We are in the midst of an era where there are incentives to push medications and pills for every illness, disease, or mental issue encountered. On the surface, it seems to make for a better business model; moving patients through the office “seemingly” faster. More patient turnover means more money coming in. More money coming in means a better ROI for those with a financial stake in the system. Unfortunately, this system has been routinely practiced for more than a decade. As we now know, as evidenced by the opioid epidemic that has swept the nation, there are huge consequences to these types of largely unchecked prescribing practices.

Staggering numbers of people suffering from chemical dependencies have died, wrecking families and communities. It has become such a prevalent social issue that the entertainment industry took notice and began producing movies such as Prozac Nation in an attempt to destigmatize the problem. An entire subset of the population has developed addictions to a wide range of substances, and in many instances, have resorted to illegal drug use to fulfill their dependencies when medical grade prescriptions became too expensive.

“The presence of a substance use disorder often doubles the odds for the subsequent development of chronic and expensive medical illnesses, such as arthritis, chronic pain, heart disease, stroke, hypertension, diabetes, and asthma”

-The Surgeon General’s Report on Alcohol, Drugs, and Health (2016)
The 2016 addiction report released by the Surgeon General revealed distressing insights into the sheer number of Americans currently suffering from, and diagnosed with, a Substance Use Disorder (SUD). Nearly 21 million people met diagnostic criteria for SUDs in 2015 alone. Of those 21 million affected, only 2.2 million received some sort of treatment. Furthermore, only 63.7% receiving treatment utilized a specialty SUD treatment program.

As we move into a new era of treatment focused on value-based care there is increasing dialogue and research being generated on the social determinants of health; those are the social, economic, cultural, and environmental factors contributing to the disparities in chronic diseases across the lifespan of an individual. This focus is especially important for understanding the causes of many chronic diseases, such as behavioral health and Substance Use Disorders.1

A problem facing both payers and providers is that long-term recovery from chronic illnesses isn’t always clearly defined. For example, a 2012 report found there was no clear consensus across the medical industry on addiction treatment and recovery methods or how to measure addiction treatment outcomes.2

This is a big problem for two reasons:

1. If providers disagree on the best treatment modality for a chronic disease, patients could be misled into ineffective treatment methods, creating unnecessary costs and possibly loss of life. In addition, with such disagreement there is not enough consistent and clear data to measure the efficacy of one treatment or outcome over another.

2. Without clear outcomes data, payers will find it increasingly difficult to effectively evaluate the performance of providers, make informed decisions on funding, and provide the greatest benefit and coverage to patients.
When assessing the social determinants of health, one area many industry analysts look to first is income levels. People in lower income brackets are disproportionately susceptible to increasing healthcare costs, especially when it pertains to chronic behavioral health conditions.

As is well known, healthcare costs are continuing to rise faster than the general cost of living. Multiple studies, including one performed by Health Affairs, have shown the price of healthcare will continue to rise year after year unless significant changes are made to directly combat financial outcomes.

The expense of healthcare creates barriers for certain populations and that expense, in combination with other social determinants of health, results in serious inequities in the distribution of healthcare in our society. Research performed at George Mason University shows the cost of healthcare for low-income people with chronic conditions increases by $4,500 annually compared to just $3,000 for higher-income people.8

These inequities are less obvious in behavioral health than in other segments of healthcare. The burden of responsibility for behavioral health treatment often falls on community centers, church organizations, and law enforcement, especially for those with SUDs. Formerly treated as criminals, a reclassification of the disease by the Affordable Care Act9 means the condition is now treated as a chronic one.

This distinction opened the door for providers to treat SUD patients clinically rather than having those patients cycle through the justice system without adequate treatment where they’re more susceptible to relapse and other severe consequences. The Surgeon General reports that substance misuse and SUD are estimated to cost society $442 billion each year in healthcare cost, lost productivity and criminal justice costs.

“[SUD] is something that impacts 21.5 million Americans in which only 2.2 million Americans are receiving services for Substance Use Disorder each year. Unfortunately, a lot of those are the same people due to high rates of recidivism.”

- Jacob Levenson, MAP CEO
Section II: The Guide to Better Outcomes

Expand the Continuum of Care

We know from our own research and experience in the field that patients suffering from SUD who are in recovery significantly reduce their risk of relapse if they sustain a recovery program for at least 12 to 18 months. Expanding the continuum of care to patients with chronic illnesses is the most obvious way to decrease the overall societal cost of treating and managing these illnesses. In the last decade, we’ve seen a shift away from fee for service, acute-care treatment toward a chronic-care model focusing on the entire continuum of care -- from prevention, detection, diagnosis, treatment, to post-treatment engagement and support which protects against relapse and helps further prevention across populations.

This is true not only for SUDs but also for chronic illnesses that exist as a direct result of SUDs. There are many correlations between substance misuse and chronic health issues such as cocaine and cardiovascular complications, alcohol with liver and pancreatic disease just to name a few. Because substance use complicates other medical conditions, early detection and management of misuse and/or SUD provides an opportunity to improve health outcomes and reduce costs.

The challenge faced by payers and providers when adhering to the continuum of care is eliminating unnecessary gaps in treatment along the continuum. One solution is to reward providers who utilize certified EHR technology to track transitions of care, and penalize providers who do not reduce readmissions. Information presented by the Kaiser Family Foundation suggests these measures have been successful as readmission rates have been falling since 2012.

The Department of Health and Human Services estimates 565,000 fewer Medicare patient readmissions from April 2010 through May 2015.

A concern for providers comes in the form of compensation:

If they’re not treating patients, how are they getting paid?

By extending the standard of care, providers can begin to be reimbursed by taking on a role in long-term recovery support. Expanding the continuum of care in behavioral health is not necessarily expensive compared to other arenas and with the accessibility of telehealth, populations throughout the country, even those which are considered underserved, can access long-term care.

Every dollar spent on SUD treatment saves $4 in health care costs and $7 in criminal justice costs.

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Post-treatment recovery support for SUDs is essential to proactively reducing the probability of relapse and/or return to lifestyle of active substance use. Reactionary treatment, in the case of treating after a use event, is far more costly compared to the cost of proactive, longitudinal support for a chronic brain disease.

A key aspect to expanding the continuum of care is to increase and improve patient engagement. More recently, payers have routinely expressed a direct desire to increase post-treatment peer-based recovery support. Peer recovery support specialists are individuals with lived experience in recovery from SUD and/or mental illness who use formal training skills to provide post-treatment recovery support services. Unlike traditional clinically-oriented providers, peer providers can address various aspects of this chronic disease and the process of recovery by drawing upon personal experience.

This type of support requires participation from all parties involved in the treatment process. A patient’s recovery support network should include supporting family members, post-treatment peer support providers, healthcare professionals, and the use of emerging technologies.

Thus, recovery support is a proactive, rather than reactive, means to support a patient in recovery from addiction / SUD.

This stance is supported by research compiled by the US Department of Health and Human Services which shows that effective recovery is facilitated by very specific forms of social support: emotional, informational, instrumental, and affiliational support. A study conducted in 2014 shows that about 74% of patients in the U.S. would use telehealth services. Telehealth / telephonic based engagement is just one of the ways that this type of support is being implemented. Another great example of emerging technology that can effectively support sustained recovery and collect valuable, real-time data appears in devices like the remote, hand-held breathalyzer.

Traditionally, this device has been primarily used to test alcohol levels, but more recently it has taken on a real-time data collection role. The device can track and report test result data to the appropriate members of a patient’s care teams allowing them to take appropriate preventative action in real-time before more serious consequences occur.

For example, someone in recovery from alcoholism that is meeting and passing regularly scheduled tests with their remote breathalyzer is probably at lower risk for relapse than someone who is all of a sudden skipping the tests all together.
It is no secret there is a big trend to integrate behavioral health into the primary care environment to enhance prevention capabilities. Primary care doctors are viewed as the highest touch point gatekeepers to identify and triage issues early preventing major issues and costs down the line.

We know today that an effective upstream identification method for SUD is Screening, Brief Intervention, and Referral to Treatment (SBIRT). This has become the industry standard for identifying signs of substance abuse because of its focus on early detection. SBIRT’s emphasis on early detection helps curb the cost of costly treatment down the line. Additionally, this type of detection doesn’t need to be performed by a physician. A patient screened by a registered nurse who finds signs of substance misuse can take appropriate action to effect a better outcome.

Upstream prevention methods are a critical component to identifying the underlying factors in addictions. In a study from BlueCross BlueShield, we see high-dose opioid prescriptions are more likely to result in opioid use disorder when compared to low-dose prescriptions. Monitoring patients who fill these prescriptions and identifying potential abuses early on is a key aspect of prevention.
Another key aspect to prevention is data. Historical data on a patient can be critical but is often missing, incomplete or inaccessible due to privacy restrictions and interoperability barriers between EHRs and other platforms. Without these kinds of preventative tools in place and without having behavioral health in the primary care environment, prevention will be much harder to achieve. The lack of comprehensive prevention strategies and appropriate early intervention only raises medical costs across the board and does not serve payer, provider, or patient well. The lack of comprehensive prevention strategies and appropriate early intervention only raises medical costs across the board and does not serve payer, provider, or patient well.

Improve Payer and Provider Collaboration

Collaboration through the collection and mobilization of actionable data and better alignment between payers and providers is at the heart of improving clinical and financial outcomes. In other chronic diseases, data informed treatment approaches are shown to reduce costs in the healthcare system. For SUD, establishing a standardized set of outcome measures and a mechanism to collect and apply them is imperative.

Providers in the SUD space have historically had very little scientific evidence to demonstrate efficacy of one treatment modality versus another to payers or health care consumers. Self-reported data from a treatment provider is difficult to trust especially when there are no standardized outcomes measures or mechanisms to collect the data in the first place.

A very basic example of standardized efficacy measurement in healthcare is an X-ray. An X-ray demonstrates evidence of the treatment provided because we can see the healed bone. We have irrefutably shown the efficacy of how a healed bone responds to treatment and we can rely on that science. Providers, payers, and the patient know the bone is stronger because of the objective efficacy measure.

“Providers and Payers have the same first priority: to provide evidence-based, quality healthcare and facilitate long-term recovery.”

-Mary Anderson, M.D. Medical Director Aetna

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This type of data is missing in behavioral health. However, long-term studies, with outcomes data, can become predictive over time. The payer and patient demand predictability, and, historically, providers have not been able to deliver predictability. Payers will continue to demand more definitive data in which to base their determinations of how long an individual will receive treatment, how long someone requires treatment, what type of treatment is most effective.

Another issue facing the field is fee for service being the dominant payment model for SUD treatment services to date. Fee for service is the primary reason why payer and patient have fallen victim to a wide range of quality and outcomes failures.

In order to improve outcomes and shift to value-based care in this field, providers need to be incentivized to extend care continuums as well as collect and demonstrate their outcomes so new and more effective payment models can be designed.

Expanding the post-treatment continuum of care and engaging the patient along that continuum can serve as the primary means for evaluating treatment efficacy. This simultaneously reduces relapse and readmission rates, not just for treatment, but also across other settings such as emergency room visits. The outcomes data collected from post-treatment support will help payers to understand the true value of treatment programs, justify/validate the effectiveness of a provider’s ability to treat a patient, and develop new payment models.

Outcomes and resources can become more predictable if we engage and support patients longer-term and, in that process, gather data and provide support and resources for effective recovery. Through this process, payers and providers will have more empirical data to make informed decisions and better outcomes across the board will be realized.

Creating Better Patient Outcomes and MAP

Because of the ever-changing nature of healthcare, there will always be room for improvement. Chief and most important among them is improvement in patient outcomes. Those improvements come from a number of places within the entire landscape of healthcare: increased collaboration and interoperability, data-driven and individualized care, patient and physician education, and advancements in technology to name a few.

With those improvements comes responsibility. Consumers have to be shown a new standard for evaluating treatment and support services that values the quality of service and outcomes above any other criteria, including amenities or luxuries that have been valued in the past.

There is a wealth of misinformation and misrepresentation available to consumers when it comes to researching treatment options for SUD and other behavioral health issues. This can mislead patients and their families, who are in dire need of effective treatment and help, to seek treatment with an organization that may
place profits above patient outcomes. With the plethora of marketing options available through digital advertising, this problem has only increased. This reality hurts the bottom line for providers who are delivering effective services in an oversaturated market, and for patients and payers who bear the burden and poor outcomes of ineffective treatment.

This misinformation and misrepresentation places the burden of consumer education on the part of the providers, payers, and industry leaders. This education involves informing healthcare consumers on what effective outcomes look like and creating and demonstrating new ways to evaluate service offerings that are data-driven. This effort improves the ability of patients to access effective care, increases the necessity for providers to deliver demonstrably effective services to compete, and creates a standardized expectation of service for value-based reimbursement.

MAP is working with payers and providers across the country to improve patient outcomes through technology-enabled engagement, data-informed care coordination, and real time and predictive data analytics.

Footnotes


5 https://appam.confex.com/appam/sc17dc/webprogram/Paper20668.html

6 http://www.investopedia.com/articles/personal-finance/072116/us-healthcare-costs-compared-other-countries.asp


8 https://appam.confex.com/appam/sc17dc/webprogram/Paper20668.html


