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

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Deanne Cornette 0:00
Hello everyone and welcome. I'm Deanne Cornette, Senior Associate at *OPEN MINDS*. Thank you for joining us today for this Recademy webinar highlighting a best practice case study. As behavioral health organizations continue to strengthen SUD treatment, many leaders are recognizing that clinical care alone doesn't determine whether someone succeeds in recovery. Transportation, housing, food insecurity, and other health-related social needs often shape whether individuals remain engaged in treatment. The challenge is in simply identifying those needs. It's building systems that allow organizations to respond in ways that are timely, practical, and sustainable. Today's Recademy webinar examines that challenge through the experience of the Illinois Health Practice Alliance, or IHPA. IHPA is a clinically integrated behavioral health network serving more than 50,000 members across Illinois. Through A real-world case study, we'll explore how IHPA redesigned care planning funding, provider partnerships, and operational workflows to better support individuals with SUD while improving engagement and reducing avoidable utilization. Joining me today is Gilbert Lichstein, the Chief Executive Officer of the Illinois Health Practice Alliance. Gilbert has spent his career advancing integrated behavioral health, value-based care, and innovative approaches to improving outcomes for individuals with complex behavioral health needs. Under his leadership, IHPA has developed practical strategies that give provider organizations greater flexibility to address the real world barriers that often influence recovery. Gilbert, thank you for joining us. We're excited to hear more about IHPA's experience and the lessons organizations and leaders across the country can take away from your work. I'll turn it over to you.

Gilbert S. Lichstein 2:08
Thanks, Deanne. Thanks for that nice introduction and thanks to you and the *OPEN MINDS* team for having me. So, I'll touch on some themes that you'll hear as I walk through this, really getting down to why this matters. So, recovery is more than just treating the illness itself. It's not just

clinical setbacks. It's the everyday obstacles that can interfere with the person getting well. Timing is everything. So, you know, we know that people's interest in engaging in treatment waxes and wanes. So it's important that the treatment system is ready to address everything about getting into treatment in the moment so that, you know, really we can ensure engagement rather than treatment dropout. Flexibility beats rigid program design. People are different. That means that a one-size-fits-all approach to treatment is not as good as a system where you're engaging with the member and tailoring the care plan to their specific needs. And then finally, technology is a tool. It's a great tool, but fundamentally, treatment system and the provider network needs to be there in order for any IT platform to work. Next slide, please. So the Illinois Health Practice Alliance, my organization, is an independent practice association in the state of Illinois. We've been operating for about 7 years and we were brought together to improve the integration of behavioral and physical health care. So really illustrate to behavioral health providers how primary care can be their lane. Their door is the door that the member is walking through to get care. So why not leverage that to help them get some of their integrated care needs met? We're also a vehicle for community-based behavioral health providers to get into value-based care. It's a way for them to attain that critical mass that's needed to drive decent agreements without becoming part of a bigger company or getting acquired. Some providers want to stay small, but want to engage in things like value-based care, and we offer a pathway to do that. Currently, we're serving over 4,500 members across the state of Illinois, and we do that through several payer agreements. Next slide, please. So just a few of the differences pre and post on my Health Practice Alliance. So, you know, before we started, providers were basically giving care to the people who showed up at the facility and raised their hand and said, I need care. So people who were in an active stage of change and could get to the facility. And they were building care plans and case conceptualizations off of the members' self-report, relying on, you know, what they saw and heard within their four walls. We, with our joint venture partners, were able to build a system that lets providers see what's happening in the entire treatment continuum when the member's in the hospital, when the members, you know, what are they, what's happening with their pharmacy, what's happening with their other claims so that you're not just relying on the member's self-report and really engaging the provider in helping the member live in a more dignified manner by reducing unnecessary hospital and ED visits, emergency department visits. Before we got there, the system really missed the needs of that segment of the population that was chronically cycling in hospitals and emergency departments. If you're living in a big city, and if you have access to claims data, you're probably seeing a cohort of individuals that's more or less living in psychiatric inpatient facilities. They might not all be in the same facility, but they're moving from one to another as soon as they no longer qualify for continued stay review. And so we really said, we want the outpatient system to meet these individuals' needs. We want them to go find and engage these individuals, bring them into care so that they could get proactive care for their conditions before they got worse. So, you know, we have the advantage of being able to pilot initiatives through a broad provider space. We can get providers quickly growing together, and we have data that allows us to do

like cohort analyses to see if pilots work. And so one pilot that we wanted to try, we had noticed that, you know, when someone is thinking about getting help with an addiction, you really need to get them in to care quickly before they decide to, you know, go use again and change their mind. And so in the state of Illinois, if you're a Medicaid beneficiary, your transportation benefit is accessed through a broker, which is a multi-day process. And so there's a built-in delay between when a person decides to enter treatment and when they can get taken to treatment. We said, what if we give the providers access to a rideshare platform, a HIPAA compliant rideshare platform through a partner vendor and funded some of those rides so they could order rides in the moment to get to residential SUD treatment or to get to medication assisted treatment? And what we found is that one change in a light cohort analysis led to a meaningful difference in the ED psychiatric inpatient admissions per thousand. So 11.8 fewer ED visits per thousand, 4.1 fewer psychiatric inpatient admissions per thousand. So we knew we were on to something. That was a rationale to try an additional pilot, which I'll talk about in the next slide, if you could advance the slide. So we pursued state funding for a model that we called On-Ramp, which was a flexible case rate designed to follow the individual. We targeted it towards people that were experiencing health equity disparities in the form of not being able to engage outpatient care. And really, it's just a case rate that members can, that providers can use to spend directly on members' social determinant needs and really a wide open definition of what that was. It could be housing, transportation, food, but it could be other things that they and the member mutually agreed upon that they think would move the needle on the person's recovery. We also allowed them to spend some of those dollars on service needs they saw that weren't otherwise billable in the taxonomy. The taxonomy had evolved to be fairly rigid. Everything that you were billing for had to be germane to the disease process itself. And that got difficult sometimes when the provider wanted to give a person a ride or wanted to address something where you couldn't quite tie it to symptomology in the moment, but you knew that it was relevant to the overall course of the person's substance use disorder. So with this program, with this flexible case rate, we did another light cohort analysis. We looked at a very similar population that did not have access to this. And we observed with this on-ramp program, 562 fewer emergency department visits per 1000 numbers and 66.2 fewer psychiatric inpatient admissions per 1000 for the period that we were looking at. So we think it's a real effect based on the light cohort and we think that, and it certainly ties to the anecdotes that you hear from providers as they describe working with members. So just how does this look different from traditional treatment? So traditional SUD treatment, you know, largely driven by the taxonomy, it thinks about, you know, what's immediately billable, what are the regulatory standards that are built into, you know, the billing entities. It doesn't typically look at social needs, social determinant needs, health-related social needs that impact whether or not someone can realistically follow through. Contrast this with the on-ramp model, providers are pressure testing the discharge plan. They're taking that friendly curious approach and saying, does it seem reasonable that the person is going to follow through with this? Does it seem like there's engagement? Does it seem like the person, the barriers to engagement have been addressed? In the traditional model, social needs only get

addressed if they fit within the billable taxonomy, traditional, you know, funding mechanisms. Here in on-ramp, a flexible case rate, let the provider address those mutually agreed upon social determinant needs. A lot of times in the traditional model, the needs assessment stopped to the checklist. It's not particularly detailed in the way that it asks about social determinant needs. What we found is that the assessment really needed to be grounded in a collaborative dialogue and providers oftentimes needed some coaching as to what a social determinant need might look like to really tease out all of those things that could be relevant. And then this was a quicker pathway to access that social determinant health. It wasn't a multi-day process. It was something that could happen in the moment, which is very helpful for engagement because people need treatment soon and it really helps people to see that the treatment provider is able to respond to needs quickly. So, you know, one thing we've observed is that traditionally providers, when they're engaging a member, they lead with treatment. It's that old adage, if you're a hammer, everything looks like a nail. And the problem there is that there's not people on the street saying, gee, I really want, you know, 15 hours a week of independent outpatient addiction treatment, or I want to be in a residential program and get, you know, 30 hours a week of group services. They're just not referencing their needs in terms of treatment offerings. They're referencing their needs in terms of, I want housing, I want a ride, I want food. So the closer you can be as a clinician to meeting them where they're at the better of an engagement tool you'll possess to build that trust. Next slide, please. So, you know, we have, we're a statewide organization. We have a lot of different providers of different stripes. We've got, you know, rural downstate health departments. We've got very large Chicagoland providers with many, you know, locations. So we can't be overly prescriptive about the workflows. And historically, the care plans have been governed by fee-for-service expectations, more of a compliance-driven approach. What we are encouraging is a stage-based approach to care planning. So really going back to that Prochaska and DiClemente, you know, model of stages of change, encouraging providers to think about the people they serve as having multiple target behaviors where they are in different stages of change and depending on what that stage of change is, utilizing a different approach. You don't want to give, you know, services to someone who's in pre-contemplation or contemplation. What you want to do there is you want to hear them out. You want to, you know, build on their ambivalence. You want to use differential responses to change and sustain talk and get them to the point where they're ready to explore therapy. If they're in a, you know, if they're in a planning or an action stage, then you make that resource available to them. And we just really try to illustrate to providers that people are in different stages of change with respect to different target behaviors and that the approach needs to respond accordingly. You know, there's a lot of activity in the space around these IT platforms that link people to social determinant needs. And, you know, great technology offerings, beautiful software, but that referral platform is only going to be strong if people use it. And these platforms need to outperform search engines. They need to outperform the systems that providers are already using themselves. Some important providers are not even on Google. They're not even, they're not, you know, they're not on any search engine. So you need to accept

the realities of the CBO operating environment. And what that means is starting with a network of willing and responsive providers and then thinking about a tech tool to improve that. Still a lot of work to do in integrating needs assessment directly into care plans. Really want to work to get more to the point where that's more integrated and fluid and that, you know, all of those social determined needs become part of a broader clinical picture. there's a misconception that, and you know, there's a lot of IT vendors that have a very compelling dog and pony show, but there's a misconception that if you throw the right platform at one of these situations, then that's going to solve your social determinant needs. So, you know, part of what makes this work is the funding mechanism. And so, you know, we were able to go with a flexible case rate that was not billed against a fee-for-service taxonomy. It was a something where we could say to providers, here are the treatment activities we would like to take place in the real world. Here's some funding for that. Build a system that addresses your overhead associated with making sure those treatment activities happen after you've exhausted all of the building opportunities and the taxonomy. One of the things that was interesting is that culturally, Medicaid providers are conditioned to do well with regulatory scrutiny. That is a challenging pivot if you're being operated a very flexible treatment model. And, you know, we had all of this money to help address social determinant needs. We wanted to get it out the door quickly to members, but that involved getting the revenue cycle people at the provider routes aligned with the clinical teams, you know, making sure everybody understood what this money was for, making sure that the internal controls were doing what they needed to do, but also not preventing the money from getting to the numbers that needed it. So that was an eye-opener, that that was a multi-month process to make that work. One of the other interesting lessons is because we were statewide in our legislative appeal, we were able to really work with legislative champions throughout the state and I think that that really strengthened our funding opportunities. Next slide, please. What can be learned from this? There really needs to be a structural shift. So you can't take an existing program and just add social determinant needs on top of that. You know, the clinicians are already busy. They already have a workload. It can't be one more thing. There needs to be specific training around how they might do that. Keep in mind, this is not really something that's taught in a lot of master's programs. So you're asking clinicians to do something that's a little bit different from how they were trained. And there really need to be incentives and benchmarks for provider behavior to motivate them to do these activities. Like I said, there may be internal friction, even with money in hand. That phrase, flexible funding can feel too good to be true, happens in an environment where you're not used to having access to it. And that can take a little while to engender the process of distributing those funds. What you measure is what you'll get. So, you know, as you're building this, make sure that your KPIs support the type of behaviors you really want to support. It's important to understand that data governance is different with respect to social determinant needs. It's not as strong as it is for healthcare. The key is, there's not robust claim systems. It's a limitation, but also an opportunity. But it's something important to think about as you stand this up in your community with community partners. What is our data governance around tracking this so that we can compare

apples to apples and see what works? And then finally, you know, the platform is a tool to help a functional network of people that are working together to address these social determinant needs. Next slide. That old adage, what gets measured gets done, you know, as really thinking about as a program leader, what is your goal? What am I building into my KPIs to make sure it gets done? So, for program leaders, just thinking about, you know, where to start, you know. It's important to size the gaps in your current funding structure. So you need to know what you want to do, but you need to know where that is not sustained financially and address that through a funding mechanism. You want to build systems and incentives that work to support the work instead of simply adding to an existing case. So we all know that feeling of layering something on to an existing program, and we all know what tends to happen to adoption and integration for those initiatives. Really thinking about building the network of engaged CBOs and partners before investing in new technology. Build the KPIs around, you know, really think about how do I measure what I really want to see done and build those KPIs from the ground up because what gets measured gets done, and do that in a standardized way with the collaboration of your partners so that you're able to make apples and apples comparisons with like providers, like state, like other entities, so that you can really see what the best practices are and learn what works well.

Deanne Cornette 23:00
Thank you for sharing with us today, Gilbert. You've already touched on how real this is in practice. So let's trace it back to the beginning. The team at IHPA has been building this directly into SUD treatment. So let's start where it began for you. What were you seeing among consumers with SUD that made IHPA realized that health-related social needs needed to become a more intentional part of treatment planning?

Gilbert S. Lichstein 23:30
Yeah, I mean, well, for me personally, it goes back to my experience as a clinician. So before this work with IHPA, I was working in SUD treatment programs and I was overseeing residential and outpatient SUD treatment programs. And I think anybody who's worked in that environment has seen countless anecdotes where people relapse, you know, between the time that they discharge from a detox unit and get to residential care, people, you know, people relapse in those in those transportation situations, people, you know, relapse in unstable housing situations. I think that, you know, this disease, this substance use disorder, condition is it can, you know, it's related to situational cues where you live. And so any treatment plan really needs to think about what living situation is the person going to have long term that you're optimizing for. If you're getting them into a new environment, then you need to think about lining them up with a safe new environment. If you're getting them into your existing, their existing environment, you need to think about how am I going to address the cues in that environment and the things that were happening in that environment that contributed to their use. So that, you know, just from, you know, in terms of my feel for the population, that was part of what motivated it. And then we

hear about it a lot from our provider community. We just hear, you know, the biggest grievance in the Medicaid system is transportation. So we knew that this, there was this ride issue. We knew that, you know, when we had tried to, we had done an initiative where we tried to launch an IT platform to address some of these social needs and the feedback we always got was housing. We want more housing resources. So, you know, it was really a lot of different data sources were lining up to illustrate to us that this was important and that we needed to be more intentional about this.

Deanne Cornette 25:19
That gives us a clear picture of the why. Of course, we know that recognizing a need and building it into a treatment model are two very different things. Once IHPA decided to make this intentional, you had to make it operational, right? So what operational challenges did you encounter when integrating health related social needs into your SUD treatment model. How did you overcome them?

Gilbert S. Lichstein 25:58
Yeah, there were there were a lot of interesting learning experiences, so we did start with a closed-loop referral platform. I think that we were very motivated by the, you know, the story that accompanied the platform, and so we built an integration between it and our care coordination platform. We promoted it to our providers. We brought them, trained them on it, and what ended up happening was they would they would go to it and it and it didn't meet expectations because the research it really just managed to surface the need for more resources, the need for more partners. And, you know, once you've brought someone to a platform like that and they have a subpar user experience, it's very hard to get them to come back. We chose not to address that as an effort to drive engagement with the platform or drive adoption with the platform. We really felt that the initiative needed to stand on its own and that it needed to draw people in by working better than the other solutions. So that told us that we needed to think more about addressing the social determinant needs themselves than about, you know, this linkage through an IT. I think from there, you know, we were able to, you know, attain this funding and challenges there were what I had mentioned before, navigating the internal controls that existed at providers for compliance with spending these dollars. You know, I think my knee jerk thought was we would put these funds out there and they would get spent instantly and then people would be coming back to us asking for more. But they had a little bit of trouble, many of the providers spending the funds at first because they weren't used to having them. It might be that the end clinician didn't know that the funds were available. It might be that the end clinician wasn't used to assessing for those needs. And so we really, you know, we got the providers together and we found best practice users within the provider community to really give an anecdotal picture of what it looks like to make that assessment and what kind of questions you can ask to engage around social determinant needs and what kind of interesting social determinant needs you discover through that engagement. So I think that it just took more

time and training than we expected to make that pivot in the provider community to having and disseminating those funds.

Deanne Cornette 29:01
So the workflows are in place and the model is holding up. The question everyone is going to want to know or ask is whether it actually moves the outcomes that matter. How is addressing health related social needs affected consumer engagement, retention and treatment, or recovery outcomes?

Gilbert S. Lichstein 29:30
Yeah, so we're, you know, the metrics that we really look at align with our shared savings models of the psychiatric inpatient admissions and all cause ED visits, and we're confident that in that light cohort analysis, on-ramp did reduce those visits per thousand. Beyond that, the, you know, countless anecdotal stories about how it took, it moved people from being unengageable to engageable. You know, as I said, a big part of the population that we're focusing on are these people that are chronically in inpatient units and they may have sort of a mistrustful relationship to the outpatient care system. This is a tool in the toolkit that the provider can use for immediate engagement, where they don't have to lead with treatment, where they can really lead with what the person wants in their frame. So that initial engagement piece, it's a real shot in the arm. Thinking about retention and treatment, it's creating that safe environment. It's creating that reliable transportation. It's creating those things that make people more likely to succeed. So we're seeing those outcomes in terms of the hospital and ED trends and just the member journeys and the provider journeys we hear about have been really moving in terms of the engagement stories.

Deanne Cornette 31:03
Those results are really compelling and as well as everything you talked to us about today, Gilbert. I guess a few people are already picturing how this could look in their own organizations. Let's make it practical for them before we close. For executives who want to better integrate health-related social needs into SUD care, what is the first operational change you would recommend?

Gilbert S. Lichstein 31:34
I mean, the way that I like to approach these problems is to think first about, you know, what the desired future state is and how you're going to measure that and what the what the KPIs are to measure that. And so then, you know, once you've once you've thought through your measuring system and you know, how you know, you know, how you're going to gauge whether or not the initiative works, and you can start to think about what treatment differences you need to put in place to meet those KPIs. And that comes down to that gap analysis in terms of, you know,

probably what you're dealing with is a fee-for-service chassis. You're dealing with an organization that was built around a fee-for-service taxonomy. So it's really about sizing where the gaps are between the model you need to drive your KPIs and the model that's in place based on the way the taxonomy was built. You know, and then once you've got that, you need to think about, you know, the alternative funding mechanisms. And that's not always an easy question. I mean, we've been approaching that iteratively, you know, really that that transition from a from a fee for service chassis to something different. We've been approaching iteratively so that, you know, providers can make that investment stepwise and through this iterative process of demonstrating results and then building on that.

Deanne Cornette 33:07
Well, thank you for sharing your experience and for giving us an inside look into how IHPA has approached this important work today, Gilbert. Today's discussion reinforces that addressing health-related social needs isn't separate from SUD treatment. It's becoming an essential part of designing systems that improve engagement, strengthen recovery, and deliver strong outcomes. The IHPA case study demonstrates that meaningful change doesn't always begin with new technology or entirely new programs. Often it starts with rethinking how organizations identify barriers, build relationships, and create the operational flexibility needed to meet people where they are. We appreciate you joining us today and I encourage you to explore Recademy's growing library of resources, ranging from webinars to executive briefings and the latest news. We hope you'll join future Recademy webinars.