November 17, 2017

The Honorable Seema Verma
Administrator
Center for Medicare & Medicaid Innovation
U.S. Department of Health and Human Services

Re: Response to CMMI’s “New Direction” Request for Information

Dear Ms. Verma,

Enclosed please find a copy of Altarum’s response to the Centers for Medicare & Medicaid Services request for proposing a new direction to promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes.

Sincerely,

Lincoln T. Smith
President & CEO
Altarum commends the Centers for Medicare & Medicaid Services (CMS) for soliciting policy ideas to create an affordable, accessible health care system that puts patients first. With appropriate patient safeguards, the class of interventions proposed—market-driven reforms, empowering beneficiaries as consumers, providing price transparency, and increasing choices and use of competition to drive quality and affordability—can help achieve CMS’s goals.

Below we outline Altarum’s expertise in these areas, comment on the proposed policy topics, and offer our own ideas for policy directions consistent with CMS’s goals. Throughout our response, we emphasize how the evidence base can support success with respect to each proposed direction. To realize the Agency’s overarching goals, market-based reforms, choice, and competition, will have to be well-targeted. Not every market has the conditions necessary to leverage competition. For example, a wider set of approaches may be appropriate for rural areas.¹

Further, while our suggestions don’t focus on specific ways in which they would reduce health disparities in the United States and improve equitable access to high value care, we can’t over-emphasize the importance of making this a fundamental component of all initiatives the Administration undertakes. Altarum’s analyses in Michigan² and Texas,³ have quantified the impact of socioeconomic disparities, detailing the economic opportunity of promoting equity, focusing not only on the cost for the individuals most affected, but also for states’ businesses, governments, and communities. It is our belief that investing in policy approaches that promote equity is not only the right thing to do, but will create a healthier, stronger, and more prosperous nation.

**SUMMARY OF EXPERIENCE AND EXPERTISE**

Altarum is a national nonprofit whose mission is to design and implement bold solutions that elevate the health and health care of all Americans. Altarum is recognized for its deep experience and expertise in a number of domains, including payment and delivery system reform, practice transformation, and population health. Some of our relevant experience includes:

- Designing, field testing, and scaling innovative payment programs for close to two decades, including the first national pay-for-performance program, Bridges To Excellence, and the first national bundled payment program, PROMETHEUS Payment®.
- Working closely with clinicians across the Midwestern United States to directly support participation in CMS quality reporting and incentive programs, Centers for Medicare and

Medicaid Innovation (CMMI) Models, and Office of the National Coordinator for Health Information Technology (ONC) initiatives.

- Developing and implementing innovative delivery models to support populations with high needs. For example:
  - executing comprehensive care plans that connect medical care providers, social services providers, frail elders, and family caregivers to consider their future, quality-of-life goals, and preferred treatments;
  - continuing integration of mental health and addiction service systems, and the concurrent integration of behavioral health with physical health systems;
  - creating expanded provider networks while increasing capacity for faith-, community-, recovery-, and culturally-based organizations to improve the recovery rate of individuals with substance use disorders; and
  - implementing continuing medical education (CME) programs to increase behavioral health screening within primary care, and CME provider education to support patient safety and responsible opioid prescribing.

- Providing technical assistance to states so that they are better able to engage consumers around policies and practices that help address high health care costs and poor quality.

**ACHIEVING INCREASED PARTICIPATION IN ADVANCED ALTERNATIVE PAYMENT MODELS (AAPMS)**

To date, most of Medicare’s emphasis on payment reform has been centered on hospital or hospital-based systems. Yet, physician decisions over the utilization of office visits, prescriptions, lab tests, images, and hospital stays influences 88% of the total spend. Though physicians control or have influence over most of Medicare’s dollars, only 16% of the total Medicare spend (Parts A, B and D) is represented by the current physician fee schedule. And in less than 10 years, the Congressional Budget Office (CBO) projects this figure will dwindle to 12%. This non-alignment is profound, especially since physicians have the ability to best manage unwarranted variations in costs and outcomes of conditions and procedures.

Further, an increasing number of clinicians are employed by hospital systems and large group practices. These clinicians may not be as directly involved in decisions made by their organization to form or join an Advanced APM. However, independent clinicians and clinicians in small groups still make up a substantial portion of the workforce and may require special attention to encourage, accelerate and ease their participation in Advanced APMs.
Finally, the long term success of AAPMs in re-shaping the delivery system to better meet the needs of patients cannot be achieved—especially for high need patients—without the active collaboration of community-based organizations and support services. Encouraging the sharing of financial gains achieved by the better management of patients to organizations outside the walls of medicine requires a special focus.

**Policy Recommendations**

**Build on CMMI’s Experience with the Existing Bundled Payments for Care Improvement (BPCI) Models**

While total cost of care Accountable Care Organization (ACO) APMs play an important role among AAPMs as a whole, Altarum believes CMMI should give greater consideration to an episode of care model that is open to all provider configurations that have the ability and willingness to take risk. Further, CMMI should allow providers to specialize in the areas they feel they are best positioned to compete.

Acute care bundles in the hospital setting are important, but so is managing specialty condition episodes in an outpatient setting. We believe the Innovation Center already has access to some of the tools it needs to innovate policy for payment reform, and one of them is the Episode Grouper for Medicare (EGM).

In 2012, CMS awarded a contract to develop EGM to Brandeis University in association with the American Medical Association-convened Physician Consortium for Performance Improvement (AMA-PCPI), the American Board of Medical Specialties Research, and Altarum. The importance of EGM is that it would allow CMMI to adopt a non-DRG model—which is biased towards hospital systems—for provider episode of care contracting, and open up participation in two ways: 1) by incorporating a wider array of provider organizations, including physicians, and 2) by placing an emphasis on the condition episodes into which most of Medicare’s dollars are flowing and where physician care teams are able to best improve care and lower costs. In early 2017, Brandeis and the American College of Surgeons advanced a model that leverages the EGM and opens up a number of episode of care APMs for a large portion of the health care system. That model has been recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for pilot testing, and we strongly encourage CMMI to aggressively pursue such an implementation.

**Re-purpose the Construction Logic of the Episode Grouper for Medicare to Test New Specialty Payment Models**

While the EGM is generally purposed to report on utilization patterns and cost, comparative analyses for similar conditions, and identification of care improvement opportunities, it is also structured to calculate unique severity-adjusted budgets for each triggered episode for every
patient (multiple episodes for complex patients). This means that in addition to reporting, it could also function for payment.

The EGM organizes Medicare beneficiary total costs into two episode categories: specific conditions and specific treatments. **Condition episodes** represent disease states and permit comparisons of resource use that vary depending on (a) physicians’ actions or inactions, and (b) decisions regarding whether and how to treat the condition, and on resulting complications (which is important for payment redesign). **Treatment episodes** permit comparisons of resource use by specialists performing the procedure, or providing the specified treatment for a predefined period of time. Treatment episodes are contingent on providing that treatment, and can vary depending on such factors as treatment intensity, setting, and complications.

As such, condition and treatment episodes can be viewed as continuous sequelae for every Medicare beneficiary, and the costs of treatment episodes can be packaged into the costs of managing underlying condition episodes. For example, outpatient cardiologists managing Ischemic Heart Disease (IHD) can be rewarded for managing beneficiaries such that frequencies of Coronary Artery Bypass Graft (CABG), Percutaneous Coronary Intervention (PCI), or Coronary Thrombolysis procedure are reduced for IHD.

**Encourage, Accelerate, and Ease Participation in Advanced APMs**

While re-purposing the EGM to pilot new physician-focused episode of care payments will help reduce some of the barriers to physician participation in APMs, CMS must go further to accelerate adoption of those APMs. In particular, it should engage physicians by promoting the benefits of participating in an APM through channels such as Learning and Action Networks, Direct Provider Mailings, Specialty Societies, Quality Improvement Networks-Quality Improvement Organizations (QIN-QIOs) and other CMS contractors. Specifically, Altarum recommends:

- **Education and Marketing:** This could include tools and materials, such as financial risk modeling tools, designed to help practices understand the benefits of joining an ACO or other APM. These materials can be designed for existing APMs to market and encourage remaining independent clinicians to join. A public report card of all APM performance (expanded from the current ACO report card) could help providers make informed decisions about which APM model might be right for them.

- **Enrollment Tool Kits:** Step-by-step instructions on what needs to be done and when (timeline, how to help) to ensure support continues after enrollment.

- **Technical Assistance:** Clinicians who participate in an APM are excluded from receiving
technical assistance (TA) under a number of other TA programs that are mostly Merit-Based Incentive Payment System (MIPS)-related. As a result, clinicians who are part of AAPMs may not receive the individualized support they need to optimize the participation benefit, and may need specific AAPM-related technical assistance. Some forms of existing AAPM technical assistance could also be leveraged to further increase achievement of participation threshold levels required for clinicians to become QPs.

- **Coordination with Vendors**: Ensure vendor certification standards require the appropriate functionality, including accuracy of data capture and reporting capabilities that allow clinicians to monitor and report APM metrics. This helps reduce the burden of reporting from the individual physicians, and would make a strong case for AAPM participation.

Other policies that could encourage clinician participation in an AAPM include:

- **Provide extra points/increased incentives** for joining within a certain time frame (as opposed to continued participation in MIPS);

- **Build more variation into the performance bonus**, which is currently set at 5% for all QPs at AAPMs. For example, increase incentives for better performing AAPMs or revisit the design of the incentive structure after the first six years;

- **Offer rolling enrollment periods** (as opposed to annual); and

- **Reduce reporting burden**. For example, allow AAPMs to report on use of Certified Electronic Health Record Technology (CEHRT) at the Tax Identification Number (TIN)-level, rather than requiring Advancing Care Information (ACI) data to be reported through the MIPS program.

**Support Development of Multi-Payer Models and Other Opportunities for Clinicians to Achieve Financial Benefits from Care Delivery Improvements Across Several Populations**

Coordinating participation in multiple quality improvement or value based payment programs with varying measures and reporting methods can pose a substantial burden on clinicians. In addition, many payers often only represent a small portion of a physician’s total practice. Encouraging the implementation of AAPMs that would have the same construct and measures across payers could significantly increase participation. However, despite the advantages of multi-payer models, we would recommend that CMMI approach these with some caution, as the development time required to gain consensus from multiple payers reduces the potential for more rapid model testing and innovation.
CONSUMER-DIRECTED CARE & MARKET-BASED INNOVATION MODELS

There are many ways in which patient empowerment can lead to better outcomes and higher patient satisfaction. Shared decision-making, done well, is one such initiative. It may also be appropriate to attach patient cost-sharing to services universally deemed to be of low value.

In general, stimulating competition across the delivery system by engaging consumers and physicians to promote higher value is an objective shared by all purchasers. The extent to which competition can improve the general affordability of health care drives the degree to which consumers benefit directly through lower cost-sharing. However, it is important to understand and account for the myriad differences among 350 million Americans, and the need to tailor approaches that are sensitive to vast cultural, social, demographic, and income variations.

Policy Recommendations

Test Models to Facilitate and Encourage Price and Quality Transparency

This includes the compilation, analysis, and release of cost data and quality metrics that inform beneficiaries about their choices. Given low adoption of such tools to date, we encourage pilots featuring strong evaluation components to better understand how to overcome current barriers to consumers’ use of such tools.⁴

Though many states have started to engage in price transparency, the vast majority either have not or are not doing enough (and have thus received an F on Altarum’s and Catalyst For Payment Reform’s annual report card on price and quality transparency). As such, we would recommend that CMS encourage all states to develop robust price transparency efforts by adding such a requirement as a potential condition for granting Medicaid waivers.

Link CMMI Payment Innovations to Benefits Changes that Would Encourage Provider Market Competition on the Basis of Cost and Quality

Recent evidence suggests that aligning consumer and provider incentives on quality and cost measures is increasingly important. Consumers must be encouraged to seek out high value care and providers incentivized to deliver it. Reference pricing models that allow consumers to choose service providers that offer high quality care at a lower price are a promising solution.

Recently, Altarum published a Blueprint for Medical Episode Spending Accounts (MESA). MESA is a value-based insurance design based on a reference pricing model, which allows consumers to choose service providers that offer high quality care at a lower price. Members pay out-of-pocket only when the cost of care exceeds the specified allowance for a given episode of care, and

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⁴ http://content.healthaffairs.org/content/35/4/662.abstract
consumers are given the tools they need to select the best care for them. Medicare Advantage plans should be encouraged to experiment more courageously with innovative benefits such as the MESA model.

CMS should also consider the creation of Medicare Part E, as an alternative to Part C, for beneficiaries that prefer to stay in traditional Medicare. Part E would include Parts A, B, and D, and would enable providers to more formally enroll Medicare beneficiaries, take financial risk for the management of those patients, and create some differential in benefits to better engage beneficiaries in the care plan developed by their provider team.

**Expand Comprehensive Care for Elders**
Altarum recommends the dramatic expansion of comprehensive care models for frail and disabled elders. These expanded elder care models should include community-anchored system measurement and management of local service supply and quality. See our section on state-based and local innovation, including Medicaid-focused models, as well as a separate, expanded submission by Altarum’s Center for Elder Care and Advanced Illness for an example of a successful model at implemented at the state level.

**PHYSICIAN SPECIALTY MODELS**
The poor outcomes and high spending experienced by patients with complex or chronic medical conditions is often exacerbated by having unmet social needs. For example, a Commonwealth Survey found that among high-need adults (those with 2 or more major chronic conditions), 62 percent had a material hardship (difficulty paying for housing, utilities, or food), compared to 32 percent of non-high-need adults.5

**Policy Recommendations**

**Create Integrated Care Teams**
Strong evidence suggests that integrated care teams that include social workers, community health workers, and/or other providers designed to address unmet social needs in conjunction with the medical care team can produce better quality and savings, if a highly targeted, customized approach for these high need patients is implemented.6

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When testing care teams headed by a specialist, we encourage side-by-side evaluation of other team heads (primary care provider, nurse coordinator, community health worker), as the savings seem to be largely derived from upstream interventions.

Further, recognizing that oral health is an integral part of overall health and wellness, we urge CMS to develop models that integrate oral health services into all aspects of health care. This will necessitate that primary care and other medical providers take responsibility for the oral health of their patients by providing education, and appropriate services and referrals, and that payment and technology support integration efforts, quality and integration.

**Develop Screening Tools to Customize Care Plans for High Need Patients**

There is robust evidence that these interventions should be highly targeted and customized to the patient population, suggesting that tested screening tools will be integral to realizing the best possible outcomes. At present, there is disparate use of these tools (although CMS has made an initial effort to create a standard). Rigorous evaluations of the patient screening tools currently in use, and wide dissemination of results, would be of great help to designing and implementing these types of models.

**Modernize Adjudication Systems to Include Administration of All APMs**

We believe the biggest obstacle to scaling up provider adoption to APMs are the archaic adjudication systems CMS subcontracts to pay Part A and B billings, because they are all geared toward fee-for-service (FFS), and therefore lack the capacity to scale sophisticated APMs. This flaw is the primary reason Medicare cannot expand the ongoing Acute Care Episode (ACE) demonstration and the Bundled Payment for Care Improvements (BPCI) Initiative. This problem is not limited to Medicare. Private sector health plans and third party administrators have the same structural issue.

We suggest that the CMMI consider drafting an RFI for private sector information technology companies to propose potential solutions. At this time, there are a handful of companies pushing in this direction. An RFI would indicate that the federal government is aware of the problem and desires new private sector solutions.

**STATE-BASED AND LOCAL INNOVATION, INCLUDING MEDICAID-FOCUSED MODELS**

There are myriad reasons why much of the activity to successfully address poor health care value
should occur at the state level.\textsuperscript{7} For one, the fragmentation of our health system typically limits the ability of any one payer or stakeholder to incentivize the provider practice changes that will lead to lower costs.\textsuperscript{8} States are well-suited to support the multi-payer coordination that is critical to promote meaningful progress on health care value.

Moreover, state governments are uniquely positioned to invest in upstream approaches that lead to healthier communities.\textsuperscript{9} To improve population health, there is a growing recognition that we must invest in the modifiable social determinants of health, including education, job development, housing, and the environment.\textsuperscript{10} Achieving value in health care requires a coordinated effort between clinical and non-clinical settings. Again, states are well-positioned to coordinate the stakeholders within these different systems. And, importantly, states are under financial pressure to prioritize and promote health system efficiency to manage their budgets, attract employers, and address the health care affordability concerns of their residents.\textsuperscript{11} Although states offer perhaps the best platform for implementing systemic change, and while all states have well-defined roles for certain segments of their health system—such as Medicaid, state employee coverage, health care delivered within the criminal justice system, and public health and safety-net coverage—relatively few states take a comprehensive, systematic approach to ensure that all consumers receive value in turn for the money they spend on health care.

Policy Recommendations

Expand New York State DSRIP-Like Programs

In New York State the DSRIP program includes a powerful incentive for Medicaid Managed Care Organizations (MCOs) to adopt and implement value-based payment (VBP) programs similar to CMS’ AAPMs. To enforce the contracting of VBP programs between MCOs and their network, the state of New York utilizes a rate setting mechanism. New York’s MCOs have specific target volumes for payments to providers that must be converted to VBP in order to avoid cuts in rates set by the state for their plan. With this policy in place, the state of New York is more likely than others to achieve the goal of converting the vast majority of Medicaid payments to providers from FFS to VBP.

\textsuperscript{7} Ibid.
\textsuperscript{8} Kristof Stremikis, \textit{All Aboard: Engaging Self-Insured Employers in Multi-Payer Reform}, Milbank Memorial Fund, 2015
\textsuperscript{9} Ibid.
\textsuperscript{10} Ibid.
Re-organize Services to Build a Reliable and Comprehensive Set of Delivery and Financing Arrangements to Support Frail and Disabled Elderly People\(^\text{12}\)

Today, millions of Medicare beneficiaries who need comprehensive, coordinated services are often unable to obtain them, and the number of elders in need will triple by 2050. One result will be overwhelming pressure on state Medicaid budgets for long-term care services.

To address this dynamics, Altarum’s MediCaring Community model lays out a blueprint for how to effect changes in governance, resource allocation, and clinical care at the local level. Staying within currently available public and private funding parameters, a MediCaring Community will monitor local system performance, identify opportunities for improved reliability and supply of services, set priorities, and invest to improve the quality and efficiency of eldercare in the community.

Altarum is working with four communities to develop actionable implementation plans for MediCaring Communities, incorporating individual community organizing strategies, accounting for available resources and their distribution, and building from each communities’ priorities.\(^\text{13}\)

Within 18 months, we project that each community would be returning savings beyond their initial investment, and in the third year, each would be returning savings of 2-4 times initial investment. This would be enough savings to fund the data collection for monitoring system performance and to invest in making social and supportive services adequate (which would yield more savings).

We recommend CMMI adopt the Medicaring Community model, and pilot it in communities where there is a commitment and drive to serve as leaders in reshaping how frail and disabled elders receive care. Reporting on the carefully evaluated progress and successful strategies implemented by these demonstration communities will enable the adoption of proven practices on a much wider scale over the next several decades.

Expand PACE (the Program of All-Inclusive Care for the Elderly) Beyond Medicaid-eligible Patients

MediCaring Communities can be created in any geographic area with a dominant medical care system that can capture shared savings, including Medicare Advantage, PACE, and ACOs. PACE is the most straightforward example, because it has a geographic basis, takes full risk for all services except housing, has a community advisory board, develops elder-driven care plans with

\(^{12}\) Altarum’s Center for Elder Care and Advanced Illness has submitted a separate response to this RFI with a more detailed version of this policy recommendation.

participants and their families, and stays with enrollees through to the end of life. However, PACE is burdened by unnecessarily difficult regulations, and has been unable to serve more than a handful of patients who are ineligible for Medicaid.\textsuperscript{14} Altarum’s extensive research on the statutes and regulations has led to our firm belief that it is within CMS’ authority to re-interpret Part D.\textsuperscript{15}

A responsive CMMI-initiated expansion of PACE, under the authority of the PACE Innovation Act, would provide an opportunity for the nation to develop an understanding of the requisite performance characteristics of highly reliable and highly efficient comprehensive care for frail and disabled elders. This will significantly enhance CMMI’s ability to support the rapidly rising number of elders and their families, provided it can relax restrictions and regulations that currently impede its implementation. Altarum’s work in this field has confirmed that multiple states, communities, and PACE programs are committed to pursuing this model.

\textbf{State Grants to Create Data and Organizational Infrastructure}

Without robust health data exchange, the ability for specialists and primary care physicians to form ad hoc teams to take on financial risk in an AAPP and drive better value is modest, at best. Currently, most states are underpowered to play the critical role required to bring about these data exchanges. CMS can provide critical startup support by helping create the data and organizational infrastructure to support states’ multi-stakeholder efforts. Specifically, the absence of timely and reliable public data limits the ability to identify health care cost drivers, poor-quality hot spots, and whether or not interventions designed to improve health care value are working. Support provided by CMS in the form of state grants should be accompanied by technical assistance, so that states can benefit from efforts already underway and should be accompanied by robust objectives regarding the role that the data will play, public transparency, and how it will lead to specific, evidenced-based actions to create an affordable, accessible health care system that puts patients first.

\textbf{MENTAL AND BEHAVIORAL HEALTH MODELS}

An analysis of 2015 New York State Medicaid data shows that 20% of all costs are directly attributed to beneficiaries with a combination of mental health, behavioral health, substance use

\textsuperscript{14} This is due, in large part because of the way that CMS has interpreted the Part D statute in conjunction with the PACE statute.

disorders, and related co-morbid conditions. Of those, 50% are caused by inpatient stays and another 20% by emergency department (ED) visits. For patients who have a combination of conditions, the hospitalization and ED visit rates, respectively, are 300% and 500% greater than for beneficiaries without any of those conditions, illustrating the importance of improving the overall care for these populations. Further, the growing opioid epidemic continues to not only have high societal costs, but a significant economic impact. According to an analysis by the National Center for Injury Prevention and Control, spending for health care and substance abuse treatment for those abusing opioids was over $28 billion and costs for those with untreated opioid use disorders (OUD) incur approximately $18,000 more in health care costs annually than those without OUD.

Policy Recommendations

**Implement Programs to Address the Opioid crisis Across a Continuum of Care, from Prevention to Treatment and Recovery—and Operate in an Integrated System of Care**

The opioid overdose epidemic in the US is driven largely by unsafe opioid prescribing, misalignment of incentives that support prescribing behavior change, and lack of integrated technological systems that enable the identification of high prescribers. Approximately 23 states require medical prescribers to receive pain management training centered on controlled substance prescribing, and substance use disorders. Altarum has developed and implemented a comprehensive program to tackle the national opioid crisis at the source—by equipping clinicians with the knowledge and tools necessary to foster responsible opioid prescribing, improving patient education around opioid use, and delivering technical assistance to promote use of prescription drug monitoring programs (PDMPs). Further we suggest programs, that go beyond providing direct training and also provide technical assistance (TA) around prescribing promote primary and behavioral health care integration, with special attention to opioid misuse and abuse prevention services (e.g., opioid alternatives, patient screenings and referrals). These programs provide an important solution, addressing the gap in prescriber training to improve safe opioid prescribing. Specifically, we aim increase prescriber knowledge and comfort with addressing opioid over-prescription with patients and staff; increase identification of patients at risk of opioid misuse; increase documentation of a follow-up plan and signed opioid treatment agreement for patients

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18. http://www.namsdl.org/library/74A86588-B297-9B03-E9AE621A8FA0F05B0/
prescribed opioids for more than six weeks; and increase use of state Prescription Drug Monitoring Programs (PDMPs) to monitor patients’ controlled substance prescription records, including prescriptions dispensed and prescribed by others. The use of prescription drug monitoring programs remains one of the best ways for clinicians to identify people who are potentially at high risk of opioid use disorder.

**Include Recovery Support Services in a Bundled Package**
Bundled payment packages present an opportunity to lower the cost of treatment, engage patients in their care (including linkage to recovery supports) resulting in a comprehensive clinical approach that will lead to improved health outcomes. It also has the potential to create a new culture regarding substance use disorder and transform the system of care delivery.

Traditionally medical clinicians and substance use disorder treatment providers have been reimbursed for specific services rendered during multiple face-to-face patient visits rather than using an outcomes-based approach.\(^1^9\) Other factors lead to disjointed and fragmented financial structures that hinder patient-centered care and increase the administrative burden and thus the cost of substance use disorder-specific care. There is a value opportunity as it relates to medical cost in a bundled payment structure. It is widely accepted that untreated or ineffectively treated behavioral health conditions, like substance use disorder, lead to increased medical treatment and associated costs, not increased behavioral health care costs. With a bundled payment structure, a patient’s substance use disorder needs can be more thoughtfully discussed and coordinated, to include recovery support providers and access to other, lower cost, community-level interventions.

**Link Individuals in Recovery to Systems of Care**
Our nation’s opioid epidemic is particularly devastating for those experiencing homelessness and disconnection from social supports. Reverse behavioral health integration shows promise as a way to expand treatment access, improve the patient experience, resulting in improved outcomes, and lower cost to the health care system.\(^2^0\) Reverse behavioral health integration occurs when primary care services, including behavioral health, co-locate or are made available at alternative sites outside of a health center. Washington State’s Recovery Café model is an opportunity for reverse integration and treatment expansion. The Recovery Café is an alternative, therapeutic, supportive community, providing a range of recovery and social supports to individuals

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traumatized by homelessness, addiction, and mental health challenges. It is based on an evidenced-based ecological model, Recovery Oriented Systems of Care (ROSC). A ROSC is patient-centered, in that it meets individuals where they are on the recovery continuum, engaging them for a lifetime (as with other chronic conditions), and addresses other social determinants of health. Through Altarum’s history with the Recovery Café providing capacity building assistance, including an evaluation design of the model, participation has resulted in sustained recovery, housing access, and linkages to social and health services, education, and employment opportunities. Patients also avoided overdose and decreased illicit substance use.

The model presents an innovative opportunity to connect individuals to primary care. Several times a week a care team consisting of a physician, nurse, behavioral health provider, and care coordinators can visit the café to provide integrated services. Behavioral health providers offer group and individual therapy. Care Coordinators address social determinants including shelter, employment, and food security. In terms of funding, this model would be Medicaid reimbursable while expanding primary care and behavioral health access.

**Employ Virtual “Healthy Recovery Lifestyle Coaching”**

There is mounting evidence that the increased uses of mobile health (mhealth) approaches have promise as an intervention to reduce substance use.\(^1\) Behaviors and activities consistent with healthy lifestyles have been shown to sustain longer-term recovery outcomes. Healthy lifestyle coaching, with a recovery context, is an intervention that can encourage specific behaviors, help an individual work toward defined personal recovery goals, ultimately maintaining recovery and an overall healthy lifestyle. Structural and other barriers in the life of an individual in recovery may prevent participation in in-person healthy lifestyle interventions. Thus, virtual health recovery lifestyle coaching is an intervention that can provide much-needed lifestyle coaching while responding to in-person participation barriers.

Similar to a model implemented by Aetna’s Active Health Management program, in a virtual healthy recovery lifestyle coaching intervention, the individual choses the healthy changes on which they would like to work. It offers a combination of virtual coaching by a trained coaching professional, with substance use recovery experience, complemented by tools that can further support healthy lifestyle choices. Individual or group coaching is available. Individual coaching provides personalized attention, focused specifically on the individual’s recovery or healthy lifestyle specific needs, strengths, and barriers. Group coaching facilitates peer support and

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\(^1\)Kazemi et al. (2017). A Systematic Review of the mHealth Interventions to Prevent Alcohol and Substance Abuse. *Journal of Health Communications*: 413-432

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inspiration in that the individual is surrounded with people who are committed to similar goals. Group coaching sessions happen via group text messages, closed social media pages, or through shared email exchange. Ideally, the virtual program is connected to an online portal where there is easy access to online peer support and other self-guided resources, 24 hours a day, 7 days a week.