental illness (MI), and 22 million (30%) had a co-occurring MI (see Figure 2).[1] This underscores both the magnitude of need and urgency of developing a more comprehensive approach.

FIGURE 2: US POPULATION IN NEED OF SUD CARE[2]

108 million people in the US live with SUD and/or MI

~49M

Living with SUD

SUD is a medical condition characterized by problematic or harmful use of substances such as alcohol, prescription medications, or illicit drugs, which can lead to significant distress and impairment of health and daily life.

EXAMPLES OF SUD

alcohol, opioids, marijuana, nicotine, and synthetic drugs

~22M

With co-occuring SUD and MI

SUD and MI often co-occur due to the combination of shared risk factors, such as biological/genetic vulnerabilities and environmental stressors. Individuals with MI may also use substances as a way of coping with their symptoms. But this can lead to abuse, which further exacerbates their condition. Diagnosing co-occuring disorders can be difficult because the symptoms of SUD and MI are often similar.

~59M

Living with MI

MI refers to a wide range of conditions that cause disturbances in thoughts, emotions, or behaviors. MI can vary in severity and, in some cases, can significantly alter daily function and even life expectancy.

EXAMPLES OF MI

depression, anxiety, bipolar disorder, schizophrenia, and obsessive compulsive disorder

Fortunately, the number of behavioral health (BH) providers has increased over the past several years as a result of both policy and reimbursement changes. The most dramatic change has been the move from SUD care as a largely cash-pay business to an increasingly in-network insurance benefit. According to a 2022 survey of health plan leaders covering 95 million commercial enrollees, the number of in-network prescribers (i.e., psychiatrists) and non-prescribers (i.e., psychologists, addiction counselors, and family and marital therapists) increased significantly between 2019 and 2022.[3] In-network psychiatrists increased 21%; in-network psychiatric nurse practitioners increased 87%; and in-network non-PhD therapists increased 52%. In addition, the number of providers who prescribed medication assisted treatment (MAT) such as suboxone for opioid use disorder increased 114%.

Unfortunately, the number of providers is still not adequate to meet demand. In fact, HRSA estimates that a deficit of close to 80,000 mental health professionals will exist by 2036, with significant gaps for both prescribers and non-prescribers.[4]

What will it take to address this crisis?

GOAL 1

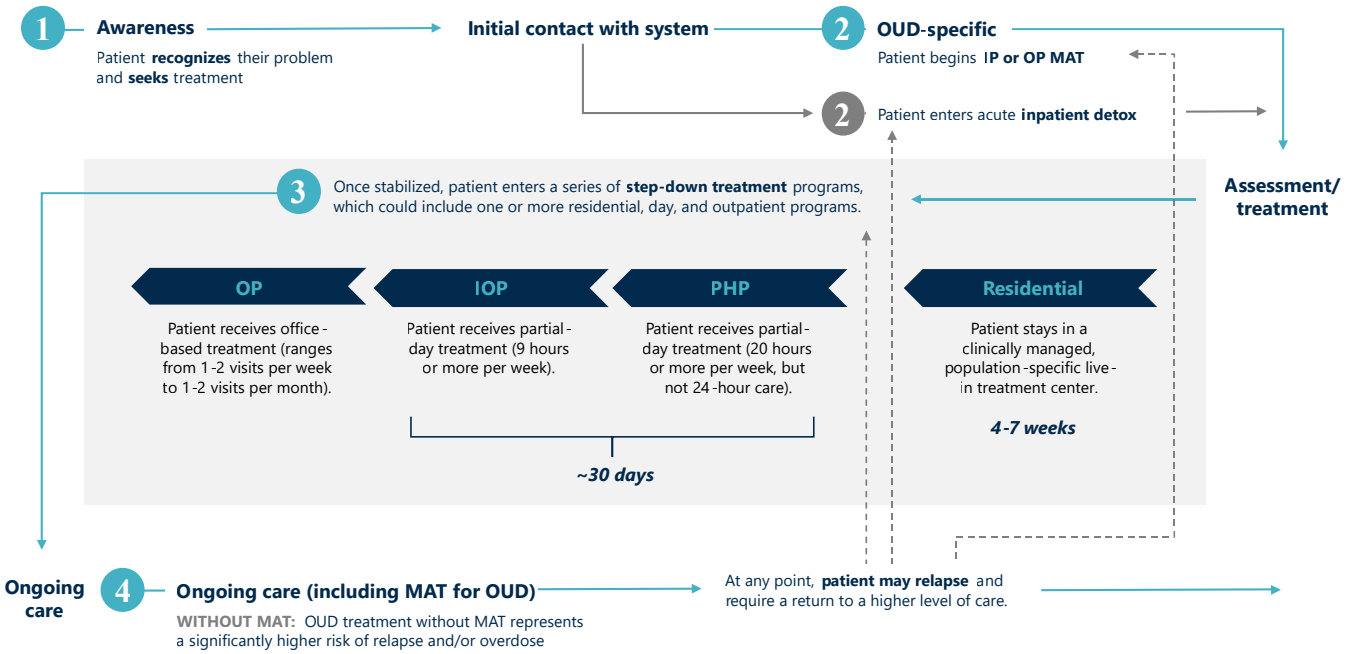
Enhancing access and coordination across the care continuum

The longer patients can stay in treatment, the more likely they will maintain sobriety. Patients receive care in many different settings, including inpatient settings for medical detox and residential programs and sober houses for supervised inpatient recovery. In addition, day programs (intensive outpatient or partial hospitalization) and general outpatient services exist for patients who can live independently and work. Where patients seek and receive care will vary depending upon the severity of their condition, cost and insurance coverage, preference, and availability of services.

Therefore, patients need access to services across the continuum to stay engaged with care. The journey (including entry points and paths) will vary depending upon the patient condition, acuity, and preferences for care. Many patients are initially admitted to a residential treatment center for treatment of their SUD condition. After treatment, patients transition to less-acute services that might include intensive outpatient, partial hospitalization programs, or general outpatient programs. Patients may receive treatment at home or may need a safe alternative to home (sober living).

It's also important for the programs to support patients with co-occurring MI across the continuum of care. That may include offering programs for patients whose primary issue is an MI condition (e.g., anxiety, depression, or post-traumatic stress disorder).

FIGURE 3: HOW TO SUPPORT ACCESS ACROSS THE SUD CARE CONTINUUM



Approximate revenue by site of service	RESIDENTIAL*	PHP	IOP	OP
	$250-$1,400 per diem	$375-$425 per visit	$180-$250 per visit	$50-$90 per visit

*Residential care spans ASAM acuity levels 3.1: Long-Term Residential Treatment, 3.5: Short-Term Residential Treatment, and 3.7: Inpatient Residential Detox. While all levels are residential, the level of clinical intensity, patient acuity, and treatment duration can vary significantly.

OUD: opioid use disorder
IP: inpatient care
OP: outpatient treatment/therapy
MAT: medication assisted treatment
PHP: partial hospitalization program
IOP: Intensive outpatient treatment

Regardless of where and when patients receive care, access to MAT (e.g., suboxone) is a necessary component of care. Patients receiving MAT have a 50% reduction in mortality (both all-cause and overdose mortality), lower rates of other opioid use, improved social functioning, reduced risk of HIV and HCV, and better quality of life. An NIH study demonstrated that patients were four times more likely to stay in treatment if on MAT.[5] And to stay on treatment, programs should offer and manage MAT across all parts of the continuum.

Unfortunately, the fragmented landscape of SUD services makes it challenging for patients to access the full continuum. While successful SUD providers may not need to own assets spanning the entire continuum of MI and SUD services, organizations must be able to help patients successfully facilitate access through a network of provider partners that support and maintain treatment continuity for patients at vulnerable transition points.

GOAL 2

Developing robust clinical programming and targeted programs

Addiction is an "equal opportunity" scourge, crossing social and economic boundaries, and affecting individuals of every age, race, ethnicity, culture, gender identity, and sexual orientation. However, certain populations are considered at higher risk for becoming addicted and/or experiencing a medical, psychological, and social impact of addiction. Comprehensive programs invest in robust clinical programming that offer a diversity of experiences for patients and clear expectations/targets across their course of treatment.

Market leaders should include features that address the cultural, clinical, and other needs specific to the population served. These include:

- **Women** often have a significant difference in how they experience SUD, according to a report from the National Institute on Drug Abuse.[6] Although women often have a shorter history of using substances, they tend to have more severe medical and psychosocial challenges when being treated. More than a third of women have experienced physical violence from someone they know intimately, which is a risk factor for depression and SUD. Women with SUD who are pregnant have specific medical needs to protect both mother and child and support the mother's psychological needs during the perinatal period.
- **Adolescents and young adults** are susceptible to experimenting with substances that could lead to addiction, which accounts for the fact that addiction often begins in adolescence.[7] Addiction risk factors include having peers who use drugs, certain behavioral profiles (e.g., impulsiveness), and familial factors, such as lack of parental supervision. In addition to addressing these risk factors, programs for this group need to be segregated from programs for adults for legal reasons.

- **LGBTQIA+ individuals** are also susceptible to developing SUD conditions and less likely to receive treatment for those conditions.[8] Notably, programs specifically geared toward this population are more effective. They deliver a greater likelihood of completing treatment, better clinical outcomes, and greater satisfaction with treatment. However, most SUD programs do not have providers with experience and who are culturally competent working with LGBTQIA+ patients.

- **Active-duty service members and veterans** have increased risk of developing SUD, which is associated with the challenges of military service.[9] Many veterans with SUD also have co-occurring MI, such as PTSD, anxiety, and depression. Successful treatment for this population needs to address barriers. That includes improving insurance coverage, destigmatizing the condition, and mitigating the negative consequence related to work by ensuring confidentiality.

- **First responders (e.g., police, emergency medical services members, and firefighters)** are at particularly high risk of addiction.[10] Studies have found that 58% of firefighters had episodes of binge drinking behavior, with 40% of female firefighters binging in the previous month.[11] Often first responders will turn to alcohol or pain medication to temporarily relieve the negative consequences of this chronic traumatic stress or their chronic sleep deprivation. Treatment focused on improving sleep is, thus, important. The stigma of seeking treatment is related to fear it would be perceived as a sign of weakness that would make them unfit to do their job. Counseling during recovery from peers who are first responders provides a safe space to share their experiences and helps normalize the condition.

- **Physicians** have a high rate of alcohol use disorder. In a 2015 survey of more than 7,000 physicians, 12.9% of male physicians and 21.4% of female physicians met diagnostic criteria for alcohol abuse or dependence.[12] Due to ready access to opioids, certain specialties, such as anesthesiology, have a higher likelihood of opioid use disorder.[13] Physicians face additional challenges in seeking care related to concerns about the loss of their professional license, requiring specific legal and regulatory guidance. Most states have physician health programs, often sponsored through medical societies, that assist impaired physicians in treatment, recovery, and monitoring. The goal is to enable physicians to reassume their professional roles.[14]

- **Individuals in treatment court** is another at-risk group.[15] Drug courts have become an important avenue for treatment for nonviolent offenders with drug-related offenses as well as individuals with extensive criminal histories for whom prior SUD treatment has not been effective. As an alternative to incarceration, referral for SUD treatment provides an effective incentive for patients with SUD to seek and stay in treatment. As of 2019, there were approximately 4,000 treatment courts, serving approximately 140,000 adults and juvenile individuals. These programs have a strict set of requirements for participants that focus on maintaining recovery through significant modifications in their lifestyles. The results are impressive, with reports of reduced recidivism (maintaining sobriety) for some programs as high as 40%. A 10-year study demonstrated a public savings of $6,444 per participant. Programs for these individuals are uniquely different from other programs, including higher Medicaid case mix and requirements for integrated support from legal, medical, and community teams throughout the recovery process.[16]

GOAL 3

Measuring and demonstrating value in care delivery

Demonstrating tangible value in care delivery will become increasingly important, and future value-based care models must include medical costs. The total cost of treating patients with BH conditions is significant. In one study of 162 million employer-sponsored insurance recipients, attributable medical costs to SUD were $15,640 per capita and $35 billion annually.[17]

Another study evaluated 21 million individuals with commercial insurance, focusing on the increased cost of treating their medical, not behavioral health, conditions: Among the 10% of patients with the highest costs, 57% of patients had BH conditions, averaging $45,782 per capita. But only $2,620 of that went to BH care.[18]

Within the same study of individuals with commercial insurance, patients with SUD accounted for only 4% of the population, but they account for 14% of the total group's healthcare spend—a disproportionate spend multiple of 3.5 times, compared to 1.8 times for individuals with mental illness only and 0.6 times for patients who have neither mental illness (MI) nor SUD (see Figure 5).[19]

FIGURE 4: THE DISPROPORTIONATE ECONOMIC IMPACT OF PATIENTS WITH SUD[20]

Patient population	% of study population	% of total healthcare spend	% of total healthcare spend
No MI or SUD	73%	44%	0.6X
MI, no SUD	23%	42%	1.8X
SUD	4%	14%	3.5X

Given the impact of BH conditions on medical spend, one might expect that the industry would be further along on the value-based care journey. One challenge is that managed care organizations have historically "carved out" BH, making it difficult to realize the benefits of reducing medical spend by investing more in behavioral healthcare. Fortunately, this is changing.

Also, payers are aware of the importance of holistic care for patients with SUD, both in improving quality of life and reducing costs. As payers continue to focus on maximizing outcomes, they need to consider enhanced per diem rates or case rates for providers that demonstrate an ability to keep patients in the care system, regardless of setting. This is particularly important during transition points in treatment when recidivism is most likely to occur: detox to recovery, residential treatment to day programs, and day programs to general outpatient programs. Payers should also create incentives for providers to institute and maintain MAT throughout the course of treatment.

Providers that are professionally managed and scaled will be most effective

Ultimately, the success of a SUD platform will require focus on the following six areas:

- **Dedicated compliance, quality, and safety programs:** Providers need to invest in a robust compliance, quality, and safety infrastructure that can respond effectively to regulatory scrutiny and mitigate compliance fraud and abuse risk. More importantly, this will provide patients and their families with confidence and trust that they will receive safe, high-quality care.
- **Effective and efficient business development:** Providers can foster preferred provider partnerships as important referral channels, particularly with large health systems (with particular focus on emergency departments) that lack the expertise of managing SUD. Providers should also identify channels to reach patients directly. This includes creating communication that destigmatizes treatment.
- **Strategic payer engagement:** Providers can improve in-network status and rates with key payers by demonstrating value in cost/quality metrics and by transitioning to value-based contracts at the appropriate time.
- **Leading clinical operating models:** Providers can build integrated multi-disciplinary care models to maximize patient outcomes. The models should be designed to achieve the following goals: keeping patients in care for maximally allowed days, reducing early discharge against clinical and medical advice, and ensuring that patients are actively supported by a coordinated care team across their experience.
- **Value-add technology and administrative capabilities:** Leading organizations providing care for patients with SUD conditions leverage technology to enhance operations, clinical care, referring provider and family communications, compliance, and more. They also focus on enhancing performance in key functional areas that support better financial performance, such as revenue cycle management and accounting/finance.
- **Supporting progressions through the continuum of care:** Providers should identify and manage patients at risk of recidivism, particularly at key transition points. They can also improve MAT utilization in all settings.

Bottom line: SUD platforms that provide care across the continuum can deliver the greatest impact

The US healthcare industry is facing a growing crisis in the management of patients with SUD. To make a meaningful impact, **SUD platforms should provide care in a materially different way, offering highly coordinated, tailored care across the continuum.**

Fortunately, both providers and payers increasingly recognize that access to a broad range of SUD services is essential for managing the health of this population. That includes developing a highly coordinated and collaborative relationship between the parties.

Taking an incremental approach ensures that resources are directed toward the highest priority areas. The first step is to identify the gaps in care along the care continuum, understanding the specific needs of the population served. This should guide decisions about how to direct investment in the operational infrastructure to make the greatest impact.

Authors

Mark Wenneker, MD

Partner, Clinical Transformation, and Behavioral Health Service Line Segment Lead

mwenneker@chartis.com

Tom O'Toole

Partner, Strategic Transformation

totoole@chartis.com

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