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SUD Recovery Incorporating Health-Related Social Needs: An IHPA Best Practice Case Study

Today's Speakers

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What You'll Learn

How – often unexpected – health-related social needs impact SUD recovery

How Illinois Health Practice Alliance (IHPA) meets over 45,000 members where they are in their treatment journey

Tactics for managing care planning through a stage-based approach

Strategies for funding and managing flexible social needs budgets

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Why This Matters

Recovery isn't only threatened by clinical setbacks.

- Everyday obstacles including transportation, housing, and lifestyle, are just as important.

Timing is everything.

- Meeting social needs when a patient is ready to receive support is often the difference between engagement and dropout.

Flexibility beats rigid program design.

- Instead of a one-size-fits-all checklist, needs should be defined on a patient-by-patient basis.

Technology doesn't inherently solve problems, relationships do.

- A strong provider network is needed for any IT platform to work.

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About *Illinois Health Practice Alliance*

- An Independent Practice Association (IPA) created to improve the integration of behavioral and physical health care in the state of Illinois
- A vehicle to support the evolution and transition to value-based contracting for community behavioral health provider organizations.
- Currently serving over 45,000 members across the state of Illinois

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The Background

Providers mostly see what happens inside their own four walls, relying on patient self-reports for additional insights

IHPA built a system that lets providers see what's happening when they're not in the room, paired with incentives to reduce unnecessary hospital visits

The system often misses the population chronically cycling through hospital and emergency department visits

Shifting from a reactive approach, IHPA finds and engages high-needs people before crisis brings them in

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On-Ramp

IHPA's flexible, state-funded model for addressing what standard treatment funding can't.

- A case-rate program that pays providers to address real social needs
- Addresses how to provide all patients with a reasonable shot at following through
  - Including a way to get to appointments and stay on medication

562.6
fewer emergency department visits

per 1,000 members

66.2
fewer psychiatric inpatient admissions

per 1,000 members

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How This Model Is Different

Traditional SUD Treatment

- Discharge plans often ignore the social needs that impact whether someone can realistically follow through
- Social needs get addressed only if they fit within the standard, billable taxonomy
- Needs-assessments often stop at a set checklist
- Access to resources, like rides, can require a multi-day process

The IHPA On-Ramp Model

- ✓ Providers pressure-test the discharge plan's reasonableness, with funding to address the gaps they find
- ✓ A flexible case rate lets providers address agreed-upon social needs
- ✓ Assessment is grounded in real, collaborative dialogue between member and provider
- ✓ Needs are met on-demand, in the moment they're identified

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“People are not normally saying, ‘I want outpatient addiction treatment.’ They're saying, ‘I want housing, a ride, food.

So, meet them where they're at, meet that social determinant need, and use it as an engagement tool to build trust.”

The Rideshare Pilot

Patients seeking residential SUD treatment need to get in quickly, while their motivation is high, not sit for days waiting on a ride.

- In Illinois's Medicaid system, scheduling a ride to residential SUD treatment means going through a transportation broker, often a multi-day process
- IHPA gave providers the ability to book on-demand rides through partnerships with vendors, instead of waiting on the broker process

A small change to one point in the process can be enough to meaningfully impact what happens downstream.

11.8
fewer emergency department visits

per 1,000 members

4.1
fewer psychiatric inpatient admissions

per 1,000 members

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Care Planning

- IHPA isn't prescriptive about provider workflow, care plans are still governed by fee-for-service funder expectations
- A referral platform is only as strong as the community partners willing to use it, but many CBOs, especially food providers, don't run on referrals or reservations
- There is still work to do in integrating needs-assessments directly into care plans and in the broader clinical picture

What IHPA Is Doing

- Encouraging a stage-based approach to care planning, matched to the member's engagement
- Starting with a network of willing, responsive providers first
- Exploring IT platforms for CBOs after building a strong network

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“I think the one misconception is that if you throw the right IT platform at it, that will fix the problem.”

“How Am I Paying For This?”

The Funding

- Providers receive it as a flexible case rate, not billed line-by-line against a fixed FFS taxonomy

The Real Hurdle

- Medicaid providers are conditioned to expect scrutiny, not flexibility
- Providers had to get revenue cycle, clinical, and operations teams aligned internally, and navigate their own agency's controls, to dispense the funds

Rolling out statewide gave IHPA room to build momentum across different provider types and regions rather than depending on one locale going well.

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What Can You Learn From This?

This shift has to be structural. Adding social needs work onto an already full caseload doesn't work. Training, systems, and incentives must be built in from the start.

Expect internal friction, even with money in hand. Flexible funding can feel "too good to be true" to teams used to compliance and scrutiny.

What you measure is what you'll get. Track whether care plans address the needs identified, not only whether an assessment got done.

The data governance gap is an opportunity, not a limitation. No uniform standard exists yet for measuring social needs, so organizations collaborate to build standards now will be ahead of the curve.

Network first, platform second. No referral technology outperforms a network of providers who are truly willing and responsive.

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“What gets measured gets done.”

Where To Start:

1. **Audit your current funding structure** and where it leaves social needs unaddressed
2. **Build the systems and incentives to support this work** instead of simply adding to the existing caseload
3. **Start building a network of engaged, responsive partners** before investing in new platforms or technology
4. **Identify meaningful KPIs**, tracking whether care plans actually addressed the needs identified in the assessment
5. **Standardize measuring social needs**, because unlike HEDIS, no uniform approach exists yet

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Strategic Discussion With
Deanne Cornette, MHA, GPC

What were you seeing among consumers with substance use disorder that made IHPA realize health-related social needs needed to become a more intentional part of treatment planning?

What operational challenges did you encounter when integrating health-related social needs into your SUD treatment model, and how did you overcome them?

How has addressing health-related social needs affected consumer engagement, retention in treatment, or recovery outcomes?

For executives who want to better integrate health-related social needs into SUD care, what's the first operational change you would recommend?

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