Strategy 3

Improve SUD Care by Changing Systems and Policies

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STRATEGY 3 Improve SUD care by changing systems and policies

In the previous section, we presented selected opportunities to improve access to evidence-based treatment within the parameters of current laws and regulations. But **access for all who need care will remain elusive until those rules and regulations reflect the best available evidence.** Philanthropy can help make that happen.

Right now: Complicated regulations, opaque markets, reduced access to care

Currently, a complicated network of rules and regulations determines who gets care and what kind of care they receive. Many policies make good sense in isolation and are enacted with the best of intentions. But policy change is a slow and complicated process, and it's not uncommon for policies to remain in place long after the evidence indicates a different approach. (The federal funding ban on needle exchanges is one example.) Other examples of restrictive policies that don't align with the evidence include:

- **Residential treatment centers with more than 16 beds can't bill Medicaid for services provided to low-income adults.** The original purpose of the law was to reduce institutionalization of mental health patients, but the current impact is a shortage of care for those who would benefit from residential treatment. Treatment centers across the nation are unable to expand to meet demand without cutting off access to Medicaid funds and putting their business model at risk.[179]

- The medication buprenorphine is recommended by physicians as the first-line therapy for opioid use disorder,[180] but **federal regulations make it difficult for this medication to be provided within treatment centers, requiring doctors to obtain a special certification and prohibiting them from prescribing to more than 100 patients** at a time.[181] While safer prescribing of all opioids is a worthy goal, buprenorphine is currently the only one subject to this level of regulation. It is regulated more than opioid painkillers themselves. As a result, for many people, it is easier to get the drug that caused their problem than it is to get a similar drug that might help solve it.

- Common "Fail First" insurance policies mandate that patients be given lower-cost treatments first, regardless of what kind of treatment their doctor recommends.[182] These policies were originally designed as cost-cutting measures and have been put into place with other medical issues, often with some success. **But for SUDs, "failing" comes in the form of relapse, which can be deadly.[183]** The result is that these policies increase the risk of death for SUD patients—even as they try to get the help they need.

- **Many SUD treatment programs don't track patient outcomes, and regulations for SUD treatment professionals are inconsistent and often lax.** For example, a recent review found that only 29 states require treatment facilities to provide clinical supervision by fully credentialed counselors, and only 8 states require a minimum percentage of clinical staff to be licensed or certified. Only 11 states require residential programs to have a physician on staff, only 10 states require any kind of follow-up care, and only 21 states require that patient outcomes be tracked.[184]

Some of these barriers affect broad groups of SUD patients. For example, the limitations on buprenorphine prescriptions are in effect no matter where you live, and federal health care reform affects all insurance plans, making those laws important factors in access to care for anyone not able to pay full costs out of pocket. (For more detail on how these laws affect health care reform, see sidebar on page 40.)

Some specific populations are especially vulnerable, however. Institutionalized groups, primarily prisoners, face additional policy barriers when attempting to access care within the system or after re-entry into their communities. Low-income individuals, such as those covered by Medicaid, are less able to pay out of pocket for better options if their insurance doesn't cover the treatment they need.

Changing these policies is a high-impact opportunity for philanthropists. In the following pages, we present examples of non-profits with the demonstrated ability to make that change happen, with examples such as:

- Closing loopholes and extending insurance coverage to more people through federal policy change (**Legal Action Center,** p. 40);
- Connecting care in the correctional system to care in the community through local policy change (**COCHS**, p. 41);
- Moving toward better care for everyone by using research to enable a more transparent market for treatment. (**Treatment Research Institute**, p. 42).

Funding organizations that work to change these policies is quite different from funding a direct-service organization. The impact on the people you hope to help is more removed from the point of funding, and the chain of cause and effect can be more difficult to see clearly. But those downsides are, for some funders, balanced by the potential to impact large numbers of people in lasting and meaningful ways as a result of a single change—sometimes with the stroke of a pen. This is not a section full of sure bets, but donors who seek game-changing tools for coping with the burden of SUDs will find exciting opportunities and strong organizational partners here.

The examples we present in the following section are only the tip of the iceberg. The featured organizations and others will continue to work toward policy change in new and different ways not captured in these pages. **The key takeaway is that changing the system is a high-impact opportunity, and philanthropy can help make it happen**.

High-impact opportunity 3.1

Change systems and policies to reflect the evidence base and increase access to care

CORE PRACTICE: System and policy change can happen as a result of direct advocacy, smart partnerships, or the development of a compelling evidence base. What works in any one case might be different from what works in another, but the common factor is a coordinating organization with the knowledge and networks to assess situations as they evolve, identifying solutions and getting the right people on board to implement them.

Target Beneficiaries: Populations whose access to care is limited by public or private regulations that are counter-productive or don't reflect the evidence. Examples include participants in a particular insurance plan, residents of a given state or institution, or everyone who needs a particular kind of care (e.g., a federally regulated medication).

Impact: More people get access to care now and in the future.

Cost-per-impact profile: The successful efforts featured here had upfront costs in the $50,000-250,000 range, though those costs aren't always covered by a single donor. Costs vary widely because projects can be very different; working for a small policy change at the city level will likely be cheaper than working for sweeping federal reforms. The costs of a single project also don't reflect that success is often collective, with many people and organizations working toward change in slightly different ways. Success can also be cumulative, the product of years of work building the credibility and relationships that make an organization influential. The price of any single effort gives a helpful sense of scale, but it's rarely the whole story.

HOW PHILANTHROPY CAN HELP: Philanthropists can support organizations with the demonstrated ability to read and influence the policy landscape. The highest-impact targets and strategies can change rapidly, and effective organizations will anticipate shifts, move quickly to seize opportunities, and course-correct as needed.

OPPORTUNITY IN PRACTICE

In the following pages, we highlight case examples from the **Legal Action Center**, **COCHS**, and the **Treatment Research Institute**. These organizations have consistently demonstrated the ability to effectively influence systems and policy and are engaged in this work on an ongoing basis. We present these success stories because, while policy change efforts are by necessity tailored to a particular time and place, it can still be helpful to see the way organizations have tackled this work in the past. **With these case examples, we aim to accurately reflect the work that's been done, while providing some insight into what these organizations and their peers might accomplish in the future.**

TAKE ACTION

Donors interested in supporting policy change can look for organizations with the networks and institutional knowledge to be effective agents for policy change. For example, if the goal is state-level change, do they have the ear of decision-makers in the right agencies? Are they aware of previous efforts so that they can build on what's been done and avoid stepping into a political minefield? Are they connected with other organizations working toward similar change? The non-profits featured in the following pages are examples of implementers that demonstrate that kind of capacity, but funders can also look for similar groups in their own communities.

Success Story

The Legal Action Center and Health Reform

For policy change that affects everyone, organizations may need to advocate at the federal level—sometimes over the course of years if not decades.. An example of successful federal policy change comes from the passage of key provisions in health care reform (see sidebar) and the role of the Legal Action Center (LAC).

The 2008 Parity Act required large commercial health plans that already provide mental health and substance use disorder benefits to deliver them equally—"at parity"—with other medical benefits. The Parity Act was a significant step forward, but many plans were exempt, and there was a major loophole: insurers that didn't provide mental health benefits were unaffected by the law. It was therefore simpler for insurers to cut all mental health benefits than to provide SUD treatment coverage that complied with the Act.

This was the backdrop leading up to the 2010 passage of the Affordable Care Act. As that law was in development, LAC and other advocates saw an opportunity to extend parity protections to millions of Americans by closing the loopholes. They advocated for mandates that: 1) required all commercial insurance and expanded Medicaid plans to cover addiction and mental health services, and 2) required that this coverage be at parity with that for other medical conditions. **In combination, these provisions could open up mental health care to tens of millions of Americans who previously would have had to pay out of pocket—or, more likely, go without.**

To make those changes a reality, LAC spent the two years preceding passage of the Affordable Care Act gathering dozens of addiction and mental health organizations and providers into a group that became the Coalition for Whole Health. LAC staffed and led the Coalition for Whole Health, coordinated its agenda, and worked to create field-wide recommendations. On behalf of the Coalition, LAC and some of its other most prominent members circulated these recommendations, educating policymakers in Congress and in federal agencies on the need for the proposed changes and the untapped potential to stem the tide of untreated addiction and mental health problems in the United States.

Impact: Health care reform has included expanded coverage for mental health care, including SUD treatment. The federal government estimates that 62 million people will gain coverage for addiction and mental health services once parity is fully implemented.[185]

Costs: It cost LAC approximately $200,000 a year for two years to build the Coalition for Whole Health and lead its advocacy related to the Affordable Care Act. These expenses were largely covered by the Open Society Foundations. Based on the federal estimate of 62 million individuals gaining mental health coverage, **LAC received approximately 6.5 cents in grant money for every person who stands to benefit from parity expansion**. It is important to note, however, that the LAC was able to deliver in part because of its long history and knowledge of the sector. Both of these assets were developed long before the single grant in question.

TAKE ACTION

To learn more about improving access to health care through federal and state policy change, visit the Legal Action Center's website at www.lac.org. The Legal Action Center also conducts SUD-related work in criminal justice, such as advocacy for alternatives to incarceration. Find out more about the Coalition for Whole Health at CoalitionForWholeHealth.org

TIPS

What policy-changers need to know about health care reform

The *Parity Act* of 2008 requires insurers to keep financial requirements and treatment limitations for mental health and SUD benefits no more restrictive than those for other categories of medical benefits.

The *Affordable Care Act* of 2010 requires all insurance plans sold on Health Insurance Exchanges or provided by Medicaid to include services for SUDs at parity with their other medical and mental health services.

Success Story

COCHS: Connections, and an evidence-based care system in Delaware

Community Oriented Correctional Health Services (COCHS) works with the public sector to **connect care in the correctional system to care in the community**, as well as to **improve access to substance use and mental health care for the broader population**. They conduct this work through multiple channels, including working directly with government officials at the federal and state level and providing coaching and assistance to organizations facing policy barriers to impact. For example, COCHS conducts regular briefings with leadership of the Office of National Drug Control Policy, helping to identify federal policy changes that could improve access to SUD treatment in jails and prisons. At the state level, they work with criminal justice agencies, health agencies, and other groups. For instance, they are currently working with state policymakers in New Jersey to help them expand their mental health coverage to include residential facilities larger than 16 beds.

In another recent project, **COCHS worked directly with a health care provider to help them expand and improve the quality of their care**. Connections Community Support Programs (Connections) is a non-profit provider of primary and behavioral health care, which includes SUD treatment and other mental health services. Via a contract with the state of Delaware, Connections was providing behavioral health services within the correctional system and in communities, allowing detained individuals to maintain continuity of mental health care when they exited prison. Their primary care services were only available outside of the prison system, however, and the split was causing logistical difficulties and making it harder for patients to maintain access to the full range of care they needed. To address those issues, Connections wanted to provide integrated primary and mental health care within and outside of the correctional system.

To make that integrated care a reality, Connections needed a primary care contract from the state of Delaware, along with their existing contract to provide behavioral health services. For that, they needed increased capacity within their primary care services. COCHS helped Connections manage this process, working with them to secure a loan from the Nonprofit Finance Fund, which enabled the organization to build the capacity they needed. COCHS and Connections also worked together to develop an implementation plan that improved treatment quality within the correctional system.

Impact: Connections was able to bid successfully for the state contract, allowing them to **integrate primary care and behavioral health for their detainee patient population, estimated at approximately 1,000 individuals per day**. Their implementation includes expansion of medication-assisted treatment, **making medication for opioid addiction available to anyone within the justice system who needs it.** Prior to these changes, important medications were not available to incarcerated individuals (with the exception of pregnant women) despite physician recommendations.

The impact is meaningful at an individual level to those who struggle with SUDs and are now able to get better care. Though it is too early to say, the improved treatment may also result in cost-savings for the justice system by breaking the cycle of drug use and recidivism.[186]

Costs: For its work coordinating the partnership with Connections, the state of Delaware, and the Nonprofit Finance Fund, COCHS spent $150,000, of which 60% ($90,000) was philanthropically funded through the Robert Wood Johnson Foundation. The remainder was structured as fee-for-service and paid by Connections. Research on similar approaches indicates that the state will likely save money overall due to reduced costs in medical care and other services. If that holds true, the philanthropic investment in COCHS will have served as the bridge to strategic deployment of public funding for a model that can be sustained over time.

TAKE ACTION

To learn more about COCHS and their work supporting systems and policy change across the country, visit their website at www.cochs.org.

TIPS

Advocacy often depends on relationships and credibility built over time. Funders looking to support policy change should seek out organizations with demonstrated credibility and sector knowledge, enabling them to bring the right stakeholders to the table and manage the process effectively.

Success Story

Treatment Research Institute (TRI) and the move toward a transparent treatment market

The Treatment Research Institute (TRI) conducts research in substance use treatment, policy, and delivery and works with public and private stakeholders to help translate those findings into practice.

TRI's work is an example of systems change outside of the political setting. Research and the dissemination of new ideas can change systems from the bottom up, for example, when a consumer seeks out a particular evidence-based therapy that they have read about. Research can also make an impact from the top down, such as when an insurance company uses new evidence to decide which treatments to fund. As both of these examples illustrate, when research is available and accessible, it can make an impact by influencing markets. The process is often slow and non-linear, but the change can be both lasting and meaningful.

An early example of this is the **study that showed SUDs to be a chronic mental illness**, published in the *Journal of the American Medical Association* in 2000.[187] This study, led by TRI researchers, has been cited widely to support the need to treat SUDs as a health issue rather than simply a matter of criminal justice.

Recent health care reform offers an illustration of systems change through applied research. Under the Affordable Care Act, insurance coverage, and therefore, demand for treatment services are expected to increase. However, there is no standardized tool to assess whether treatment programs can deliver the level of care necessary to meet patient needs. Without the right information, there are few ways for consumers (individuals or insurers) to choose effective treatment options over less-effective ones. To address this gap, TRI is in the early stages of developing **quality assessment tools and training protocols** to be used by Medicare and Medicaid, among others.

Impact: The reconceptualization of SUDs as a chronic medical illness was a key factor enabling SUD treatment's inclusion as an "essential health benefit" under health care reform.[188] (For more on the impact of health care reform, see page 40 for related work by the Legal Action Center.)

The treatment quality assessment tools are expected to improve the overall quality of SUD care, as increased transparency makes it possible for market forces to incentivize good treatment outcomes. Without that transparency, consumers are left to rely on less-relevant but more visible factors such as price, luxury amenities, or size, and treatment centers will continue to direct their resources toward those aspects of their program.

Costs: Projects such as the assessment tools may take a year or longer, with typical costs in the range of $200,000. However, that funding can be a mix of philanthropic and public dollars, as TRI receives government support for some research activities.

TAKE ACTION

To learn more about TRI and their research into addiction treatment, policy, and health systems improvement, visit their website at www.tresearch.org

TIPS

Many of the organizations profiled in these pages are well-known to each other and often work in formal or informal collaboration; this cross-pollination benefits the field, allowing for greater exchange of knowledge and ideas. Funders interested in supporting research or policy change can consider funding a joint effort or working with an organization with the reputation and capacity to mobilize networks effectively.