

Welcome
2015
**OEAP Annual Resource
Conference**



*Understanding Substance Abuse:
Current Trends in Treatment and Recovery*

September 15, 2015
State Fire Marshal Training Academy

Substance Related Disorders: Innovations in Treatment and Recovery

Learner's Guide

Presenter: Joseph Hullett, MD
National Medical Director, Optum Behavioral



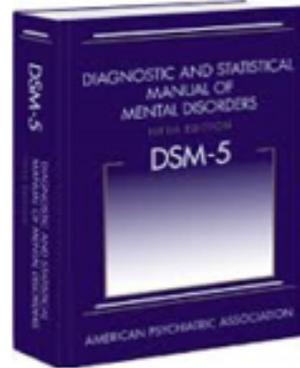
What's New in Diagnosis?



Notes: _____

New criteria (DSM-V)

- Substance intoxication and withdrawal categories remain
- Substance abuse and dependence categories have been eliminated
- A new, over-arching category of "Substance-related and Addictive Disorders" includes abuse and dependence among eleven criteria that define individual Substance Use Disorders
- Substance **use** is framed as a normative behavior that may or may not be associated with signs/symptoms that define a use disorder
- Substance use disorders are patterns of use associated with 2 or more specific signs/symptoms within the previous year



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Notes:

Signs and symptoms of substance use disorder

- Basically the same as in DSM-IV
 - A criterion of criminal involvement was eliminated; craving was added
 - Addiction (compulsive harmful drug use) may or may not be part of a substance use disorder and may or may not involve dependence (physiological response to stopping use)
- Criteria for Substance Use Disorder
 - Consuming more than originally planned
 - Worrying about stopping or consistently failed efforts to control use
 - Spending a large amount of time using drugs/alcohol, or obtaining them
 - Use results in failure to "fulfill major role obligations" (home, work, or school)
 - "Cravings"
 - Continued use despite mental/physical health problems caused or worsened by it
 - Continued use despite negative effects in relationships
 - Repeated use in dangerous situations (e.g. driving, heavy equipment operation)
 - Giving up or reducing other activities because of drug/alcohol use
 - Tolerance – needing larger amounts to get the desired effect or noticing less effect from repeated use of the same amount
 - Withdrawal – physical symptoms related to stopping use (e.g. anxiety, irritability, depression, fatigue, insomnia, nausea/vomiting, cramps, tremor or seizure)

2-3 = Mild 4-5 = Moderate 6 or more = Severe



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Notes:



What's new in Benefits?



Notes: _____

Beyond the Procrustean bed

- Almost from the beginning, substance abuse treatment was a bed that people were stretched to fit – the 30 day, residential program
- Costs per individual were high, dropout and relapse significant
- Little evidence supported the superiority of such approaches
- Evidence based criteria for hospital (inpatient) care and detoxification were relatively clear and accepted; however, criteria for residential rehabilitation were politically charged
- Plans typically adopted the second Procrustean method: provide a bed far too small and cut off the feet to fit (i.e., dollar/course of treatment limits that effectively excluded treatment)



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The Mental Health Parity and Addiction Equity Act created a rich new benefit

- Plugged loopholes in the 1996 Mental Health Parity Act from which substance abuse benefits had been excluded
- Effective 1/1/12, annual dollar/day or course of treatment limits were prohibited for most plans
- Geographic limitations could be no more restrictive than those for medical benefits
- Out of network benefits (if offered) had to be at par with those for medical
- Out of pocket expenses were capped
- In effect, an entirely new, unlimited benefit was added to employer plans
- Simultaneously, constraints on OON utilization were weakened



The **parity** bed



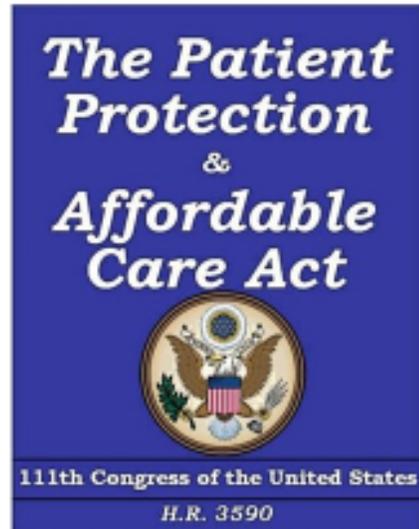
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Affordable Care Act (ACA) added new populations:

- Persons previously excluded by restrictions
- Persons previously uncovered who obtain subsidized exchange coverage
- 18-25 y/o **dependents**
 - Prior to ACA 18-25 y/o in most employer plans were healthy; however, plans dropped 18 year olds not in school
 - Thus, 18-25 y/o in commercial plans had jobs, were married to workers or were in college – all predictors of mental health
 - Actually, the incidence of both major mental disorder and significant substance abuse peaks during this time; but sufferers were less likely to have remained on commercial plans
 - Plans experienced significant unexpected trends post-ACA attributable to this cohort



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What's new? More people getting needed treatment



But...

- Employer MH/SA costs skyrocketed over 2012 and 2013
- A significant portion of the trend was due to substance abuse treatment costs related to 18-25 y/o dependents
- An enormous driver was destination, out of network care that was often not-evidence based and less effective



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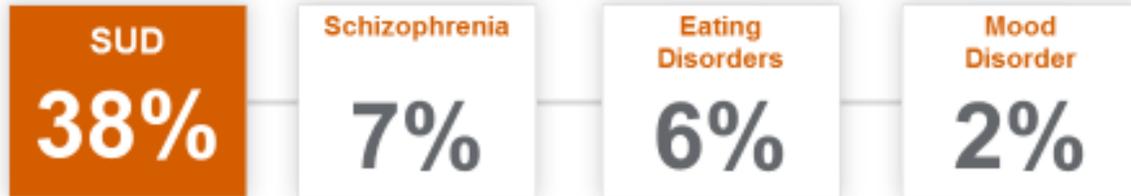
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Cost drivers: Case complexity

Substance use disorder

accounted for the majority of Optum costs in 2013¹



National SAMHSA prevalence estimates of comorbidity with other behavioral conditions²

32.4%

had a co-occurring substance use disorder, among those **with a mental illness**

40%

had a co-occurring substance use disorder among those **with a severe mental illness**



1. Optum analysis of percentage of treatment cost per diagnosis category versus total behavioral treatment incurred Jan 1 through Dec 31, 2013 (paid through Mar 31, 2014 (not including incurred but not reported (IBNR)-claims)) for dependents aged 18-25 among national AHO and fully insured, PACE/POP/S membership; Issues, Risks and Costs (IRC) 14. 2. Substance Abuse and Mental Health Services Administration. (2011). Results from the 2012 National Survey on Drug Use and Health: Summary of national findings (2011-Publication No. SMA 11-476). NSDUH Series 11-48.

Notes: _____

18-25 year old dependent trend

41% increase in **overall PMPM costs** for this cohort over the past two years¹

80% increase in PMPM costs for this cohort **with substance use disorders**¹

Key drivers

-  **More people entering the system**
11.4% overall increase¹ due primarily to extended coverage under the ACA
-  **Increased use and intensity of services**
primarily in residential settings and ancillary lab testing
-  **General increase in opiate treatment**
due to a combination of prescription and illicit drug use



1. Optum analysis of behavioral care costs and population increases (comparisons of incurred dates Jan 1 through Dec 31, 2011, paid through Mar 31, 2012) (not including incurred but not reported (IBNR) claims) against Jan 1 through Dec 31, 2010, paid through Mar 31, 2011, (not including IBNR claims) for dependents aged 18-25, among national, ACO and fully insured, HMO/POS membership, 99999, Husband and W/O, 99294.

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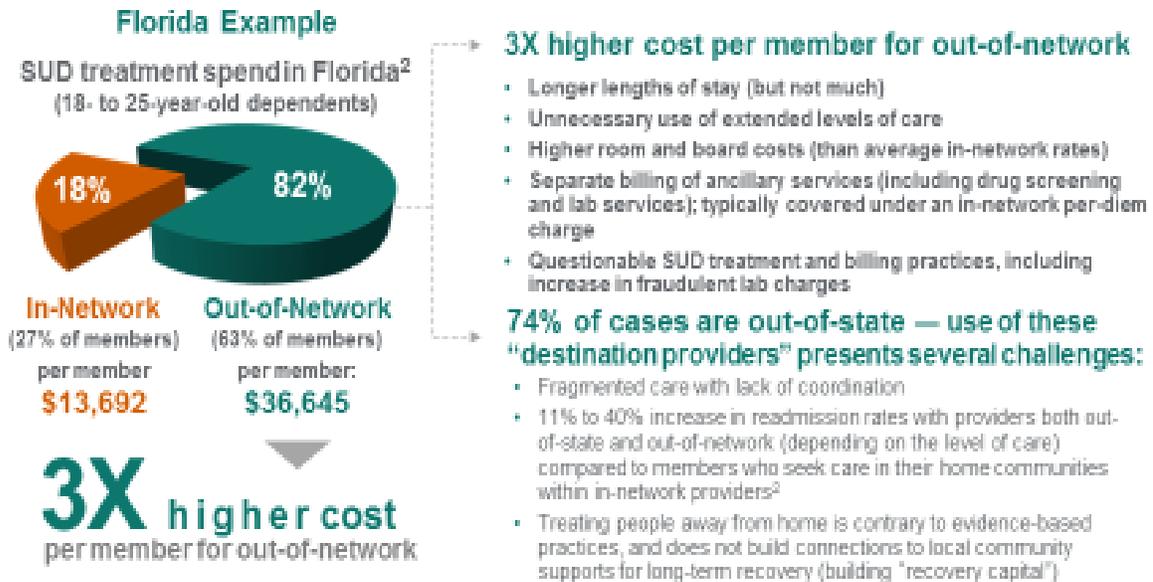
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The out-of-network challenge for this cohort

36% of our overall utilization spend is driven by out-of-network service — driving a 79% increase in PMPM costs from 2011 to 2013¹



1. Optum analysis of inpatient care costs and population trends by comparison of in-network rates Jan 1 through Dec 31, 2011 and through Dec 31, 2013 (not including incurred but not reported (IBNR) claims) against Jan 1 through Dec 31, 2012 and through Dec 31, 2013 (not including IBNR claims) for dependent ages 18-25 using national ICD procedure codes, ICD-9-CM procedure codes, ICD-9-CM diagnosis codes, and ICD-9-CM procedure codes. 2. Optum analysis of inpatient care costs among 18- to 25-year-old members using ICD-9-CM procedure codes for non-acute substance abuse treatment that developed in 2010, 2011, and 2012. Includes the complete book of business (national) ICD-9-CM procedure codes. Analysis includes comparisons between in-network vs. out-of-state out-of-network and in-network vs. out-of-network, in-out and readmission rates, 2011-2012, 2012-2013.



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Inappropriate Drug testing

Some treatment providers and sober home operators are being offered a chance to share the profits of their patients' and residents' drug tests

Examples of typical stratagems

1. Billing for *quantitative* tests (how much of a drug is present) when there are no positive initial *qualitative* (presence of a substance) results*
2. Charging excessive amounts beyond usual and customary for lab tests
3. Excessive drug screenings during a Residential stay (screening up to five times a week when the patient has not left the facility)
 - Facility tests residents via a single screen for up to 15 substances
 - If that single screen comes up positive, the specimen then goes to confirmation testing to determine which of the 15 substances it was positive for (\$100 for each confirmation) = \$1,500 a test

Five tests per patient per week X \$1,500 per test = \$7,500 per patient per week

ALCOHOLISM
DRUG ABUSE WEEKLY

Drug testing 'partnership' lures treatment centers despite ethics issues

"With an out-of-network payment, there's no utilization review, no contract and no tracking, and the patient co-pay gets written off"

"The people getting ripped off are the insurance companies, and the people paying premiums, whose rates are going up because of these scams"

— Alcoholism & Drug Abuse Weekly, March 17, 2014



*A qualitative lab test detects the presence of a substance, a toxin or a drug without measuring the amount. A quantitative test measures the amount. Only if the qualitative results are positive should a quantitative test be conducted.

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Finding treatment: MBHO more helpful than the Internet

When patients look for treatment on the Internet, they are at the mercy of call centers and websites that may divert them to certain programs based on their insurance coverage. This is where managed behavioral health organizations (MBHOs) can, if given the opportunity, help the patient navigate what has become the increasingly competitive and often unethical business of Internet marketing, *ADAW* has learned. The

Bottom Line...

Managed behavioral health organizations can help patients navigate the scams of the Internet when seeking treatment.

holy grail for these programs is the patient with out-of-network coverage — something that has MBHOs scrambling to try, often unsuccessfully, to intervene. It's only when patients contact their insurance company for assistance in finding a program, or when they go to an in-network program, that the company can help find quality care that is affordable.

"We encourage members to call us for assistance," said Joseph Hullett, M.D., national medical director for Optum Behavioral Solutions, based in Santa Ana, California. "But one of the things we've seen is that people will just Google, and the first

[See MBHOs page 2](#)



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What can we do?



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Adaptation – intelligent design or survival of the fittest?



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Intelligent design

- Optum in 2012 chartered a company wide group charged with a white-board rethinking of our approach to both substance abuse treatment and management with a goal to improve quality of care and thus **outcomes**.
- Expert led workgroups looked at
 - Evidence based best practices for treatment
 - Resource/treatment gaps (e.g. MAT)
 - Treatment outcomes
 - Objective provider ranking of quality and efficiency
 - Best practices for care management
 - Guidelines
 - Training and job aids
 - Supervision and accountability
- Implemented a system wide retraining/retooling



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Lesson 1: state of substance use treatment is poor



- "Current approaches to risky substance use are inconsistent with the science and evidence-based care." ★
- "Most of those currently providing addiction treatment are not equipped with the knowledge, skills or credentials necessary to provide evidence-based care."
- "Detoxification frequently is considered treatment rather than a precursor to treatment."

- The National Center on Addiction and Substance Abuse at Columbia University, June 2012

Why?

- Limited benefits and high out of pocket expenses made SA treatment unprofitable
- Little impetus to invest in research, treatment improvement, or training
- Treatment providers, often underpaid, were philosophically-experientially motivated, often undertrained, and science averse



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Evidence-based practice

- Interventions are “evidence based” when consistent scientific evidence has shown them related to preferred client outcomes
 - Types and hierarchy of evidence
 - Controlled scientific studies
 - Consensus opinions/guidelines
 - Individual, small-n reports
- Not proven effective, however, does not mean proven ineffective
 - e.g. Client retention in treatment is also tied to positive outcomes.
 - Methods that demonstrate improved retention may be preferable to evidence based practices for which retention was a variable insufficiently incorporated in study design
- Evidence based practice means that evidence **informs** professional expertise and client values



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Notes:

13 Principles for Effective Drug Treatment

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available.
3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.
4. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
6. Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.
9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.
10. Treatment does not need to be voluntary to be effective.
11. Possible drug use during treatment must be monitored continuously.
12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at the risk of infection.
13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.



Notes:

Effective treatment is comprehensive

Components of Comprehensive Drug Abuse Treatment



The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.



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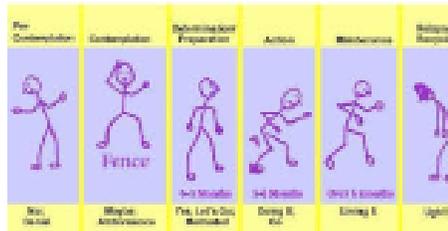
Effective treatment is “manualized” and goal directed



Notes:

Growing evidence base supports

- **Cognitive behavioral interventions** — Manualized approach to psychological awareness and skill-building via focus on thoughts and feelings and their connection to behaviors as well as exercises and exposure
- **Community reinforcement** — Connects the client with community services
- **Peer based facilitation** —Offers individualized alternatives to 12-step (e.g., SMART Recovery, on-line groups, individual peer support)
- **Motivational enhancement therapy** — Uses non-judgmental, motivational interviewing strategies and interventions based on a stages of change model
- **Contingency management** — Uses behavioral contracting where clients have opportunities to earn rewards for specific behaviors (particularly effective with stimulant users).
- **Systems treatment** — treating clients in their natural social environment. Couples therapy, family therapy and multi-systemic family therapy are all examples of systems treatment models
- **Pharmacological (MAT) therapies** — Uses specific medications for substance abuse (e.g. Antabuse, naltrexone, buprenorphine, acamprosate, methadone) to reduce cravings, relapse, foster engagement in treatment, allow for skills building. Also included are medications needed to treat behavioral and medical co-morbidities (e.g. pain)



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Other areas of increased attention

- Delivery system redesign that encompasses a collaborative, more integrated approach to care with decision support tools and shared information
- Individualized recovery focus that may involve harm-avoidance as opposed to abstinence (e.g. planning for relapse and controlled use)
- Person-centered care that incorporates the patient's wants, needs, and preferences in an individualized recovery plan that promotes informed decision making through a partnership of member, provider and family
- Attention to special needs (e.g. women (financial independence, pregnancy, child care), minorities, youth, elderly, 18-25 y/o dependents, homeless, incarcerated, psychiatrically and medically comorbid)
- Personalized (local) care management
- Encouragement of community treatment



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Notes:

Consumer Survey: Results

Top 5 Most Helpful Elements Care					
Individual		Family		Family with Loss	
Mutual aid group		Mutual aid group		Clean Environment	
Family and friends		Clean environment		Family and Friends	
Peer support		Family and friends		Peer Support	
Clean environment		Peer support	Tied	Mutual support	Tied
Relationship to counselor		Relationship to counselor			
		Medications		Individual counseling	
Top 5 Difficulties Getting Care					
Insurance issues	58%	Delay in getting help	38%	Cost of care	58%
Cost of care	58%	No follow-up after care	38%	Availability of care	
Delay in getting help	48%	Insurance issues	29%	No follow-up after care	
Availability of care	48%	Cost of care	29%	Insurance issues	50%
No follow-up after care	33%	Too far away	29%	Delays in getting help	42%
Top 5 Elements in Defining Recovery					
Abstinence	80%	Improved functioning	80%	Improved functioning	100%
Improved functioning	83%	Abstinence	73%	Improved relationships	92%
Maintain focus on recovery	80%	Improved relationships	67%	Reduction in depression	83%
Improved relationships	79%	Improved physical health	63%	Reduction in anxiety	
Improved physical health	71%	Maintain focus on recovery			improved physical health
		Stable Mood			
Top 5 Care and Support Settings					
Mutual aid group	66%	Mutual aid group	39%	Detoxification (IP)	50%
Outpatient counseling	25%	Detoxification (IP)	39%	Residential care	40%
Residential care	23%	Residential care	29%	Outpatient counseling	30%
Detoxification (IP)	22%	Outpatient counseling	25%		
Community-based support	20%	Community-based support	21%		



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Consumer Survey: Results

Importance of Treatment to Recovery					
Individual		Family		Family with Loss	
Essential	89%	Essential	54%	Essential	33%
Very helpful	15%	Very helpful	11%	Very helpful	8%
Hindered	2%	Hindered	0%	Hindered	0%
Made no difference	5%	Made no difference	21%	Made no difference	50%
No treatment	9%	No treatment	14%	No treatment	8%

Top 5 Attributes of Ideal Treatment					
Experience in addiction	75%	Experience in addiction	80%	Offer variety of pathways	75%
Staff in recovery	73%	Offer variety of pathways	67%	Licensed or accredited	67%
Offer variety of pathways	68%	Staff in recovery	60%	Experience in addiction	
Expectations of recovery	63%	Expectations of recovery	57%	Expectations of recovery	50%
Licensed or accredited	39%	Ind. Counselor licensed		Staff in recovery	



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Notes:

Barriers to adoption of best or better practice

- Difficulty interpreting the evidence
- Incompatibility with agency values and procedures
- Poor visibility into peer comparison
- Rapid changes foster hesitancy
- Traditionally, medical advances are reluctantly adopted (research to practice is about 15 years)
- Need for training and supervision
- Physicians and medications may not be available
- Reimbursement and profit margins



Notes:

Member Partnership vis a vis Out of Network Care

- Develop strategy to discourage destination treatment for SUDS
 - Educate members after destination treatment episode of benefits of local care (FBI 2.0)
 - Enhance referral process from EAP to support local treatment
 - Develop counter-marketing strategy
 - Incent adoption of ambulatory treatment locus
- Explore new case management services to improve treatment outcomes and reduce readmissions
- Implement "Sherpa" program to assist parents of adult dependents to locate evidenced based INN treatment or recovery options
- Explore opportunity for MBI with chronic pain, ER and other populations



Notes: _____

Continuing to bend the quality/affordability curve

- Prevention and Education
 - Education & Motivation
 - Screening
 - Self-help interventions
- Professional training
 - Evidence based practice guidelines
 - Screening tools (CIWA, COWS, etc.)
 - Promote full Psychiatric evaluation to address psychiatric co-morbidity
 - Medical assessment
 - Appropriate lab use
- Early intervention/treatment
 - Patient Engagement & Education
 - Detox Tapers; Sx-Driven (EBP)
 - Motivational Interviewing,



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Bending the curve (cont.)

- Rehabilitation
 - CBT, Contingency Mgt., Cue Exposure Tx., etc.
 - MAT (where indicated) in conjunction with psychosocial Tx.
 - Stage appropriate treatment choices
 - Dual Diagnosis (Dx, Rx & Tx)
- Supports
 - On line chat (in the works)
 - Wrap around Care Advocacy service
 - Mobile phone apps
 - Community Supports, Recovery Coaches, & Services
 - Relapse resources
- Network management tools directed at outcomes (P4P, practice management, alignment of provider incentives)
- Refinement of our stratification algorithms to better channel SUD subtypes and populations (e.g. 18-25 dependent)
- Improve InNet access and responsiveness
- Counter-marketing pilots to address destination facilities
- Refine our SUDS facility tiering to better utilize high quality/high-efficiency programs
- Incorporate longer term 6 mo and 1 year outcomes measures into contracting and steerage



Notes: _____



Medication Assisted Treatment (MAT)



Notes: _____

M.A.T. – Background

- Why is medication assisted treatment so shunned?
 - Some meds may be enabling or cause relapse, but all medication is often suspect, e.g. lithium, antidepressants
 - There is a prevailing ambivalence about addiction as a medical rather than a motivational disorder
- Hence, except for detoxification and occasional acceptance of Antabuse, rehabilitation has been left to psychosocial therapies + 12-Step participation
- Methadone maintenance was the first “breakthrough” but opposition continues
- Data shows medication **magnifies** counseling effect
 - Methadone and Suboxone: no meds=no patients
- Data shows counseling **magnifies** medication effects, especially for patients with significant psychosocial problems



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Evidence based medication-assisted detoxification

- Medication assisted detoxification should be individualized and symptom driven, not per schedule
- Phenobarbital should be avoided for alcohol and most-sedative tranquilizers
- For alcohol a symptom driven benzodiazepine substitution and taper
- For anxiolytic dependence a gradual outpatient taper is often needed
- Extended Buprenorphine (Subutex) and Buprenorphine/ Naltrexone (Suboxone or Zubsolv) detoxification for opiates; however, methadone may be indicated for significant heroin addiction or based on history of failure



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Notes:

Evidence based medication-assisted rehabilitation

- Opiates
 - Suboxone or Zubsolv extended taper or maintenance (implants?)
 - Methadone taper or maintenance
- Alcoholism
 - Naltrexone: daily oral or monthly IM (Vivitrol)
 - Antabuse
 - Campral
 - Topamax (off label)
- Amphetamine (naltrexone?)
- Cocaine (Modafinil?)
- Nicotine
 - Nicotine replacement (agonist)
 - Bupropion SR (Zyban®) (antagonist)
 - Varenicline (Chantix®) (partial agonist)

Learning to live
without drugs



one step at a time...

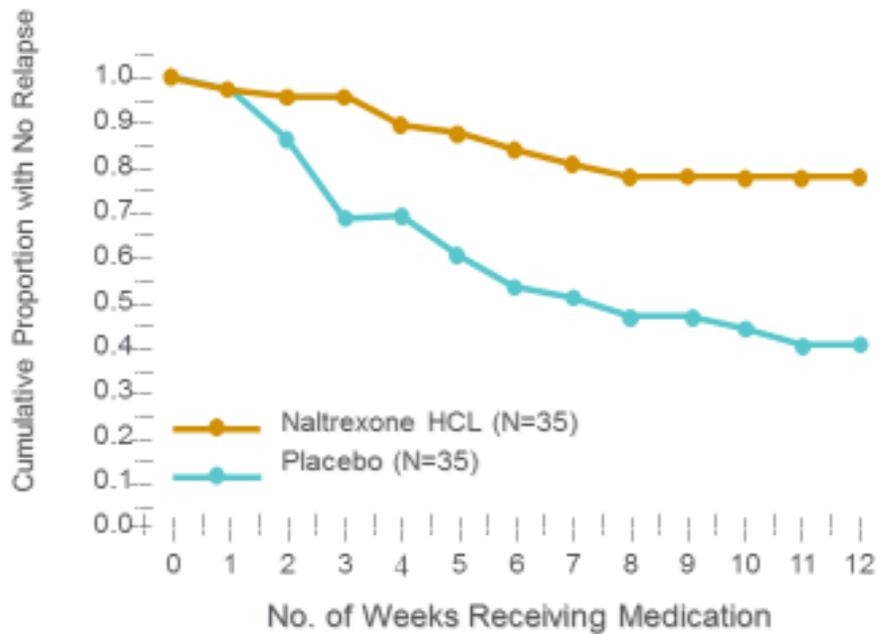


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Naltrexone in Alcohol Rehabilitation: Non-relapse



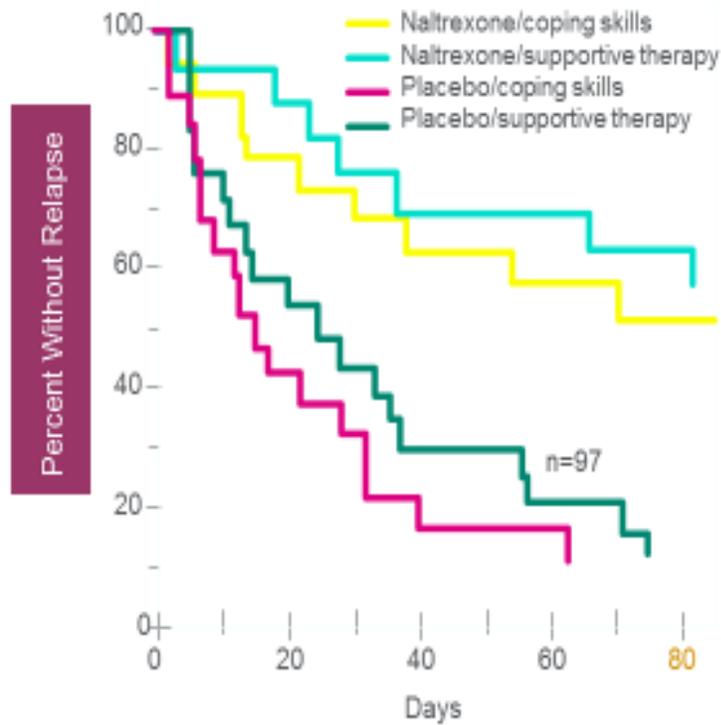
Volpicelli et al, Arch Gen Psychiatry, 1992; 49: 876-880

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Naltrexone in Alcohol Rehabilitation:



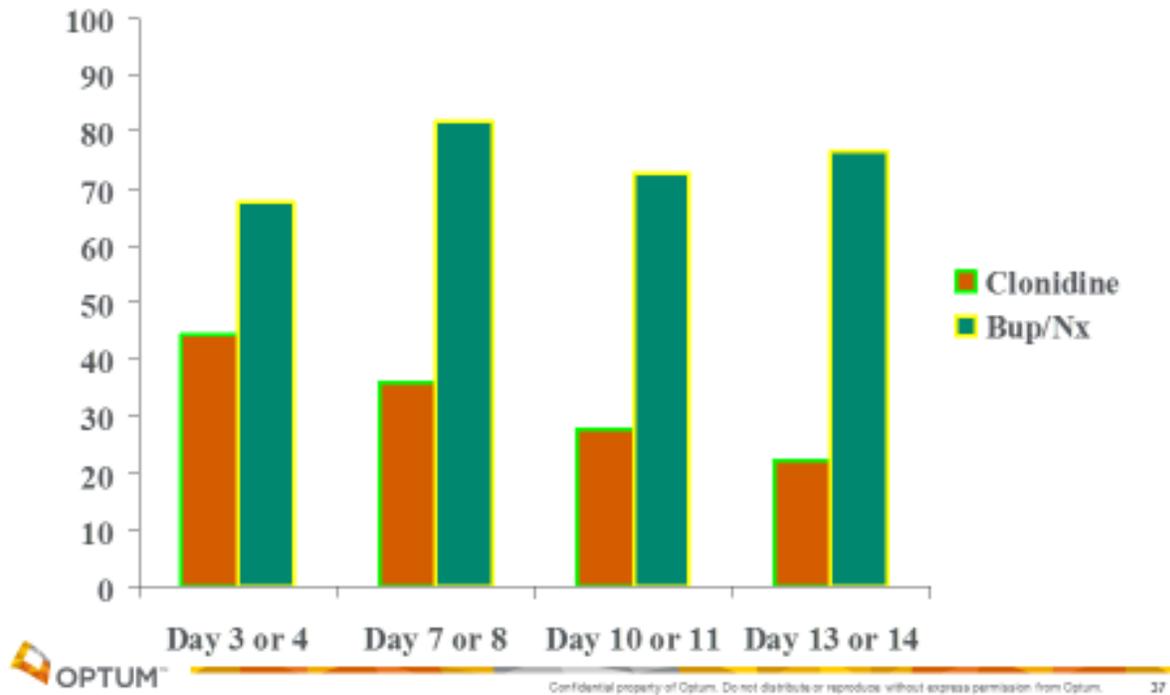
O'Malley et al. *Arch of Gen Psychiatry*, Vol 49, Nov 1992

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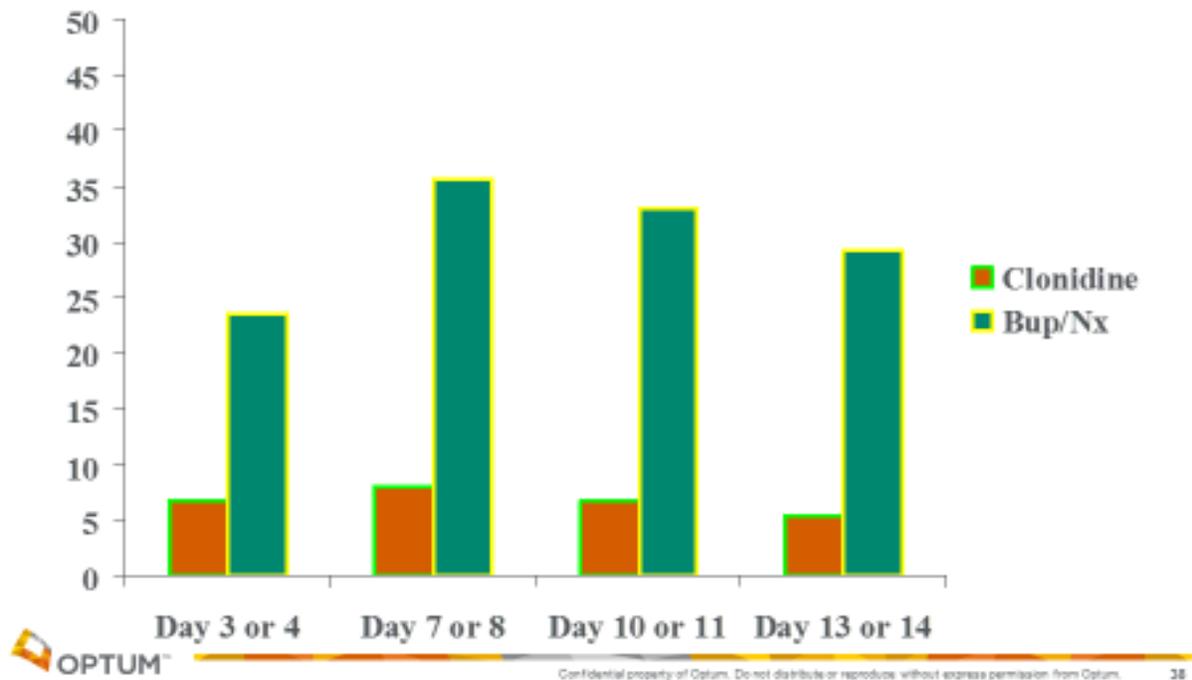
Notes:

Clonidine vs. Buprenorphine: Percent Present and Clean from Inpatient detox at Days 13-14 (Ling et al)



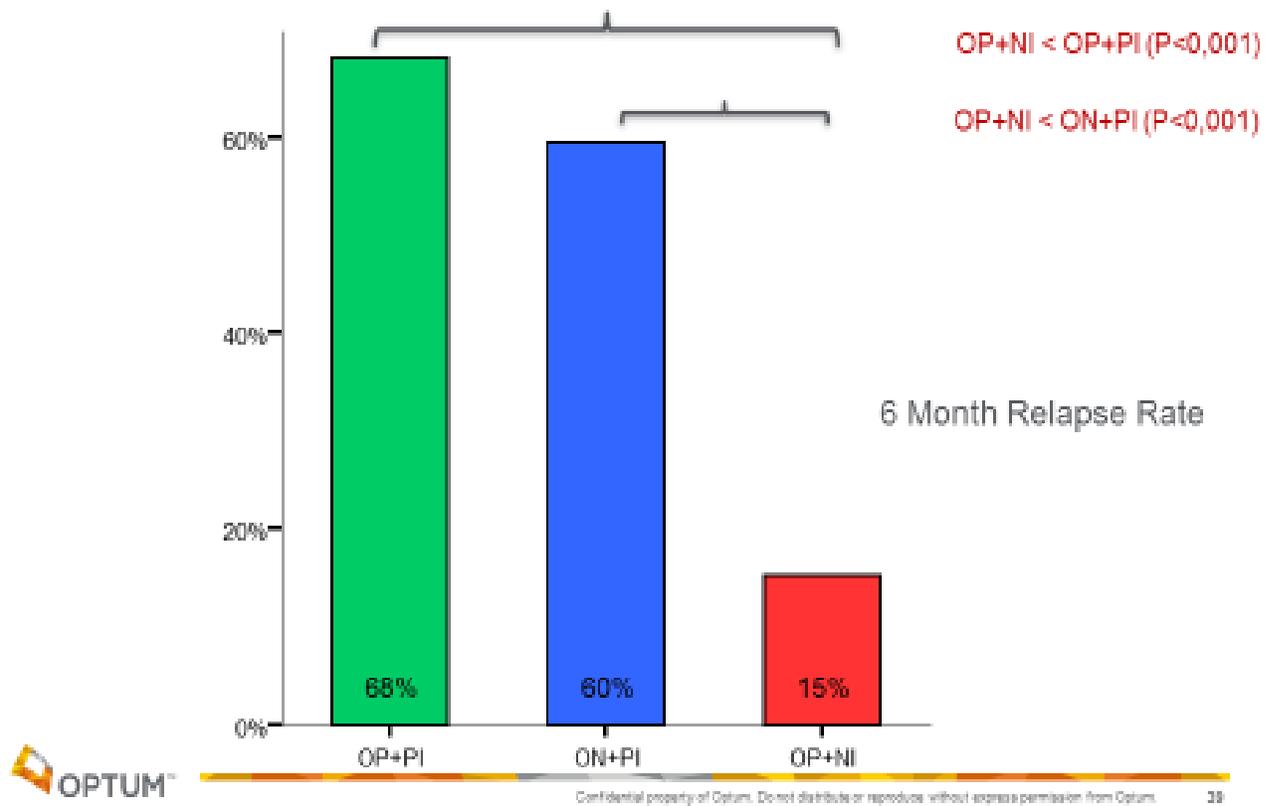
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Clonidine vs. Buprenorphine: Percent Present and Clean from Outpatient Detox at Days 13-14 (Ling et al)



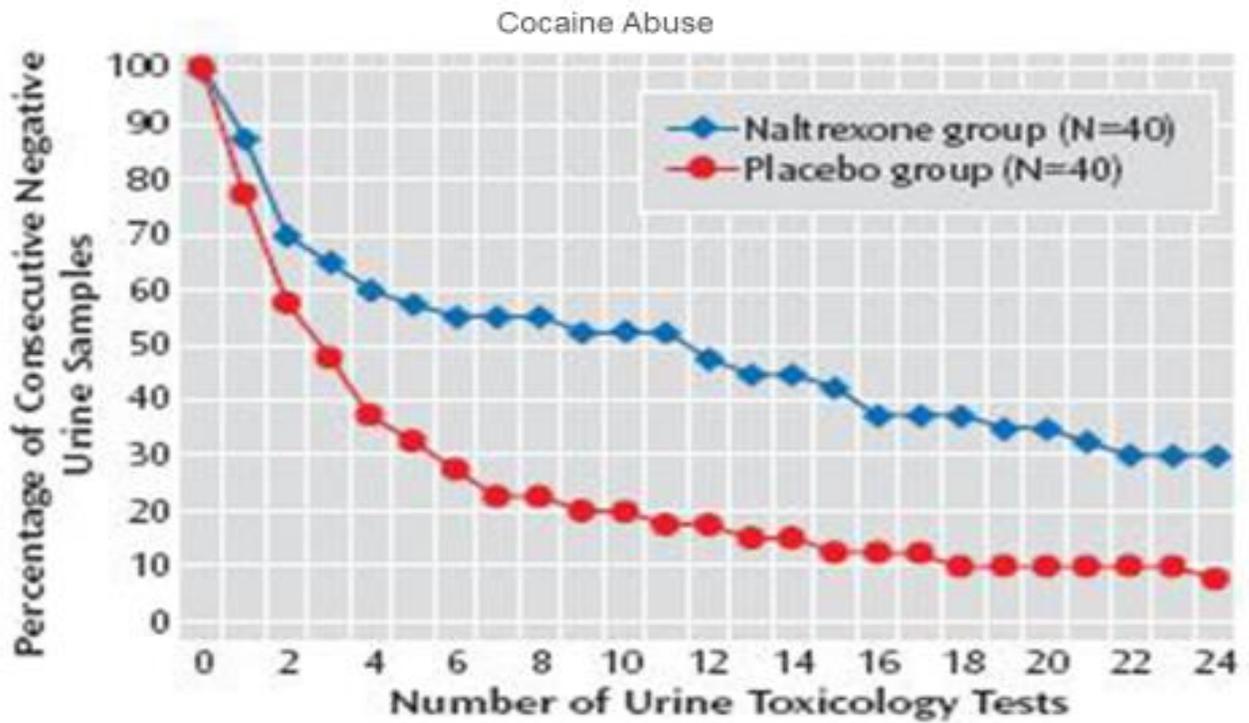
Notes:

Naltrexone Implant in Opiate Addiction (Not yet in U.S.)



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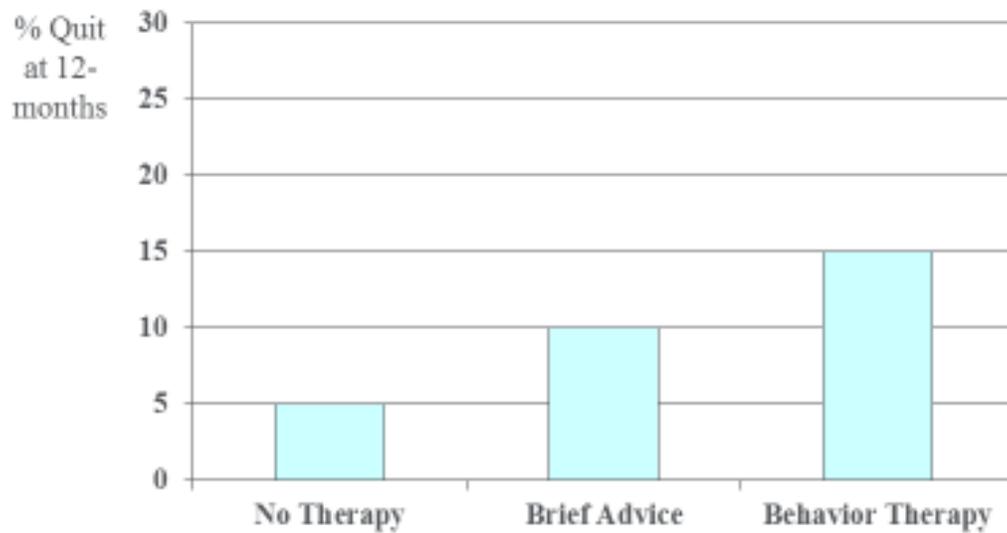
FIGURE 4. Survival Curves Representing Continuous Rates of Abstinence for the Naltrexone and Placebo Groups During the 12-Week Trial (Intention-to-Treat Analysis)



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Nicotine Dependence

Effectiveness of Non-Pharmacologic Treatments



Lerman, Patterson, & Berrittini, 2005.

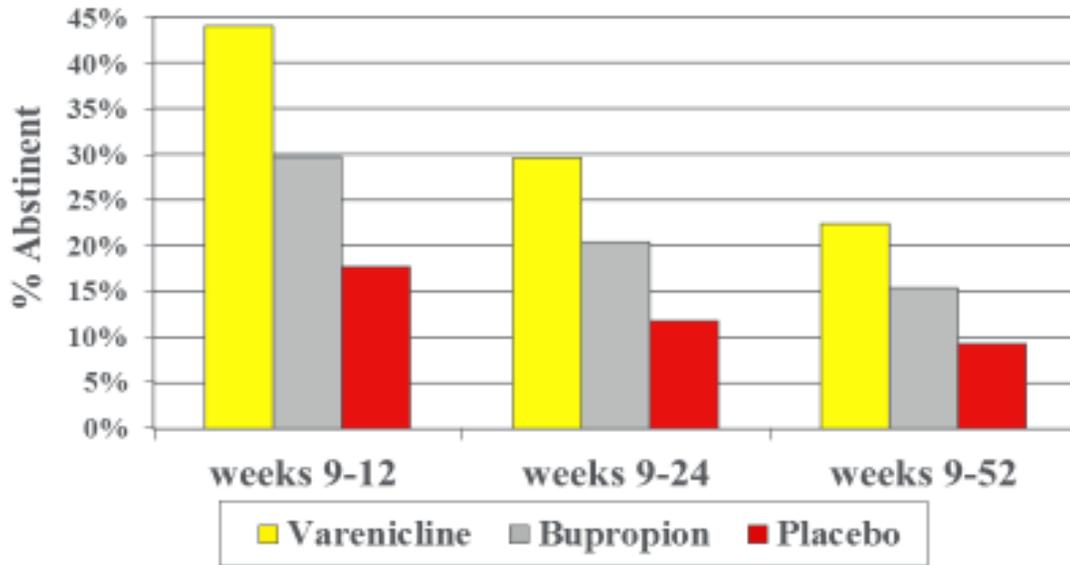
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Notes:

Current treatments

Abstinence Rates Varenicline vs. Bupropion vs. Placebo



Nides et al. Am J Health Behav 32: 664-675, 2008

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